Shifa Clinic Orange County: Identifying Areas, Needs, and Barriers to Health Access in Medically Underserved Areas of Orange County.

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ABSTRACT

Orange County is a socioeconomically diverse region of the state of California. The purpose of this study was to identify regions in Orange County that are medically underserved and characterize the needs of these communities and the barriers that prevent residents from seeking medical attention. Results from this study would later be used to guide the establishment of the Shifa Clinic. Using GIS software, we identified the Garden Grove and Santa Ana city junction region as the most medically underserved area in Orange County. Prevalent minority groups in the identified area were Latinos and Asians (namely Vietnamese). Using focus group (five organizations) and telephone surveys (twenty three respondents) we found that major health needs of the community included behavioral/mental health, obesity, diabetes, and dental health. The main challenges identified to healthcare access included resource-related deficits such as lack of financial or insurance coverage, transportation challenges and lack of time. The second major barrier was fear of deportation by immigration authorities. When asked questions about the most valuable characteristics of a clinical and medical services, respondents identified trust, customer service, and valuable services as the most important qualities. One main conclusion was also the importance of augmenting referral services that the clinic cannot provide such as: housing, food provisions, etc. Finally, services that provide health care for children are useful tools for recruiting other members of the family to seek health services at the clinic. Future studies are needed to test the accuracy of these findings as well as to provide constant feedback to the changing needs of a community.

A. INTRODUCTION

Orange is a county located in the southwestern region of the state of California. The county spans an area of 2,455 km^2 incorporating thirty four cities. Most of Orange County is suburban with the exception of established urban cities including Anaheim, Santa Ana, Orange, Huntington Beach, and Fullerton. According to a 2008 estimate, there are approximately 3 million residents in Orange County. Economically, Orange County can be divided into Northern and Southern regions with the latter being wealthier due to recent developments, community planning and investments from start-up companies etc. The North however such as Santa Ana, and Garden Grove, is less affluent and includes many underserved areas and populations. These areas traditionally suffer from a lack of access to resources including access to health care. Medically underserved areas suffer relative or absolute deficiency in healthcare facilities such as hospital beds, equipment, or medical personnel. Medically underserved populations however, are populations that due to socioeconomic or other reasons are unable to seek medical or preventative care. One such region for instance is located along the southeast junction of Santa

Ana and Garden Grove which is defined by the California Department of Public Health as both a medically underserved region and population.

B. PURPOSE

The purpose of this needs assessment is to (1) identify the most medically underserved region of Orange County, (2) assess the health needs of that community (3) Identify barriers to healthcare and (4) identify what the community believes is valuable medical service. These four objectives are important to ensuring that we achieve the amount of health outcomes for our investment. Understanding the attitudes of community members towards approaches and services will help us tailor these services to increase community participation, trust, and ultimately the level of utility of our services. Identifying current resources in the community will help us either enhance or cover other areas that of service that have not been addressed by resource providers in the community. Not only is this sound to achieve better results but it will also help compliment existing services in the community. Finally it will help when approaching other stake holders in the community as we seek sponsorships from these individuals and organizations.

C. DATA COLLECTION

Identifying Area of Need

We needed to identify an area of Orange County which had the greatest need for the establishment of a free clinic. We used the California Health Atlas, a geographical information survey (GIS) tool available on the California Department of Public Health website. This interactive program was able to identify regions in California which had the highest population of medically underserved people, as well as medically underserved areas. Ideally the region in Orange County where these two regions would overlap would represent the areas of highest need. Using this tool, we concluded that the area of highest need was the Santa Ana and Garden Grove junction which was flanked by the Interstate Five freeway in the northwest and the 405 freeway in the southeast (see map below).

Data Collection on Local Stakeholders

Focus Group

The needs assessment design used a two-pronged approach beginning with an email solicitation of a focus group session that was to be held at the district office in Santa Ana. Non-respondents were followed up with a telephone call to attempt to complete a telephone survey. There were a total five (5) groups that were able to attend the focus group. The format of the focus group was as follows:

-Introduction

-name, organization, service area, brief commentary on the types of services offered

Completion of a printed survey

-Discussion topics including five questions

Each participant was given ample time to give their answer on a turn basis. The meeting was recorded for record keeping and reference purposes.

