



MINUTES OF THE BOARD OF SUPERVISORS  
COUNTY OF LOS ANGELES, STATE OF CALIFORNIA

Violet Varona-Lukens, Executive Officer  
Clerk of the Board of Supervisors  
383 Kenneth Hahn Hall of Administration  
Los Angeles, California 90012

S-1

Dr. Allison L. Diamant, Dr. Lillian Gelberg, and Dr. Steve Asch, UCLA researchers, gave a verbal report as detailed in the attached report entitled, "Patient Assessment Survey II" relating to the Department of Health Services' Medicaid 1115 Waiver Demonstration Project, and answered questions posed by the Board.

After discussion, no action was taken by the Board (Supervisor Knabe being absent).

4070103-S1

Attachment

July 1, 2003

*PATIENT ASSESSMENT  
SURVEY II*

**FINAL REPORT**

*Executive Summary*

**Submitted to:**

**THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH  
SERVICES MEDICAID WAIVER DEMONSTRATION PROJECT  
OFFICE**

*Submitted by:*

Allison L. Diamant, MD, MSHS for the PAS II Research Team

## **PAS II Research Team**

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## **I. EXECUTIVE SUMMARY**

### *Background*

The Los Angeles County Department of Health Services (LAC-DHS) plays an integral role in the provision of health care to many low-income adults and children in Los Angeles County. The majority of patients who receive health care through the LAC-DHS are under- or uninsured for health care. The LAC-DHS, in conjunction with a variety of community clinics, provide a health care safety net for a growing number of patients who are at increased risk for having unmet health care needs and poor health.

This project, the Patient Assessment Survey II (PAS II), was designed and implemented as part of the evaluation process of the Medicaid Demonstration Project and as an extension of the 1999 Patient Assessment Survey (PAS I) (Diamant, et al., 1999). Planning for the PAS II began in the summer of 2001, with data collection 2/02 – 7/02, followed by data entry, cleaning, analysis and reporting through 5/03. In addition, the findings from this project will be used to inform the planning process for publicly funded health care in Los Angeles County. The overall goal of this project is to assess primary care patients' reported access and barriers to health care, experiences with care and their satisfaction with the LAC-DHS system. In addition, the project is designed to assess trends over time and to compare LAC-DHS patients with other patient populations, including the general population of Los Angeles County.

### *Overview of Methods*

The target population for this project includes both previous users of the system and new patients (individuals who had not received County health care services previously). In PAS II, patients were interviewed on-site at LAC-DHS facilities throughout Los Angeles County, with representation in all eight Service Planning Areas (SPAs). The sample was divided among four types of facility: 639 from Comprehensive Health Centers (CHC), 574 from Health Centers (HC), 494 from Hospital Outpatient Clinics (HOC), and 604 from Public Private Partnership Program Clinics (P/PP) for a total of 2,521 participants (2,026 adult and 495 pediatric patients).

For adults, individuals were eligible to participate in this study if they were visiting a primary care clinic (General adult medicine, general pediatrics, family medicine or urgent care/walk-in) for a medical visit at a County facility or contracted P/PP on the day of the interview, spoke either Spanish or English, and were able to participate in the process of informed consent. In addition, children had to be 6 months to 17 years of age, and accompanied by a parent or guardian who served as the proxy respondent for the survey. Data collection was performed over a 6-month period beginning Monday February 25<sup>th</sup> at Lake Los Angeles HC and Tarzana Treatment Center – Lancaster and ending Friday July 26<sup>th</sup>. Completion of the survey was based on face-to-face interviews with patients at the facilities included in the study. Sampling and recruitment of patients into the survey took place in the waiting room(s) of eligible intake points. As part of the verbal informed consent process, participants were told that they would receive a monetary incentive (i.e., \$10) if they completed both the main and post-visit interviews.

During the period of data collection over 16,000 patients were included in the head-count, and of the 5,550 patients approached to participate, 3,229 were estimated to be eligible. Among the eligible patients 2,521 completed the main (pre-visit) interview and were included in the final sample – our response rate therefore was 78.1%.

Results are presented for adults and children separately, and for adults and children by the following subgroup analyses: gender, race/ethnicity, insurance status, health status, facility type, and SPA.

## **DESCRIBING THE POPULATION\***

The mean age of adult patients was 43.1 years (range 17 to 96). Among the adults 5% were > 65 years of age and older, and among women 50% were age 18 to 44. The age range for the pediatric sample was 6 months up to 17 years of age with a mean of 7.5 years. The pediatric age distribution was as follows: 6 months to less than 5 years (40%), 5 years to 7 years (21%), 8 years to 12 years (23%), and 13 to 17 years (16%).

Just over two-thirds (68%) of adult patients were female. Insured patients were more likely than uninsured patients to be female (73% and 66%\*). Just over half (55%) of children were female. A greater proportion of the uninsured were girls compared to the children with insurance (63% and 48%\*\*).

The majority of adult patients at LAC-DHS sites including P/PP clinics identified themselves as Latino (73%), followed by African Americans (11%), Whites (8%), Asian/Pacific Islanders (3%), and Others (2%). In addition, a majority of pediatric patients were also Latino (87%), followed by African Americans (7%), Whites (4%), Asian/Pacific Islanders (1%), and Others (1%).

Sixty-eight percent of adult patients were born outside of the U.S. For non-U.S. born patients the mean number of years living in the U.S. was 14.6 (range 1 to 60 years). Three-quarters of pediatric patients were born in the United States. The 25% of the sample that immigrated to the United States had lived in the US for a mean of 4.8 years (range 0-15 years).

Over half (51%) of adult patients reported Spanish as their primary language, almost one third (31%) spoke English; 16% spoke both Spanish and English; and 2% of patients reported a primary language spoken at home other than Spanish or English. Fifty-two percent of the children primarily speak Spanish at home, 19% speak English, 24% speak both Spanish and English, and 2% speak other languages in their homes.

Less than half (44%) of adults had graduated from high school, with a mean grade of regular school completed of 9.2, and a range from zero to 17 years.

Over half of adults indicated that their annual household income was \$10,000 or less. Patients who were insured were more likely than those without insurance to have an annual income of \$10,000 or less (57% and 51%\*). Thirty-eight percent of pediatric patients had an annual household income of \$10,000 or less, which was lower than for adult patients. There was no significant subgroup variation.

Among adult patients only 20% had at least one fulltime job, 14% had one part-time job, 2% had two or more part-time jobs and 63% were not employed. Among those patients who were

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

employed, the number of paid hours worked each week ranged from one to eighty, with a mean of 32.2.

Four-fifths (81%) of adult patients lived in their own home or apartment, 14% were living in a temporary situation with family or friends and 5% were living in another setting (e.g., motel/hotel, shelter, on the street). Ninety-eight percent of respondents reported that they were able to stay in their current residential situation for the next 30 days. Among those adult patients who reported that they lived in their own home or apartment 18% owned their residence.

Forty-two percent of adult patients had at least one child ( $\leq 17$  years of age) living in the household, with a mean of 1.4 (range 0 to 9). Fourteen percent of adult patients had an adult who was 65 years of age and older living in their household, with a mean of 0.2 (range 0 to 10). The mean number of all people living in an adult patient's household was 3.9 (range 1 to 12). Eleven percent of pediatric patients had an adult 65 years of age and older as part of their household. Total household size varied from 2 to 12 individuals with a mean of 4.9.

## **ACCESS TO CARE**

### *HEALTH INSURANCE*

Health insurance is important for everyone because it provides a minimum degree of financial access to health care. However, although health insurance has been demonstrated to be a key component of accessing the health care system, millions of Americans remain uninsured for health care. To meet their medical needs many people rely on the safety net for their medical care. The safety net in Los Angeles is a loosely woven system of medical organizations that includes community and free clinics, and the LAC-DHS health care system.

#### Adults

Less than one-quarter (23%) of adult patients were insured at the time of the interview. While 37% of patients were employed fulltime or part-time, only 10% of their employers or spouse's employers paid for or offered health insurance coverage. Women were somewhat more likely than men to have health insurance or other coverage for health care (24% vs. 19%\*).

Over half (57%) of adults currently uninsured reported they had never had health insurance. Also among the uninsured only 37% had ever applied for MediCal. To try to understand why people might not apply for MediCal coverage we asked individuals whether each of the following might have contributed to their decision. People responded yes or no to each item. Three-fifths of patients did not think they were eligible; just over one third (37%) were afraid they would have to pay back the cost of the medical care they received; one-quarter indicated they do not like to use welfare programs; and, 17% were afraid they or someone in their family could be deported.

Among non-U.S. born patients who were uninsured and had not applied for MediCal just over one-quarter (29%) were fearful it might affect whether they could become a citizen; one-tenth had some other reason.

#### Pediatrics

Fifty three percent of parents reported that their children currently had health insurance. Among the reasons given for not being insured, not being able to afford health insurance was the most

common response (39%), but the following reasons were also given: not eligible because of work status (16%), parents' employment does not offer health insurance (16%), not a citizen/immigration issues 13%), parent changed/lost job (12%), gets health care free (9%), lost public coverage (6%), family situation changed (6%), did not know where to go to apply (5%), and did not know how to fill application (5%). (Note: multiple responses were allowed). Parents at most facility types said that the primary reason their children were not insured was due to not being able to afford health insurance.

Only 52% of parents said they had ever applied for MediCal for their children. The majority of parents who had not applied for MediCal felt that their children were not eligible (49%), and additional reasons included the following: 31% were afraid would have to pay back the medical care received, 29% do not like to use welfare programs, and 22% were afraid that they or someone in their family would be deported. Among non-US born children the primary reason for not applying for MediCal or other government health care programs was fear that it would affect their children's application for citizenship (38%).

