



Orange County Health Needs Assessment Project

COMMUNITY HEALTH: WORKING THE PUZZLE

**ORANGE COUNTYWIDE HEALTH NEEDS ASSESSMENT
EXECUTIVE SUMMARY**

SPRING REPORT, 1999

MISSION STATEMENT

“Develop a process in which a vast range of community stakeholders engage in planning and conducting a comprehensive health assessment of Orange County, that embraces a broad definition of health, and; which serves as the basis for future public and private sector policy development, implementation and resource allocation decisions.”

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

Introduction and Background

The Orange County Health Needs Assessment (OCHNA) project has been generously funded in part by The California Endowment, and is a collaborative effort by 27 Orange County Healthcare Association of Southern California member hospitals, the County of Orange Health Care Agency, CalOPTIMA, and the March of Dimes. The Coalition of Orange County Community Clinics, the Healthcare Council of Orange County, the Orange County Medical Association, the Mental Health Association of Orange County, and the United Way of Orange County were also integral members of this project. The project also received additional support and funding from MultiPlan and BlueCross of California/California Care.

Addressing Important Countywide Needs

There has been a void in Orange County for some time with respect to a coordinated effort involving health care providers, local government, and the community to determine and prioritize health needs. The last concerted effort dates to the late 1970s and early 1980s through the Federal Health-Planning Program (P.L. 93-641). The now defunct Orange County Health Planning Council (the federally designated Health Systems Agency for Orange County) attempted to engage health care providers and health care consumers in shaping the development of Orange County's health care delivery system to more closely match community health needs. For a variety of reasons, related to both the process structure and government imposed mandates, the health planning effort was not successful and federal funding ceased in 1985.

The advent of the “competitive model” of health care delivery brought with it an atmosphere less conducive to collaboration. Passage of Senate Bill 697 in 1994 aided in refocusing attention on identifying and addressing community health needs and allowed for a collaborative approach to identifying health needs. The health needs assessments previously produced by nonprofit hospitals were inconsistent, focused only on specific communities, and utilized a variety of data sources and methodologies that did not allow comparison of results. It is our belief that this current effort has engendered the collaboration necessary to produce an assessment that has been countywide in scope, containing data that is consistent and usable at the local community level.

The collaborative OCHNA project is envisioned to serve as a foundation for greater community cooperation to meet health needs. Through use of a common assessment, nonprofit hospitals will be better able to coordinate and target outreach efforts of their community benefit programs and avoid duplication of services with others. Investor-owned hospitals share a similar interest in assuring their community outreach efforts are aligned with identified needs in the communities they serve. The identified needs and their prioritization will provide direction to the County of Orange as it determines deployment of public health resources, in turn resulting in a more coordinated allocation of both public and private health resources in Orange County.

In addition, it is hoped that the countywide health needs assessment will also stimulate greater collaboration between and among health care providers, government agencies, and community organizations. This report signals not the end of a year-long project but rather marks the first step in a continuous and concerted effort to address the health needs of the Orange County community.

Survey Methodology

This report is based on the analysis of the OCHNA survey data collected over the period of May 16, 1998 to October 16, 1998. The data were collected via the Computer-Assisted Telephone Interviewing (CATI) technique and utilized the random digit dialing method for respondent selection. Two independent surveys were conducted. One survey collected data from 2,487 adult residents (aged ≥ 18 years) on health and health care variables and the other survey collected data from 2,556 adult residents on lifestyle and behavioral factors. Because the 2 surveys contained many questions in common, common questions were grouped into a combined data file that contains data on 5,043 respondents. Results presented in this report are based on the analysis of data in the combined data file. The surveys were administered in English, Spanish, Vietnamese, and Korean languages and effort was taken to ensure they were both culturally and linguistically appropriate. In addition, oversamplings of the Vietnamese and senior populations were conducted.

Population Weighting¹

Prior to analysis, current demographic information on Orange County residents was obtained and used to develop case weights so that unbiased population estimates could be computed from the sample data. Information on 3 demographic variables (gender, age, and race) was used to develop the case weights (combination of these 3 variables yielded 30 population strata).

Missing Data

Demographic data were missing for 2 (age and race) of the 3 variables used for forming population strata. A weight of zero was assigned to the cases with missing data on these 2 variables leading to a 3% reduction in the sample size from 5,043 to 4,893.

Defining Terms

Clear and consistent use of terminology is necessary in order to understand the access, utilization, and barriers data, as they relate to health care services in Orange County. To that end, we will use the following terms and phrases: *No health care coverage* indicates individuals and families who have absolutely no form of health care insurance, including but not limited to private insurance programs (e.g., employer-based coverage, coverage provided under a parent or spouse's employer, COBRA employment health coverage, or individually purchased health plan) and/or government-subsidized health insurance programs (e.g., MediCal/CalOPTIMA, Medicare, Medical Services for Indigents). 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).

¹ Author acknowledges the assistance provided by Greg Robinson, Ph.D., in developing the case weights. The source of demographic data shown in Table 1 is the Center for Demographic Research, California State University, Fullerton; January 1, 1995 estimates.

ACCESS TO HEALTH CARE IN ORANGE COUNTY

First, the Good News:

According to the Orange County Health Needs Assessment survey, 83% of Orange County residents have health care coverage, with 21.6% indicating they had more than one source of coverage. Orange County has a higher rate (59.6%) of employer based coverage than the State (58.2%, according to Schauffler and Brown, *The State of Health Insurance in California*, 1998), with an additional 16.3% of residents having coverage through a family member's employment. Three out of four (75%) Orange County adults with health coverage have some form of employer-based health coverage. Of those residents with health coverage, 49.5% indicated having HMO coverage. Among low-income respondents, 17% indicated they go to a community clinic for health care services. Finally, it is estimated that 88% of seniors, (aged 65 and older) have health care coverage.