Phone Survey

The next step was to identify different groups in the community who represented stake holders and leaders that would serve as potential informants. This was important for the goal of gathering information about the community in performing the needs assessment but also to look at both the distribution of these resources as well as the needs that remain unmet. To accomplish this we established a set of guidelines for the definition of a stakeholder. We defined a stakeholder as a group or organization whose mission is to provide service to the community regardless of profit objectives. These have traditionally included schools, religious institutions, non-profit organizations, county healthcare agencies etc. Having established this definition, we used the online resources such as the yellow pages and others to identify these groups. We identified seventy seven (77) groups across the cities of Santa Ana and Garden Grove.

The telephone survey was administered by undergraduate students who chose to volunteer for the establishment of the clinic. The telephone survey consisted of twenty (20) questions which included inquiries into demographic information, perceived challenges, perceived needs, and willingness to take part in future collaboration with the establishment and partnership with the Shifa clinic effort. Telephone survey data was collected from twenty three (23 Centers) that were willing to participate in the survey. Unfortunately not all respondents were able to answer all of the questions. Furthermore, due to administrative challenges, students administering the telephone surveys used various editions of the phone survey.

D. RESULTS

Focus Group

The focus group was attended by five groups including: Orange County Healthcare Agency (Santa Ana), Coalition for Orange County Community Clinics, Project Connections Family Resource Program, Corbin Family Resource Center (Santa Ana) and Calvary Church (Santa Ana). There were seven total attendants besides clinic volunteers who participated in the focus group. The meeting began with a brief synopsis about the Shifa Clinic Project and the purpose behind the focus group as it fits in the context of the need assessment. The briefing was followed by introductions by each member of the group. Participants were given free rein to talk about their organization, its history and its objectives. Following this, participants were handed a survey which included the telephone survey as well as a copy of the focus group questions to retain during the focus group session. Participants were then given a ten minute break to stretch and enjoy some refreshments that were provided. After the break, participants reconvened for the focus group discussion. The discussion format involved was kept open, so when the group was challenged with question participants were free to answer in no particular order. Most participants provided feedback for all the questions that were posed. During the meeting, notes were taken as well as voice recording (with granted permission from the participants prior to the meeting).

Telephone Survey

Demographics

The 23 groups that submitted to the phone survey included 14 groups from Santa Ana and nine groups from the city of Garden Grove. The distribution of the groups included eleven K-12 schools, eight centers of health services, three non-profit organizations, and one religious institution. When asked to identify the major ethnicity of their service population, twenty identified Hispanics, four identified Vietnamese, and three identified white. When asked about the perceived social class of their service population, seven groups reported populations being at or below the poverty line, eight reported lower middle class, and seven reported middle class.

The main demographic served by the representatives in the focus groups were Hispanic, namely mothers and children. It was interesting to note however that while this was the gateway demographic, the service offered were not confined to these groups. Ultimately this was also a gateway for other family services including geriatric medical care and health services for fathers and other members of the family. The focus group further identified mothers as the most willing to seek health services.

Main health issues

When asked what groups thought were the main public health issues facing their populations, 15 of the total 23 respondents provided answers. The main health issues identified by respondents were (in order of frequency): behavioral/mental health, dental health, obesity and diabetes. Of

the15 respondents for this question, 4 identified dental health as the major health issue. Three of the four groups that identified dental health as a major health issue were K-12 schools while the latter came from a homeless shelter.

According to the focus group, the main health-related issues facing their populations were childhood obesity, mental diseases, domestic violence, homelessness, maternal health, substance abuse and sexually transmitted diseases. It is important to point out that the groups represented in the focus group were quite homogenous in their service populations. All of the groups were largely focused on maternal, family and child health.