#### *RECEIPT OF MEDICAL CARE IN THE PRECEDING 12 MONTHS*

Prior receipt of medical care is a significant predictor for future use of medical services. Patients were asked how many times they had seen a health care provider in the past year, and where they had sought services. In the 12 months prior to the day of the interview, 80% of adult patients had seen a physician for medical care. Adult patients had made a mean of 3.9 visits to a physician (range 0 to 90). Eighty-two percent of children had made a visit to a doctor or nurse. Children made an average of 4.2 visits for medical care in the preceding year (range 1 to 31),

One of the major differences between PAS II and PAS I was the eligibility requirement in the earlier study that patients had to have made one or more visits to an LAC-DHS facility (including P/PP sites) during the year preceding the start of the study. In this study patients were not required to have had any prior interaction with the LAC-DHS in an attempt to better understand patients' experiences within the system. Prior to their current visit 86% of adult patients who had seen a physician in the past year had made a previous visit to an LAC-DHS provider (includes LAC-DHS sites and P/PP sites) within the preceding 12 months (69% of all adult patients). Of those children who had seen a physician in the past year, 89% had been seen at a County facility (73% overall).

Use of medical services for acute illnesses or injury may be an indication of episodic health care seeking, or it may be consistent with the services offered by primary care providers, which includes caring for people with acute and chronic medical conditions. In the past 12 months 23% of adult patients had experienced an illness or injury that required immediate medical care from a physician at a County facility (not an emergency department). Among those patients seen at a County facility for an illness or injury during the past 12 months, 48% reported that they were always seen as soon as they wanted. Fourteen percent of children had had an illness or injury that needed care right away but were not seen in an emergency department, and they had made an average of 3.1 visits to County clinics for this reason. Almost three fifths (59%) of the time they always received medical care for this reason as soon as they wanted.

Access to regular or routine medical care with a focus on preventive health care testing and counseling is an important component of primary medical care services. In the past 12 months,

60% of adult patients had made an appointment for regular or routine medical care at a County facility. Among those adult patients who had made an appointment for regular or routine medical care 55% reported that they were always seen as soon as they wanted. Seventy-five percent of the parents/guardians of pediatric patients had made an appointment for regular or routine medical care for their child during the preceding 12 months, and 54% of children always received medical care as soon as their parent/guardian wanted.

Receipt of necessary medical care may come in the form of help or advice given over the telephone, as well as medical services provided in a doctor's office or health care facility. A system that allows patients to obtain medical advice from a qualified health care provider without making a visit has the potential to facilitate medical care and to increase the number of patients cared for. In the past 12 months 17% of adult patients had called a County clinic during office hours for medical advice or help for themselves, and 47% of patients reported always receiving the advice or help they needed. Just over one-fifth (21%) of parents reported having called a County clinic during office hours to get medical advice or help for their child during the past 12 months, and 50% of parents reported always getting the help or advice they needed.

Many patients have reported waiting for prolonged periods of time at a doctor's appointment. This phenomenon is not unique to the LAC-DHS, but occurs in many HMOs and private practice settings. In some cases, patients' conflicting responsibilities may not allow them to wait for extended periods of time, particularly if they had a scheduled appointment around which they made other plans. One tenth of adult patients indicated that they had left a County clinic without being seen by a physician within the past 12 months. Patients most commonly reported that they had left without being seen was because it took too long/they had somewhere to go (56%), or the physician was not there/there were no appointments (27%). Twelve percent of parents reported having gone to a County facility and leaving without being seen by a doctor at least once during the past 12 months. Forty-three percent reported that the reason they left without being seen was due to either a doctor not being available or no available appointments; 28% reported that the wait was too long, and 24% indicated a variety of other reasons.

At the current visit, over half (54%) of adult patients presented with an acute illness or injury, just over two-fifths (42%) were there for follow-up, 8% for a general checkup, 3% for a medication refill and 1% to be referred to a specialist. Among pediatric patients the reason for their current visit was primarily for an illness/injury (54%), a follow-up appointment (28%), a general checkup (20%), or immunizations (2%).

#### *OTHER OPTIONS FOR MEDICAL CARE*

At the time that this study was performed a majority of the Health Centers were anticipated to close. To learn more about patients' decision making regarding seeking needed medical care participants were asked where they would go for medical care if their current clinic were permanently closed. A majority of adult and pediatric patients would continue to seek medical care within the County system, including 64% of adult and 56% of pediatric patients at other County facilities and 10% of adult and 13% of pediatric patients who would rely on EDs for their care.

### *USUAL SOURCE OF CARE*

Having a usual source of care (USOC) is known to improve the likelihood that people will receive necessary medical care for acute, chronic and preventive health care needs, regardless of health insurance status. However, having health insurance makes it more likely that one will have access to a USOC. A USOC may be a person or facility that an individual identifies as the place they have gone in the past and the likely place they will go in the future for their medical care. Just over half (53%) of adult patients reported having a usual source of care, as did almost three-quarters (73%) of pediatric patients.

### *SEEKING MEDICAL CARE IN MEXICO*

Due to the large Mexican and Central American population in Los Angeles County, and the proximity of Los Angeles to the U.S./Mexican border we assessed the use of medical services in Mexico including visits to a physician and purchase of prescription medications. During the past 12 months 5% of adult and pediatric patients had visited a physician in Mexico. The most common reason adult and pediatric patients had seen a physician in Mexico was because they had become ill while visiting in Mexico (42% and 59%, respectively). In the past 12 months 6% of adult patients had bought medicine from Mexico to use in the U.S.

### *SPECIALTY CARE*

Over one fifth (22%) of adult patients were referred to a specialist for medical care during the past 12 months. Of those patients referred, 75% had seen a specialist. The specialties to which adult patients were most commonly referred during the preceding 12 months included Ophthalmology (25%), Obstetrics/Gynecology (18%), Cardiology (14%), Orthopedics (9%) and Gastroenterology (9%). Fourteen percent of children were referred to a specialist and 73% of these children actually saw a specialist. Children were most commonly referred to the following specialists: Ophthalmology/Optomety (26%) and Neurology (20%). At their most recent specialty referral, just under one-third (29% and 28%, respectively) of adult and pediatric patients were seen by a specialist within one week of scheduling their appointment. However, just under half (47%) of adults and about one-third (34%) of pediatric patients had waited for one or more months.

### *DENTAL CARE*

Dental care even more so than medical care forms an increasing unmet need for low-income and uninsured adults, although many adults with dental insurance do not receive regular dental check-ups and cleanings. In the past 12 months less than one-third (29%) of adult patients had undergone a regular dental checkup, and 20% of patients had seen a dentist for a particular dental problem. Less than two-fifths of parents (37%) reported that in the past 12 months their child had received a regular dental check-up, and 14% indicated that their child received dental care for a particular problem.

Among those people who had a dental problem but were not seen by a dentist the most common reasons included an inability to afford dental services (52%), and not having a place to go/not knowing where to go (13%). If children needed dental care within the past 12 months, but did not get it, parents were most likely to have reported they were unable to afford dental care (19%) and that they did not know where to go for dental care (11%). Among children age 6 to 17 just

over one-tenth (11%) had missed one or more days of school in the past year because of tooth pain or dental problems.

#### *EMERGENCY DEPARTMENT USE*

People may seek medical care at the Emergency Department (ED) for a variety of reasons and, it is not always possible to determine whether the visit to the ED was “appropriate” based on patient report. Approximately one fifth (22% and 19%, respectively) of adult and pediatric patients had experienced an emergency condition that warranted care from an ED during the preceding 12 months. Overall almost one-quarter (24% and 23%, respectively) of adult and pediatric patients had made at least one visit to an ED in the past year. Interestingly, 36% of adult and 39% of the parents of pediatric patients would be willing to accept a scheduled appointment with a physician in lieu of waiting in the ED.

#### *UNMET NEED FOR MEDICAL CARE*

Unmet need for medical care may result in complications and worse health outcomes, including higher rates of morbidity and mortality. A lack of health insurance and low-income have been found to be predictors for greater risk of unmet need, although patients may go without various kinds of medical care for a number of reasons. In this section patients indicated whether they had gone without needed medical services during the preceding 12 months, and some of the reasons why they had not received or had delayed necessary medical care.

Approximately one-fifth (21% and 19%, respectively) of adult and pediatric patients had missed at least one medical appointment during the prior year. One-tenth of adult and 7% of pediatric patients had gone without medication; 17% of adult patients had gone without eyeglasses; and 12% of adult and 8% of pediatric patients had not received medical care when they needed it during the preceding year.

#### *COMPETING PRIORITIES FOR FINANCIAL RESOURCES* •

Competing priorities for financial resources are found more commonly among the low-income and uninsured, and require people to make difficult decisions in terms of prioritizing their basic needs. Patients were asked about using financial resources to pay for basic needs (food, clothing, rent, etc.) in lieu of obtaining medical care, as well as paying for medical care instead of basic needs. Almost one-quarter (23%) of adult patients and only 9% of pediatric patients had gone without needed medical care in the past year because they needed the money to pay for their basic needs. In addition, 12% of adult patients and 5% of pediatric patients went without one or more of their basic needs to use the money to obtain needed medical care.

#### *LANGUAGE ACCESS TO CARE*

Communication is important for providing and obtaining necessary and adequate medical care. Discordant language ability may lead to misunderstanding and inappropriate care. Among the 25% ( $n=375$ ) of adult Latino patients who wanted interpreters in the past 12 months, 52% reported *always* or *usually* having one when they wanted one. Of those adult Latino patients who used interpreters in the past 12 months, 77% reported having trained interpreters or nurses, 12% had other clinic staff, 12% relied on relatives and 3% had friends. Thirty-nine percent of

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friends and relatives who interpreted for Latinos in the past 12 months were younger than 18 years of age. Thirty-nine percent of Latinos who used an interpreter in the past 12 months reported feeling uncomfortable discussing their medical problems with their physicians due to the presence of the interpreter. Among the 29% of parents/guardians who reported wanting an interpreter (n=125), 48% reported *usually* or *always* having one when they wanted. Of the Latino parents/guardians who used interpreters in the past 12 months, 83% were trained interpreters or nurses, 11% were other clinic staff, and 11% were relatives.

