PARTNERSHIP HEALTHPLAN of CALIFORNIA

Cultural, Linguistic and Health Education Group Needs Assessment Summary Report

2006

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Cultural, Linguistic and Health Education Needs Assessment for Medi-Cal Members

April 2006

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This document meets the Group Needs Assessment requirements of California Department of Health Services Contract and Medical Managed Care Division Letter 99-02

Acknowledgements

Special thanks to the Cultural and Linguistic Team that contributed to this project by providing information, evaluation and review:

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Special thanks to the following staff that provided assistance:

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EXECUTIVE SUMMARY

The Group Needs Assessment (GNA) was conducted to fulfill the contractual obligations of the California Dept. of Health Services, Medi-Cal Managed Care Division (MMCD) contract and concomitant MMCD policy letters on the subject of the GNA. The purpose of the GNA is to explore the cultural, linguistic and health education needs of the Medi-Cal population of Partnership HealthPlan of California (PHC) which provides services for Napa, Solano and Yolo Counties.

Data used was collected from a variety of sources. Primary data was collected through a Medi-Cal Member Survey (members from all categories: child, adult, seniors and persons with disabilities), a Provider Survey and a Community Partner Survey. Secondary data sources include: literature reviews, State of California, Solano, Napa and Yolo Counties statistics, utilization, encounter, pharmacy and customer contact data from the Plan's database, Partnership HealthPlan of California HEDIS statistics as well as other data sources as appropriate.

Member surveys were mailed to 3,000 members in June 2005. The results listed below are based on a 29% response rate and represent the percent of respondents who gave PHC a score of 7 or higher on a scale of 1 – 10.

Overall satisfaction with Partnership HealthPlan…… 91%
Overall satisfaction with personal doctor or nurse……. 90%
Overall satisfaction with Specialist……. 88%
Overall satisfaction with Health Care received……... 88%

Provider surveys were mailed to 324 provider offices. There were 303 (94%) providers who responded. 86% of the respondents indicated that their office provides translation services for patients who speak little or no English.

The current ethnic composition of PHC members for all three counties, based on enrollment data reveal that Hispanic/Latino's currently make-up 31% of membership and African Americans comprise 19%. White/non-Hispanics is the largest group throughout all three counties. More than half (53%) of PHC members are under the age of 21, and this group is primarily Hispanic. Children age 5 and make up 20% of PHC's membership. The largest number of Whites, Blacks and Hispanics are in the age group of 22-44.

The findings of this report demonstrate Partnership HealthPlan of California's roadmap for the delivery of health care to members. There is work to be done around identified service gaps for members whose primary language is not English as well as for members who speak English as their primary language. Some salient findings include:

Rates for Well-Adolescent Visits are below the benchmark of 52% despite a number of interventions since 2000. PHC is an active participant in the DHS statewide Adolescent Health collaborative that began in 2004. The HEDIS® measure will be used to measure the rate of teen visits and a survey will be used to measure quality of the visit.

Cultural and language access present an ongoing need across the county's perinatal services. While all community clinics have Spanish language capabilities, the county has over 100 primary languages represented in its population and some of the most common, such as Tagalog, are not widely available among service providers. Community providers often turn to the MCH perinatal programs as a resource for multiple language and ethnic materials, and the MCH Bureau is working with Partnership HealthPlan of California's Growing Together Perinatal Program (GTPP) to facilitate training of providers regarding cultural capability with respect to pregnant African Americans and teens.

Asthma is an area where interventions can improve inpatient admissions, emergency department use, and our members' quality of life through the promotion of adherence to accepted clinical guidelines by providers and members.

INTRODUCTION

PARTNERSHIP HEALTHPLAN OF CALIFORNIA'S HISTORY

The Partnership HealthPlan of California began operations on May 1, 1994, and is a public/private organization designed to provide a cost effective method of health care delivery to Medi-Cal recipients in Solano, Napa and Yolo Counties in Northern California. The Health Plan's goals are to improve access, quality and cost effectiveness, through a managed care system and operate with a $250 million annual budget. The HealthPlan links members with a primary care provider and has been successful in reducing inappropriate use of emergency rooms, providing an appropriate level of inpatient care, developing innovative case management programs and providing more services locally.

The HealthPlan was developed from a broad base of community support through the Solano Coalition for Better Health, a local coalition formed in 1988 to address the problem of health care access for the county's growing number of medically uninsured and underserved. Coalition members include representatives from Solano County's hospital and health systems, Solano County, social services providers, community clinics, business and employment agencies, the faith community, and others.

Under State law, the Solano, Napa and Yolo County Boards of Supervisors have created a health authority with quasi-independent political jurisdiction to contract with the State for managing the care of the county's Medi-Cal beneficiaries and to oversee operation of the HealthPlan. The HealthPlan is organized as a health insuring organization, and is legally a subdivision of the State of California, but is not part of any city, county or state government system.

In March, 1998, the HealthPlan expanded into neighboring Napa County. The Health Plan's Commission, or board of directors, expanded from 14 to 18 members to include new representatives from Napa County. In 2001, the HealthPlan expanded to Yolo County adding four more members to the Board. The Boards of Supervisors appoint the Health Plan's Commission, including: consumer, community, business, nurse, physician, hospital, health maintenance organization, community clinic, local government and County Health Department representatives. Total MediCal enrollment in the HealthPlan is approximately 85,000 members.

In late 2005, the HealthPlan started its Healthy Kids program for children through age 18 who are ineligible for other publicly funded programs, such as MediCal or Healthy Kids. The program is operational in Napa, Solano, Sonoma and Yolo Counties and combined enrollment is approximately 1,600.

OUR MISSION

The mission of the Partnership HealthPlan of California is to be a public, private collaborative partnership to provide quality, accessible, and efficient health benefits and services to Medi-Cal members and other select populations in the region.

GOALS AND OBJECTIVES OF NEEDS ASSESSMENT

The goal of the needs assessment is to improve the health status of all members and decrease the incidence and severity of disease and disability. Identifying and addressing unique needs of member subgroups helps to reduce health disparities correlated to ethnicity, language, geography, and other variables.

First of all, assessment, quality improvement, and program development are a continuous process at Partnership HealthPlan of California. Secondly, Medi-Cal contracts require a comprehensive assessment and report every five years.

The objectives of the needs assessment are to:

- Identify health risks, beliefs and practices for different subsets of our members.
- Explore cultural and linguistic barriers to effective care and possible solutions.
- Identify what help providers need to deliver culturally and linguistically competent care and education for diverse patients.
- Determine available Plan and community resources and gaps in resources.
- Integrate findings into policies and develop plans to address identified needs.

METHODOLOGY

Partnership HealthPlan of California used multiple data sources and methodologies to capture a comprehensive view of the cultural, linguistic, and health education needs of all members. This report combines primary research conducted by the Plan with secondary data sources so that member-specific information can be seen in the context of a larger picture of community health.
Primary research included a member survey and focus groups, provider surveys, input from our consumer advisory committee (CAC), and interviews with key community leaders, advocates, and service providers who work with our membership. Additionally, providers, members, and advisory groups communicate emergent needs on an ongoing basis.

During the project the Plan's Health Educator participated in multiple community-based committees that work to improve cultural and linguistic capacity with regard to health and wellness and serves as a member on the CHOS/LI Cultural and Linguistic committee. The Health Educator holds a Master's in Public Health degree in health education. Directions were provided by the Plan's senior leadership and professional staff.

BACKGROUND ON CULTURE AND LINGUISTICS

A review of the literature shows a growing recognition of the need for cultural awareness and appropriate linguistic services as the impact of patients from different cultures is felt by the health care system. California has one of the most ethnically diverse populations and according to census figures, minority population with the state have grown over the last fifteen years.

Language barriers can make it difficult for providers and patients to communicate and can discourage from seeking care. Cultural beliefs, as well as knowledge, attitude, and behavior can influence patient compliance and understanding and can affect positive health outcomes. The need for health care professionals to become culturally competent is growing as our population becomes more diverse.

CULTURE AND COMPETENCY

In most literature on the topic, cultural competency is defined as "a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations." Cultural competency reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns

of patients and families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups. Cultural competency improves the health care visit by:

- Allowing the provider to obtain more specific and complete information to make an appropriate diagnosis
- Facilitating the development of treatment plans that are followed by the patient and supported by the family
- Enhancing compatibility between Western and traditional cultural health practices
- Leading to improved patient satisfaction, and compliance and fewer delays in seeking care. (Bureau of Primary Health Care, 2001).

Cultural competence also takes into consideration population-specific issues including disease prevalence and health risks as a result of race or ethnicity, which can also be affected by acculturation or source of immigration. (Bureau of Primary Health Care)

LANGUAGE COMPETENCY

The role that language plays in creating barriers to accessing health care is emphasized in several studies. America is a country of many races and cultures, and with each passing year, more health care providers are recognizing the challenge of caring for patients from diverse linguistic and cultural backgrounds. Health care professionals and managers must have a basic understanding of the impact of language and culture on health care delivery in order to efficiently organize services that meet the needs of both the institution and a diverse patient population. The challenge of learning a new language is significant. Basic language proficiency often takes years to achieve, and even then, familiarity with medical terminology of the difficulty communicating over the telephone. Meanwhile, the health problem may become more severe or advanced requiring more expensive or invasive treatment.

Misunderstandings about the time, date, and location of appointments are more likely to occur if the patient does not understand English. Even when patients arrive at the facility on time, they may be late for appointments because of difficulty communicating with registration staff. Furthermore, the medical interview and examination present unlimited possibilities for confusion and potential serious misunderstanding can occur since complete and accurate medical history is crucial to an accurate diagnosis. Sophisticated technology and diagnostic procedures are not substitutes for clear patient-provider communication. In addition, miscommunication can result in unnecessary or inaccurate tests. Even when tests are necessary, if patients are not given instructions in a language they can understand, they may not be adequately prepared physically or psychologically to undergo these sometimes painful and frightening procedures. Likewise, if patients are to comply with a treatment plan, they must have a clear understanding of what is required of them.

For professionals in the health care setting, awareness of personal cultural biases is a prerequisite for cross-cultural competence. The competent professional cultivates a non-judgmental attitude of respect, interest, and inquiry. From this viewpoint, the cross-cultural encounter is approached as an opportunity for learning and growth. (DiversityRx.com)

LANGUAGE BARRIERS

One of the biggest barriers to high-quality health care for millions of U.S. residents has nothing to do with medicine. There are 50 million (19%) people in the United States who speak another language other than English at home and another 22 million who have limited English proficiency. According to Dr. Glenn Flores, language barriers can have deleterious effects. Patients who face such barriers are less likely than other to have a usual source of medical care; they receive preventive services at reduced rate; and they have an increased risk of non-adherence to medication

Among children with asthma, those who confront language barriers have an increased risk of intubation. Those patients are less likely than other to return for follow-up appointments after visits to the emergency department, and they have higher rates of hospitalizations and drug complications.

INTERPRETER SERVICES

There is a strong need for language and interpreter services to allow members to have access to the health care system. In an effort to ensure equal access to federally funded programs under Title VI of the Civil Rights Act of 1964, interpreter services must be provided to limited English proficient individuals participating in federally funded programs (Office for Civil Rights). More importantly, health plans or providers cannot require or suggest that non-English speaking individuals are eligible for Medi-Cal or federally funded programs provide their own interpreter, such as family or friend. While a patient may have a family member or friend interprets if they choose, experts agree that there are drawbacks to this.

HEALTH LITERACY

Health Literacy is the ability to read, understand, and act on healthcare information. Healthy People 2010 defines health literacy as " the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Many individuals may have difficulty reading English because it is not their native language; literacy refers more to one's reading and comprehension skills, regardless of the language they speak. The health literacy problem is a crisis of understanding medical information rather than of access to information. The health of 90 million people in the United States may be at risk because of the difficulty some patients experience in understanding and acting on health information — which, in turn, has a negative impact on health outcomes and the entire health care system

Older people, non whites, immigrants, and those with low income are disproportionately more likely to have trouble reading and understanding health related information. According to the National Adult Literacy Survey (NALS), 66% of U.S. adults age 60 and over have inadequate or marginal literacy skills; 50% of welfare recipients read below fifth-grade level; 50% of Hispanic Americans and 40% of African Americans have reading problems. Inadequate literacy was an independent risk factor for hospital admissions among 3,260 elderly managed care enrollees. Health literacy problems were independently associated with worse glycemic control among 408 English and Spanish patients with diabetes.

Although, medical information is becoming increasingly complex, health care professionals do not always explain information in a way that patients can understand. Health care professionals may not even know when patients do not understand medical information or instructions. Many patients do not ask health care providers to explain difficult or complicated information because they are embarrassed or intimidated. If patients do not understand medication and self-care instructions, an essential part of their medical care is missing, which can put their health at risk.

Research suggests that people with low health literacy:

- Make more medication or treatment errors
- Are less able to follow treatments
- Lack the skills needed to negotiate the health care system
- Are at a higher risk for hospitalization than people with adequate literacy skills

The Center for Health Care Strategies recommends that health care providers try to create a "shame-free" environment where low-literate patients can get help without feeling stigmatized. Practitioners must be aware that

noncompliance with recommended treatments or failure to keep appointments may be a result of poor reading skills and inability to follow written instructions.
Experts believe that more than half current patient educational materials are too difficult for the average American to read. These experts suggest that people at all literacy levels benefit from health materials that are simple and attractive. (Doak etal 1996)

Materials should be produced at a 6th grade readability level with appropriate layouts and visuals to help make materials more effective. Create interaction with reader, emphasize desired patient actions and behaviors, spell out useful, realistic action steps and make documents culture, age and gender specific. Content should be presented in an uninterrupted layout, not to use vertical text, instead use "road signs" and chunking" can attract the readers' attention and reinforce the message. Paragraphs should be short and focused on a single topic, avoid sentences that are long and complex. The use of clear captions, ample "white space," and avoid reverse type, caps and italics. Health literacy experts agrees that patients who are given easy to read materials have been known to have a higher rate of compliance, remember better, and make fewer mistakes. (Pfizer Principles for Clear Health Communication 2005)

CULTURAL AND ETHNIC DISPARITIES WITH ACCESS

One of the most compelling arguments for improving cultural and linguistic competence in health care is to reduce disparities in health outcomes among different groups. PHC is part of a local initiative to reduce health disparities as envisioned by Healthy People 2010, the nation's health goals for this decade (US DHHS, 2000). Disparities may be correlated to income level, race, ethnicity, gender, disability, geographic location and/or sexual orientation. Mediating factors are access to medical care and information, lack of health insurance, access to healthy food and physical activity, exposure to environmental risks, health literacy, and in some cases genetic differences. Consider these examples compiled by the Office of Minority Health, U.S. Department of Health and Human Services:

- African Americans, Latinos, and Native Americans, respectively, are 2.4, 2.0, and 2.3 times more likely than non-Hispanic whites to be diagnosed with diabetes, and more likely to suffer complications such as hospitalizations, amputation, end-stage renal disease, and death.
- •African Americans and Native Americans are 1.6 times more likely to be obese than non- Hispanic whites, and 1.5 and 1.3 times more likely to have high blood pressure.
- Latinos, Asians/Pacific Islanders, and Native Americans are more likely to get cervical cancer and more likely to die from it than non-Hispanic whites.
- AIDS is 8 times more prevalent in African American males, 3 times more prevalent in Latino males, and 1.3 times more prevalent in Native American males than in non-Hispanic white males. The disparity is even greater for women. African American women have 25 times the rate of AIDS, Latinas have 6 times, and Native American women have 2.4 times the rate of non-Hispanic white women.
- Infant mortality is highest for African Americans and Native Americans, at 2.4 and 1.5 times the non-Hispanic white infant mortality rate, respectively.
- Some Asian American subgroups have a 13 times higher risk of tuberculosis and a 25 to 75 higher risk of Hepatitis B infection than Americans as a whole. (US DHHS, OMH 2005)

The National Institute of Medicine reviewed the research on the causes of disparities in health care in their report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* (IOM, 2002a) The report concludes, "Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled." They find that minorities are less likely than whites to receive medically necessary services across a range of health conditions and common procedures.