Barriers to Healthcare Access

The main barrier to access to healthcare was resource-related challenges. Of twenty respondents, fifteen (75%) identified resource-related deficits. These resource deficits have included lack of finances or insurance coverage (62.5%), transportation (25%) and time from work (12.5%). The second challenge to accessing healthcare is fear of deportation or being reported to the INS. Six of twenty respondents (30%) reported the populations they serve feared that their information would be handed over to immigration officials who might then deport them. It is important to realize that respondents identified more than one barrier which was counted separately which explains that the sum is over 100%. Other much less frequent barriers have included apathy and the willingness to wait out the illness.

Focus group members identified three main barriers to seeking health care which included lack of or inadequate housing, fear of the INS and lack of transportation. These were salient responses in all of the groups that participated in the focus group with the exception of the Calvary Church.

What Users Value

When asked what users of health services valued good customer service, confidentiality, earning their trust and comfort. Seven respondents (43.8%) indicated that users valued good customer service, six respondents indicated that confidentiality (37.5%), and three respondents (18.75%) said that comfort and trust were things they valued. Others included speaking the same language and cultural competence.

The results of the focus group further emphasized the importance of three main qualities and identified a number of serious barriers around the perception of value that users have towards services. The first quality was trust and confidentiality. Trust was defined as the ability to rely on what the service providers claim they can do. This includes reliance on pledges of confidentiality, accuracy of information, and following through on services that they provider claims are available.

The second is confidentiality as the main fear associated with all the groups represented at the focus group is the INS. Members recalled that the presence of police or INS vans or buses was a

major and longer lasting deterrent to people seeking services at the facility. The third quality that is very much valued by the users was consistency especially in the method of service. One of the participants indicated that when the service provider changes their method of providing service or arrangements for the provision of service this reflects negatively on the organization. Lack of consistency breeds perceptions of incompetence as well as distrust in the ability of the organization to provide useful health services.

E. ANALYSIS

One over-arching conclusion from the needs assessment is that each demographic has various challenges that need to be addressed. For instance, children's main health burdens included mental health, dental health, childhood obesity, and diabetes. Women, on the other hand face a different set of challenges including sexually transmitted disease, reproductive health, mental health, domestic violence and substance abuse. While the resources needed to meet both sets of concern may certainly overlap, the method of outreach for these two populations maybe different.

Another and perhaps equally important conclusion is that trust and confidence are immensely important to the cooperation and utility of any service provider. The qualities involved with trust and confidence included confidentiality, competence, accuracy and consistency. Another, perhaps, more temporal concern is the initial establishment of that trust. According to the focus group, it is extremely difficult to establish trust without building networks of cooperation with existing groups who already enjoy the trust of the community. This network is also important when extended to other groups, facilities, and services which may help supplement services that the clinic does not offer including housing, food provision etc. The ability of an organization to effectively serve as a gateway to other resources is a critical part of its value to users.

The focus group was able to identify an opportunity for effectively outreaching to the community. According to many of the participants, mothers were usually the most proactive in seeking medical services for their children. This was utilized as a method to recruit not only the mothers but other members of the family later on to seek medical services. When child health services are advertised it could potentially be easier to recruit mothers who will serve as ambassadors to promote trust in the family and community to the organization's services.

F. IMPLICATIONS FOR ACTION

Given the results of our needs assessment we have been able to identify a number of key needs, barriers as well as areas of opportunity for the development of our free clinic More importantly however it has given us an idea of how best to model our approach and to market the clinic to users. Generally speaking, the telephone surveys have provided us with the nature of the challenges while the focus group has given us perspectives on how best to meet them. The overwhelming majority of our service demographic was found to be Hispanic, the partners most

interested in participating are the public institutions such as schools and programs sponsored by the local Health Care Agency.