**SCHEDULING CURRENT APPOINTMENT**

Approximately one-third (37% and 30%, respectively) of adult and pediatric patients had walked into the clinic without an appointment, while another one-third (37% and 32%, respectively) of adult and pediatric patients had waited more than two weeks for their current appointment.

Twenty-eight percent of adult patients and 19% of parents/guardians thought that they had waited too long for their appointment.

**TRAVEL TIME\***

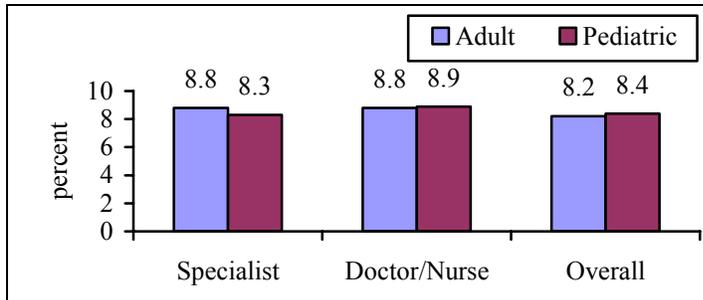
Almost two-fifths (38%) of adult and half of pediatric patients spent less than 15 minutes, while only 9% of adult and 7% of pediatric patients spent one or more hours traveling to their current medical appointment.

**WAITING TIME**

Over half of adult and pediatric patients had waited for one or more hours from their scheduled appointment time to be seen by a physician. At their current visit, approximately two-thirds of adult and the parents of pediatric patients (63% and 67% respectively) reported that they had seen a physician as soon as they wanted.

**SATISFACTION**

**RATINGS OF SATISFACTION AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



Ratings were on a scale from the lowest 0 to the highest 10

Twenty-five percent of the adult patients reported at some time being so unhappy with the services at a County facility that s/he wanted to complain and 33% of the unhappy ones did complain – 8% overall. Similarly, 23% of the parents/guardians had wanted to complain, and 21% of them did so – 5% overall.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

The majority (73%) of adult patients and the parents/guardians of pediatric patients said they would be very likely to return to this clinic if they could go to any clinic for medical care, and a similar proportion reported that they would recommend their current clinic to a friend or relative.

## *HEALTH BEHAVIORS*

### *Physical Activity*

Only one third of adults reported engaging in vigorous exercise for at least 10 minutes at least once each week, although three-quarters of patients indicated that they walked for at least ten minutes at least once in a usual week. Of those 75% of patients almost half walked for more than 45 minutes at a time. These findings indicate that patients are not as active as they should be to reduce their risk for chronic conditions. While it is true that this is a population of patients in care, many of the conditions they suffer from could potentially be alleviated to some degree or better controlled through regular physical activity and a balanced diet that could lead to necessary weight loss. Physicians, nurses and other health care providers need to spend time with patients advocating regular physical activity. At a societal level adequate facilities need to be available, including neighborhoods that are safe to walk around during the day and at night.

Children and adolescents appear to be spending a large proportion of time watching television or using the computer (29% spent three or more hours each day watching television). This inactivity may put them at elevated risk for becoming overweight with a resultant risk for obesity related conditions as previously mentioned – diabetes, hypertension, and cardiovascular disease. Further emphasis needs to be made by health care providers, as well as by educators to increase the level of physical activity among children and adolescents.

### *Body Mass Index*

Obesity is at epidemic proportions in this country among both children and adults, giving rise to an increased risk for chronic medical conditions such as diabetes, hypertension and heart disease. Risk for obesity is based on lack of physical activity and excess caloric intake or a lack of appropriate nutritional balance in food consumption.

Over two thirds (73%) of adults in this study were either overweight (38%) or obese (35%). This finding is somewhat higher than rates in the national or state population. Only a small portion of patients reported being told by their health care provider that they were overweight, and an even smaller proportion had received assistance or counseling from someone in a doctor's office to help them lose weight.

### *Consumption of fruits and vegetables*

Participants reported eating a mean of only 2.2 servings of fruits and vegetables on the day preceding the interview, while the mean number of daily servings of fruits and vegetables that patients thought they should eat was 3.8. These levels are both well below the suggested goal of five or more servings of fruits or vegetables in a day for a health and balanced diet. The cost and availability of fresh fruits and vegetables may be contributing to the paucity of fresh produce in people's diets. Studies have indicated that when people have ready access to markets, and when the stores carry reasonably priced produce and other healthful food options that people are more likely to purchase these items and to prepare them for their families.

### *Smoking*

Cigarette smoking is closely associated with multiple acute and chronic medical conditions. Studies have demonstrated that counseling by a physician to stop smoking is one of the most effective interventions. Smoking rates among patients in PAS II were lower than expected with over four-fifths of patients reporting that they had never smoked.

### *PREVENTIVE HEALTH CARE*

#### *Physician Health Screening Behaviors*

We assessed physician screening behaviors for alcohol, smoking, recreational drug use, sexual activity and gender of sexual partners, and risk for domestic or intimate partner violence. Rates of screening ranged widely from asking about cigarette smoking (73%) and alcohol use (70%), to sexual activity (39%), gender of sexual partners (15%) and risk for violence (13%).

These are all behaviors or experiences that may contribute to one's health status. Some of these personal behaviors are modifiable such as smoking, alcohol and drug use and physicians should take the opportunity to counsel patients about the health risks associated with them. Sexual activity can be a risk to health through the transmission of sexually transmitted diseases, survival sex, or unintended pregnancy. Clinicians should be asking all patients about their sexual activity to determine those at elevated risk.

Additionally, domestic or intimate partner violence is far more prevalent than many health care providers think. However, most patients indicated that they were not asked about domestic or intimate partner violence.

#### *Colorectal Cancer Screening*

Colorectal cancer (CRC) is a readily diagnosable condition, with considerable treatment options and good outcomes for those patients diagnosed at an earlier stage. Rates for CRC screening among the adults age 50 years and older were lower than national averages, and lower than other patient populations. This may easily be explained for flexible sigmoidoscopy and colonoscopy which are only performed for diagnostic purposes with in the LAC-DHS system. However, annual fecal occult blood testing (FOBT) is inexpensive, and appears to be significantly underused in this population.

#### *Pediatric Immunizations*

Immunizations protect children from serious infectious diseases and are considered an important marker of the adequacy of preventive care (HEDIS). Incomplete immunization levels may also indicate an adequate number of well-child visits. The majority of children were receiving their immunizations at the facility where the interview took place. Based on the results it appears that some review is taking place on the part of health care providers to assess whether children are up to date on their immunizations, although only 11% of parents reported always being told when to bring their child in for immunizations. The explanation for this may be that health care providers are not explicitly telling parents when to bring their children back, but are scheduling return visits at the appropriate time.

### *HEALTH STATUS*

Only 15% of adult patients reported their health status as excellent or very good while 24%

reported fair or poor health. Comparison with published SF-12 scores indicate that patients in this sample have overall worse physical and mental health status (Lundberg et al., 1999; Sugar et al., 1998; Ware, et al., 1995; Wu et al., 1997). The findings in this study indicate that adult patients who reported poor health were more likely to have made a visit for medical care, although many people in poor health still reported considerable barriers to receipt of needed health care.

### *QUALITY AND PROCESS OF CARE*

#### *Quality of Care for Diabetes- Adult*

Diabetes is a major cause of morbidity and mortality; and medical care for diabetes accounts for almost 15% of national health care expenses (Javitt et al., 1995). The development of standardized quality of care indicators for diabetes includes a focus on ophthalmologic/retinal care, foot care, blood pressure control, glycemic control, and cholesterol (Beckles et al., 1998; DCCT 1993).

Sixteen percent of adult patients reported being told they had diabetes, although there was no racial/ethnic variation in the prevalence of diabetes in this sample. Patients with diabetes within the LAC-DHS system appear to be receiving diabetes related care at rates similar to that provided in other health care settings. Nationally as well as locally, compliance with quality of care indicators for diabetes is lower than optimal, and should be the focus of patient and provider education.

#### *Quality of Care for Asthma*

##### Adult

Asthma is a respiratory condition that affects adults as well as children, and may cause significant morbidity and mortality if not properly treated. Treatment may include the use of inhalers on an as needed basis, regular use of inhaled medications and if necessary systemic steroids.

In this sample 9% of adult patients had been told they had asthma. Over half of adults with asthma were using a beta agonist, but only 15% were using an inhaled steroid. Based on the proportion of patients who had persistent symptoms of asthma (22% everyday and 19% a few days a week), these patients appear to be under treated. This may be a reflection of one or more of the following: lack of knowledge on the part of providers, availability of medications and patient adherence. Adults at CHCs were the most likely to have received asthma related education. If there are standardized education programs or curriculum on asthma for providers and/or patients at these sites, they might be distributed to other facilities.

##### Pediatric

Asthma in children has been found to disproportionately affect children in urban areas, and those whose families are poor. In this sample, 10% of parents reported they had been told their child had asthma, with some variation by insurance status. Insured children were more likely than those who were uninsured to have asthma (14% vs. 4%).

The majority of pediatric patients were using only a beta-agonist inhaler, with only 6% using an inhaled steroid, while 25% of children had been on a course of oral steroids at least once during the preceding year. These findings may indicate inadequate or inappropriate asthma care due to

poor patient (and parent) education, and a lack of understanding about the appropriate use of steroid inhalers (they are not to be used as “rescue medications” but rather for long-term prevention/control purposes). In addition, these findings may reflect physician’s lack of knowledge regarding the use of inhaled steroids as the standard of care of pediatric patients with persistent asthma and patients’ inability to obtain the medication due to financial and other barriers. Furthermore, over one-third of pediatric patients with asthma had made a visit to an ED during the past year, with a mean of 1.34 visits. Health care providers are educating parents and patients at rates of 43% to 73%, although only one-quarter of children with asthma had received an influenza injection during the flu season.