The Not-So-Good News:

- ✓ **Nearly 17%** (335,000) of Orange County adults (aged 18 and older) are *without any* type of health care coverage.
- ✓ **Just over 12%** of adults have health care coverage through Medicare (7.8%) and Medi-Cal (4.6%) and could be considered underinsured.
- ✓ **Almost 52%** of those without any health care coverage are from Latino/Hispanic and Vietnamese populations, representing 150,000, or one in four adults within these subpopulations.
- ✓ **Just over 9%** of survey respondents reported needing to see a doctor in the last year, but could not do so because of cost. Low income respondents were significantly more likely to be in this position than those with middle to high incomes.

The following statements apply to survey respondents who indicated annual household incomes under \$20,000 per year. These respondents represent 296,027 Orange County residents (17%). Such respondents were characterized as follows:

- ✓ Significantly more likely than those with higher annual incomes to rate their overall health status as fair or poor
- ✓ Less likely to have any form of health coverage (only 69.8% indicated having health coverage compared to 90.3% for those in high income categories)
- ✓ More than twice as likely to not have health coverage through an employer
- ✓ Less likely to purchase their own health plan
- ✓ Unable to afford premiums for health care coverage (30%)
- ✓ Nearly 5 times more likely to have Medi-Cal coverage
- ✓ Without any dental coverage (34.2%)

- ✓ Without any vision health coverage (approximately 66%) and more likely to be the low-income category
- ✓ Less likely (23%) to have seen a health care provider within the last year

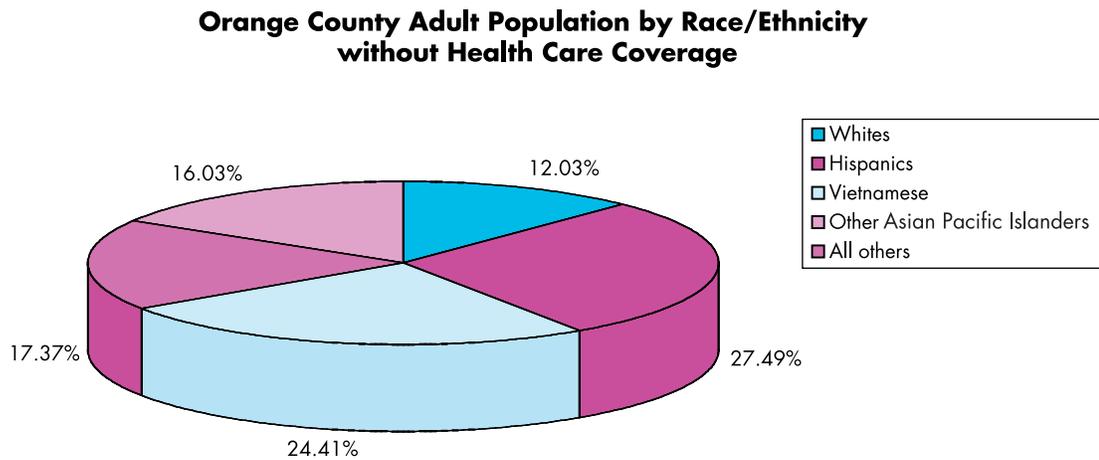
Ethnic and Racial Difference in Health care Coverage

The black population represents approximately 1.8% of the total Orange County population, which equates to 36,559 adults and 12,678 children. It is important to note that the survey sample for the black population in Orange County was too small for statistical reliability; therefore, the estimates presented *must* be considered with caution. It is estimated that 2,615 (10.6%) black adults and 357 (3.4%) black children are without any health care coverage.

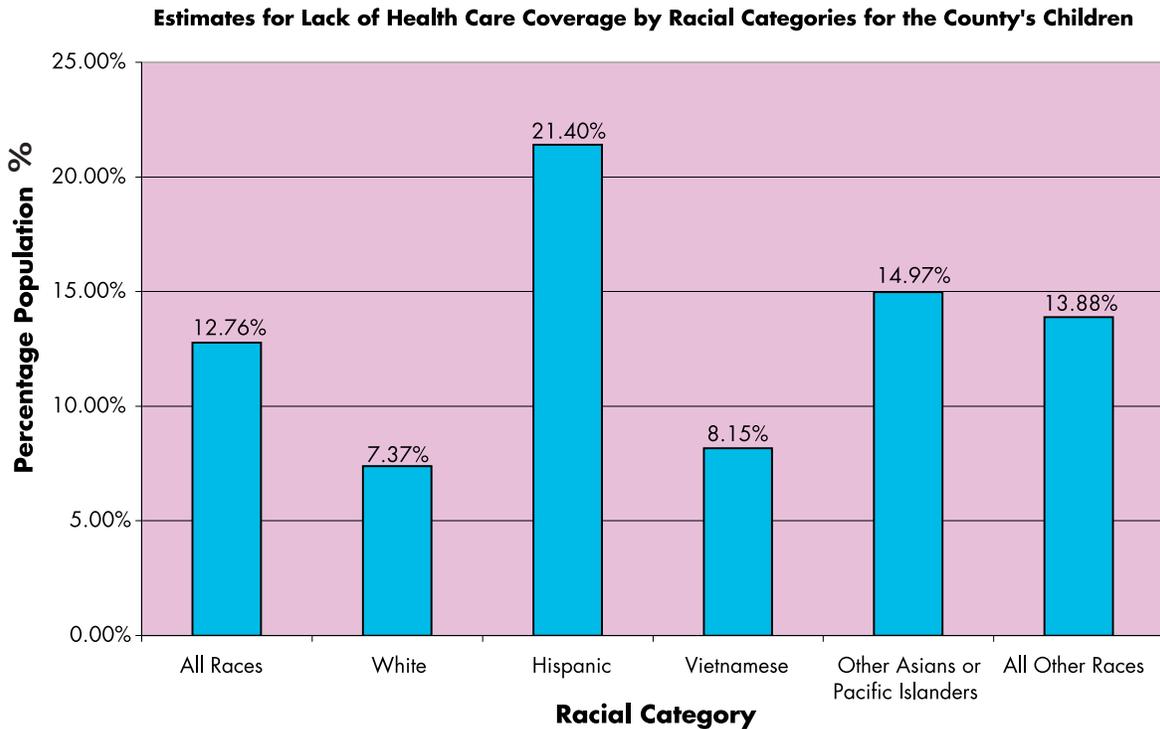
The following data highlight the health care coverage disparity among ethnic groups for children in Orange County:

- ✓ Almost 13% (89,840) of children in Orange County are without *any* health coverage.
- ✓ 57% of children without *any* health care coverage are Latino/Hispanic; more than 1 in 5 or more than 50,000 (22%), Latino/Hispanic children are without *any* coverage.
- ✓ Just over 8% of Vietnamese children have no source of health care coverage.
- ✓ More than 7% of white children are without any health care coverage.

The pie chart below illustrates the large disparity in health care coverage among different ethnic groups in Orange County. Latino/Hispanic and Vietnamese adults are much more likely than their white counterparts to be *without* any source of health care coverage.



As is seen in the adult population, non-white children are more likely than their white counterparts to be without health care coverage, and Latino/Hispanic children are the most likely to be without health care coverage (see bar graph below).



[A Picture of Poverty in Orange County](#)

Poverty in Orange County is obscured by the relative affluence of many residents. The median family income is \$61,812 and 49.7% of resident households earn \$50,000 or more per year. Consequently, few residents are affected by or, more important, even aware of the toll living in Orange County exacts on those with lower incomes. The living experience is distinctively different for the 296,027 residents (16.8%) whose annual household income is less than \$20,000 a year. It is expensive to live in Orange County, one of the most high-priced counties in the United States. What is considered a livable wage elsewhere is low income here, and cannot be relied on to provide adequately for a family of 4.

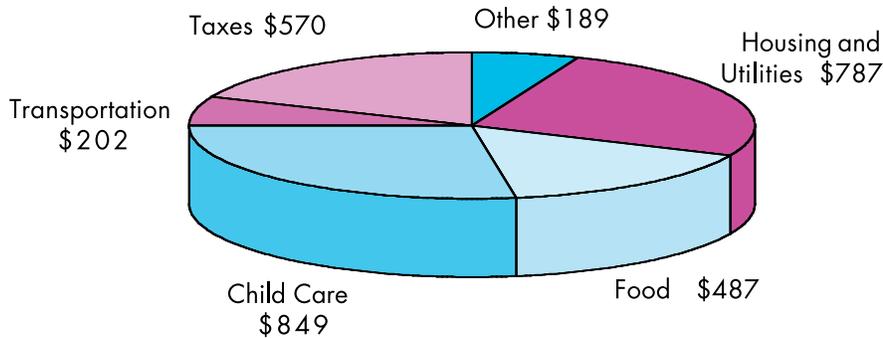
When families struggle to meet basic needs and feed their children, purchasing health care coverage is often not affordable. The OCHNA survey results indicated residents with annual household incomes below \$20,000 are 20% less likely to have any form of health care coverage than residents with annual household incomes over \$50,000. Considering the federal poverty level is set at \$16,450 per year for a family of 4, some Orange County residents cannot afford to buy their own health care coverage yet are ineligible for public assistance programs such as Medi-Cal,

MSI, and Healthy Families. In reality, living at or below the poverty level starts at a much higher point in Orange County than federal poverty guidelines indicate.

What does it cost to live in Orange County? *Reaching 100% of California's Children with Affordable Health Insurance: A Strategic Audit of Activities and Opportunities, September 1998* by the Children's Partnership breaks down a family's monthly budget based on an income that is 225% of the poverty level (see pie chart below).

A California Family's Monthly Budget at 225% of the Federal Poverty Level

(Two parents, a 3 year old child and a 7 year old child with an annual income of \$37,013 or \$3084 per month.)



The model breaks out the basic expenses a family of 4 with an annual income of \$37,013 might incur in California. These figures, however, must be compared with the cost of such products and services in Orange County.

For example, \$787 is allocated for housing and utilities. This figure is low because although monthly rents for 2-bedroom apartments can be found in the \$600 to \$800 range, the average monthly rental in Orange County is \$920 to \$940. According to McCormack's *Orange County 1998 Guide*, rental prices rose about 6.5% over a 12-month period during 1996-1997. Higher rental costs in Orange County are also reflected in data provided by the Center for Demographic Research at California State University, Fullerton, which shows 36.8% of renters in Orange County pay more than 35% of their income in rental costs. A basic guideline is monthly rental payments should not exceed one third of the renter's monthly income. As noted in the table below, for those making minimum wage in Orange County, 70% of their wages would be required for rental costs.

	Orange County	California
Lowest fair market rent for 2-bedroom apartment	\$600	\$479
Lowest rent as a percentage of minimum wage*	70%	56%

*Based on hourly minimum wage in 1997, \$5.15

The costs above are for rent only. A family of 4 could reasonably expect to pay a minimum of \$85 per month in basic utilities (telephone, gas, water, and electricity). Other expenses in the pie chart do not equate to the conservative estimates of those same expenses in Orange County.