An Effective Referral Program will be an essential part of Clinic Services

Most of the organizations encountered in this assessment offer some form of referral services, albeit in varying degrees and competency. This is simply due to the fact that those seeking help have challenges that are multi-factorial and oftentimes the issues they come to seek help for are effects of greater living challenges such as homelessness, violence, lack of available resources etc. Given the many needs that exist in the population as well as the limited resources of any future clinic, it is important to conclude that any future battery of services the clinic offers must be supplemented with an effective referral program that will act as a gateway to other service providers. In this needs assessment we identified a number of needs including homelessness, transportation, social-oriented service, financial need-based services etc. Therefore in order to effectively provide comprehensive medical consultation and ultimately, we must also provide users with information to access other services that will help mitigate the barriers to seeking care as well as access to services the clinic does not provide.

Gateway Demographic: A Critical Means to Mitigate Access Challenges

One of the biggest barriers to healthcare access is fear of being deported by immigration. However when asked which group was the most likely to seek healthcare, the focus group unanimously agreed that mothers were the most likely population but only when seeking help for their children. It was also concluded that though most of the focus group served women with children, it was simply a gateway to recruit other members of the family to seek healthcare. Therefore an important consideration to take is which demographic will serve as the “gateway” for other members of the family to be recruited. Healthcare access for children is not only a feasible and provides the highest public health outcome returns, but it is also the most likely to succeed in terms of securing participation and trust from other members of the child’s family.

Furthermore, the results of the phone survey indicated that k-12 schools were most cooperative and most likely to be involved with any future clinic. Schools are a particularly attractive group to partner with when looking to outreach to the community. Health services to children are services that are projected to be the most welcomed by the community as well.

The Three Main Standards of Service

The results of this assessment identified three main qualities that are not only key to building trust but is also critical to enhance cooperation and participation among members of the community. These include confidentiality, valuable and relevant service as well as customer service skills. The provision of valuable, relevant service can be achieved in an iterative manner; adherence to the two others will depend heavily on volunteer development and training. Adherence to the Health Insurance Portability and Accountability Act standards are one such

example among a cohort of staff development trainings are key to establish the desired work culture. Customer service skills involving patient respect, compassion and professionalism are also important components to the adhering to standards of service. Finally relevant services further enhance the value of the service to its users. These include services that are not available, are not performed with the same level of proficiency, or as expensive elsewhere. Such services should represent the focus of the service. The identification of these services will constantly evolve which underscores the important of regular organizational evaluation to provide constant feedback in that regards.

Focus of Services

The focus of services needs to be congruent to the identified health challenges of the community. This needs assessment has identified behavior and mental health, obesity, and dental health as major health concerns for the community. In the telephone survey the most participating group were K-12 schools, whereas in the focus group child and maternal health organizations were the most prevalent. In both instances mental and behavioral health as well as obesity and diabetes were among the most commonly identified health issues. Therefore it is important to focus to meet these challenges. The one barrier might be the difference between the identified health burdens of the community and the perceived health burdens of the community. Though, the health problem may indeed be a pressing issue, cooperation and perception of service value will depend on whether the user also believes that these health issues are important to them.

G. Conclusion

The needs assessment was conducted for the purpose of providing guidance for the establishment of a free health clinic in the Orange County. Establishing this service requires us to identify areas of greatest need to provide services where they are most lacking, and therefore most needed. We also need to identify what services are most required in order to achieve the largest impact possible. Finally we need to identify the barriers that prevent people from seeking these services and steps to take in order to increase trust, utility, and cooperation within the community. Here we have attempted to identify gather information towards these three objectives.

There were many major challenges with this study. First, students used various versions of the telephone survey which might have introduced confounders as well as questions that had very few respondents. The second challenge is that many respondents did not answer the entire questionnaire so the sample size for each question was generally lower than the number of total respondents. Finally, the focus group and the telephone survey had certain biases based on the prevailing majority represented. In the case of the telephone survey, k-12 schools were the majority, whereas the focus group had a predominantly women, maternal and child health as their primary focus. Therefore, this assessment is not without deficiencies and future and regular

studies are needed to assess the accuracy of this assessment as well as the shift of this information over the years.