The IOM report attributes the differences to both health systems inequities and to unconscious biases and stereotyping by healthcare providers. The authors recommend policy level changes in health care systems and education for providers and patients. Health care systems should allocate care based on published clinical guidelines,

improve access through the provision of interpreter services, and consider economic incentives to reward improved provider practices. Research indicates that cross-cultural training for providers is effective in improving provider knowledge, attitudes, and skills for effective communication. (IOM, 2002c) Evidence also suggests that consumer education on what to expect during exams and how to communicate with providers can make a difference. (IOM, 2002b)

A recent analysis of the 2001 California Health Interview Survey found that being in managed care is associated with greater access across all racial and ethnic groups for having a usual source of care for utilization of cancer screening. Patients in Medi-Cal managed care also had higher rates of participation in chronic disease management programs compared with employment based/private coverage. (Nordyke and Wu, 2004)

The National Healthcare Disparities Report defines access to health care as "the timely use of personal health services to achieve the best health outcomes." (USDHHS, AHRQ, 2005, p. 59)
The authors note that good access requires three components:

- "Getting into the health care system" – includes having health insurance and finding a medical home.
- "Getting care within the health care system" - includes finding a doctor who is accepting patients, getting timely appointments, transportation, and provider hours that are compatible with patient school or work constraints.
- "Finding providers who meet individual patient needs" – includes cross-cultural understanding and "relationships based on mutual communication and trust".
  (USDHHS, AHRQ, 2005, p. 59)

PHC continues to address all three components to improve access for our members and reduce health disparities. Access and denial of care for ancillary services are monitored through the complaints, grievances, and appeals process, member satisfaction surveys, and through Potential Quality Issue (PQI) reports initiated by providers, PHC staff, or member complaints.

The Provider Relations Department conducts telephone surveys of PCP offices to ascertain access to urgent, routine, and preventive appointments and accessibility to a practitioner or an answering service after regular business hours. Results of those surveys are reported to the QUAC for input and recommendations for appropriate corrective actions. Analysis of accessibility indicators is also part of the "grand analysis" of member satisfaction.

The PHC Over/Under Utilization Workgroup meets quarterly to review selected areas for appropriate access and utilization and may consider ancillary services during utilization review. Member satisfaction survey results and call monitoring showed that members have problems accessing DME, medical supplies, and prescriptions. Issues included a lack of direction from the practice site and practitioners are not providing medical justification for non-formulary medications.

PHC's Provider Relations has worked in 2006 to educate practice sites on specialty directories and the Pharmacy department has worked with pharmacies to identify specific practitioners with prescription documentation problems.

REGIONAL DEMOGRAPHICS AND HEALTH INDICATORS

Partnership HealthPlan of California serves Solano, Napa and Yolo Counties. This section reviews the demographics and health indicators for each county to give a context for understanding of our members' needs. The following sections describe PHC Medi-Cal member population and health status.

REGIONAL DEMOGRAPHICS

Solano County

Solano and Napa counties have similar demographics and economics, whereas Yolo County is comprised of a rapidly growing and diverse population of distinct rural, urban and suburban communities, each with disparate challenges and strengths. Solano County is larger both geographically and in population and has more truly rural areas with less access to health care and public transportation. Solano County is located midway between Sacramento and San Francisco, and is considered to be one of the nine counties of the San Francisco Bay Area. The county covers 829 square miles with seven incorporated cities, several suburban tracts and extensive rural agricultural land area. Almost 96% of Solano County residents live in urban areas of the county. No one city is home to more than 30% of the county population, but the three largest cities (Vallejo, Vacaville and Fairfield) each have over 20% of the population. The county is also home to Travis Air Force Base.

Solano County straddles US Interstate 80, a major transportation corridor between the San Francisco Bay Area and Sacramento and on into the Sierra Nevada. The County is also served by several other highways, including Interstates 780, 680 and 505 and State Highways 12, 37, and 113. Traffic congestion in the county is significant and continues to get worse as housing prices and available land push the Bay Area population toward the outlying counties. Despite the major Interstates and Highways, transportation is a significant challenge for the county. Each city in the county has an independent public transit system. While there are links between some of the systems, it takes significant time to travel between cities and there are no public transit links to Rio Vista.

Napa County

Napa County is a county located north of the San Francisco it is part of the Napa Metropolitan Statistical Area. As of 2005 the population is 132,764. The county seat is Napa.

Napa County, once the producer of many different crops is known today for its wine industry, rising in the 1960s to the first rank of wine regions with France and Italy. The combination of natural beauty, pleasant Mediterranean climate, and proximity to San Francisco, Oakland, and Sacramento has made it into one of the United States' most desirable areas in which to live. However, its citizens are famous for their resistance to suburban development, with the result that 33 of California's 58 counties--including many that are far from major urban areas--are more populous. Estates in the county, particularly those with views of San Pablo Bay, have been known to sell for nearly ten million dollars.

The Napa wine country was the inspiration for the fictional Tuscany Valley on the nighttime soap opera Falcon Crest, among many others.

Yolo County Yolo County (land area 1013 square miles) is located in the California Central Valley between the Sacramento River to the east and the Coast Range to the west. The eastern two-thirds of the County consist primarily of flat plains and basins. The western third consists of hills and mountains bordering the Capay Valley and rising up to 3,000 feet in elevation. Flooding has historically been a problem in eastern parts of the County and remains a concern in areas where levees have been constructed or are currently proposed. Bordering counties include Sacramento and Sutter Counties to the east, Solano County to the south, Lake and Colusa Counties to the north and Napa County to the west.

There are four incorporated cities (Davis, West Sacramento, Winters and Woodland) and several distinct unincorporated areas within the County. The County's central location in California and close proximity to metropolitan areas in Sacramento and the Bay Area have contributed to make it a hub for education, commerce, housing and transportation. Citizens of Yolo County are represented by five local Supervisory Districts, State Assembly Districts 2 and 8, State Senate District 5 and US Representative District

Table 4.1 lists key demographics for the three counties. In each county, non-Hispanic Caucasians is the largest group, followed by Hispanic. English and Spanish are the primary languages spoken. In Yolo County there are small

communities of people who speak Russian, (2%). Solano and Napa income levels are comparable, whereas 12% of Yolo County residents are living at or below federal poverty level.

Table 4.1 Demographics by County

Demographics	Solano County	Napa County	Yolo County	California
Population (2005 estimate)	411,593	132,764	184,932	36,132,147
By race/ethnicity (2000 census)				
Caucasian, non-Hispanic	64%	89.3%	80.7%	77.0%
Hispanic/Latino	19.0%	27.6%	27.5%	35.2%
African American	15.3%	2.0%	2.6%	6.7%
Asian/Pacific Islander American	14.1%/1%	5.2%/0.4%	11.7%/0.4%	12.2%/0.4%
Russian	0.8%	0.4%	2%	16%
Native American	0.9%	1.0%	1.4%	1.2%
Other	3.5%	2.4%	2.0%	4%
Language other than English spoken at home (2003 estimate)	24.6%	25.2%	32.1%	39.5%
Spanish	5.3%	11.3%	8.1%	27.0%
Asian & Pacific	.02%	7.5%	1.6%	8.8%
Russian	0.8%	0.4%	2%	16%
Population living at or below poverty (2004 estimate)	8.4%	7.9%	12.1%	16%
Total Medi-Cal enrollment (2004)	53,510	11,987	27,185	6,462,611
Percent of population in Medi-Cal	7.69%	0.9%	14.7%	18%

US Census Bureau: State and County Quick Facts. Data derived from Population Estimates, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report Revised 12-Jan 2007

HEALTH STATUS INDICATORS

Table 4.2 compares key health indicators for the three counties to state data. The leading causes of death are coronary heart disease, stroke, and cancer. Solano and Napa counties have mortality rates at or below the state average and below the Healthy People 2010 objectives for these three causes; however Yolo County has the highest rates. Similarly, rates of all reportable communicable diseases are all lower than the state average, with the exception of Solano County's rates in Chlamydia and Hepatitis C.

All three counties are striving to meet Healthy People 2010 goals. Solano County and Yolo County residents report having some form of health insurance (including Medi-Cal), compared to 87.8% in Napa County. Perinatal health indicators are low compared to the state average for all three counties and better than the state average, but not reaching all Healthy People 2010 goals. Other health issues of community concerns in the three counties are access to care; perinatal health; use of tobacco, alcohol, and other drugs; chronic illness; and rates of health promoting behaviors such as diet and exercise.

Table 4.2 – Health Indicators by County

Health Indicators	Solano County	Napa County	Yolo County	California	Healthy People 2010 Goal
Individuals who have Insurance	92.3	87.8	93.5	86%	100%
Top 6 causes of death, age-adjusted rate per 100,000 population					
Coronary Heart Disease	162.4	133.3	261	164.7	166.0
Stroke	53.3	63.4	88	52.4	50
All cancers	156.6	191.2	258	164.1	158.6
Unintentional Injuries	25.4	34.0	52	29.3	17.5
Chronic lower respiratory disease	36.5	40.1	78	39.5	N/A
Pneumonia & influenza	22.0	26.1	56	23.6	N/A
Incidence of communicable disease, per 100,000 population					
Hepatitis C	60.0	0.00	0.00	0.13	1
AIDS	9.8	4.57	4.40	13.72	1
Tuberculosis	10.1	5.09	3.81	8.7	1
Chlamydia	342.4	98.28	206.61	324.31	N/A
Syphilis	.64	.51	.54	3.43	.20
Measles	0.0	0.0	0.0	0.01	0.00
Perinatal health indicators					
Prenatal Care in the 1st trimester	25.1%			86%	90%
Low birth weight	6.9%	5.7	5.5	7%	5%
Infant mortality per 1000 births	5.5			5.7	4.5
Births to teen age 15-19 per 1000 population	32.1	2905	21.1	39.2	43 for age 15-17
Chronic Disease					
Diagnosed with asthma, self-reported, >1 yr old	19%	10.6%	16.4%	13.6%	N/A
Diagnosed with diabetes, self-reported, adults	8.5%	8.3%	6.3%	7%	2.5%
Adults overweight/obesity (BMI from self-report height and weight)	33.1% 22.8%	33.7% 22.5%	33.1% 22.8%	49%	60%healthy weight/15% obesity
Health Behaviors					
Tobacco use by adults & teens	17.6%	19.4%	8.8%	15%	12%
Moderate/vigorous physical activity 3 to 5 days/weeks	37.2% 30.3%	42.3% 30.1%	40% 43.8%	72%	30%
Eat 5 or more servings of fruits & vegetables each day	45.5%	51.8%	55.5%	50%	50% fruit 75% vegetable

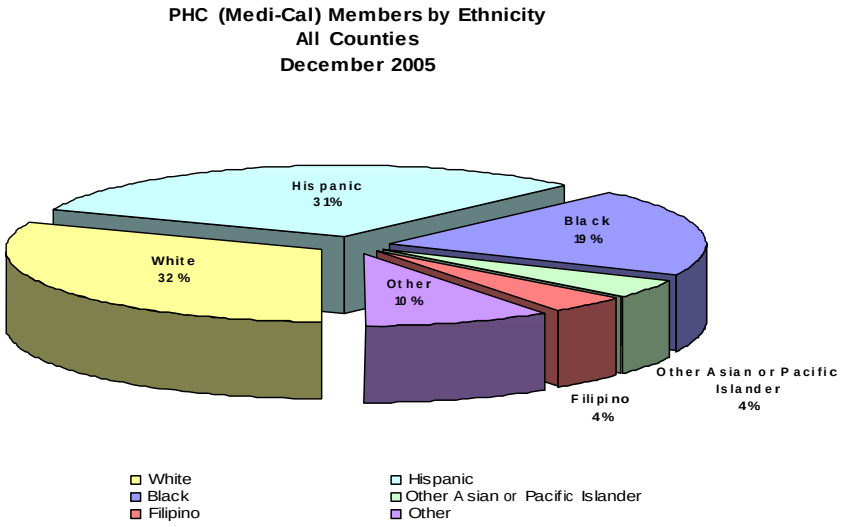
Sources: California Department of Health Services, 2006; California Health Interview Survey (CHIS), 2001 & 2003

MEMBER DEMOGRAPHICS

As of December 2005, there were 84,879 Medi-Cal members with Partnership HealthPlan of California. The following information will describe our members, where they live, as well as their primary language.

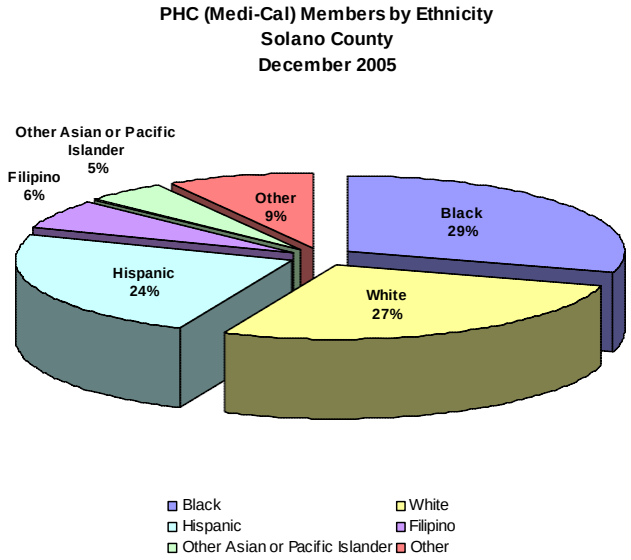
Ethnicity

The chart below illustrates the current ethnic composition of PHC members for all three counties, based on enrollment data. Members who are Hispanic/Latino currently make-up 31% of our membership, and African Americans are 19%. White/non-Hispanics is the largest group throughout all three counties.



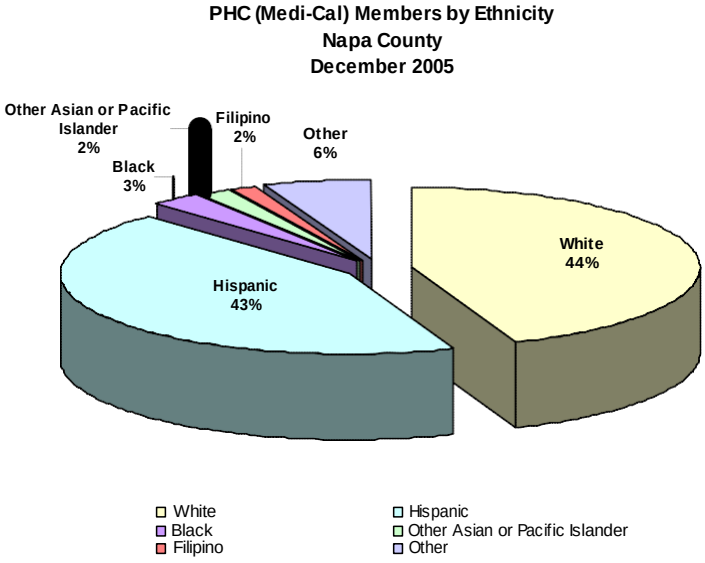
	White	Hispanic	Black	Other Asian or Pacific Islander	Filipino	Other	Total
All Counties Total 2005	26,696	26,222	16,529	3,799	3,344	8,289	84,879
% of All Counties Total 2005	32%	31%	19%	4%	4%	10%	100%

The following graphs are illustrating our ethnic composition by counties. In Solano County the African Americans (29%) membership is larger compared to the Hispanic/Latino membership (24%).