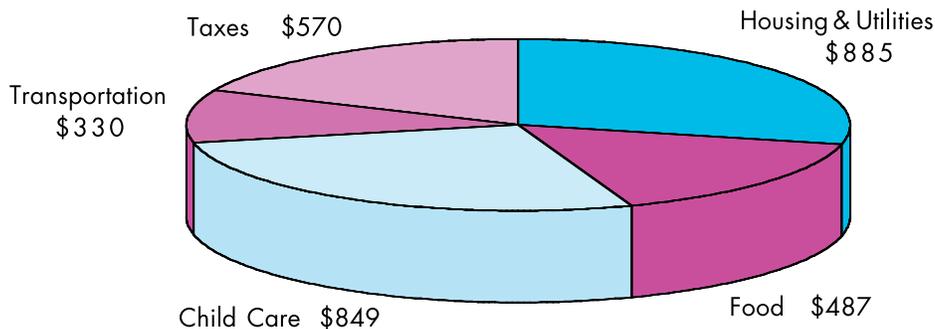
Transportation for a family of 4 is likely to cost for more in Orange County than the estimated \$202. The cost of mandated automobile insurance and gasoline alone could be expected to exceed this estimate. Even assuming an older car without monthly payments, repair and maintenance costs for such a vehicle can quickly become a drain on the family budget. The California estimated budget, as illustrated, does not account for car repairs and other adverse life experiences. One may ask, "What about public transportation?" Assuming, once again, that both parents can find jobs and a home within walking distance of bus stops, monthly bus passes can currently be purchased for \$75 (\$37.50 per adult). However, transporting children to and from day care would still pose an obstacle. A more realistic estimate of transportation expenses would include a modest car payment (\$150), insurance (\$90), gasoline (\$60), and maintenance (\$30) totaling \$330 per month.

The \$849 allocated for child care was not adjusted in any manner nor was the cost of food. Although the \$487 budget for food would likely provide acceptable nutrition for the family, it would not cover other necessities such as toiletries (toothpaste, shaving cream, razors, shampoo, etc.) or household necessities (laundry and dish soap, trash bags, etc.).

An estimate of costs, based on Orange County prices, brings the monthly cost of living to \$3,121, or \$37,450 annually. These costs would *overextend* the family's budget and would make the family ineligible for any public assistance programs, including Healthy Families. This budget does not allow for other basic needs such as clothing, school supplies, and personal items, much less health insurance for the children in the family. It should be noted also there are no funds allocated for entertainment, after-school programs such as Boy Scouts or Girl Scouts, field trips, or even a child's class picture. The quality of life for a family living at this income level is certainly different from that of a similar family in the same income bracket in another part of the country or a higher income bracket here in Orange County. When looking at the high cost of living in Orange County, it is difficult to imagine making ends meet with an annual income of \$16,450, the federal poverty guidelines for family of 4 — less than half the income on which the budget for an Orange County family (see pie chart below) was calculated.

An Orange County Family's Monthly Budget at 225% of the Federal Poverty Level

(Two parents, a 3 year old child and a 7 year old child with an annual income of \$37,013 or \$3,084 per month.)



Orange County has a great deal of wealth and an extremely low unemployment rate — 2.6 percent. In fact, only two cities— Santa Ana and Westminster— have unemployment rates above 4%. Who represents this 2.6% of the population? According to the OCHNA survey, respondents earning less than \$20,000 per year are more likely to be out of work or unable to work than their counterparts earning more than \$50,000. People in the low income category are also more likely to be homemakers, students, or retired. The survey results indicate there is a huge disparity in access to health care services among the differing income levels, and those differences affect the most vulnerable residents— the very young and the most elderly and frail seniors.

Measuring Access to Health Care

The health care environment in Orange County currently includes 21 community clinics and 35 general acute care hospitals, 17 of which are not-for-profit hospitals; there is no county hospital. In addition, the number of primary care and specialty care physicians is 20% and 16% higher, respectively, than the national average (A Case Study: Health System Change in Orange County, Calif., Sept. 1997). The Orange County Medical Association (October 1998) estimates there are 5,870 practicing physicians in Orange County, of which 64% (3,765) are specialists (i.e., surgeons, dermatologists, radiologists, ophthalmologists, etc.) and 36% (2,105) are primary care physicians. While there appears to be an adequate supply of physicians and hospitals, there is not necessarily equal access to health care services.

Medi-Cal/CalOPTIMA

In order to assess the continuum of care on which access is measured, there must be some understanding of the services government subsidized (public sector) health coverage provides and to whom those services are provided. Programs such as Medi-Cal or the Orange County Medical Services for Indigents (MSI) have regulations and eligibility requirements that dictate who can be covered and what services may be available to each client. For this reason alone an individual or family covered under MSI may be considered to be “underinsured.” Reimbursement to providers and hospitals for many of the services covered under MSI are generally considered to be below the actual cost of providing those services.

Under CalOPTIMA, Orange County’s managed care program for Medi-Cal beneficiaries, residents who qualify for full medical coverage have access to preventive, ongoing acute, and chronic medical services. This coverage includes inpatient and outpatient medical services and institutional long-term care coverage. In spite of the global medical coverage provided under CalOPTIMA, it is not clear that all eligible residents are using the available services or even applying for coverage. Medi-Cal/CalOPTIMA recipients represented only about 5% of survey respondents.

During 1997, CalOPTIMA’s average enrollment was 225,000, or approximately 8% of the total population of Orange County. However, the percentage of Orange County residents living below the federal poverty level was estimated to be higher, at nearly 13% (Medi-Cal Policy Institute: County-by-County Data, 1998). Income data from the OCHNA survey indicated 16% of respondents earned less than \$20,000 per year, with 4% of those reporting incomes of less than \$10,000 per year. These findings would suggest more residents may, in fact, qualify for Medi-Cal coverage than are currently enrolled.