#### *Mental Health - Patterns of Care for Depression*

Depression is under-diagnosed in this country among all populations of patients. It has potentially life-altering effects on quality of life and performance of daily activities, and may have a disproportionate affect on low-income uninsured patients because of limited access to mental health care. The lack of receipt of mental health services may be an indication of the barriers to receipt of needed care in LA County as well as other individual and societal perceptions that act as barriers to care. In addition, although a high proportion of patients who had a perceived need for mental health care had received care, over one-third of these individuals had received treatment from a non-medical provider. This calls in to question the appropriateness and efficacy of the treatment that patients are receiving for mental health conditions. The very high rates of depressive symptoms in this patient population seem to indicate a need for the expansion of mental health services throughout LA County.

#### *FOOD SECURITY*

Low-income individuals are at particular risk for not having adequate nutritional resources, mainly due to inadequate financial resources. Even with access to food in general, people may be limited in their ability to obtain healthy and nutritious food options, and may consume whatever food is available in lieu of going hungry. Lack of access to food may have particular implications for people with chronic medical conditions as well as growing children. Significant proportions of both adults and children in this sample were at ongoing risk for not being able to obtain adequate food. In fact, pediatric patients appear to be at higher risk than adult patients for not having access to adequate food, including nutritional options. Adult and pediatric patients appeared to be using food kitchens at similar rates.

#### **Conclusions**

On the whole the results of this survey indicate that patients using LAC-DHS primary care clinics receive care that is appropriate according to national guidelines and comparable to other patient populations. The continuation of the Public Private Partnership Program (P/PP) appears to have increased patients’ access to and use of necessary and appropriate health care. We draw this conclusion based on patients’ reports about where they receive their medical care; the comparisons of care provided by the different facilities; and the levels of patient reported ratings of care. However, there still appear to be areas in the provision and receipt of health care by patients through the LAC-DHS that can be greatly improved. This study provides important information for the development and implementation of programs that provide health care to vulnerable populations, as well as developing ongoing processes of data collection and evaluation to assess the impact and effectiveness of the programs.

*PATIENT ASSESSMENT  
SURVEY II*

**FINAL REPORT**

**Submitted to:**

**THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH  
SERVICES MEDICAID WAIVER DEMONSTRATION PROJECT  
OFFICE**

*Submitted by:*

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## **I. EXECUTIVE SUMMARY**

### *Background*

The Los Angeles County Department of Health Services (LAC-DHS) plays an integral role in the provision of health care to many low-income adults and children in Los Angeles County. The majority of patients who receive health care through the LAC-DHS are under- or uninsured for health care. The LAC-DHS, in conjunction with a variety of community clinics, provide a health care safety net for a growing number of patients who are at increased risk for having unmet health care needs and poor health.

This project, the Patient Assessment Survey II (PAS II), was designed and implemented as part of the evaluation process of the Medicaid Demonstration Project and as an extension of the 1999 Patient Assessment Survey (PAS I) (Diamant, et al., 1999). Planning for the PAS II began in the summer of 2001, with data collection 2/02 – 7/02, followed by data entry, cleaning, analysis and reporting through 5/03. In addition, the findings from this project will be used to inform the planning process for publicly funded health care in Los Angeles County. The overall goal of this project is to assess primary care patients' reported access and barriers to health care, experiences with care and their satisfaction with the LAC-DHS system. In addition, the project is designed to assess trends over time and to compare LAC-DHS patients with other patient populations, including the general population of Los Angeles County.

### *Overview of Methods*

The target population for this project includes both previous users of the system and new patients (individuals who had not received County health care services previously). In PAS II, patients were interviewed on-site at LAC-DHS facilities throughout Los Angeles County, with representation in all eight Service Planning Areas (SPAs). The sample was divided among four types of facility: 639 from Comprehensive Health Centers (CHC), 574 from Health Centers (HC), 494 from Hospital Outpatient Clinics (HOC), and 604 from Public Private Partnership Program Clinics (P/PP) for a total of 2,521 participants (2,026 adult and 495 pediatric patients).

For adults, individuals were eligible to participate in this study if they were visiting a primary care clinic (General adult medicine, general pediatrics, family medicine or urgent care/walk-in) for a medical visit at a County facility or contracted P/PP on the day of the interview, spoke either Spanish or English, and were able to participate in the process of informed consent. In addition, children had to be 6 months to 17 years of age, and accompanied by a parent or guardian who served as the proxy respondent for the survey. Data collection was performed over a 6-month period beginning Monday February 25<sup>th</sup> at Lake Los Angeles HC and Tarzana Treatment Center – Lancaster and ending Friday July 26<sup>th</sup>. Completion of the survey was based on face-to-face interviews with patients at the facilities included in the study. Sampling and recruitment of patients into the survey took place in the waiting room(s) of eligible intake points. As part of the verbal informed consent process, participants were told that they would receive a monetary incentive (i.e., \$10) if they completed both the main and post-visit interviews.

During the period of data collection over 16,000 patients were included in the head-count, and of the 5,550 patients approached to participate, 3,229 were estimated to be eligible. Among the eligible patients 2,521 completed the main (pre-visit) interview and were included in the final sample – our response rate therefore was 78.1%.

Results are presented for adults and children separately, and for adults and children by the following subgroup analyses: gender, race/ethnicity, insurance status, health status, facility type, and SPA.

## **DESCRIBING THE POPULATION\***

The mean age of adult patients was 43.1 years (range 17 to 96). Among the adults 5% were > 65 years of age and older, and among women 50% were age 18 to 44. The age range for the pediatric sample was 6 months up to 17 years of age with a mean of 7.5 years. The pediatric age distribution was as follows: 6 months to less than 5 years (40%), 5 years to 7 years (21%), 8 years to 12 years (23%), and 13 to 17 years (16%).

Just over two-thirds (68%) of adult patients were female. Insured patients were more likely than uninsured patients to be female (73% and 66%\*). Just over half (55%) of children were female. A greater proportion of the uninsured were girls compared to the children with insurance (63% and 48%\*\*).

The majority of adult patients at LAC-DHS sites including P/PP clinics identified themselves as Latino (73%), followed by African Americans (11%), Whites (8%), Asian/Pacific Islanders (3%), and Others (2%). In addition, a majority of pediatric patients were also Latino (87%), followed by African Americans (7%), Whites (4%), Asian/Pacific Islanders (1%), and Others (1%).

Sixty-eight percent of adult patients were born outside of the U.S. For non-U.S. born patients the mean number of years living in the U.S. was 14.6 (range 1 to 60 years). Three-quarters of pediatric patients were born in the United States. The 25% of the sample that immigrated to the United States had lived in the US for a mean of 4.8 years (range 0-15 years).

Over half (51%) of adult patients reported Spanish as their primary language, almost one third (31%) spoke English; 16% spoke both Spanish and English; and 2% of patients reported a primary language spoken at home other than Spanish or English. Fifty-two percent of the children primarily speak Spanish at home, 19% speak English, 24% speak both Spanish and English, and 2% speak other languages in their homes.

Less than half (44%) of adults had graduated from high school, with a mean grade of regular school completed of 9.2, and a range from zero to 17 years.

Over half of adults indicated that their annual household income was \$10,000 or less. Patients who were insured were more likely than those without insurance to have an annual income of \$10,000 or less (57% and 51%\*). Thirty-eight percent of pediatric patients had an annual household income of \$10,000 or less, which was lower than for adult patients. There was no significant subgroup variation.

Among adult patients only 20% had at least one fulltime job, 14% had one part-time job, 2% had two or more part-time jobs and 63% were not employed. Among those patients who were

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

employed, the number of paid hours worked each week ranged from one to eighty, with a mean of 32.2.

Four-fifths (81%) of adult patients lived in their own home or apartment, 14% were living in a temporary situation with family or friends and 5% were living in another setting (e.g., motel/hotel, shelter, on the street). Ninety-eight percent of respondents reported that they were able to stay in their current residential situation for the next 30 days. Among those adult patients who reported that they lived in their own home or apartment 18% owned their residence.

Forty-two percent of adult patients had at least one child ( $\leq 17$  years of age) living in the household, with a mean of 1.4 (range 0 to 9). Fourteen percent of adult patients had an adult who was 65 years of age and older living in their household, with a mean of 0.2 (range 0 to 10). The mean number of all people living in an adult patient's household was 3.9 (range 1 to 12). Eleven percent of pediatric patients had an adult 65 years of age and older as part of their household. Total household size varied from 2 to 12 individuals with a mean of 4.9.

## **ACCESS TO CARE**

### *HEALTH INSURANCE*

Health insurance is important for everyone because it provides a minimum degree of financial access to health care. However, although health insurance has been demonstrated to be a key component of accessing the health care system, millions of Americans remain uninsured for health care. To meet their medical needs many people rely on the safety net for their medical care. The safety net in Los Angeles is a loosely woven system of medical organizations that includes community and free clinics, and the LAC-DHS health care system.

#### Adults

Less than one-quarter (23%) of adult patients were insured at the time of the interview. While 37% of patients were employed fulltime or part-time, only 10% of their employers or spouse's employers paid for or offered health insurance coverage. Women were somewhat more likely than men to have health insurance or other coverage for health care (24% vs. 19%\*).

Over half (57%) of adults currently uninsured reported they had never had health insurance. Also among the uninsured only 37% had ever applied for MediCal. To try to understand why people might not apply for MediCal coverage we asked individuals whether each of the following might have contributed to their decision. People responded yes or no to each item. Three-fifths of patients did not think they were eligible; just over one third (37%) were afraid they would have to pay back the cost of the medical care they received; one-quarter indicated they do not like to use welfare programs; and, 17% were afraid they or someone in their family could be deported.

