

INTRODUCTION AND BACKGROUND

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, which 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.

Orange County Health Needs Assessment A Collaborative Joint Project of the Healthcare Association of Southern California and the Orange County Health Care Agency

The Healthcare Association of Southern California (HASC) and the Orange County Health Care Agency (HCA) are pleased to have collaborated on this timely and significant undertaking. HASC and HCA are committed to producing a countywide health assessment for the 2.6 million people of Orange County and to prioritizing the identified needs. The project has received additional funding from The California Endowment, to which HASC and HCA had jointly applied, which further broadens the health assessment capabilities allowing for larger population samples and more diverse group participation in the community focus groups.

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) did attempt to engage both health care providers and health care consumers to shape 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 health needs identification. The health needs assessments initially produced by nonprofit hospitals were of great value, though they focused only on specific communities and utilized data sources and methodologies that did not allow comparison of results. It is our belief that this effort has engendered the collaboration necessary to produce an assessment that has been countywide in scope and has also produced consistent findings that are usable at the local community level.

The collaborative Orange County Health Needs Assessment 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 their community benefit programs and avoid duplication of services with others. Investor-owned hospitals share a similar interest in assuring that their community outreach efforts are aligned with identified needs in 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. This will in turn result in a more coordinated allocation of public and private health resources in Orange County.

In addition, it is hoped 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 more accurately the first step in a concerted effort to address the health needs identified.

Survey Methodology

This access data report is based on the analysis of the OCHNA survey data collected over the period May 16, 1998 to October 16, 1998. The data were collected via 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 (age ≥ 18 years) residents on health and health care variables while the other survey collected data from 2,556 adult residents on life style and behavioral factors. Since the two surveys contained many questions in common, these 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 this combined data file. The surveys were administered in the English, Spanish, Vietnamese and Korean languages, and effort was taken to ensure that these were both culturally and linguistically appropriate. In addition, over sampling 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 can be computed from the sample data. Information on three demographic variables (gender, age and race) was used to develop the case weights (combination of these three variables yielded 30 population strata).

Missing Data

Demographic data were missing for two of the three variables (age and race) used for forming population strata. A weight of zero was assigned to the cases with missing data on these two 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 it relates to health care services in Orange County. To that end we will use the following terms and phrases: “**no health care coverage**,” indicates those individuals or families who have *absolutely no form* of health care insurance. This includes, but is not limited to, private (e.g. employer-based coverage, coverage provided under a parent or spouse’s employer, COBRA employment health coverage, and those who purchase a health plan on their own), and/or government subsidized health insurance programs (e.g. Medi-Cal/CalOPTIMA, Medicare, Medical Services for Indigents). The term “**underinsured**” will indicate those individuals or families that may have government-assisted health care coverage or 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). Also, it should be noted that in data referring to the income categories of survey respondents, income is the household income of the respondent, as opposed to their individual income.

Please see the appendix for a complete technical report.

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 (CDR), California State University, Fullerton; January 1, 1995 estimates.

Summary of Senate Bill 697 (SB697)

(Full text of Senate Bill 697 can be found in the Appendix of this document)

- ❖ Sponsored by the California Association of Catholic Hospitals and the California Healthcare Association
- ❖ Passed by the Legislature and signed by the governor in September 1994
- ❖ Effective January 1, 1995

Legislation Requirements of SB697 for Not-for-Profit Hospitals

- ❖ Reaffirm its mission statement by July 1995
- ❖ Conduct a community needs assessment every 3 years beginning in 1995
- ❖ Develop and adopt a community benefits plan by April 1996, and annually update the plan
- ❖ Annually submit a copy of the plan to the Office of Statewide Health Planning and Development within 150 days after the hospital's fiscal year end