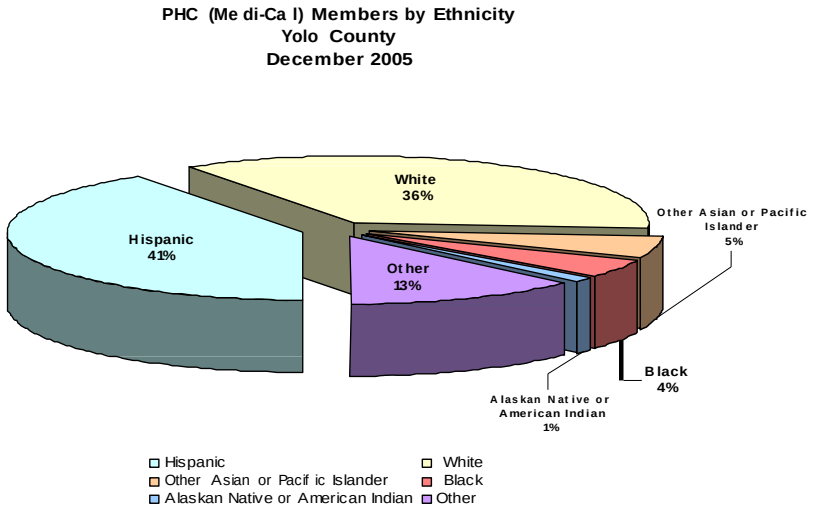
	Black	White	Hispanic	Filipino	Other Asian or Pacific Islander	Other	Total
Solano Total 2005	15,167	13,708	12,144	3,116	2,384	4,393	50,912
% of Solano Total 2005	29%	27%	24%	6%	5%	9%	99%

In Napa County, PHC's Hispanic member population (43%) which is the highest compared to all three counties.



	White	Hispanic	Black	Other Asian or Pacific Islander	Filipino	Other	Total
Napa Total 2005	4,592	4,503	304	186	163	622	10,370
% of Napa Total 2005	44%	43%	3%	2%	2%	6%	100%

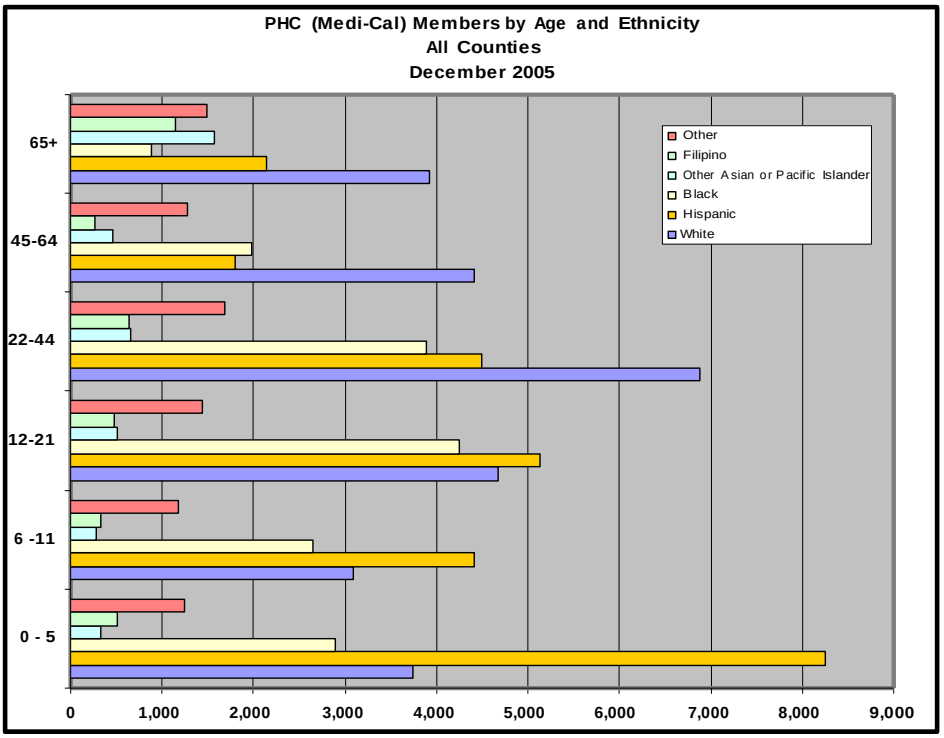
In Yolo County, members who are Hispanic/Latino currently make up 41% of our membership.



	Hispanic	White	Other Asian or Pacific Islander	Black	Alaskan Native or American Indian	Other	Total
Yolo Total 2005	9,575	8,396	1,229	1,058	234	3,105	23,597
% of Yolo Total 2005	41%	36%	5%	4%	1%	13%	100%

Age and Ethnicity

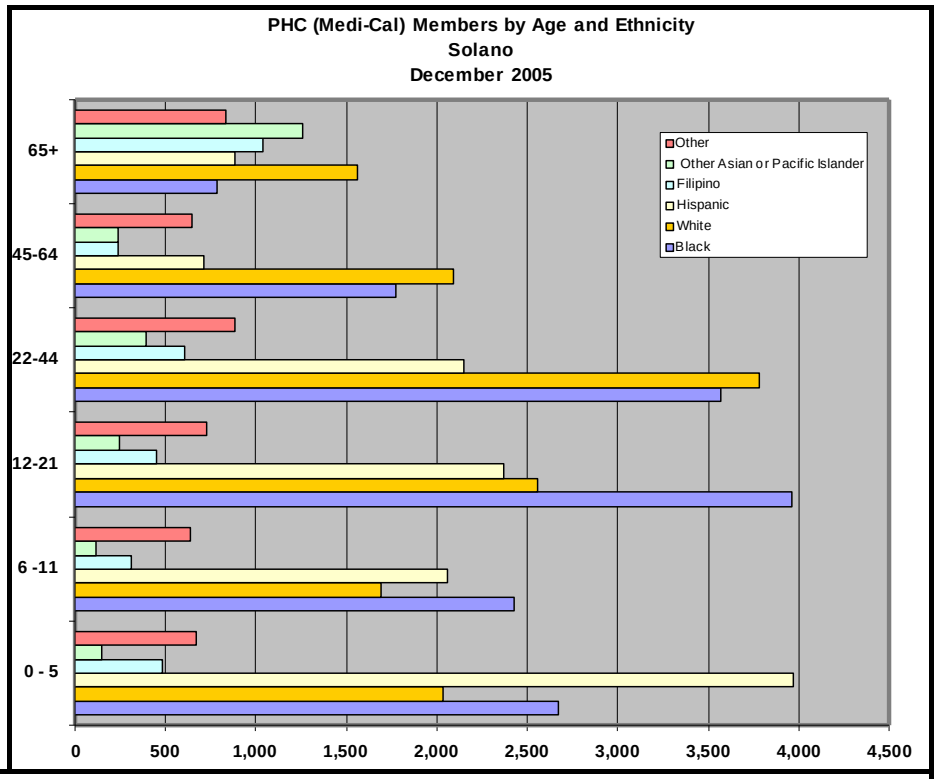
More than half (53%) of our MediCal members are under the age of 21, and this group is primarily Hispanic. Children age 5 and under make up 20% of our MediCal membership. The largest number of Whites, Blacks and Hispanics are in the age group of 22-44.



Age	White	Hispanic	Black	Other Asian or Pacific Islander	Filipino	Other	Total 2005	Percent of Total
0 - 5	3,747	8,254	2,893	329	507	1,238	**16,968**	**20%**
6 -11	3,080	4,405	2,645	275	332	1,168	**11,905**	**14%**
12-21	4,676	5,133	4,250	509	475	1,442	**16,485**	**19%**
22-44	6,873	4,497	3,892	653	639	1,686	**18,240**	**21%**
45-64	4,406	1,795	1,969	464	255	1,275	**10,164**	**12%**
65+	3,914	2,138	880	1,569	1,136	1,480	**11,117**	**13%**
Total	**26,696**	**26,222**	**16,529**	**3,799**	**3,344**	**8,289**	**84,879**	**100%**

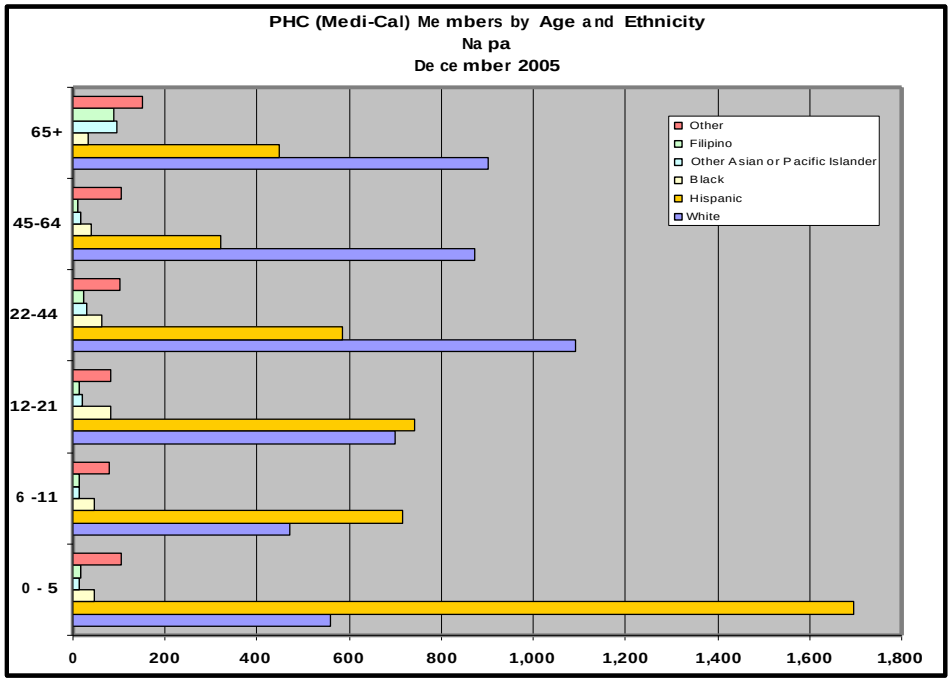
Solano County

In Solano County (55%) of our members are children under the age of 21, again this group is primary Hispanic.



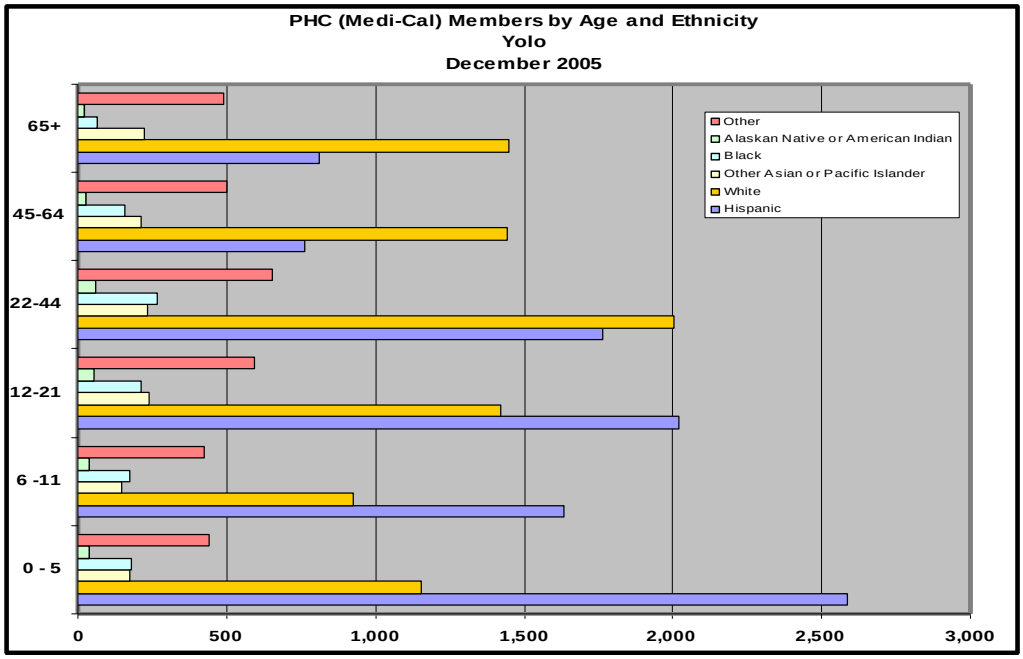
Age	Black	White	Hispanic	Filipino	Other Asian or Pacific Islander	Other	Total 2005	Percent of Total
0 - 5	2,667	2,037	3,973	480	143	666	**9,966**	**20%**
6 -11	2,426	1,687	2,055	313	114	633	**7,228**	**14%**
12-21	3,957	2,555	2,371	447	249	726	**10,305**	**20%**
22-44	3,566	3,778	2,148	604	390	886	**11,372**	**22%**
45-64	1,771	2,090	714	236	234	647	**5,692**	**11%**
65+	780	1,561	883	1,036	1,254	835	**6,349**	**12%**
Total	**15,167**	**13,708**	**12,144**	**3,116**	**2,384**	**4,393**	**50,912**	**100%**

Napa County



Age	White	Hispanic	Black	Other Asian or Pacific Islander	Filipino	Other	Total 2005	Percent of Total
0 - 5	557	1,697	46	14	16	105	**2,435**	**23%**
6 -11	469	716	45	13	13	79	**1,335**	**13%**
12-21	700	740	82	18	14	82	**1,636**	**16%**
22-44	1,091	584	61	30	22	102	**1,890**	**18%**
45-64	872	320	38	17	11	105	**1,363**	**13%**
65+	903	446	32	94	87	149	**1,711**	**16%**
Total	**4,592**	**4,503**	**304**	**186**	**163**	**622**	**10,370**	**100%**

Yolo County

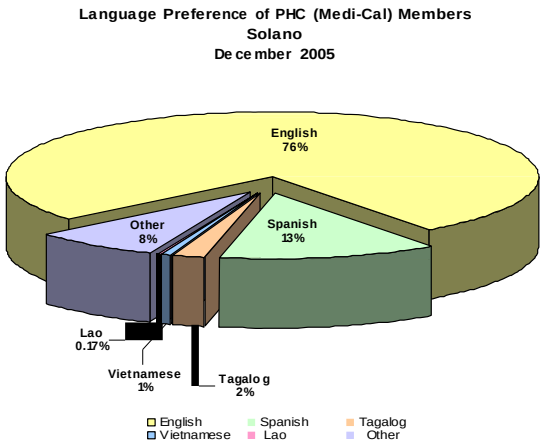


Age	Hispanic	White	Other Asian or Pacific Islander	Black	Alaskan Native or American Indian	Other	Total 2005	Percent of Total
0 - 5	2,584	1,153	172	180	36	442	**4,567**	**19%**
6 -11	1,634	924	148	174	36	426	**3,342**	**14%**
12-21	2,022	1,421	242	211	53	595	**4,544**	**19%**
22-44	1,765	2,004	233	265	60	651	**4,978**	**21%**
45-64	761	1,444	213	160	29	502	**3,109**	**13%**
65+	809	1,450	221	68	20	489	**3,057**	**13%**
Total	**9,575**	**8,396**	**1,229**	**1,058**	**234**	**3,105**	**23,597**	**100%**

SOLANO COUNTY

Language

In Solano County the language preference is 76% of our members speak English and 13% speak Spanish, 8% speak some other language, 2% speaks Tagalog, 1% speak Vietnamese and less than 1% speak Lao.