Among non-U.S. born patients who were uninsured and had not applied for MediCal just over one-quarter (29%) were fearful it might affect whether they could become a citizen; one-tenth had some other reason.

#### Pediatrics

Fifty three percent of parents reported that their children currently had health insurance. Among the reasons given for not being insured, not being able to afford health insurance was the most

common response (39%), but the following reasons were also given: not eligible because of work status (16%), parents' employment does not offer health insurance (16%), not a citizen/immigration issues 13%), parent changed/lost job (12%), gets health care free (9%), lost public coverage (6%), family situation changed (6%), did not know where to go to apply (5%), and did not know how to fill application (5%). (Note: multiple responses were allowed). Parents at most facility types said that the primary reason their children were not insured was due to not being able to afford health insurance.

Only 52% of parents said they had ever applied for MediCal for their children. The majority of parents who had not applied for MediCal felt that their children were not eligible (49%), and additional reasons included the following: 31% were afraid would have to pay back the medical care received, 29% do not like to use welfare programs, and 22% were afraid that they or someone in their family would be deported. Among non-US born children the primary reason for not applying for MediCal or other government health care programs was fear that it would affect their children's application for citizenship (38%).

#### *RECEIPT OF MEDICAL CARE IN THE PRECEDING 12 MONTHS*

Prior receipt of medical care is a significant predictor for future use of medical services. Patients were asked how many times they had seen a health care provider in the past year, and where they had sought services. In the 12 months prior to the day of the interview, 80% of adult patients had seen a physician for medical care. Adult patients had made a mean of 3.9 visits to a physician (range 0 to 90). Eighty-two percent of children had made a visit to a doctor or nurse. Children made an average of 4.2 visits for medical care in the preceding year (range 1 to 31),

One of the major differences between PAS II and PAS I was the eligibility requirement in the earlier study that patients had to have made one or more visits to an LAC-DHS facility (including P/PP sites) during the year preceding the start of the study. In this study patients were not required to have had any prior interaction with the LAC-DHS in an attempt to better understand patients' experiences within the system. Prior to their current visit 86% of adult patients who had seen a physician in the past year had made a previous visit to an LAC-DHS provider (includes LAC-DHS sites and P/PP sites) within the preceding 12 months (69% of all adult patients). Of those children who had seen a physician in the past year, 89% had been seen at a County facility (73% overall).

Use of medical services for acute illnesses or injury may be an indication of episodic health care seeking, or it may be consistent with the services offered by primary care providers, which includes caring for people with acute and chronic medical conditions. In the past 12 months 23% of adult patients had experienced an illness or injury that required immediate medical care from a physician at a County facility (not an emergency department). Among those patients seen at a County facility for an illness or injury during the past 12 months, 48% reported that they were always seen as soon as they wanted. Fourteen percent of children had had an illness or injury that needed care right away but were not seen in an emergency department, and they had made an average of 3.1 visits to County clinics for this reason. Almost three fifths (59%) of the time they always received medical care for this reason as soon as they wanted.

Access to regular or routine medical care with a focus on preventive health care testing and counseling is an important component of primary medical care services. In the past 12 months,

60% of adult patients had made an appointment for regular or routine medical care at a County facility. Among those adult patients who had made an appointment for regular or routine medical care 55% reported that they were always seen as soon as they wanted. Seventy-five percent of the parents/guardians of pediatric patients had made an appointment for regular or routine medical care for their child during the preceding 12 months, and 54% of children always received medical care as soon as their parent/guardian wanted.

Receipt of necessary medical care may come in the form of help or advice given over the telephone, as well as medical services provided in a doctor's office or health care facility. A system that allows patients to obtain medical advice from a qualified health care provider without making a visit has the potential to facilitate medical care and to increase the number of patients cared for. In the past 12 months 17% of adult patients had called a County clinic during office hours for medical advice or help for themselves, and 47% of patients reported always receiving the advice or help they needed. Just over one-fifth (21%) of parents reported having called a County clinic during office hours to get medical advice or help for their child during the past 12 months, and 50% of parents reported always getting the help or advice they needed.

Many patients have reported waiting for prolonged periods of time at a doctor's appointment. This phenomenon is not unique to the LAC-DHS, but occurs in many HMOs and private practice settings. In some cases, patients' conflicting responsibilities may not allow them to wait for extended periods of time, particularly if they had a scheduled appointment around which they made other plans. One tenth of adult patients indicated that they had left a County clinic without being seen by a physician within the past 12 months. Patients most commonly reported that they had left without being seen was because it took too long/they had somewhere to go (56%), or the physician was not there/there were no appointments (27%). Twelve percent of parents reported having gone to a County facility and leaving without being seen by a doctor at least once during the past 12 months. Forty-three percent reported that the reason they left without being seen was due to either a doctor not being available or no available appointments; 28% reported that the wait was too long, and 24% indicated a variety of other reasons.

At the current visit, over half (54%) of adult patients presented with an acute illness or injury, just over two-fifths (42%) were there for follow-up, 8% for a general checkup, 3% for a medication refill and 1% to be referred to a specialist. Among pediatric patients the reason for their current visit was primarily for an illness/injury (54%), a follow-up appointment (28%), a general checkup (20%), or immunizations (2%).

#### *OTHER OPTIONS FOR MEDICAL CARE*

At the time that this study was performed a majority of the Health Centers were anticipated to close. To learn more about patients' decision making regarding seeking needed medical care participants were asked where they would go for medical care if their current clinic were permanently closed. A majority of adult and pediatric patients would continue to seek medical care within the County system, including 64% of adult and 56% of pediatric patients at other County facilities and 10% of adult and 13% of pediatric patients who would rely on EDs for their care.

### *USUAL SOURCE OF CARE*

Having a usual source of care (USOC) is known to improve the likelihood that people will receive necessary medical care for acute, chronic and preventive health care needs, regardless of health insurance status. However, having health insurance makes it more likely that one will have access to a USOC. A USOC may be a person or facility that an individual identifies as the place they have gone in the past and the likely place they will go in the future for their medical care. Just over half (53%) of adult patients reported having a usual source of care, as did almost three-quarters (73%) of pediatric patients.

### *SEEKING MEDICAL CARE IN MEXICO*

Due to the large Mexican and Central American population in Los Angeles County, and the proximity of Los Angeles to the U.S./Mexican border we assessed the use of medical services in Mexico including visits to a physician and purchase of prescription medications. During the past 12 months 5% of adult and pediatric patients had visited a physician in Mexico. The most common reason adult and pediatric patients had seen a physician in Mexico was because they had become ill while visiting in Mexico (42% and 59%, respectively). In the past 12 months 6% of adult patients had bought medicine from Mexico to use in the U.S.

### *SPECIALTY CARE*

Over one fifth (22%) of adult patients were referred to a specialist for medical care during the past 12 months. Of those patients referred, 75% had seen a specialist. The specialties to which adult patients were most commonly referred during the preceding 12 months included Ophthalmology (25%), Obstetrics/Gynecology (18%), Cardiology (14%), Orthopedics (9%) and Gastroenterology (9%). Fourteen percent of children were referred to a specialist and 73% of these children actually saw a specialist. Children were most commonly referred to the following specialists: Ophthalmology/Optomety (26%) and Neurology (20%). At their most recent specialty referral, just under one-third (29% and 28%, respectively) of adult and pediatric patients were seen by a specialist within one week of scheduling their appointment. However, just under half (47%) of adults and about one-third (34%) of pediatric patients had waited for one or more months.

### *DENTAL CARE*

Dental care even more so than medical care forms an increasing unmet need for low-income and uninsured adults, although many adults with dental insurance do not receive regular dental check-ups and cleanings. In the past 12 months less than one-third (29%) of adult patients had undergone a regular dental checkup, and 20% of patients had seen a dentist for a particular dental problem. Less than two-fifths of parents (37%) reported that in the past 12 months their child had received a regular dental check-up, and 14% indicated that their child received dental care for a particular problem.

Among those people who had a dental problem but were not seen by a dentist the most common reasons included an inability to afford dental services (52%), and not having a place to go/not knowing where to go (13%). If children needed dental care within the past 12 months, but did not get it, parents were most likely to have reported they were unable to afford dental care (19%) and that they did not know where to go for dental care (11%). Among children age 6 to 17 just

over one-tenth (11%) had missed one or more days of school in the past year because of tooth pain or dental problems.

#### *EMERGENCY DEPARTMENT USE*

People may seek medical care at the Emergency Department (ED) for a variety of reasons and, it is not always possible to determine whether the visit to the ED was “appropriate” based on patient report. Approximately one fifth (22% and 19%, respectively) of adult and pediatric patients had experienced an emergency condition that warranted care from an ED during the preceding 12 months. Overall almost one-quarter (24% and 23%, respectively) of adult and pediatric patients had made at least one visit to an ED in the past year. Interestingly, 36% of adult and 39% of the parents of pediatric patients would be willing to accept a scheduled appointment with a physician in lieu of waiting in the ED.

#### *UNMET NEED FOR MEDICAL CARE*

Unmet need for medical care may result in complications and worse health outcomes, including higher rates of morbidity and mortality. A lack of health insurance and low-income have been found to be predictors for greater risk of unmet need, although patients may go without various kinds of medical care for a number of reasons. In this section patients indicated whether they had gone without needed medical services during the preceding 12 months, and some of the reasons why they had not received or had delayed necessary medical care.

Approximately one-fifth (21% and 19%, respectively) of adult and pediatric patients had missed at least one medical appointment during the prior year. One-tenth of adult and 7% of pediatric patients had gone without medication; 17% of adult patients had gone without eyeglasses; and 12% of adult and 8% of pediatric patients had not received medical care when they needed it during the preceding year.