Orange County Medical Services for Indigents

An ongoing mandated program (Welfare and Institutions code 17000 et seq.) covering all Orange County, Medical Services for Indigents plans, develops, implements, and monitors medical services for indigents. While this program does not include routine physical examinations, routine dental care, and routine eye examinations, MSI is designed to provide a coordinated, cost-effective system for the delivery of mandated health services necessary to protect life, prevent significant

disability, or prevent serious deterioration of health for county-responsible patients. The program is generally designed to serve the working poor, who have a demonstrated medical need, are between 21 and 64 years of age, making less than 200% of the federal poverty level, and have no other source of medical care coverage.

The County negotiates an annual contract with hospitals and providers, and pays out approximately \$43 million in state and county funds for delivery of contracted health services. MSI serves approximately 20,000 persons per year, and currently serves 1,600 patients with chronic illnesses requiring continuous management – diabetes, hypertension, and asthma. Qualifying for this program may be difficult for some Orange County residents because of eligibility criteria and administrative processes, and others may not even be aware the program exists.

Government subsidized health care coverage, as described above, and other programs such as Healthy Families (a partially subsidized program that provides health, vision, and dental coverage to children aged 1 to 18), have financial eligibility requirements based on official federal poverty guidelines (FPG). According to the 1998 FPG, a family of 4 is living at 100% of the poverty level when earning a gross annual household income of \$16,450 (\$1,371 monthly gross income). Eligibility requirements for many government subsidized programs, such as MediCal and the new Healthy Families, are for those whose household incomes are at or below 200% of the FPG. A family of 4 would meet this requirement with a gross annual income of less than \$33,000.

Utilization of Health Care Services

- ✓ The OCHNA survey indicates that 18% (372,000) of adult residents visited an emergency room in the last year. Of those, 42% were younger than 35 years and 68% were white.
- ✓ Nearly 400,000 (1 in 5) adults did not visit *any type of* health care provider in the year prior to the survey. Another 20% of adults had visited a health care provider only once in the year prior to the survey, while 278,000 (1 in 7) had visited a health care provider 7 or more times in the year prior to the survey.
- ✓ Men (24%) were more likely than women (15%) to *not* have visited a health care provider. Older adults were more likely than their younger counterparts to have visited a provider. In addition, Latino/Hispanic adults were less likely than white adults to have visited a health care provider in the last year.

The degree to which health care services are utilized depends on a number of environmental, social, and economic factors within a community. These factors include the availability and acceptability of the medical care services offered, the health care system's organizational structure, and whether access to health care is considered the individual's or the community's responsibility. In addition, the characteristics of the population itself influence how and when access and utilization of health care services will be sought. Age, gender, and ethnicity, as well as their financial, educational, and occupational status influence people's ability to cope with challenges and command resources to address their needs. In turn the perceived need for health care services and the subsequent use of those services are greatly influenced by individuals and/or communities themselves. The beliefs, attitudes, and personal and cultural values as well as the knowledge of health and health services are important factors in determining the likelihood that any given service, program, or provider will be utilized by a consumer (Andersen, Ronald M. and Davidson, Pamela L., Measuring Access and Trends, Causes and Characteristics of Health Care Utilization).

Barriers

Results of the OCHNA survey and focus groups reveal both perceived and actual barriers to obtaining health care. This research confirmed that a large number of adults and children within certain ethnic and economic groups are in greatest need of health care services. Unfortunately, they also experience more barriers to obtaining those services. As with the definition of access, the concept of what constitutes barriers to obtaining health care services can be defined differently by each population.

The Community Perspective

OCHNA contracted for 16 community focus groups to be conducted to gain insight and information directly from consumers, health care professionals, and specific communities. In the focus groups, both providers and health care clients described the barriers they have encountered and what they perceived as obstacles. Some reasons for not seeking or receiving care are given below.

Barriers for Seniors

- ✓ Cost of long-term and home care, cost of medication, lack of financial coverage for home care provider or assisted living
- ✓ Transportation or traveling by bus, which is extremely difficult. Bus stops are frequently far from medical facilities. Often, several bus transfers are necessary to get to a single destination. Consequently, a trip to the doctor may take 4 hours. This concern was significant for the senior population and an insurmountable obstacle for the frail elderly.
- ✓ Difficulty in receiving referrals to a specialist

Seniors in the focus group had the following comments regarding access to specialists, substance abuse, and mental health concerns:

For Medi-Cal, we have to join a health group. If we want to go to specialists, we have to go through primary care physicians... Before... I could go straight to my heart doctor. Now they give appointments after 14 or 10 days, must be through my primary care doctor. I have to ask for permission. Very inconvenient. (2:5)

...Because of depressed elders, an increase in the amount of suicides, especially among [the] men. And we don't think about the fact that some of those suicides may be medication driven, and not necessarily a man... growing old.

...we have a lot of substance abuse in this population.

Plus the medications, then the overload. (1:22)

...What I see is a big gap ...in the geriatrics psychiatric interface. And we have clients who have either, you know, traditional mental health or (age related) cognitive mental health problems.. And if they had proper geriatric mental health services, that intervention would make a world of difference. (1:18)

Barriers for Immigrant Populations

- ✓ Lack of information, language barriers, a lack of respectful demeanor by health care professionals to clients
- ✓ Lack of trust or understanding within certain ethnic communities of health care providers and government programs (this is separate from and in addition to issues of legal status and documentation)
- ✓ Lack of familiarity with available programs. They believe if they are unable to pay for services, they will not receive quality care.
- ✓ Cultural propensity to refrain from questioning authority figures, as this is seen as disrespectful and inappropriate behavior
- ✓ Many providers have inflexible hours of operation. Many people forgo going to the doctor so they will not miss work.