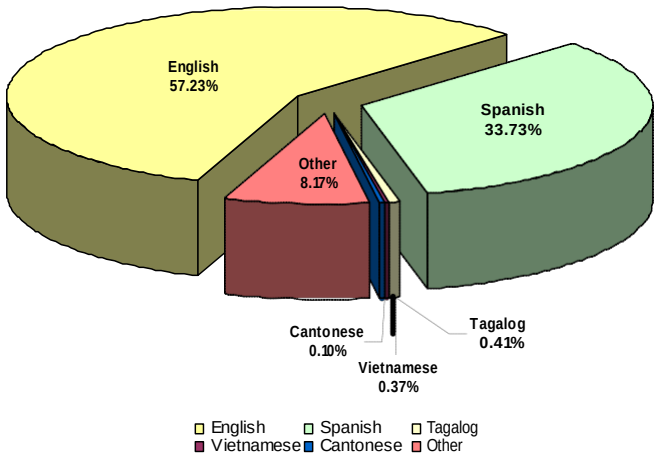
Top 10 Languages Spoken by PHC Members (Solano Cty)

Language	Under Age 18	Over Age 19	Total
English	19,829	18,920	38,749
Spanish	4,781	1,991	6,772
Tagalog	94	924	1,018
Vietnamese	146	164	310
Lao	28	61	89
Cantonese	12	56	68
Arabic	8	31	39
Russian	20	15	35
Farsi	5	29	34
Sign Language	15	19	34

NAPA COUNTY

As shown in the graph below in Napa County our members' primary language is English (57.23%) and secondary is Spanish (33.73%) again, other language ranks high at 8.17% and Tagalog, Cantonese and Vietnamese is less than 1%

Language Preference of PHC (Medi-Cal) Members
Napa
December 2005

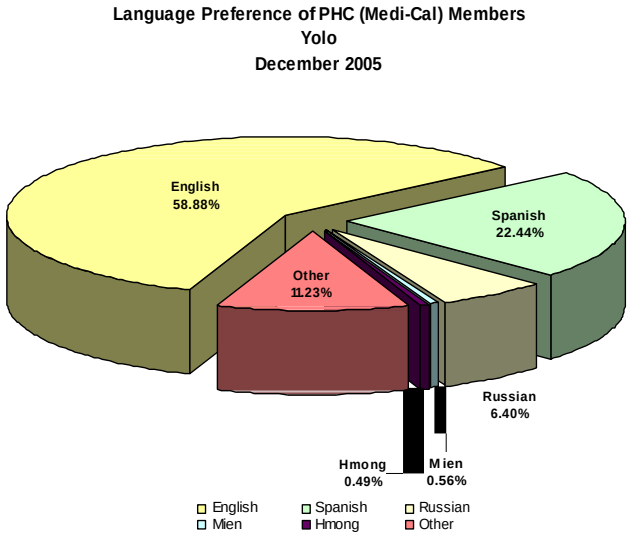


Top 10 Languages Spoken by PHC Members (Napa Cty)

Language	Under Age 18	Over Age 19	Total
English	2,555	3,380	5,935
Spanish	2,416	1,082	3,498
Tagalog	2	40	42
Vietnamese	17	21	38
Cantonese	2	8	10
Arabic	4	2	6
Farsi		4	4
Russian	2	2	4
Ilocano (Filipino dialect)		3	3
Lao		3	3

YOLO COUNTY

As illustrated in the graph below, in Yolo County our members' primary language is English (58.88%) and Spanish (22.44%), other language is 11.23%, and Russian (6.40%) and Hmong & Mien is less than 1%

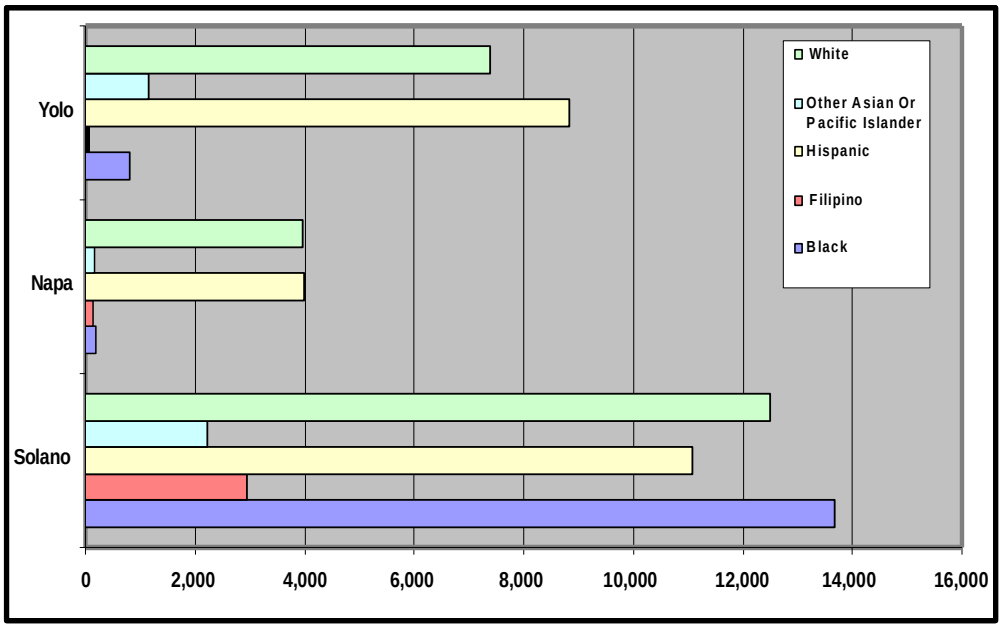


Top 10 Languages Spoken by PHC Members (Yolo)

Language	Under Age 18	Over Age 19	Total
English	7,039	6,855	13,894
Spanish	3,391	1,903	5,294
Russian	596	915	1,511
Mien	80	52	132
Hmong	77	39	116
Lao	39	45	84
Farsi	31	51	82
Cambodian	35	39	74
Cantonese	22	48	70
Vietnamese	17	31	48

GEORGRAPHIC DISTRIBUTION

The following graph illustrates where PHC members live by county region and city, grouped by ethnicity. Currently, 61% of our members live in Solano County, with the city of Vallejo having the largest number of PHC members at 7,341. Solano County has the largest member population of African Americans and Hispanics, then Yolo County has the second highest member population of Hispanics and there are over 1,500 Russians.



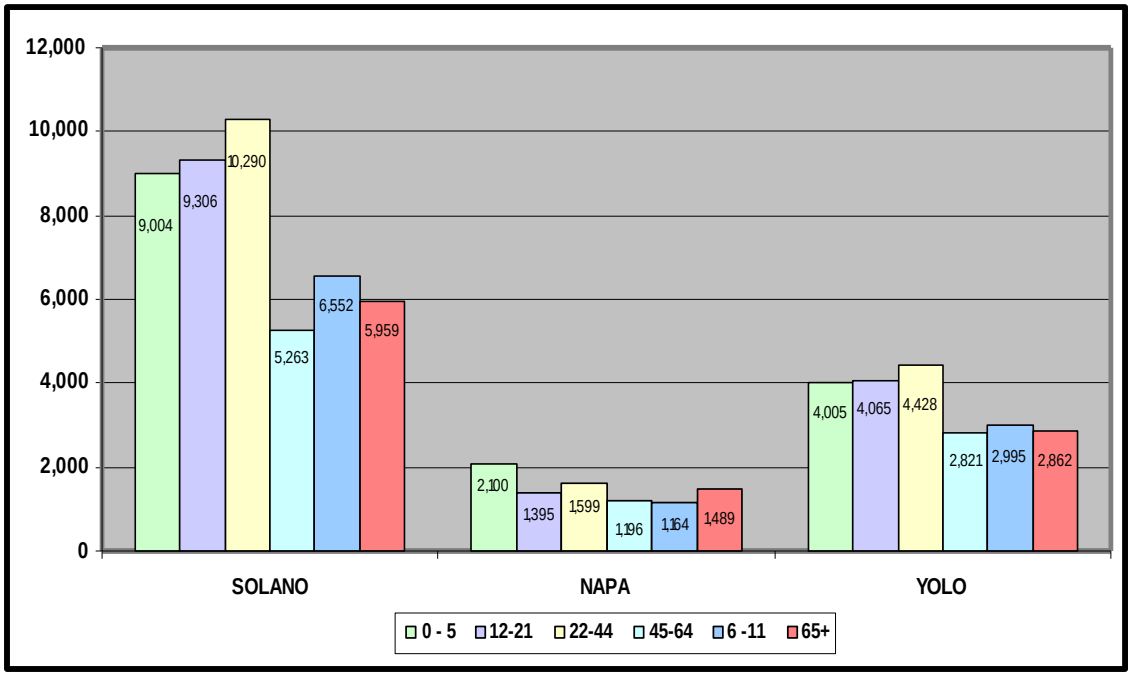
City & County	Black	Filipino	Hispanic	Other Asian Or Pacific Islander	White	Total	%
Solano	13,678	2,934	11,078	2,230	12,492	42,412	**61%**
Benicia	249	71	169	46	782	1,317	
Dixon	101	10	1,024	34	592	1,761	
Fairfield	3,687	490	3,660	648	3,199	11,684	
Rio Vista	13	2	112	1	336	464	
Suisun City	1,098	233	822	316	762	3,231	
Vacaville	1,189	167	2,222	194	3,588	7,360	
Vallejo	7,341	1,961	3,069	991	3,233	16,595	
Napa	184	140	3,984	162	3,958	8,428	**12%**
American Canyon	95	119	297	95	374	980	
Angwin	1	1	32	1	65	100	
Deer Park			4	1	4	9	
Napa	76	20	3,391	64	3,195	6,746	
St. Helena	7		227	1	116	351	
Yountville	5		33		204	242	
Yolo	811	63	8,819	1,145	7,392	18,230	**26%**
Clarksburg			106	1	21	128	
Davis	263	7	794	192	1,321	2,577	
Dunnigan	28		81	2	74	185	
Esparto	3		241	5	116	365	
Knights Landing			161	11	69	241	
Madison			102	3	31	136	
West Sacramento	344	44	2,354	583	2,945	6,270	
Winters	15		644	1	261	921	
Woodland	158	12	4,223	347	2,530	7,270	
Yolo			113		24	137	
Total*	**14,673**	**3,137**	**23,881**	**3,537**	**23,842**	**69,070**	**100%**

*Figure only reflects members living in a city within each designated county and the top 5 ethnicities.

Actual total membership is higher.

AGE BY CITY

This graph shows members age by city for December 2005. This type of data can help us identify and plan heath programs for our member populations that require certain heath services based on age.



City/County	Age 0 - 5	Age 12-21	Age 22-44	Age 45-64	Age 6 -11	Age 65+	Total
SOLANO COUNTY	9,004	9,306	10,290	5,263	6,552	5,959	46,374
Benicia	249	270	352	182	195	200	1,448
Dixon	429	348	421	188	263	204	1,853
Fairfield	2,828	2,641	2,779	1,389	1,847	1,413	12,897
Rio Vista	95	102	110	73	59	55	494
Suisun City	675	772	805	381	560	443	3,636
Vacaville	1,574	1,631	1,907	765	1,197	857	7,931
Vallejo	3,154	3,542	3,916	2,285	2,431	2,787	18,115
NAPA COUNTY	2,100	1,395	1,599	1,196	1,164	1,489	8,943
American Canyon	173	199	170	150	142	275	1,109
Angwin	25	16	36	13	15	5	110
Deer Park	1		2		6	1	10
Napa	1,781	1,114	1,329	942	945	977	7,088
St. Helena	112	55	48	44	43	71	373
Yountville	8	11	14	47	13	160	253
YOLO COUNTY	4,005	4,065	4,428	2,821	2,995	2,862	21,176
Clarksburg	34	25	24	12	23	12	130
Davis	543	540	731	344	392	408	2,958
Dunnigan	46	33	31	25	37	24	196
Esparto	93	78	69	33	61	50	384
Knights Landing	45	46	46	40	36	40	253
Madison	25	26	34	10	26	22	143
West Sacramento	1,287	1,654	1,696	1,267	1,143	1,125	8,172
Winters	221	198	166	116	143	133	977
Woodland	1,680	1,441	1,599	960	1,117	1,027	7,824
Yolo	31	24	32	14	17	21	139
Total*	**15,109**	**14,766**	**16,317**	**9,280**	**10,711**	**10,310**	**76,493**

*Figure only reflects members living in a city within each designated county. Actual total membership is higher.

HEDIS CHART

Performance measurement

Table 2 lists trended results of HEDIS® and other performance measures.

Table 2 – HEDIS and other clinical performance measures.

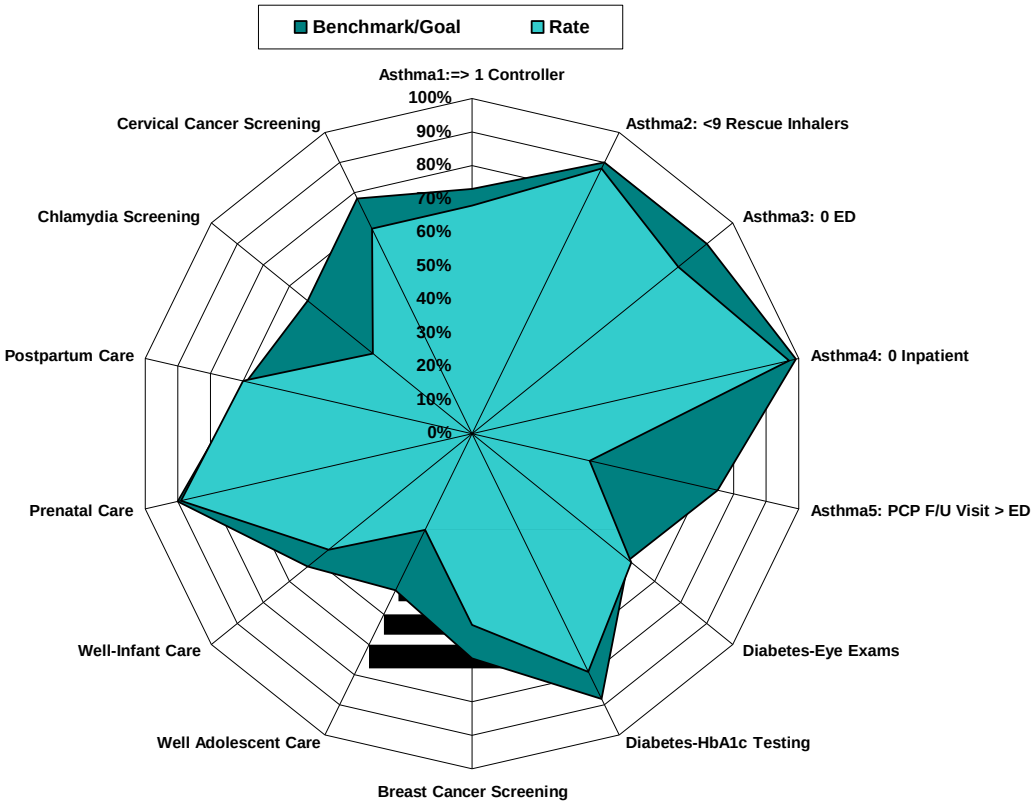
HEDIS® or other Measure	2000	2001	2002	2003	2004	2005	Benchmark [1]
Prenatal & Postpartum Care (new 2001)							
• Timeliness of Prenatal Care	---	77%	75%	---	81%	89%	90%
• Postpartum Care 21-56 days after delivery		55%	62%		64%	70%	69%
Childhood Immunizations				---			
• Combo 1 (4DtaP, 3OPV, 3HepB, 2HIB, 1MMR,)	50%	59%	58%		69%	72%	75%
• Combo 2 (Combo 1 + VZV)	44%	55%	56%		68%	71%	73%
Well Infant Visits 1st 15 Months							
• 6 or more well visits	22%	33%	33%	30% [2,3]	36%	55%	63%
Well Adolescent Visits							
• 1 or more well visits in the prior year	27%	36%	30%	---	24%	32%	52%
Comprehensive Diabetes Care							
• Annual eye exam	57%	58%	55%	---	55%	61%	60%
• HbA1c test in the measurement year	38%	49%	66%	52% [2,3]	79%	79%	88%
• HbA1c <9	---	---	---		66%	66%	77%
• LDL-C test in measurement or prior year	---	---	---	---	81%	84%	89%
• LDL-C <130	---	---	---	---	58%	62%	60%
• LDL-C <100	---	---	---	---	35%	41%	39%
• Monitoring for nephropathy	---	---	---	---	41%	52%	54%

Use of Appropriate Medications for People with Asthma	59% [2]	65%	67%	71%	69%	68%	73%
• Asthmatics with > = 1 controller medication		83%	85%	86% [2]	88%	88%	None
• Asthmatics with <9 canisters of beta agonist	84% [2]	73% [2]	78% [2]		80%	79%	None
• Asthmatics with 0 ED visits	72% [2]	96% [2]	97% [2]	79% [2]	98%	97%	None
• Asthmatics with0 inpatient admissions	96% [2]			98% [2]			
Lead Screening							
• 1 lead test on or before 27 months of age	---	37%	46%	---	45%	56%	None
• 2 lead tests on or before 27 months of age		8%	7%	---	9%	8%	
Cervical Cancer Screening	57% [2]	55% [2]	55% [2]	50% [2]	54%	68%	78%
Breast Cancer Screening	55% [2]	52% [2]	53% [2]	55% [2]	52%	57%	67%
Chlamydia Screening in Women	37%	42%	48%	32%	27%	38%	63%

[1] The benchmark is the 90th percentile of the 2005 NCQA Means, Percentiles, & Ratios for Medicaid plans reporting to NCQA.