#### *COMPETING PRIORITIES FOR FINANCIAL RESOURCES •*

Competing priorities for financial resources are found more commonly among the low-income and uninsured, and require people to make difficult decisions in terms of prioritizing their basic needs. Patients were asked about using financial resources to pay for basic needs (food, clothing, rent, etc.) in lieu of obtaining medical care, as well as paying for medical care instead of basic needs. Almost one-quarter (23%) of adult patients and only 9% of pediatric patients had gone without needed medical care in the past year because they needed the money to pay for their basic needs. In addition, 12% of adult patients and 5% of pediatric patients went without one or more of their basic needs to use the money to obtain needed medical care.

#### *LANGUAGE ACCESS TO CARE*

Communication is important for providing and obtaining necessary and adequate medical care. Discordant language ability may lead to misunderstanding and inappropriate care. Among the 25% ( $n=375$ ) of adult Latino patients who wanted interpreters in the past 12 months, 52% reported *always* or *usually* having one when they wanted one. Of those adult Latino patients who used interpreters in the past 12 months, 77% reported having trained interpreters or nurses, 12% had other clinic staff, 12% relied on relatives and 3% had friends. Thirty-nine percent of

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• Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

friends and relatives who interpreted for Latinos in the past 12 months were younger than 18 years of age. Thirty-nine percent of Latinos who used an interpreter in the past 12 months reported feeling uncomfortable discussing their medical problems with their physicians due to the presence of the interpreter. Among the 29% of parents/guardians who reported wanting an interpreter (n=125), 48% reported *usually* or *always* having one when they wanted. Of the Latino parents/guardians who used interpreters in the past 12 months, 83% were trained interpreters or nurses, 11% were other clinic staff, and 11% were relatives.

**SCHEDULING CURRENT APPOINTMENT**

Approximately one-third (37% and 30%, respectively) of adult and pediatric patients had walked into the clinic without an appointment, while another one-third (37% and 32%, respectively) of adult and pediatric patients had waited more than two weeks for their current appointment.

Twenty-eight percent of adult patients and 19% of parents/guardians thought that they had waited too long for their appointment.

**TRAVEL TIME\***

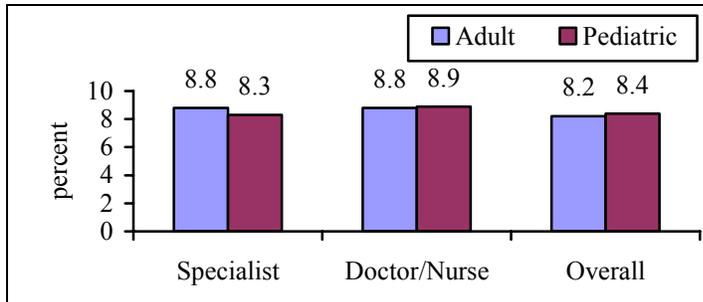
Almost two-fifths (38%) of adult and half of pediatric patients spent less than 15 minutes, while only 9% of adult and 7% of pediatric patients spent one or more hours traveling to their current medical appointment.

**WAITING TIME**

Over half of adult and pediatric patients had waited for one or more hours from their scheduled appointment time to be seen by a physician. At their current visit, approximately two-thirds of adult and the parents of pediatric patients (63% and 67% respectively) reported that they had seen a physician as soon as they wanted.

**SATISFACTION**

**RATINGS OF SATISFACTION AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



Ratings were on a scale from the lowest 0 to the highest 10

Twenty-five percent of the adult patients reported at some time being so unhappy with the services at a County facility that s/he wanted to complain and 33% of the unhappy ones did complain – 8% overall. Similarly, 23% of the parents/guardians had wanted to complain, and 21% of them did so – 5% overall.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

The majority (73%) of adult patients and the parents/guardians of pediatric patients said they would be very likely to return to this clinic if they could go to any clinic for medical care, and a similar proportion reported that they would recommend their current clinic to a friend or relative.

## *HEALTH BEHAVIORS*

### *Physical Activity*

Only one third of adults reported engaging in vigorous exercise for at least 10 minutes at least once each week, although three-quarters of patients indicated that they walked for at least ten minutes at least once in a usual week. Of those 75% of patients almost half walked for more than 45 minutes at a time. These findings indicate that patients are not as active as they should be to reduce their risk for chronic conditions. While it is true that this is a population of patients in care, many of the conditions they suffer from could potentially be alleviated to some degree or better controlled through regular physical activity and a balanced diet that could lead to necessary weight loss. Physicians, nurses and other health care providers need to spend time with patients advocating regular physical activity. At a societal level adequate facilities need to be available, including neighborhoods that are safe to walk around during the day and at night.

Children and adolescents appear to be spending a large proportion of time watching television or using the computer (29% spent three or more hours each day watching television). This inactivity may put them at elevated risk for becoming overweight with a resultant risk for obesity related conditions as previously mentioned – diabetes, hypertension, and cardiovascular disease. Further emphasis needs to be made by health care providers, as well as by educators to increase the level of physical activity among children and adolescents.

### *Body Mass Index*

Obesity is at epidemic proportions in this country among both children and adults, giving rise to an increased risk for chronic medical conditions such as diabetes, hypertension and heart disease. Risk for obesity is based on lack of physical activity and excess caloric intake or a lack of appropriate nutritional balance in food consumption.

Over two thirds (73%) of adults in this study were either overweight (38%) or obese (35%). This finding is somewhat higher than rates in the national or state population. Only a small portion of patients reported being told by their health care provider that they were overweight, and an even smaller proportion had received assistance or counseling from someone in a doctor's office to help them lose weight.

### *Consumption of fruits and vegetables*

Participants reported eating a mean of only 2.2 servings of fruits and vegetables on the day preceding the interview, while the mean number of daily servings of fruits and vegetables that patients thought they should eat was 3.8. These levels are both well below the suggested goal of five or more servings of fruits or vegetables in a day for a health and balanced diet. The cost and availability of fresh fruits and vegetables may be contributing to the paucity of fresh produce in people's diets. Studies have indicated that when people have ready access to markets, and when the stores carry reasonably priced produce and other healthful food options that people are more likely to purchase these items and to prepare them for their families.

### *Smoking*

Cigarette smoking is closely associated with multiple acute and chronic medical conditions. Studies have demonstrated that counseling by a physician to stop smoking is one of the most effective interventions. Smoking rates among patients in PAS II were lower than expected with over four-fifths of patients reporting that they had never smoked.

### *PREVENTIVE HEALTH CARE*

#### *Physician Health Screening Behaviors*

We assessed physician screening behaviors for alcohol, smoking, recreational drug use, sexual activity and gender of sexual partners, and risk for domestic or intimate partner violence. Rates of screening ranged widely from asking about cigarette smoking (73%) and alcohol use (70%), to sexual activity (39%), gender of sexual partners (15%) and risk for violence (13%).

These are all behaviors or experiences that may contribute to one's health status. Some of these personal behaviors are modifiable such as smoking, alcohol and drug use and physicians should take the opportunity to counsel patients about the health risks associated with them. Sexual activity can be a risk to health through the transmission of sexually transmitted diseases, survival sex, or unintended pregnancy. Clinicians should be asking all patients about their sexual activity to determine those at elevated risk.

Additionally, domestic or intimate partner violence is far more prevalent than many health care providers think. However, most patients indicated that they were not asked about domestic or intimate partner violence.

#### *Colorectal Cancer Screening*

Colorectal cancer (CRC) is a readily diagnosable condition, with considerable treatment options and good outcomes for those patients diagnosed at an earlier stage. Rates for CRC screening among the adults age 50 years and older were lower than national averages, and lower than other patient populations. This may easily be explained for flexible sigmoidoscopy and colonoscopy which are only performed for diagnostic purposes with in the LAC-DHS system. However, annual fecal occult blood testing (FOBT) is inexpensive, and appears to be significantly underused in this population.

#### *Pediatric Immunizations*

Immunizations protect children from serious infectious diseases and are considered an important marker of the adequacy of preventive care (HEDIS). Incomplete immunization levels may also indicate an adequate number of well-child visits. The majority of children were receiving their immunizations at the facility where the interview took place. Based on the results it appears that some review is taking place on the part of health care providers to assess whether children are up to date on their immunizations, although only 11% of parents reported always being told when to bring their child in for immunizations. The explanation for this may be that health care providers are not explicitly telling parents when to bring their children back, but are scheduling return visits at the appropriate time.

### *HEALTH STATUS*

Only 15% of adult patients reported their health status as excellent or very good while 24%

reported fair or poor health. Comparison with published SF-12 scores indicate that patients in this sample have overall worse physical and mental health status (Lundberg et al., 1999; Sugar et al., 1998; Ware, et al., 1995; Wu et al., 1997). The findings in this study indicate that adult patients who reported poor health were more likely to have made a visit for medical care, although many people in poor health still reported considerable barriers to receipt of needed health care.

### *QUALITY AND PROCESS OF CARE*

#### *Quality of Care for Diabetes- Adult*

Diabetes is a major cause of morbidity and mortality; and medical care for diabetes accounts for almost 15% of national health care expenses (Javitt et al., 1995). The development of standardized quality of care indicators for diabetes includes a focus on ophthalmologic/retinal care, foot care, blood pressure control, glycemic control, and cholesterol (Beckles et al., 1998; DCCT 1993).

Sixteen percent of adult patients reported being told they had diabetes, although there was no racial/ethnic variation in the prevalence of diabetes in this sample. Patients with diabetes within the LAC-DHS system appear to be receiving diabetes related care at rates similar to that provided in other health care settings. Nationally as well as locally, compliance with quality of care indicators for diabetes is lower than optimal, and should be the focus of patient and provider education.

#### *Quality of Care for Asthma*

##### Adult

Asthma is a respiratory condition that affects adults as well as children, and may cause significant morbidity and mortality if not properly treated. Treatment may include the use of inhalers on an as needed basis, regular use of inhaled medications and if necessary systemic steroids.