Immigrant participants had these comments regarding language, trust, and respect:

... There were times that you cannot express yourself well enough. I think that they [providers] should always have someone who can speak Spanish in case we need information or something like that. (2:20)

My daughter's pediatrician, he does cure her. I have doubt, however. I know that he knows what is wrong with my daughter but for some reason he doesn't want to tell me what it is. (2:14-15)

You've got maybe five minutes with a provider, if you're lucky... A little time with the doctor, and you cannot build trust... We're not an assertive community, and it isn't because we don't have any self-respect or self-esteem. It's that we don't question physicians. We don't question priests. We don't question teachers. (1:18)

Barriers for Children and Youth

- ✓ Lack of comprehensive information about health and how their choices can affect their health
- ✓ Belief that if they are unable to pay for services, they will not receive quality care
- ✓ Lack of mental health services and information regarding depression and suicide. Youth participants were explicit in expressing their need for these services to be available to them at their schools.

Teens had these comments regarding health coverage and key health issues for kids:

...And...at least have coverage for the kids because...you know, [with] the adults, I can see them [providers of coverage] saying, okay, we're not going to cover you because you're an adult, you should go out and get a job. But I think they should have full coverage for kids. (2:22)

I think they should have more [information and services] with depression...Because like...a lot of times...you just want to die because you're...a lot of the things are stupid, but to us they're big...And they should have classes on support groups about people who want to kill themselves. (2:40-41)

Yea. I've seen drugs in action. My best friend from fifth grade...fifth grade. This is what, 11 years old? She...she started smoking weed. Started smoking crack. She got pregnant. She had a miscarriage. She got pregnant again. She had an abortion. She got pregnant again and had a baby. It just... I mean, it basically... what she knew, she just like proved the statistics that drugs can lead to so many things that can go wrong in your life. (2:33-34).

Barriers for Providers

- ✓ Transportation, language and communication barriers, complex application forms, and administrative constraints
- ✓ Many cited both written and spoken language to be barriers. Belief that when clients do not understand the language, they do not know where or how to obtain services provided to low income groups.
- ✓ Belief that many clients are unable to afford services because of lack of or inadequate insurance coverage
- ✓ Clients' lack of knowledge regarding appropriate use of hospital emergency room services
- ✓ An absence of nurses in the school system to provide an important, and often the first, portal of entry to health care services and subsequent referrals to available health care programs for low income children and their families
- ✓ Lack of services or lack of knowledge about services that are easily accessible in their communities (in this case accessible means close proximity, culturally and linguistically appropriate, and convenient hours of operation)

Providers had these comments about service delivery, transportation and coverage for chemical dependency:

...A one-stop place where families can come in and access a variety of services so they don't have to drive all over town to get the dental care, to get the health care and to get the counseling, to get the parenting class that they need...and if it can't be in one center, then close in proximity so that transportation isn't an issue. (1:26)

Some policies, some coverage is very good, and I have no difficulties getting referrals...the most frustrating...are the ones that just basically don't have the benefit to cover... the type of problem we're dealing with. And I see that most frequently with chemical dependency. That's an issue. And there is no benefit for that type of coverage. It's very difficult because I think the community is pretty limited in what we can offer, and it's a very unstructured type of resource that's out there. (1:13)

Barriers for Mothers, Pregnant Women and Teens

- ✓ Lack of child care. Therefore, they must figure out how to bring all their children to a doctor's appointment. It was also indicated that providers discouraged clients from bringing "well" children to office appointments.
- ✓ Transportation to and from visits, especially with children in tow

Participants had this to say regarding perinatal health, key health concerns, and accessing services:

We always look for a person who has already had babies to tell us how does it feel, what do you think is going to happen? I mean, we always have fears about those things.

Well, I think that the first concern when one gets pregnant is to look for medical attention, right? Because I think especially for us who are older the difficulty is in the language [barriers]. And so we always try to ask to get advice from other people, where should we go for care? How should we take care of ourselves... (1:3)

...Well, my pregnancy went well, but the truth is that I did not like the way the doctors treated me..

...It was my first baby and I had a lot of questions. And all they would say is 'it's okay, everything's fine, you're fine, your baby's fine.' I also had problems because I had anemia.(1:4-5)

The following barriers were cited by almost all focus group participants in all categories:

- ✓ A poor attitude of many providers toward their clients. Clients often feel their provider does not respect them. This was voiced strongly and repeated often among the senior, immigrant, and youth populations.
- ✓ Belief that health care providers are motivated by profit; only people with money will receive quality care. This belief is reinforced by not having a “personal relationship” or ongoing connection to a health care professional.
- ✓ Lack of coverage for mental health services or inadequate coverage that does not allow for continuous treatment.

One provider had this to say about coverage of mental health services:

Well...even the coverage...employers offer...in terms of the behavioral health area, a lot of the smaller employers don't cover it. Although it may even be mandatory now, but I'm not sure of it. Even still, ...in terms of reimbursement, they cover only 50 percent of the cost or they limit the amount of visits. (1:8)

Access and Utilization Summary

In Orange County, as elsewhere, families with lower incomes are likely to experience limited access to health care services. The direct consequences for those living below or near the federal poverty level and the indirect consequences for the entire community are very serious. For families living in poverty, limited access to health care services significantly diminishes their quality of life. Furthermore, the quality of life of the entire community is impaired as a result of having to bear the burden of substantial cost, both in terms of dollars spent and actual health status of residents.