[2] Indicates rate calculation for measure was not audited by a Certified HEDIS® Compliance Auditor. [3] Data collection methodology changed from hybrid to administrative for this measurement year

Figure 1 - How is PHC doing on quality measures compared to benchmarks in 2005?



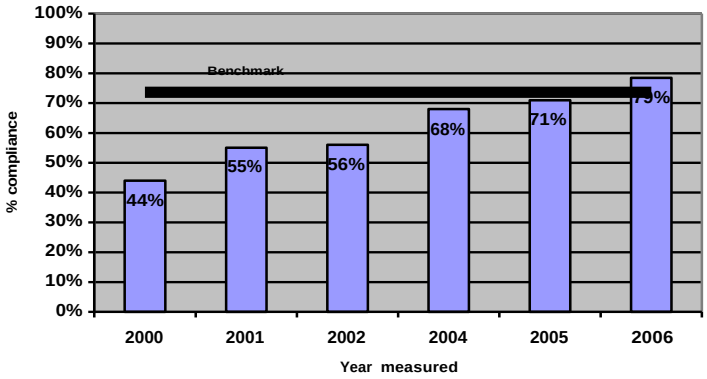
INITIAL HEALTH ASSESSMENT (IHA)

In 2005, DHS included completion of the Staying Healthy Initial Health and Behavioral Risk Assessment (IHEBA) screening tool as a required component of the IHA. Before adding the IHEBA component, the IHA rate was over 90%. After adding IHEBA, IHA completion rate dropped to below 10%. Since we are not able to ascertain completion of the IHEBA using administrative data, PHC monitors performance through data collected during the medical record portion of the Facility Site Review (FSR). In 2005, practice sites with deficiencies in this review area were revisited for a focused review. If system changes had not been made to improve performance as outlined in the Corrective Action Plan (CAP), practice sites were required to initiate a QI project and to report interventions and re-measurement to PHC using a standard format. When focused review visits were made, many sites had not implemented changes to improve performance and were required to initiate QI projects. As of December 2005, there are 13 practice sites with an active QI project.

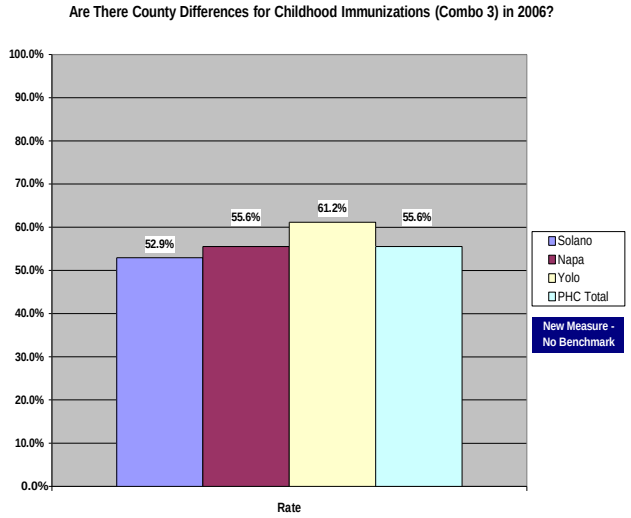
CHILDREN AND ADOLESCENT
Childhood Immunizations

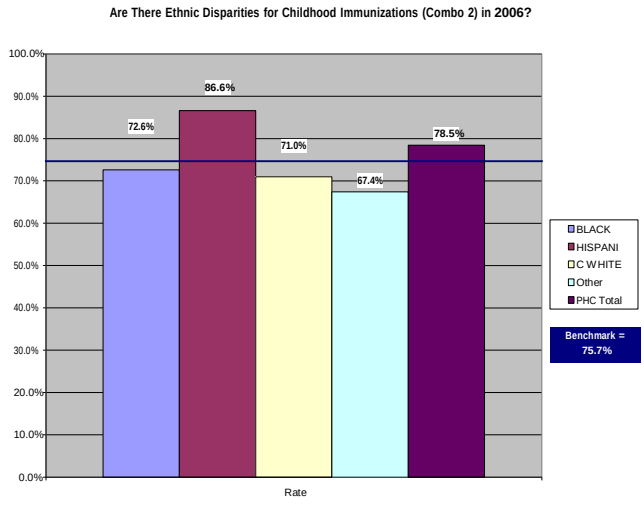
This HEDIS® measure calculates rates for timely, full immunization of 2 year olds and the PHC rate for 2005 was 71%, near the NCQA 90th percentile benchmark of 73%. In 2006, PHC worked with Napa and Solano county health departments to recruit practice sites to participate in regional electronic immunization registries. Ultimately, all regional registries will be linked together to form the Statewide Immunization Information System. We believe that registry implementation is the most effective intervention to improve immunization rates. It gathers documentation of patient vaccinations in one place, accessible to practices and the health plan, and provides a mechanism to monitor vaccine status and generate reminders. In each county, the Public Health department is designated as the authority to implement immunization registries.

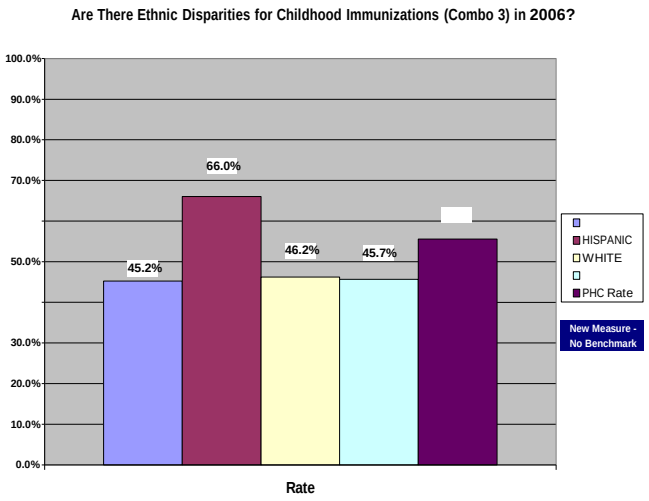
Childhood Immunizations - Timely, Full Immunization by Age 2

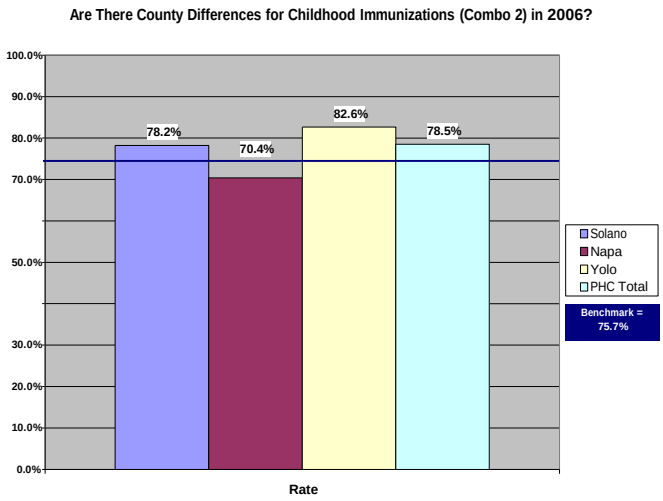


In Solano County the JPA has been signed with BARR, but progress has been slow. Solano County applied for a grant from the state of California to work on registry deployment. PHC is a subcontractor and our role will be to market the registry, complete workflow and technology assessments at primary care practices, and coordinate completion of the MOU with the county. Site visits began in 2005 and will continue until full implementation of the registry. We signed an MOU and have been working with Shots for Tots, the Yolo regional registry, to phase in Yolo county practice sites. All but one practice has signed MOUs in Yolo. In Napa County, PHC is assisting the Napa Public Health department to recruit practice sites in 2007.



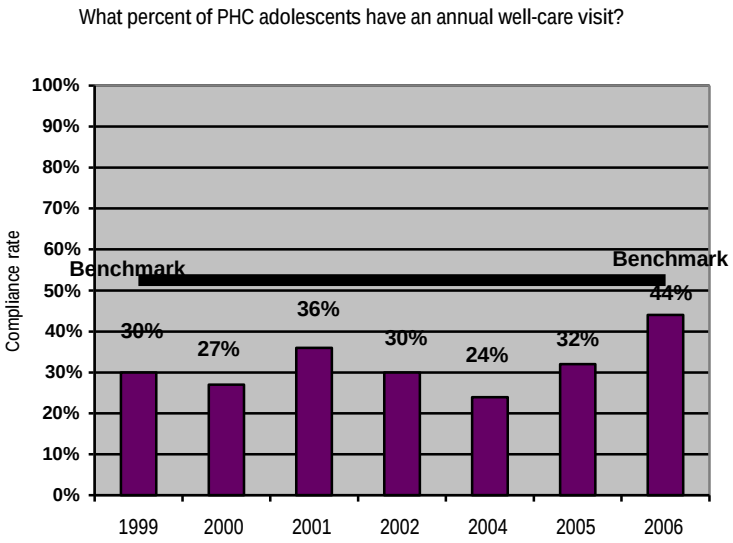






Well-Adolescent Visits

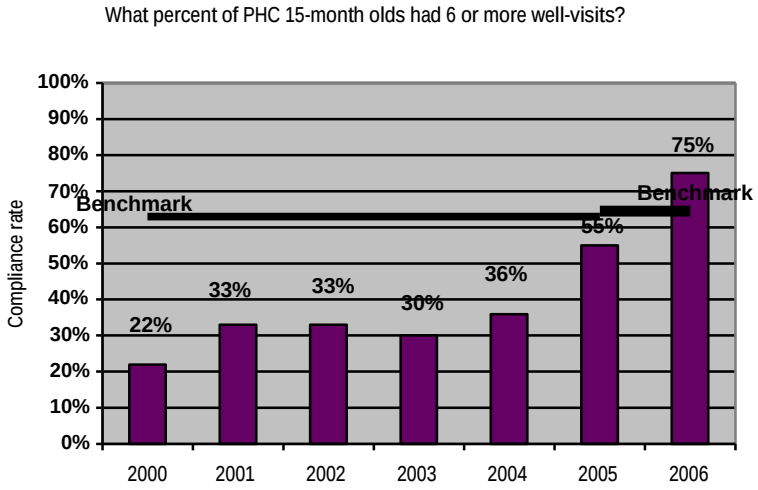
At 32%, our 2005 HEDIS® rate for Well-Adolescent Visits is well below the benchmark of 52% despite a number of interventions since 2000. PHC is an active participant in the DHS statewide Adolescent Health collaborative that began in 2004. PHC participated in a pilot teen survey to assess the quality of the teen visit from the patient perspective. Feedback from the pilot was used to finalize the survey process. The HEDIS® measure will be used to measure the rate of teen visits and the survey will be used to measure quality of the visit. Current performance is significantly below both the NCQA benchmark and performance of other California Medi-Cal managed care plans. A PIT was convened in early 2006 that include a Nurse Practitioner who conducts sports physicals at the high schools to explore how we can collaborate. Subsequently, PHC began receiving data when sports physicals were done at the school.



Well-Infant Visits in the 1st 15 Months of Life

At 36%, our 2004 HEDIS® rate for Well-Infant Visits (6 or more visits) was well below the benchmark of 55%. Data for this measure has been collected using the administrative method. A spot-audit performed in 2004 showed that some visits are not captured in administrative data. Initial visits are sometimes billed using the mother's Medi-Cal number and other visits are billed to the state when there are gaps in eligibility. In 2005, PHC changed HEDIS data collection methodology from administrative to hybrid to capture the missed visits. Results showed significant rate improvement resulting from the revised data collection method. The hybrid methodology was also used for the 2006 measurement year. This measure is one of the preventive service indicators in the quality bonus and is worth 25% of the total quality bonus points for pediatric sites, and 12.5% for family practices. Three practice sites

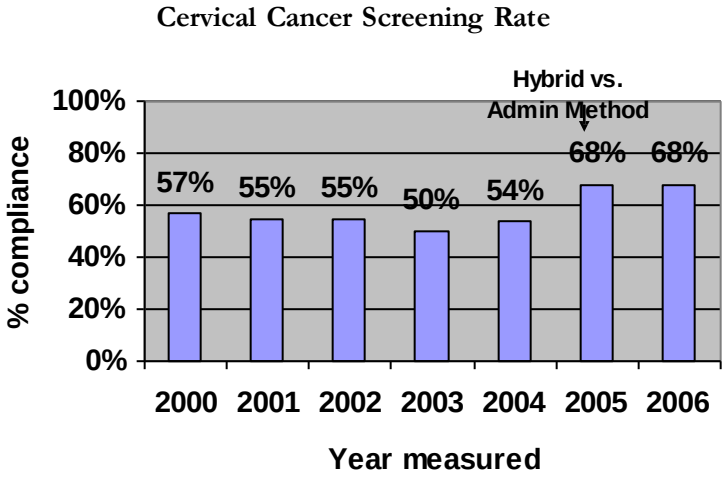
requested reports in 2005 for children approaching 15 months and these were completed and provided by the QI Project Coordinator. With the 2006 rate well above the benchmark of 66%, our goal will be to sustain the improvements made in 2005 and 2006.