In this sample 9% of adult patients had been told they had asthma. Over half of adults with asthma were using a beta agonist, but only 15% were using an inhaled steroid. Based on the proportion of patients who had persistent symptoms of asthma (22% everyday and 19% a few days a week), these patients appear to be under treated. This may be a reflection of one or more of the following: lack of knowledge on the part of providers, availability of medications and patient adherence. Adults at CHCs were the most likely to have received asthma related education. If there are standardized education programs or curriculum on asthma for providers and/or patients at these sites, they might be distributed to other facilities.

##### Pediatric

Asthma in children has been found to disproportionately affect children in urban areas, and those whose families are poor. In this sample, 10% of parents reported they had been told their child had asthma, with some variation by insurance status. Insured children were more likely than those who were uninsured to have asthma (14% vs. 4%).

The majority of pediatric patients were using only a beta-agonist inhaler, with only 6% using an inhaled steroid, while 25% of children had been on a course of oral steroids at least once during the preceding year. These findings may indicate inadequate or inappropriate asthma care due to

poor patient (and parent) education, and a lack of understanding about the appropriate use of steroid inhalers (they are not to be used as “rescue medications” but rather for long-term prevention/control purposes). In addition, these findings may reflect physician’s lack of knowledge regarding the use of inhaled steroids as the standard of care of pediatric patients with persistent asthma and patients’ inability to obtain the medication due to financial and other barriers. Furthermore, over one-third of pediatric patients with asthma had made a visit to an ED during the past year, with a mean of 1.34 visits. Health care providers are educating parents and patients at rates of 43% to 73%, although only one-quarter of children with asthma had received an influenza injection during the flu season.

#### *Mental Health - Patterns of Care for Depression*

Depression is under-diagnosed in this country among all populations of patients. It has potentially life-altering effects on quality of life and performance of daily activities, and may have a disproportionate affect on low-income uninsured patients because of limited access to mental health care. The lack of receipt of mental health services may be an indication of the barriers to receipt of needed care in LA County as well as other individual and societal perceptions that act as barriers to care. In addition, although a high proportion of patients who had a perceived need for mental health care had received care, over one-third of these individuals had received treatment from a non-medical provider. This calls in to question the appropriateness and efficacy of the treatment that patients are receiving for mental health conditions. The very high rates of depressive symptoms in this patient population seem to indicate a need for the expansion of mental health services throughout LA County.

#### *FOOD SECURITY*

Low-income individuals are at particular risk for not having adequate nutritional resources, mainly due to inadequate financial resources. Even with access to food in general, people may be limited in their ability to obtain healthy and nutritious food options, and may consume whatever food is available in lieu of going hungry. Lack of access to food may have particular implications for people with chronic medical conditions as well as growing children. Significant proportions of both adults and children in this sample were at ongoing risk for not being able to obtain adequate food. In fact, pediatric patients appear to be at higher risk than adult patients for not having access to adequate food, including nutritional options. Adult and pediatric patients appeared to be using food kitchens at similar rates.

#### **Conclusions**

On the whole the results of this survey indicate that patients using LAC-DHS primary care clinics receive care that is appropriate according to national guidelines and comparable to other patient populations. The continuation of the Public Private Partnership Program (P/PP) appears to have increased patients’ access to and use of necessary and appropriate health care. We draw this conclusion based on patients’ reports about where they receive their medical care; the comparisons of care provided by the different facilities; and the levels of patient reported ratings of care. However, there still appear to be areas in the provision and receipt of health care by patients through the LAC-DHS that can be greatly improved. This study provides important information for the development and implementation of programs that provide health care to vulnerable populations, as well as developing ongoing processes of data collection and evaluation to assess the impact and effectiveness of the programs.

## II. BACKGROUND

The Los Angeles County Department of Health Services (LAC-DHS) plays an integral role in the provision of health care to many low-income adults and children in Los Angeles County. The majority of patients who receive health care through the LAC-DHS are under- or uninsured for health care. The LAC-DHS, in conjunction with a variety of community clinics, provide a health care safety net for a growing number of patients who are at increased risk for having unmet health care needs and poor health.

This project, the Patient Assessment Survey II (PAS II), was designed and implemented as part of the evaluation process of the Medicaid Demonstration Project and as an extension of the 1999 Patient Assessment Survey (PAS I) (Diamant, et al, 1999). Planning for the PAS II began in the summer of 2001, with data collection 2/02 – 7/02, followed by data entry, cleaning, analysis and reporting through 5/03. In addition, the findings from this project will be used to inform the planning process for publicly funded health care in Los Angeles County. The overall goal of this project is to assess primary care patients' reported access and barriers to health care, experiences with care and their satisfaction with the LAC-DHS system. In addition, the project is designed to assess trends over time and to compare LAC-DHS patients with other patient populations, including the general population of Los Angeles County.

## III. SPECIFIC AIMS

***AIM 1:*** *To describe self-reported access to and use of health care by adult and pediatric patients at LAC-DHS primary care facilities: having a regular source/site for health care, number of visits patients made to their regular/usual source of care in the County system during the preceding year, receipt of specialty care, receipt of health care from other providers, receipt of dental care, mental health care, hospitalization, patterns of episodic care (frequency and reasons for use), and use of emergency department services.*

***AIM 2:*** *To assess the existence of perceived barriers to health care such as: difficulty making an appointment; difficulty telephoning for medical assistance or advice; transportation and travel time to a medical appointment; language skills and interpreter services; office staff and provider helpfulness; respect and communication; inability to afford medical care; competing needs; and, lack of health insurance.*

***AIM 3:*** *To assess patients' satisfaction with the medical care they received at their current visit through the LAC-DHS system and their perception of the capability of LAC-DHS providers to serve their primary care needs in a timely and culturally appropriate manner (e.g., cultural competence and language skills, helpfulness, communication, respect, shared decision-making) and how this compares to other patient samples.*

***AIM 4:*** *To evaluate preventive and condition-specific health care experiences reported by primary care patients in the LAC-DHS system.*

***AIM 5:*** *To compare access to care and use of services and perceived barriers to care among patients who receive care within the LAC-DHS to the general population of Los Angeles County and to other patient populations.*

## **IV. METHODS**

### *1. Overview of Methods*

The target population for this project includes both previous users of the system and new patients (individuals who had not received County health care services previously). In PAS II, patients were interviewed on-site at LAC-DHS facilities throughout Los Angeles County, with representation in all eight Service Planning Areas (SPAs). The sample was divided among four types of facility: 639 from Comprehensive Health Centers (CHC), 574 from Health Centers (HC), 494 from Hospital Outpatient Clinics (HOC), and 604 from Public Private Partnership Program Clinics (P/PP).

Questionnaire development involved the research team at UCLA, representatives from various departments at LAC-DHS, as well as community representatives. The survey included multiple domains: assessing access to health care including health insurance, usual source of care, use of health care services including acute, routine and preventive health care, barriers to care and unmet need, process of care for specific ambulatory care sensitive conditions, patient satisfaction, health risk behaviors, food security, and sociodemographic characteristics of the samples.

For adults, individuals were eligible to participate in this study if they were visiting a primary care clinic (General adult medicine, general pediatrics, family medicine or urgent care/walk-in) for a medical visit at a County facility or contracted P/PP on the day of the interview, spoke either Spanish or English, and were able to participate in the process of informed consent. In addition, children had to be 6 months to 17 years of age, and accompanied by a parent or guardian who served as the proxy respondent for the survey. Data collection was performed over a 6-month period beginning Monday February 25<sup>th</sup> at Lake Los Angeles HC and Tarzana Treatment Center – Lancaster and ending Friday July 26<sup>th</sup>. Completion of the survey was based on face-to-face interviews with patients at the facilities included in the study. Sampling and recruitment of patients into the survey took place in the waiting room(s) of eligible intake points. As part of the verbal informed consent process, participants were told that they would receive a monetary incentive (i.e., \$10) if they completed both the main and post-visit interviews.

During the period of data collection over 16,000 patients were included in the head count, and of the 5,550 patients approached to participate, 2,791 were found to be eligible. Among the eligible patients 2,521 (2,026 adult and 495 pediatric patients) completed the main (pre-visit) interview and were included in the final sample – our response rate therefore was 78.1%.

Results are presented for adults and children separately, and for adults and children by the following subgroup analyses: gender, race/ethnicity, insurance status, health status, facility type, and SPA.

### *2. Target Population*

To meet one of the major evaluation needs of the Medicaid Demonstration Project, the current project focuses on adult and pediatric patients at LAC-DHS primary care facilities throughout Los Angeles County. These include comprehensive health centers-CHCs, personal health centers-HCs, hospital outpatient clinics-HOCs, and public/private partnership clinics-P/PPs.

Patients from the following clinics at each participating facility were sampled: general adult medicine, general pediatric medicine, family medicine and urgent care/walk-in.

Based on recommendations from representatives of LAC-DHS in the PAS II working group, the target population for this study did not include patients from dental clinics, public health clinics, specialty clinics, emergency departments or patients who were hospitalized at the time of the survey. Patients at public health and dental clinics were not included because those facilities do not provide comprehensive primary care services and patients from specialty clinics and inpatient services were not included because those patients also visit primary care clinics at other times. In addition, inclusion of these patients would not have allowed for comparisons of the measures of interest across facility types.

By including new patients in the target population, the survey may, in the future, be used to evaluate whether these two populations experience significantly different barriers when trying to access needed health care. If they do, such a finding could have important planning and policy implications.

### 3. Institutional Review Board Application

As of September 2001 an IRB application had been submitted to UCLA and received preliminary approval pending review of the study instruments and IRB approval from the five medical centers involved in the study. This preliminary approval established the use of a verbal informed consent in conjunction with an Information Sheet, rather than obtaining written consent, to maintain patient anonymity. An application to LAC-DHS IRB had been submitted in August 2001, but the Chairperson of the LAC-DHS IRB deemed it unnecessary to obtain IRB approval from the County as IRB approval was to be obtained from the participating medical centers. Work was begun on the IRB submissions to Harbor/UCLA Medical Center, LAC-USC Medical Center, Olive View Medical Center, High Desert Hospital and King/Drew Medical Center including identification of on-site principal investigators who would help coordinate submission of the IRB materials. The application to King/Drew Medical Center was submitted at the end of September.