For many people without health care coverage, the emergency room (ER) of the nearest hospital may still be the most common “portal of entry” to the health care system when sickness or injury occurs. (The OCHNA survey data indicated 18.3% of respondents used hospital ER services in the last year.) Such use of the ER is not an effective nor efficient way to deliver health care services. Inappropriate use of hospital ERs does not improve health status nor does it lead to patient satisfaction. Additionally, the overall cost of health care services for everyone is significantly increased.

For many Orange County residents living in poverty, lack of education and knowledge about the health care system and programs for which they may be eligible add to their difficulty in accessing necessary health care services. For those from cultures that consider illness and disability differently, they are prevented from seeking timely and effective care. Those who speak little or no English experience difficulty in finding culturally and linguistically capable providers of care and appropriate educational materials. A consequence of such barriers in Orange County has been the emergence of unqualified and unlicensed practitioners, some of whom have caused harm and in some cases killed their patients who turned to them for health care services.

General Health and Prevention Summary

The following information highlights the findings from the OCHNA survey as they pertain to general health and prevention. A substantial determination of access to health care is based on whether adequate preventive measures are taken. These measures are most likely encountered during routine checkups. Access to regular, continuous preventive care can positively affect one's general overall health and can result in detection of illness and disease in the earliest stages of onset when treatment can be the most successful and cost-effective.

- ✓ 44% of respondents indicated they had not visited their doctor for a routine checkup within the last year. When asked if their children had visited a doctor in the last 12 months for a routine checkup, 7% had not.
- ✓ Oral diseases are among the most common health problems in the United States according to the Healthy People 2000 Review (1997), which reported 94% of all adults show evidence of current or past tooth decay. OCHNA survey results showed 47% of respondents had not visited the dentist within the last 6 months.
- ✓ Orange County data indicate that cancer is the second leading cause of death in the county, and breast cancer is the leading cause of cancer deaths among women. Survey results indicated 59.6% of female respondents have had a mammogram, with 64.2% of those having had one in the last year.
- ✓ Rates of prostate cancer incidence and mortality are 2 times higher for black men than white. More than 75% of prostate cancers are diagnosed in men over age 65. OCHNA male survey respondents indicated 35.6% have had a blood test for prostate cancer detection and of those, 65.4% have had a screening within the last year.
- ✓ Healthy People 2000 states that reducing the incidence of low birth weight is one of their objectives: "Birth weight is one of the most important predictors of the overall health status and survivability of newborn infants." According to Orange County data, the infant mortality rate was 5.8 per 1000 live births for all residents. The black infant mortality rate was the highest at 10.3 per 1000 live births.
- ✓ National survey results showed use of alternative therapies was not confined to any particular socioeconomic group. However, OCHNA respondents in the high income category had a greater incidence of using alternative therapies. In all, 28% of respondents had used alternative therapies within the past year. The majority of those (66%) used the alternative therapy instead of traditional medical treatment rather than in conjunction with traditional medicine.

Behavioral/Mental Health Summary

It is important to note there is a large information gap both in the quality and quantity of primary and secondary data for behavioral/mental health indicators. The OCHNA survey was not able to address this information gap adequately, because of a variety of factors including legal and ethical issues of confidentiality (the client's right to privacy) and poor or absent reporting mechanisms. For the same reasons, there are virtually no data on a secondary level available for evaluation. This report provides only limited data from survey respondents and discussion results from 3 community-based focus groups conducted specifically on mental health issues.

Members of the OCHNA Steering Committee and the OCHNA Advisory Committee targeted this particular health indicator as being of great importance with overlapping impact on other health issues. The use and abuse of alcohol and drugs (self-medicating behaviors are not uncommon

among individuals experiencing a variety of mental health stressors); depression, isolation, and loneliness, and poverty can be related to mental health concerns.

- ✓ 5% of OCHNA survey respondents reported having a mental condition, with a significantly higher percentage (9.1%) reporting in the low income category. The majority of those considered their condition to be a “moderate” to “serious” threat.
- ✓ In Orange County between 1994 and 1996, there was an average of 8.6 deaths by suicide per 100,000 people. This is below the Healthy People 2000 objective of 10.5 deaths per 100,000; however, unreported suicides (accidents, motor vehicle deaths, police shootings, etc.) also account for an untold number of additional deaths, and therefore, warrant our attention.
- ✓ Nearly one fourth of those respondents reporting a mental condition are not receiving treatment and of those, one third cited “no reason to go” as their reason for not having received or never having received treatment.
- ✓ Within 30 days prior to the survey, nearly 4% of respondents reported 30 days of poor mental health. A significantly higher percentage of those responses came from the low income category.

Major Diseases – Current Health Status Summary

- ✓ **Asthma** cases totaled 183,280 in Orange County. Of those surveyed, 9% reported they had been diagnosed with asthma; of those, 88% have received treatment. The proportion of Latino/Hispanics discharged from Orange County hospitals for asthma was relatively high (25%) given the proportion of all Latino/Hispanic discharges (15%). Additionally, more than 18% of respondents indicated their child (or children) now have, or have been diagnosed with, asthma. Low income respondents showed a higher incidence of asthma than respondents in other income categories. Low income people are more likely to live in substandard housing which increases their exposure to high levels of allergens from mites, cockroaches, and other factors that aggravate the problems associated with asthma, especially for children.
- ✓ **Cancer** is the second leading cause of death in Orange County, according to 1998 health statistics prepared by the Orange County Health Care Agency (HCA). According to the OCHNA survey, 5% of respondents have been diagnosed with cancer, and 88% of those diagnosed had received treatment. Nearly 30% are currently receiving treatment. According to HCA data, the average number of hospital discharges for cancer-related care from 1994 through 1996 was 13,526. The financial costs to Orange County were \$365,060,845; this is an average annual cost of \$121,686,948.
- ✓ **Cardiovascular (ischemic and other heart) disease’s** average number of deaths for Orange County was 4,907 between 1994 and 1996. According to those completing the OCHNA survey, 6% have been diagnosed with cardiovascular disease. Of those, 87% have received treatment and 74% are currently receiving treatment. Low income respondents were more likely to have been diagnosed with heart disease.
- ✓ **Diabetes**, according to the Centers for Disease Control, is the seventh leading cause of death in the United States. OCHNA survey results indicate 6% of respondents have been diagnosed with diabetes, spanning all age ranges from 1 to 76 years and older. Of those diagnosed with diabetes, 20% were diagnosed during pregnancy. Currently, 56% of those diagnosed are taking insulin or some other medication. Results indicated a higher incidence of diabetes for persons in the low income category.