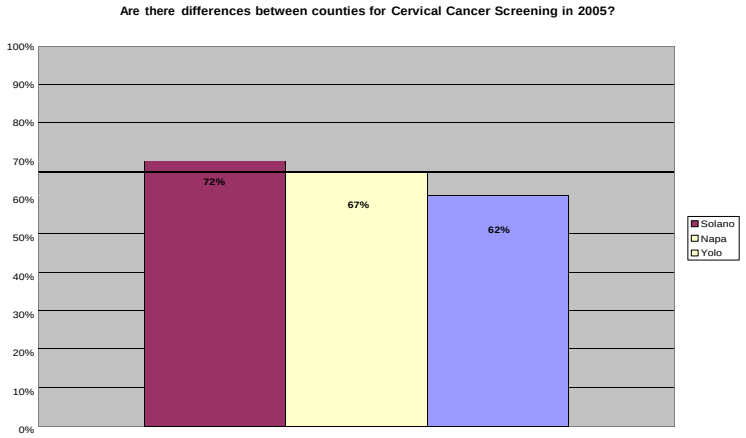
WOMEN CANCER SCREENING SERVICES

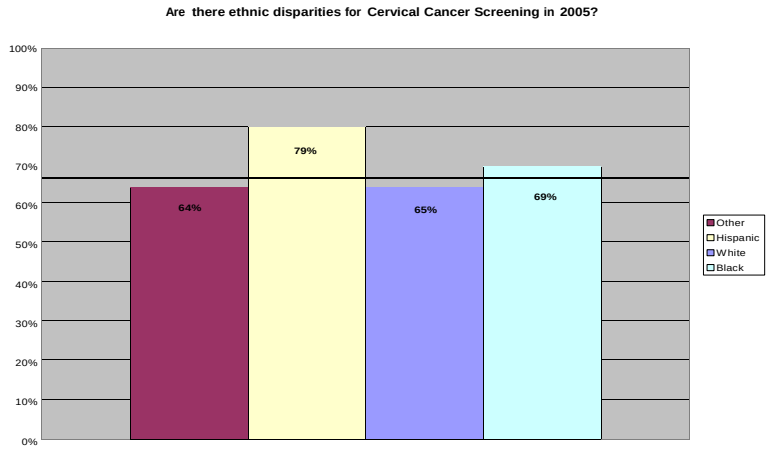
Cervical Cancer Screening

Performance in this measure, 68% using the administrative method, was below the benchmark of 78%. Comparing the 2006 68% rate to the 2004 rate of 54%, there was significant improvement as defined by NCQA. A baseline of 54% requires an improvement of at least six percentage points to be considered significant. The measure requires a one-year continuous enrollment period for Medi-Cal and a look-back period of 3 years for a Pap smear. We suspected that we may be missing many services using the administrative method and have been hesitant to send



lists to practices because of the very large denominator. In 2006, we collected the data using the hybrid method to capture services performed and covered by other payers. Using the methodology improved the rate significantly so we will measure using the hybrid method until the administrative method provides a reliable rate. This area was not selected as a top priority because of a low incidence of cervical cancer. The measure was included in the DocSite registry as a preventive service so that prompts would occur when a Pap smear is due for a patient.



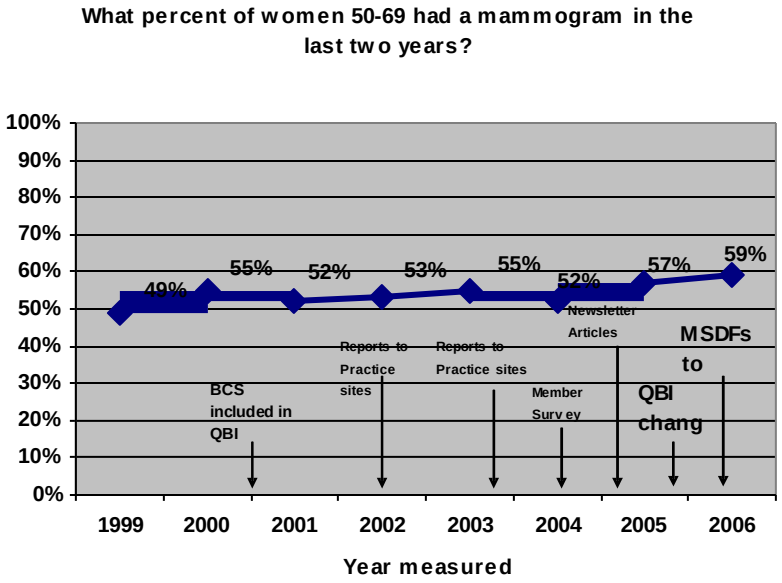


Breast Cancer Screening

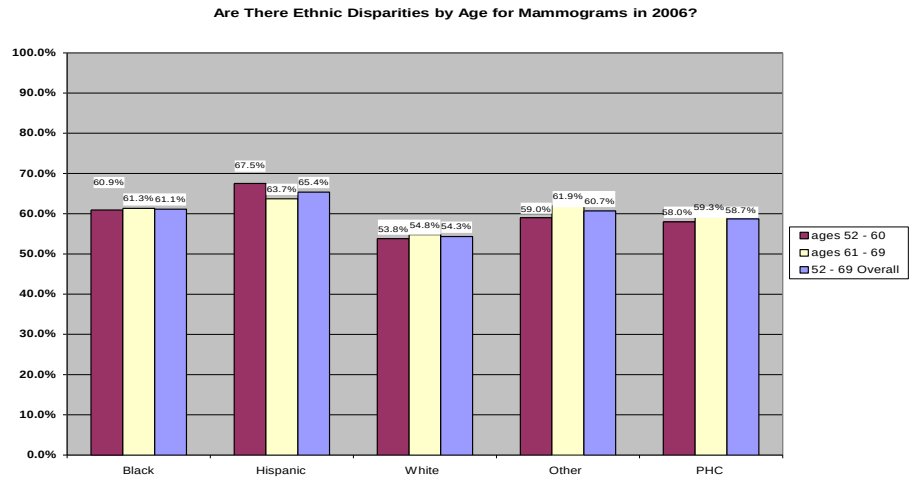
Annual reports, initiated in 2001, continue to be distributed to PCP sites listing women that had not had a mammogram in the last two years according to PHC data. In 2006, the age band was expanded to include women age 40-50 to align with the HEDIS specifications. This intervention was selected to address the issue that many practice sites do not have tracking systems in place to identify members needing periodic screening services. Feedback from practitioners indicated that they felt this type of report is one of the most effective interventions we can do to assist their offices.

Interventions in 2006 included:

- Retained the Quality Bonus Incentive (QBI) indicator of a performance rate based on evidence that practice sites were using the annual mammogram reports appropriately. The numerator is the number of forms returned with a qualifying response and the denominator is the number of forms sent to the site.
- Reports (8,424) were delivered to 93 practice sites listing 3,124 women in July 2006. The packet included a tool listing the most common reasons women don't have a mammogram and appropriate ways to address the barrier with the patient. The QBI measure and impact were explained to practitioners and staff. A percentage of the MSDF forms that listed a date of service and result will be validated and the administrative data will be used to calculate the HEDIS® rate in 2007.



The difference from the measurement in 2004 and the most recent measurement in 2006 is 7%. This is significant improvement as defined by NCQA (a comparison of the current rate to the 2004 baseline rate of 52% requires a six percentage point increase to be considered significant). We expect to see additional improvement for the 2007 measurement year as practices use the MSDF process for the third year. The graph below illustrates a disparity with Caucasian women (54.3%) that are not getting mammograms. These are poor, white women with multiple health problems and drug abuse. The rate for African American women (61.1%), Hispanic women (65.4%) and other (60%). There is data that indicates older Hispanic women are not getting mammograms as well. The overall PHC rate is 58.7%.

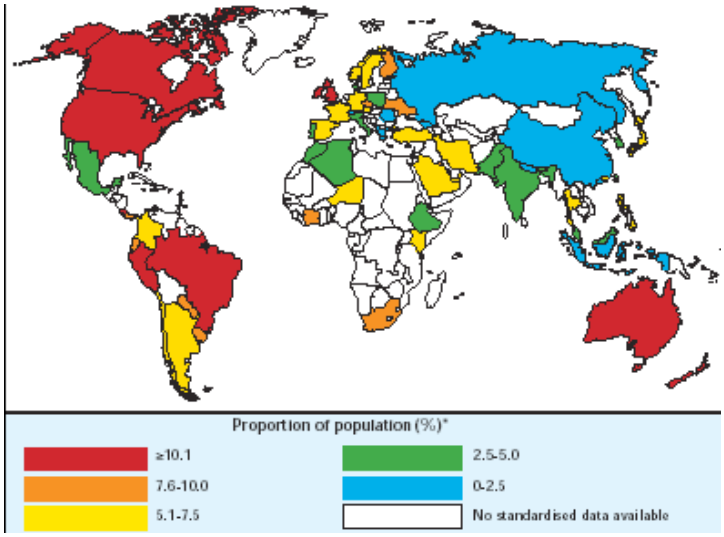


HEALTH MANAGEMENT PROGRAMS
ASTHMA

Asthma affects an estimated 17 million Americans or 6.4% of the U.S. population and children account for 4.8 million of the nation's asthma sufferers (www.niaid.nih.gov/factsheets/asthma.htm). The development of asthma is determined by the interaction between genetics and environmental exposures. As a chronic lung condition, Asthma is associated with a variety of symptoms related to a slowed rate of breathing such as swelling of the lungs, excess mucus in the lungs, and narrowing of the airways. An asthma attack occurs most often when the lungs become extremely swollen or clogged.

The 2004 Global Burden of Asthma Report revealed that asthma is not only the most common chronic diseases in the world, but it is also becoming increasingly prevalent as more and more communities adopt Western lifestyles and become urbanized. As shown in Figure 13 below, the prevalence of Asthma is greatest in developed countries (such as the United States and Canada) and heavily industrialized countries.

Global Burden of Asthma



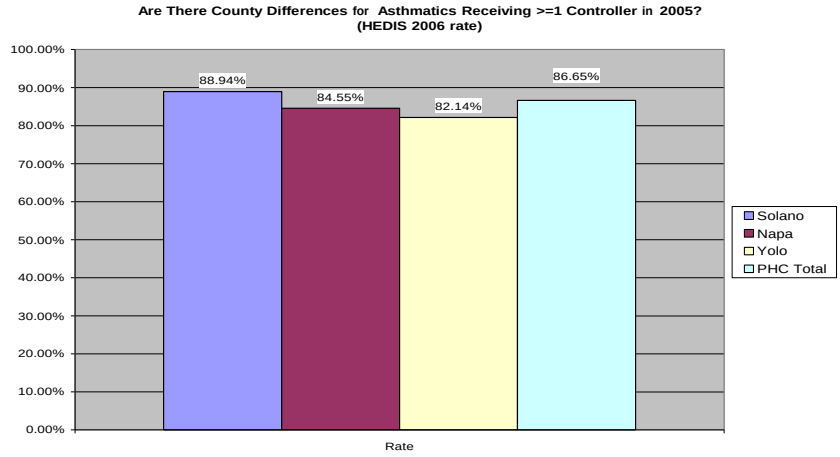
In California 4.5 million adults, adolescents and children had been diagnosed with asthma (13.6% of all Californians) in 2003, up from four million (12%) in 2001. This increase is consistent in younger children, adolescents and adults. Among the 4.5 million Californians diagnosed with asthma, more than 2.5 million suffered from an asthma attack or other asthma symptoms in 2003 (56% if those diagnosed). An additional 3.4 million Californians who have not been diagnosed with asthma – 10% of all Californians--suffer from asthma like breathing problems. (CHIS 2005)

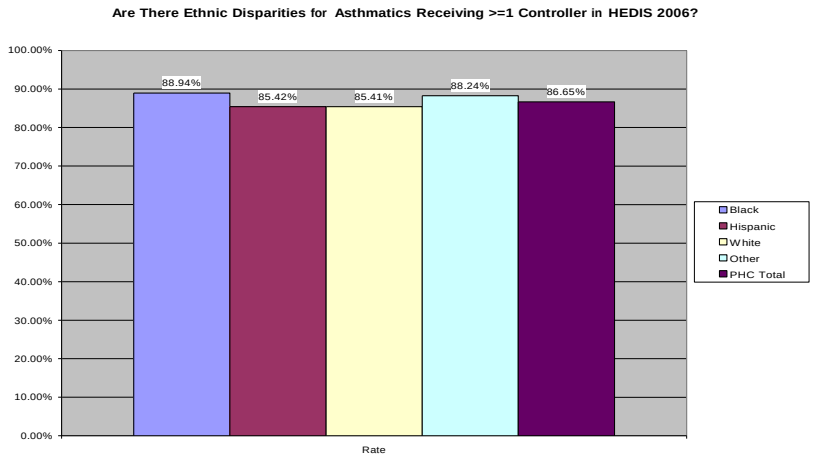
Partnership HealthPlan of California has had a comprehensive asthma program since 2000. Asthma management is one of PHC's approved DHS IQIPs and is one of our most prevalent chronic conditions. Asthma is an area where interventions can improve inpatient admissions, emergency department use, and our members' quality of life through the promotion of adherence to accepted clinical guidelines by providers and members. Baseline measurement of the process and outcome indicators was completed in 2000 and indicators are measured annually. There has been significant and sustained improvement in all four indicators from the baseline to the 2005 re- measurement. In 2006, interventions included:

- Reports listing asthmatics with more than 5 canisters of rescue medications dispensed in a twelve-month period are provided to practice sites annually in March and September. Reports were modified to include members that were hospitalized or had more than one ED visit even if their beta agonist use was not over the threshold.

- The asthma registry is updated regularly and shows that prevalence is increasing with a prevalence rate of ~15%. This is consistent with an increase in asthma prevalence statewide.
- A panel education session was convened in April 2006. The event was well attended by physicians and practice site staff.
- A targeted member mailing was done in April 2006 to ~7,500 asthmatics to give information about asthma control.
- Improvements were achieved for members who have follow up with their PCP after an emergency room visit for asthma. In 2004, only 20% of members had a follow up visit with their PCP within 21 days and the most recent measurement in 2006 sustained a 36% follow up visit rate that was achieved in 2005.
- PHC participated on the California Plan Practice Improvement Project (P/PIP). We recruited two practice sites to participate in the collaborative with other California Medi-Cal health plans. The project convened Virtual Learning Sessions with national experts in improving asthma care. Participating practices and health plans shared their learnings and best practices to spread improvements. The two practices are continuing process changes made during the PPIP
- The QBI indicator was unchanged in 2006. The indicator calculates the beta agonist overuse measure as follows: *Denominator: # persistent asthmatics assigned to the practice site*
  Numerator: # persistent asthmatics with <=5 canisters of beta agonist + # members with >5 canisters and a controller ratio of 0.5 or greater (# weighted controller ÷ # all weighted asthma meds)
- The care coordination was shifted to focus outreach activities to practice sites vs. members. Education and support are provided through periodic visits by a health educator and training is provided to practice site staff using a curriculum called Asthma Care Training (ACT). Measures of effectiveness of training are being developed and will be implemented in 2007.

The process and outcome measures were recalculated for measurement years 2004 and 2005 so that rates for 2006 could be compared. The following graphs show the results of recalculation compared to the 2006 rate. The changes in the specification reduced the denominator size because it was designed to identify people with persistent asthma indications for both the measurement and prior year. This rationale behind this change was to eliminate people who have indications of persistent asthma for one isolated year. As shown in the graph below, Solano County (88.94%) has the highest rate of asthma compared to all three counties.





DIABETES

Estimates from the Center for Disease Control suggest that approximately 7% of the US population has diabetes and close to 6.2 million of these cases are undiagnosed. In 2005, it is estimated that about 1.5 million adults 20 years and older were newly diagnosed with diabetes nationwide (CDC, National Diabetes Fact Sheet, United States. 2005). The Center for Disease Control estimates that one in every 400 to 600 children and adolescents has diabetes and that a total of 176,500 people 20 years or younger has diabetes.

PHC began calculating rates for the entire HEDIS® Comprehensive Diabetes Care measure in 2004. Indicators include annual eye exams, HbA1c testing, HbA1c control, LDL-C testing, LDL-C control, and monitoring for nephropathy. Interventions in 2005 included:

- PHC continued to add to the diabetes repository. To date, we have identified over 6,600 diabetics indicating a prevalence rate ~7.8%. The database is used to stratify the population and provide data to practice sites about their diabetics.
- PHC continued work on various diabetes interventions with fifteen practices in Solano, Napa, and Yolo counties. Practices received training on Group Medical Appointments and standalone chronic condition registries were implemented at several sites.
- The QBI diabetes indicator was modified in FY 2004/2005 and the Physician Advisory Committee continued the DSDF comprehensive measure. The numerator for QBI is the number of DSDF forms received by PHC with a qualifying response and the denominator is the number of DSDF forms sent to the practice sites. Over 55% of the 4,196 forms sent in 2004 were returned with qualifying responses. Data collection for 2005 is still in progress.
- PHC applied for grant funding to supplement activities. We have been successful in acquiring nearly $300,000 in funding to improve care for diabetics. The EPiC DM grant allowed us to expand the PALS Diabetes collaborative to community clinics in Napa and Yolo. These clinics implemented GMAs and included trained promotores and health outreach workers in the GMAs. The Business Case for Quality grant will allow us to develop methodologies to calculate ROI using interventions at the diabetes collaborative sites. We added private practices to the PALS collaborative with the MVP grant, which focuses on diabetics with cardiovascular disease (CVD) and/or depression. The self-management (SM) grant has focused on training in engaging diabetes CVD patients in their chronic condition management for a subset of the MVP practice sites.

In 2004 PHC contracted with Optimal Renal Care (ORC) and in 2005 with LifeMasters (LM), NCQA certified case management companies. ORC provides case management for about 70 members on dialysis to optimize their overall health care by promoting timely outpatient dialysis and coordination between health care providers. LM outreaches to about 2,500 members to assist practice sites by providing patient education and follow-up to PHC members with diabetes or cardiovascular disease.

Prenatal & Postpartum Care

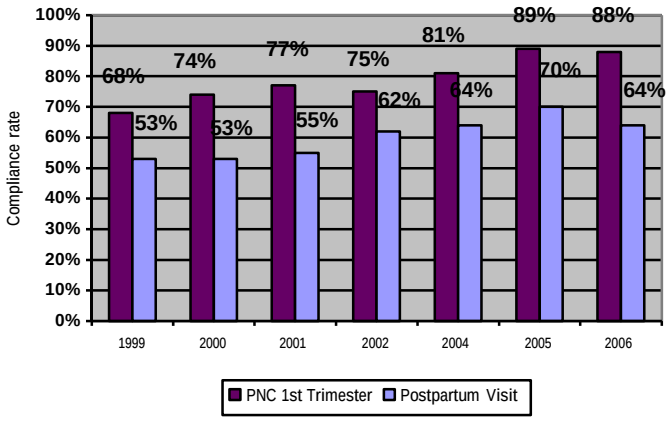
Cultural and language access present an ongoing need across the county's perinatal services. While all community clinics have Spanish language capabilities, the county has over 100 primary languages represented in its population and some of the most common, such as Tagalog, are not widely available among service providers. Community providers often turn to the MCH perinatal programs as a resource for multiple language and ethnic materials, and the MCH Bureau is working with Partnership HealthPlan of California's Growing Together Perinatal Program (GTPP) to facilitate training of providers regarding cultural capability with respect to pregnant African Americans and teens.

The average number of PHC members giving birth each year is 1,904 based on claims received for deliveries in the past three years. We know from the data received for our Great Beginning Prenatal Program that the majority of our pregnant members are in the age range of 17-29.

PHC has demonstrated continued and sustained significant improvements in both prenatal and postpartum care measures. The PHC rate is approaching the benchmark of 90% for prenatal care and is just under the 69% benchmark for postpartum care. PHC has the highest rate of all Medi-Cal managed care plans in California for prenatal care, and the second highest for post-partum. To augment efforts aimed at identification of pregnant women early in the pregnancy, PHC continues to offer a free pregnancy test to PHC members. Members call the GTPP staff after they get the test results to discuss the results. Staff can then assist the member to seek early prenatal care. The GTPP program stratifies pregnant women into "low-risk" and "high-risk" categories, and completes more intense interventions for high-risk members. GTPP continues to offer a member incentive for completing a postpartum visit within 21-56 days after delivery. Care coordination staff has identified an access issue in Solano County. Members entering care are experiencing delays that may involve months for an initial prenatal visit or to access CPSP services. They are working with Provider Relations and the provider network to analyze barriers and find solutions to the access problem.

PHC is collaborating with Solano County to focus on improving care and outcomes for pregnant teens, African-Americans, and substance abusing women. PHC is a subcontractor of Solano County on Proposition 10 funded grants for these activities. In addition to intervention activities, PHC has continually improved administrative data collection methods to reduce medical record abstraction requirements for HEDIS. In 2006, positive numerator events were determined from administrative data for 266 of the 378 sample cases. This reduced the medical record abstraction burden by 70%.

How is PHC doing in Prenatal and Postpartum Care measures?



Practitioner Site: _____

Completed By: _____
(Name and Title)

PHC Provider Survey
Cultural, Linguistic and Health Education Needs Assessment
January 2005

1. What percentage of your patients belong to the Partnership HealthPlan of California? _____%

2. Do you or your office staff translate for patients who speak little or no English? ___Yes / ____No

3. How do you assess the fluency and translating ability of those office staff that provide translation service? (Check all that apply)

	Our office doesn't assess employee translation ability.
	Certified Medical Translator (certification is required).
	The employee has had formal classroom education in language.
	It is the employee's first language spoken at home.
	Other staff evaluates the translator who speaks language.

Please list the name and the title of your staff member(s) that translate and in what language?

Name & Title of Translating Staff Member	LANGUAGE
1.	
2.	
3.	
4.	
5.	

4. How do you handle limited English or non-English speaking patients? (Check all that apply)

	Have bilingual office staff translate
	Use PHC AT&T Language Line.
	Patient's family member over 18 translates.
	Patient's family member under 18 translates.
	Patient's friend translates.
	Patient brings a professional volunteer translator.
	We speak slowly and simple, in English directly to the patient.
	We use someone that speaks the language from a nearby office.
	Other:

5. How often do you feel your culturally diverse, limited English or non-English speaking patients, access primary and preventive health care in comparison to proficient English speaking patients?

	Cultures other than The Practitioner's	Limited English/ Non-English speaking
More Often		
About the Same		
Less Often		

6. If you feel that culturally diverse, or limited English or non-English patients access Primary and preventive healthcare less often, what do you feel are some of the barriers? (Check all that apply)

	Cultures other than The Practitioner's	Limited English/ Non-English speaking
Transportation Problems		
Language Barriers		
Patient not aware service is a benefit		
Patient does not know who PCP is		
Patient believes illness is part of one's destiny		
Patient is afraid doctor may find a problem		
No childcare		
Patient prefers alternative medicine		
Patient fears hospital		
Patient afraid of legal/immigration problems		
Lack of education/comprehension		
Provider is not always aware of the patient's language capabilities or their cultural beliefs.		
Provider front office staff unable to successfully communicate and complete a scheduled appointment or generate a return call from PCP.		
Other:		

7. What services would you like PHC to provide to assist you with your limited English or non-English speaking patients? (Check all that apply)

Telephone Translation	
Provide personal translators to accompany patient to appointment	
Provide training so that office could become certified medical translators	

8. What services would you like PHC to provide to assist you with your culturally diverse patients? (Check all that apply)

Provide cultural awareness training for practitioners.	
Provide cultural awareness training for staff.	
Provide written materials for staff on culturally related health care practices.	
Provide periodic provider newsletter articles specifically on cultural issues.	

9. What kinds of educational services would you like PHC to make available for your patients? (Check all that apply)

Educational Materials on Web	
Community Health Education Classes	
Community Support Groups	
Care Coordination/Case Management	
Other:	

10. Overall, on a scale of 1 to 5, how well do you feel you understand the beliefs and practices of the following cultures? (1 being do not understand at all and 5 being understand very well)

Latino/Hispanic	
Filipino	
Asian	
Pacific Islander	
Caucasian	
African-American	
Russian	
Hmong	

11. Indicate all health topics that you think should be included in health education services (e.g. health education classes or written materials), such as Breastfeeding, Diabetes, Hypertension, Smoking, Asthma, etc.

TOPICS	LANGUAGE(S)
Other:	

PHC Provider Survey Results- January 2005

Cultural, Linguistic, and Health Education Needs Assessment

303 providers responded (of the 324 providers surveyed) (94% response)

1. What percentage of your patients belongs to the Partnership HealthPlan of California?
   - 0-25% 156 providers listed this percentage
   - 26-50% 62 providers listed this percentage
   - 51-75% 19 providers listed this percentage
   - 76-100% 11 providers listed this percentage
   - ? 11 providers wrote a question mark
   - Blank 44 providers left this question blank

2. Do you or your office staff translate for patients who speak little or no English? (Yes or No)
   - 216 Yes
   - 82 No
   - 5 No reply/blank

3.1 How do you assess the fluency and translating ability of those office staff that provide translation service? (Check all that apply)
   - 97 Our office does not assess employee translation ability
   - 35 Certified Medical Translator (certification is required)
   - 40 The employee has had formal classroom education in language
   - 147 It is the employee's first language spoken at home
   - 41 Other staff evaluates the translator who speaks language

3.2 Please list the name and the title of your staff member(s) that translate and in what language.
(Listed below are the number of provider sites that speak the language listed beside each one)
   - 59 English Only
   - 1 Arabic
   - 5 Cantonese
   - 1 Chabacano
   - 5 Chinese
   - 6 Farsi
   - 1 Fijian
   - 2 Finnish
   - 6 French
   - 11 Hindi
   - 6 Hmong
   - 1 Ibanag
   - 5 Ilocano

5	Italian
2	Japanese
6	Korean
1	Lao
5	Mandarin
3	Mien
1	Orrisan
1	Persian
8	Portuguese
7	Punjabi
16	Russian
208	Spanish
1	Swedish
38	Tagalog
1	Telegu
1	Thai
2	Turkish
4	Ukrainian
1	Urdu
4	Vietnamese

4. How do you handle limited English or non- English speaking patients?
(Check all that apply)

202	Bilingual Staff Translates
95	PHC ATT Lang Line
224	Family Member Over 18
103	Family Member Under 18
173	Patient's Friend
77	Professional Volunteer
66	Speak English Slowly
47	Nearby Office Translates
20	Cyra Comm/ Cyra Phone
15	Other

5. How often do you feel your culturally diverse, limited English or non- English speaking patients, access primary and preventive health care in comparison to proficient English speaking patients?
(Compare the frequency of healthcare access by patients that are proficient in speaking English vs. those that do not speak English proficiently.)

23	More Often
154	About the Same
89	Less Often

6. If you feel that culturally diverse, or limited English or non- English patients access Primary and preventative healthcare less often, what do you feel are some of the barriers? (Check all that apply)

119	Transportation Problems
129	Language Barriers
91	Patient Not Aware Service is a Benefit
83	Patient does not know who PCP is

23 Patient believes illness is part of one's destiny
40 Patient is afraid doctor may find a problem
49 No childcare
24 Patient prefers alternative medicine
38 Patient fears hospital
51 Patient afraid of legal/ immigration problems
112 Lack of education/ comprehension
45 Provider is not always aware of the patient's language capabilities or their cultural beliefs
29 Provider front office staff unable to successfully communicate and complete appointment or generate a return call from PCP
8 Other
93 No reply/ Blank

7. What services would you like PHC to provide to assist you with your limited English or non- English speaking patients? (Check all that apply)
   101 Telephone Translation
   175 Provide personal translators to accompany patient to appointment
   57 Provide training so that office could become certified medical translators

8. What services would you like PHC to provide to assist you with your culturally diverse patients? (Check all that apply)
   38 Provide cultural awareness training for practitioners
   53 Provide cultural awareness training for staff
   128 Provide written materials for staff on culturally related health care practices
   112 Provide periodic provider newsletter articles specifically on cultural issues

9. What kind of educational services would you like PHC to make available for your patients? (Check all that apply)
   80 Educational materials on Web
   144 Community Health Education Classes
   121 Community Support Groups
   143 Care Coordination/ Case Management
   12 Other

10. Overall, on a scale of 1-5, how well do you feel you understand the beliefs and practices of the following cultures? (1= do not understand at all and 5= understand very well)

	1	**2**	**3**	**4**	**5**
Latino/Hispanic	15	14	49	75	120
Filipino	71	42	59	41	52
Asian	51	59	76	51	25
Pacific Islander	81	59	58	46	13
Caucasian	12	3	7	38	214
African	14	15	37	83	126

American					
Russian	95	64	50	27	28
Hmong	143	64	26	14	4

11. Indicate all health topics that you think should be included in health education services. (e.g. health education classes or written materials), such as Breastfeeding, Diabetes, Hypertension, Smoking, Asthma, etc.

4	Alcoholism
2	Antibiotic Use/Overuse
5	Arthritis
42	Asthma
7	Behavioral Health
4	Birth Control
5	Breast Cancer
31	Breastfeeding
3	Chiropractic/ Spinal Care
13	Chron. Renal Insuff.
4	Depression
86	Diabetes
8	Drug Addiction
12	Exercise
4	Glaucoma
1	Heart Disease
27	High Cholesterol
54	Hypertension
4	Immunizations
1	Lung Disease
2	Mammograms
38	Nutrition
21	Obesity
1	Osteoporosis
7	Pain Mngmt/ Back Pain
8	Pap Smears
3	Parenting
10	Pregnancy
17	Preventative Care
8	Prostate Screening/ Hlth
4	Retinopathy
1	Sex Education
63	Smoking
7	STD's
1	Stress Management
4	Violence Prevention
1	Viral/ Bacterial Infection
13	Women's Health

61	Other

Member Survey

Kung kailangan ninyo ng tulong sapagtugon ng mga tanong sa survey na ito, puede po kayong tumawag sa Partnership HealthPlan of California sa tel # (800) 863-4155.

Nêú quý vi cân giúp πβ thông dich nhân câu hoi quan trong n~y, vui l∩ng goi Partnership HealthPlan of California tai sô´ πiên thoa (800) 863-4155.

Member Survey

Our members are very important to us!

Please take a few minutes to complete this survey so we have a better understanding of our members health care needs.

Before you start, there are a couple of things you need to know:

- In the survey you will see the words "primary care doctor" or "PCP". This is the doctor that you are assigned to by the Partnership HealthPlan of California (PHC).
- If this survey was mailed to your child, spouse or friend and you are filling it out, remember, we want to hear about their experiences as a PHC member.

If you have any questions, please call the PHC Member Services Department, Monday-Friday, 8:00 a.m. to 5:00 p.m., at 707/863-4120 or 1-800-863-4155.

YOUR RESPONSE WILL BE KEPT CONFIDENTIAL

Cultural, Linguistic and Health Education Needs Assessment
Adult Member Survey

1. How would you describe your health today?

Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

2. Are you comfortable talking with your primary care doctor (PCP) about your medical concerns?

Yes _____ No _____

If no, why not?

_____
_____
_____

3. If you need a translator at your PCP's office, who usually translates for you?

No translator needed _____ Family member _____
Friend _____

PCP, nurse or medical assistant _____ Other office staff _____

Professional translator _____ AT&T language line _____

4. Who would you prefer to translate at your PCP's visits?

No translator needed _____ Family member _____
Friend _____

PCP, nurse or medical assistant _____ Other office staff _____

Professional translator _____ AT&T language line _____

5. If you <u>did not</u> see your PCP for a check-up in the last 12 months, what was the main reason you did not go?

I do not feel such care is needed _____ I do not have a PCP _____

I do not know who my PCP is _____ I was not aware of these services _____

I believe in natural healing _____ Takes too much time _____

I am afraid the PCP might find a problem _____

I believe illness is part of one's destiny ____

I was not aware these services were covered by PHC _____

I do not know how to schedule an appointment for check-ups _____

No transportation _____ Language problem _____ No child care _____

Other _____

6. Do you feel your PCP or health care provider understands your cultural beliefs and practices that may affect your health?

Yes _____ No _____

If no, why not?