Lifestyle - Risk Factors Summary

The importance of proper nutrition, adequate exercise, and maintaining a healthy body weight on achieving good health is undisputed. The correlation of these factors with the propensity toward having heart disease, high blood cholesterol levels, stroke, cancer, diabetes, and many other health conditions has been widely reported. OCHNA respondents indicated only 47% of their physicians had discussed exercise with them and fewer (44%) reported that a physician had spoken to them about nutrition or diet.

- ✓ Since the 1970s, the number of overweight adults has increased across all ethnic and gender groups. In Orange County, 34% of residents are overweight and 14% are obese. Conversely, less than 4% of residents are underweight. Of those who are underweight, only 24% of those actually consider themselves to be underweight.
- ✓ According to the OCHNA survey results, 90% of children are not meeting the guideline for daily consumption of fruits and vegetables.
- ✓ Nearly 19% of OCHNA respondents said they exercised 5 or more days per week. In addition, as income levels increased so did the likelihood of having taken part in physical activities in the past month. However, when respondents were asked how many times per month they exercised, an inverse relationship is found. Individuals in the low income category (household income less than \$20,000) were more likely to have exercised 5 or more days per week.
- ✓ Alcohol is implicated in 39% of all fatal traffic crashes and nearly half of all intentional injuries including homicides and suicide, according to the Department of Health and Human Services. Nearly 62% of OCHNA survey respondents reported alcohol use within the past month. Persons in the high income category (household income more than \$50,000) were more likely than those in the low income category to consume alcohol in the past month. The percentage of those respondents having reported driving after having “too much to drink” was nearly 4%.
- ✓ The prevalence rate for adults smoking in Orange County for 1998 was just under 18%, which is nearly 3% higher than the Healthy People 2000 objective. Since 1990, Orange County has consistently shown a lower adult smoking prevalence rate, as well as a decline in the daily consumption of cigarettes than the state. In 1998, 69% of Orange County smokers had attempted to quit smoking, and more than 74% stated they would like to quit smoking.

Injury Prevention Summary

- ✓ According to the California Department of Health Services, firearm injuries are a leading cause of death and disability in California. In 1995 and 1996 fire arms injuries were the leading preventable cause of death for young people under age 21, higher than the rate for motor vehicle injuries. The OCHNA survey data indicated 23% of respondents kept guns in their homes. Of those, 72% stated their primary reason for keeping a handgun in the home was for safety or self-protection. Just over 18% engaged in unsafe practices, such as keeping a gun loaded and unlocked.
- ✓ Drowning is the third most common cause of death among children younger than 4 in the United States, and the leading cause of death in children under 5 in California, Arizona, and Florida. Drowning is the leading cause of death in Orange County in children aged 1 through 4. In California and Orange County, the majority of childhood drownings and near drownings occur in residential swimming pools or spas at the residence of the child, relative, or friend.
- ✓ In 1996, 10 people died from bicycle-related injuries in Orange County, and in 1997, 17 died. Bicycle helmets are 85% to 88% effective in mitigating head and brain injuries in all types of bicycle incidents. Reported helmet use among California and Orange County children is higher than the national rate, possibly because of the helmet law. However, despite the law's adoption in 1995, usage is still low, with 21% of respondents reporting their children "never" wear helmets.

THE FUTURE - PARTNERSHIPS FOR CHANGE

Purpose and Goals for the Coming Year

It is our intent to repeat a countywide health assessment in 2001. OCHNA recognized the benefit of developing a sound statistical baseline to measure ourselves against over time. For this reason we chose the CDC's BRFSS survey as our model, allowing us to collect data that would be consistent and uniform over time and that would be comparable to both state and national survey data. The current survey gleaned a wealth of information, much of which will require further in-depth analysis and subsequent reports over the coming year. In addition, OCHNA is willing to help guide and/or facilitate the development of future survey tools in regard to specific populations or targeted health issues as may be needed. We are also committed to providing assistance in understanding and using the data obtained in either the community-wide survey or the secondary county data to support the continued assessment efforts of our community partners. This ~~first~~ phase has been data driven and is recognized as the necessary first step in building a foundation for change. It is also necessary to measure our progress and evaluate the varying degrees of success.

The completion of this report does not signal the end of assessing health needs in Orange County, but simply the first step in a continuous, dedicated process aimed at improving the health status of all Orange County residents. Next year effort will focus on planning and developing strategies to implement the information learned into action plans and results. It is essential that we continue to involve and mobilize our community through the development of a broader base and expanding the participation of community stakeholders.

It is clear that any long-term planning will need to be inclusive and comprehensive in nature; it will require the highest level of decision makers from all key sectors. The process must be mindful of the concrete parameters necessary to manage change successfully. Though difficult, priorities must be established, achievable short- and long-term goals set, and timelines and measurable outcomes defined. In order for Orange County to become the "healthiest place on earth," the concept of true collaboration must be embraced and the belief affirmed that increasing access to health care is necessary to improving the health of those in need, while at the same time essential for maintaining the good health of those who are doing well.