_____
_____
_____

7. Have you ever used any of the following sources of care or services?

Herbalist _____ Chinese practitioner _____ Curandero _____
Faith healer _____

Chiropractor _____ Acupuncturist _____ Psychic _____
Herbal therapy _____

Home remedies _____ Massage therapy _____ Other _____

8. If you used any of the sources of care, why did you choose to see them?

They understand my illness better _____ Their treatment made me feel better _____

They speak my language _____ Their treatments are more acceptable _____

My PCP rushed me _____

I could not communicate with my PCP _____

I did not understand the treatment my PCP recommended _____

I did not like the side effects of my PCP's treatment _____

My PCP did not provide treatment that made me feel better _____

It was difficult to make an appointment with PCP due to language barriers _____

They are safer than traditional medicine _____

9. Whose opinion do you trust the most for questions about your health?

PCP _____ Nurse _____ Pharmacist _____
Pastor _____

Acupuncturist _____ Chiropractor _____ Herbalist _____
Psychic ____

Spiritual healer _____ Friends and relatives _____

Other church members _____ None of the above _____

Other ____

What are the three main ways you like to learn new things about your health.

Books or pamphlets _____ Newspapers or newsletters _____ TV _____

Talking to an expert _____ Looking at pictures _____ Video _____
Having someone show me _____ Friends or family _____ Radio _____

Class or support group _____ Internet _____ Other _____

H:\My documents\cult-ling\2006\Adult eng survey.doc

Member Survey (Russian)

Опрос среди членов Программы

Члены нашей Программы крайне важны для нас!

Пожалуйста, выделите несколько минут для того, чтобы заполнить этот вопросник с тем, чтобы мы имели лучшее представление о потребностях наших членов в мероприятиях по охране их здоровья.

Прежде чем вы приступите к этому, обратите внимание на два момента, которые вам нужно знать:

- В материалах опроса вы увидите слова «первичный лечащий врач» (английская аббревиатура "PCP"). Это тот доктор, к которому вы приписаны Калифорнийской программой здравоохранения на основе партнерства (PHC).
- Если материалы опроса были присланы по почте вашему ребенку, жене или другу, и вы заполняете их, то вам следует помнить, что мы хотим слышать об их личном опыте пребывания членом Программы PHC.

Если у вас возникнут какие-либо вопросы, то, пожалуйста, звоните в Отдел обслуживания членов Программы (PHC) с понедельника по пятницу с 8:00 часов утра до 5:00 часов дня по телефону (707) 863-4120 или 1-800-863-4155.

СОДЕРЖАНИЕ ВАШИХ ОТВЕТОВ БУДЕТ КОНФИДЕНЦИАЛЬНЫМ

Решение задачи просвещения в вопросах культуры,
языка и охраны здоровья требует обработки
результатов опроса среди взрослых членов Программы – (Adult)

3. Как бы вы описали сегодняшнее состояние вашего здоровья?

Отличное _____ Очень хорошее_____ Хорошее _____ Удовлетв. _____ Слабое _____

4. Чувствуете ли вы себя удобно при разговорах с вашим первичным лечащим врачом (PCP) относительно ваших медицинских проблем?

Да _____ Нет _____

Если нет, то объясните почему _____

_____

3. Если в клинике вашего первичного лечащего врача (PCP) вам требуется переводчик, то кто обычно переводит в таких случаях для вас?

Переводчик не нужен _____ Член семьи _____ Друг _____

Доктор, сестра или помощник врача _____ Другой сотрудник клиники _____

Профессиональный переводчик _____ Языковая линия компании AT&T _____

4. Кого бы вы предпочли видеть переводчиком во время ваших визитов в клинику вашего первичного лечащего врача (PCP)?

Переводчик не нужен _____ Члена семьи _____ Друга _____

Доктора, сестру или помощника врача _____ Другого сотрудника клиники _____

Профессионального переводчика _____ Языковую линию компании AT&T _____

10. Если вы <u>не</u> посещали вашего первичного лечащего врача (PCP) для обследования в течение последних 12 месяцев, то что было главной причиной того, что вы не приходили?

Я не считал(а), что мне это нужно _____ У меня нет лечащего врача (PCP) _____

Я не знаю, кто мой первичный лечащий врач (PCP) _____ Я не знал(а) о таких услугах ____

Я верю в естественное излечение _____ Требует слишком много времени _____

Я боюсь, что врач (PCP) обнаружит проблему _____

Я считаю, что болезнь предопределена судьбой _____

Я не был(а) уверен(а), что эти услуги оплачиваются Программой PHC _____

Я не знаю, как заказать номерок к врачу для проведения обследования _____

Нет транспорта _____ Языковая проблема _____ Отсутствует присмотр за детьми ____

Прочие _____

11. Считаете ли вы, что ваш первичный лечащий врач (PCP) или другое лицо, оказывающее вам медицинские услуги, понимает особенности верований и практических действий, вытекающих из вашей культуры, которые могут повлиять на состояние вашего здоровья?

Да _____ Нет _____

Если нет, то объясните почему _____

_____

12. Пользовались ли вы когда-нибудь одним из следующих источников лечения или получения услуг медицинского характера?

Знахарь, лечащий травами ____ Китайский врач ____ Испанский врач _____ Знахарь, лечащий молитвами ___

Хиропрактик _____ Иглотерапевт ___ Экстрасенс _____ Травотерапия _____

Домашние средства ____ Массажная терапия _____ Прочие _____

13. Если вы пользовались каким-нибудь из этих видов лечения, то почему вы сделали выбор в их пользу?

Они лучше понимают мою болезнь _____ Их лечение дало улучшение _____

Они говорят на моем языке _____ Их лечение более приемлемо _____

Мой врач (PCP) торопил меня _____

Я не мог общаться со своим врачом (PCP) _____

Я не понимал лечение, которое рекомендовал мой первичный лечащий врач (PCP)_____

Мне не нравились побочные эффекты лечения первичным врачом (PCP) _____

Лечение моим врачом (PCP) не приносило улучшения моего самочувствия _____

Мне было трудно получить номерок к врачу из-за языкового барьера _____

Их лечение безопаснее традиционной медицины _____

14. Чьему мнению по вопросам вашего лечения вы доверяете больше всего?

Первичного врача (PCP)___ Медсестры _____ Аптекаря _____ Священника _____

Иглотерапевта _____ Хиропрактика ____ Знахаря, лечащего травами ____Экстрасенса ____

Религиозного знахаря ___ Друзей и родственников _____

Других членов церкви _____ Никого из вышеназванных _____

Прочих лиц ____

15. Каковы три основных пути, которые вы предпочитаете для того, чтобы узнать новое относительно вашего здоровья?

Книги или брошюры ____ Газеты или информационные бюллетени ____ Телевизор ____

Разговоры с специалистом _____ Просмотр картинок _____ Видео _____

Мне нужен кто-то указать эти пути ___ Друзья или семья _____ Радио _____

Класс или группа поддержки _____ Интернет _____ Прочие _____

Member Child Survey

Kung kailangan ninyo ng tulong sapagtugon ng mga tanong sa survey na ito, puede po kayong tumawag sa Partnership HealthPlan of California sa tel # (800) 863-4155.

Nêú quý vi cân giúp πβ thông dich nhân câu hoi quan trong n~y, vui l∩ng goi Partnership HealthPlan of California tai sô´ πiên thoa (800) 863-4155.

Member Survey

Our members are very important to us!

Please take a few minutes to complete this survey so we have a better understanding of our members health care needs.

Before you start, there are a couple of things you need to know:

- In the survey you will see the words "primary care doctor" or "PCP". This is the doctor that you are assigned to by the Partnership HealthPlan of California (PHC).
- If this survey was mailed to your child, spouse or friend and you are filling it out, remember, we want to hear about their experiences as a PHC member.

If you have any questions, please call the PHC Member Services Department, Monday-Friday, 8:00 a.m. to 5:00 p.m., at 707/863-4120 or 1-800-863-4155.

YOUR RESPONSE WILL BE KEPT CONFIDENTIAL

Cultural, Linguistic and Health Education Needs Assessment
Child Member Survey

5. How would you describe your child's health today?

Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

6. Are you comfortable talking with your child's primary care doctor (PCP) about their medical concerns?

Yes _____ No _____

If no, why not?

_____

_____

3. If your child needs a translator at his/her PCP office, who usually translates for your child?

No translator needed _____ Family member _____ Friend _____

PCP, nurse or medical assistant _____ Other office staff _____

Professional translator _____ AT&T language line _____

4. Who would you prefer translate at your child's PCP visits?

No translator needed _____ Family member _____ Friend _____

PCP, nurse or medical assistant _____ Other office staff _____

Professional translator _____ AT&T language line _____

16. If your child <u>did not</u> see his/her PCP for a check-up in the last 12 months, what was the main reason your child did not go?

I do not feel such care is needed _____ I do not have a PCP _____

I do not know who my PCP is _____ I was not aware of these services _____

I believe in natural healing _____ Takes too much time _____

I am afraid the PCP might find a problem _____

I believe illness is part of one's destiny _____

I was not aware these services were covered by PHC _____

I do not know how to schedule an appointment for check-ups _____

No transportation _____ Language problem _____ No child care _____

Other _____

17. Do you feel your child's PCP or health care provider understands your child's cultural beliefs and practices that may affect your child's health?

Yes _____ No _____

If no, why not?

_____

_____

_____

18. Has your child ever used any of the following sources of care or services?

Herbalist _____ Chinese practitioner _____ Curandero _____ Faith healer _____

Chiropractor _____ Acupuncturist _____ Psychic _____ Herbal therapy _____

Home remedies _____ Massage therapy _____ Other _____

19. If your child used any of the sources of care, why did you choose to see them?

They understand my illness better _____ Their treatment made me feel better _____

They speak my language _____ Their treatments are more acceptable _____

My PCP rushed me _____

I could not communicate with my PCP _____

I did not understand the treatment my PCP recommended _____

I did not like the side effects of my PCP's treatment _____

My PCP did not provide treatment that made me feel better _____

It was difficult to make an appointment with PCP due to language barriers _____

They are safer than traditional medicine _____

20. Whose opinion do you trust the most for questions about your child's health?

PCP _____ Nurse _____ Pharmacist _____ Pastor _____

Acupuncturist _____ Chiropractor _____ Herbalist _____ Psychic ____

Spiritual healer _____ Friends and relatives _____

Other church members _____ None of the above _____

Other _____

21. What are the three main ways you like to learn new things about your child's health.

Books or pamphlets _____ Newspapers or newsletters _____ TV _____

Talking to an expert _____ Looking at pictures _____ Video _____

Having someone show me _____ Friends or family _____ Radio _____

Class or support group _____ Internet _____ Other _____

Phone Survey Results

347 phone surveys were completed from October 2004 – April 2005, with the goal of identifying specific reasons for dissatisfaction and to implement interventions to correct dissatisfaction, when possible. The results of the phone surveys demonstrated that 98% of the members surveyed were satisfied with the service provided by the Member Service staff. Further, it was determined that dissatisfaction was generally related to a service and/or benefit that was not covered by Medi-Cal.

Annual Member Satisfaction Survey Results

The surveys were mailed to 3,000 members in June 2005. The results listed below are based on a 29% response rate and represent the percent of respondents who gave PHC a score of 7 or higher on a scale of 1 – 10.

Overall satisfaction with Partnership HealthPlan……. 91%
Overall satisfaction with personal doctor or nurse……. 90%
Overall satisfaction with Specialist……. 88%
Overall satisfaction with Health Care received……... 88%

Member Focus Groups

The 2004 Member Focus groups targeted members who had received behavioral health services at their primary care site, members with chronic conditions who had two or more admissions within the previous 12 months, members who chronically missed scheduled medical appointments, members with uncontrolled diabetes, and members participating in the Walgreen's specialty injectables program. As always, the focus groups were very informative and gave PHC staff the opportunity to hear directly from PHC members. Below is a summary of consistent themes and issues from these four focus groups of 60 participants.

- Over-all members were very pleased with the service they receive through PHC. They feel they can approach PHC and will receive professional, timely and respectful support.
- Participants have had a consistently positive experience with Members Services. Not only is staff supportive and helpful, many commented that they felt that they were treated as valuable individuals.
- Despite attention to effective communication systems by PHC, many members were not aware of the scope of services and assistance available to them through PHC.
- Support groups and/or other opportunities where members can get together to share concerns, information and successes are viewed as very valuable. Members indicated that they would attend such events.
- Case management, whether through PHC, the PCP, or another source, was seen as very helpful in more effectively managing participants' health.
- Obtaining what participants felt were the right pharmaceuticals for them in a timely manner was frequently an issue.
- Most participants were pleased with their PCP and those that were not found it relatively easy to find the right PCP for them.
- Members felt that they did experience some prejudice that was due to their economic status rather than due to their racial/ethnic status.

PHC measures member satisfaction with the Consumer Assessment of Health Plan Survey (CAHPS) that was developed by the National Committee for Quality Assurance (NCQA). The most recent CAHPS was mailed to a random selection of PHC members in the Spring of 2004

Below are the CAHPS survey results of Detailed Composite Scores. Results from composite score were derived by combining the results for several questions that asked "how often" members had certain experiences using a scale of always, usually, sometimes, never, or "how much of a problem" using the scale of big, small or not a problem. The composite Score measure main issues of concern (e.g. Getting needed Care, Getting Care Quickly, How Well Doctors Communicate, Courteous and Helpful Office Staff and Customer Service). These Plan specific composite scores were then compared to the Medi-Cal Average. The Medi-Cal Average was based on the average response from the 29 California Medi-Cal Managed Care Plans that participated.

- Getting Care Needed: PHC exceeded the Medi-Cal average by 3%, Access to a personal doctor, nurse and/or a specialist, getting care believed necessary, and delays in healthcare while waiting for approval from the health plan
- Getting Care Quickly: PHC exceeded the Medi-Cal average by 8%. (Help or advice needed, care for illness, injury or condition, and taken to the exam room within 15 minutes of appointment.)
- How well Doctors Communicate: PHC exceeded the Medi-Cal average by 8%. (Listened carefully, explained things so members could understand, showed respect for what members had to say and spent enough time with members).
- Courteous and Helpful Office Staff: PHC exceeded the Medi-Cal average by 11%. (Treated members with courtesy and respect, were as helpful as members thought they should be).
- HealthPlan's Customer Service: PHC fell below the Medi-Cal average by 7%. (Finding or understanding information in written materials and getting help needed when calling customer service).

HEALTH PLAN CULTURAL AND LINGUISTIC SERVICES

Multi-Lingual Services

The Partnership HealthPlan of California recognizes the need for services that address the needs of limited English proficient members. These services are important components to ensure access to care and healthier outcomes for health plan members. To this end, the PHC has implemented policies and procedures in compliance with Federal and State regulations to provide meaningful access to services for members of our health plan who are limited English proficient.

Currently these include:

- hour telephonic interpreter services (Language Line)
- In-person interpreters for scheduled appointments
- All member materials provided in both English, Spanish and Russian
- Staff and provider training in cultural competency

In order to reduce language barriers, the Provider Directory given to PHC members indicates languages spoken at provider offices, pharmacies and other allied health providers. In addition, our Member Services Department can assist members in finding a provider who speaks their language or in arranging interpreter services for their office visit. Members are informed of these services in our Member Handbook and in the member newsletter.

Utilization of Interpreter Services

Partnership HealthPlan of California contracts with interpreters who can provide face-to-face interpreter service for members with language barriers.

COMMUNITY COLLABORATIONS

The health educator works with health providers and agencies that serve our health plan members to identify opportunities for offering health education classes.

- Solano Asthma Coalition –
- Solano Tobacco Education Coalition
- African American Disparity Elimination Group
- Napa Asthma Camp Committee
- Child Obesity Coalition

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