During October a meeting was scheduled at High Desert Hospital in November to present the study to the Executive Committee in lieu of an IRB application. On-site principal investigators were identified at 3 of the 4 other sites and IRB applications were submitted to Harbor/UCLA Medical Center and LAC-USC Medical Center.

In November an onsite Principal Investigator was identified at Olive View and the IRB application was completed and submitted at the beginning of the month. Dr. Diamant presented the study to the Executive Committee at High Desert Hospital in lieu of an IRB application. IRB applications were pending at the other medical centers. IRB approval was received from Olive View MC and High Desert Hospital during that month. Further inquiries and requests for clarification from King/Drew MC were addressed.

Preliminary IRB approval was received from Harbor/UCLA MC in December with a request for clarification of some issues. Further inquiries and requests for clarification from King/Drew MC were also addressed. In January, 2002 we responded to the request for clarification of issues to

Harbor/UCLA and preliminary IRB approval was received from Harbor/UCLA MC as well as LAC-USC MC. In addition, multiple IRB inquiries and requests for clarification from King/Drew MC were received and responded to.

During February, 2002 the English and Spanish versions of the adult and pediatric surveys were distributed to all medical center IRBs. The translated version of the information sheet was also submitted. Again, repeated IRB inquiries and requests for clarification from King/Drew MC were received and responded to. Due to excessive delays through the King/Drew MC IRB the plan for requesting patient informed consent for a future medical record review, which had been approved at all of the other sites, was removed from the project. Due to the delays the UCLA IRB granted approval to begin the study the last week in February, 2002 at sites not under the auspices of the King/Drew IRB, while awaiting final IRB approval from King/Drew.

Final IRB approval was received from King/Drew MC in early March and forwarded to the UCLA IRB. Data collection was initiated at King/Drew and affiliated sites in week four on March 21<sup>st</sup>, 2002.

#### 4. Instrument Development:

Survey instrument development included regular working group meetings of the UCLA team and joint meetings with LAC-DHS personnel, and community representatives.

##### *a. Measures*

We developed the survey instrument using previously validated items and scales from published surveys. Items in the body of the survey instrument included: insurance status/coverage for health care, health status (functioning, well-being, chronic conditions, disease severity), access to health care, perceived barriers to care, use of health care services (number of doctor visits, type of health care providers, number of hospitalizations, number of emergency room visits), receipt of health care services (e.g., child immunizations, Pap smears and mammograms for women, smoking cessation counseling for smokers), condition-specific care for adults with diabetes, hypertension, congestive heart failure, hypercholesterolemia, asthma, and depression, and children with asthma, tobacco use, as well as patient satisfaction and the patient's experience on the day of the interview.

Insurance status, use of health care services, and perceived barriers to care were assessed using items developed for the HIV Cost and Services Utilization Study (HCSUS) (Bozzette et al., 1998; Shapiro et al., 1999). Functioning status and well-being were measured using the SF-12 health survey which was developed for the Medical Outcomes Study (Ware et al., 1996). The Rost-Burnam depression screener was included to assess the prevalence of depressive tendencies in this population. Questions from the Pacific Business Group on Health's longitudinal study of medical group performance were adapted to assess receipt of preventive health care services and counseling (Damberg et al., 1998). We used published quality of care criteria for the development of the items assessing the quality of care provided to adult patients with diabetes, hypertension, congestive heart failure, hypercholesterolemia, asthma, and depression, and children with asthma.

The development of the Consumer Assessment of Health Plans Survey (CAHPS) was sponsored by the Agency for Health Care Policy and Research to assess patient access, use and satisfaction with health care, mainly in the setting of managed care plans. A set of core items was developed for all consumers (Hays et al., 1997) and targeted items were developed for special sub-populations including Medicaid (Brown et al., 1997), Medicare (Schnaier et al., 1997), children (Shaul et al., 1999) and those with chronic illnesses or disabilities. An adaptation of the CAHPS® survey to the clinic-level has recently been developed by the Quality Measurement Advisory Service (QMAS) and the CAHPS® investigators. This survey includes 4 global rating items (personal doctor or nurse, specialist care, health care at the clinic, and the clinic), and elicits reports about access to care (4 items), communication (4 items), and helpfulness of office staff (2 items). Ratings of care received during the index visit were obtained using items similar to those in the visit-specific survey developed for the Medical Outcomes Study (Ware et al., 1988).

For other domains of importance for which we could not identify previously validated items or scales we developed items within the working group and subjected them to cognitive interviews, pilot testing and pre-testing in our sample population.

#### *b. Cognitive interviews, translation and pre-testing*

Cognitive interviews were conducted throughout the questionnaire development phase of the PAS II project. Cognitive interviews were performed face-to-face on an individual basis to assess the face and content validity of the items. Individual participants answered the items in the survey and were asked questions that probed their understanding of the items. A total of 28 cognitive interviews were completed from December 5<sup>th</sup>, 2001, through February 1<sup>st</sup>, 2002. The purpose of these interviews was to determine respondent comprehension of what the questions asked and to assess the instrument's ability to be administered smoothly and conversationally. A further objective for the cognitive interviews was to test the ability of newly designed questions not used in the PAS I instrument to provide the desired information. Eighteen of the cognitive interviews were conducted with adult patients, using the Adult questionnaire. Twelve of these were in Spanish, six in English. Ten cognitive interviews were conducted with a parent or guardian of a child, using the Pediatric questionnaire; of these, six were in Spanish, four were in English. Revisions were made to the survey instrument iteratively based on feedback from the cognitive interviews.

Once the cognitive interviews had been completed, and the questionnaire instruments and translation finalized, a total of seventeen pretest interviews were conducted for final testing of the screening and questionnaire instruments. The pretest interviews were conducted from February 5<sup>th</sup> through February 13<sup>th</sup>, 2002. Eleven pretest interviews were conducted using the Adult questionnaire, seven in Spanish and four in English. Six pretest interviews with Pediatric cases were conducted, of these, three were in Spanish and three were in English.

### *5. Sample frame development and sample selection*

#### *a. Sample frame development*

The planned sample size was 2,400, with 600 to come from each facility type. Prior power calculations confirmed that this allocation would achieve at least 80% power with  $\alpha = 0.01$  in detecting small mean differences (0.2 of a standard deviation) between facility types. At the facilities we included all those clinics designated as providing primary care services, specifically:

general internal medicine, general pediatrics, family medicine and urgent care/walk-in. Patients were excluded if they were unable to give informed consent for participation due to cognitive impairment, or if they were minors under 18 years of age without an accompanying adult. Patients reporting an emergency room as their regular source of care were not excluded if they were otherwise eligible.

In September 2001 we began contacting sites to verify their services and schedules, and to obtain an estimate of the number of patients seen in their clinics. During October project staff continued to contact sites to verify their services and schedules, and to obtain an estimate of the number of patients seen in their clinics. The patient counts included individuals with scheduled appointments as well as “walk-in” patients. At P/PP sites we were specifically interested in counts of P/PP eligible patients (i.e., patients for whom the provider would receive reimbursement from LAC-DHS based on the P/PP contract). All LAC-DHS sites were contacted as well as all of the clinics in the P/PP program. Contact with sites continued through December to verify facility/clinic services and schedules, and to obtain an estimate of the number of patients seen in their clinics. Project staff continued to contact sites throughout January 2002. In addition, site visits to all LAC-DHS facilities were scheduled and performed by Dr. Diamant. By the end of January, site visits to meet with facility and clinic directors were completed at 33 of 37 LAC-DHS sites. Visits were scheduled at three of the four remaining sites. Messages were left but went unanswered at the fourth site.

Through February phone calls to facilities were used to verify each facility’s services and schedules. Site visits to meet with facility and clinic directors were completed at the remaining 4 LAC-DHS sites. The sample of P/PPs was established (n=31) which provided for 93% inclusion of P/PP patients. Site visits were made to all 31 P/PPs sites. In mid-February the project team was notified by LAC-DHS that five of the personal health centers would be closing by June 2002 and should not be included in the study (Compton, Burbank, Northeast, Paramount and Sepulveda).

Sample selection was achieved by stratified three-stage sampling, with PPES (probabilities proportional to estimated size) employed in the first two stages and equal probability sampling in the third. Sixty-two health facilities were selected in the first stage, with stratification by facility-type at four levels and nested regional stratification at seven levels. The second stage, selection of facility-days, was implemented in three six-week waves; in each wave selection was stratified by facility at 62 levels and day-of-wave at 36 levels. In the third stage, patients were selected with stratification by time-of-day.

Our sampling procedure does not sample from the headcount population directly. Instead it samples from the *encounter population* consisting of all encounters between patients in the headcount population and LAC-DHS primary care clinics during the study period. The encounter population differs from the headcount population in how patients are counted. In the headcount population, each unique patient would be counted once. In the encounter population, a patient is counted at each visit during the study period. Someone who makes three visits during the study period would still be represented in the headcount population as one patient, but is represented in the encounter population as three encounters. Therefore, our encounter population is skewed towards high frequency users, and a patient who made more visits during

the study period is more likely to be sampled. The encounter population can be converted into the headcount population through visit-frequency weighting, which is discussed in the section on weighting.

In the sample description that follows, references to ‘respondents’ or ‘patients’ always refer to the encounter population.

#### *b. Participant eligibility*

For adults, individuals were eligible to participate in this study if they were visiting a primary care clinic (General adult medicine, general pediatrics, family medicine or urgent care/walk-in) for a medical visit at a County facility or contracted P/PP on the day of the interview, spoke either Spanish or English, and were able to participate in the process of informed consent. For the pediatric sample, individuals were eligible to participate if they were visiting a primary care clinic for a medical visit at a County facility or contracted P/PP on the day of the interview, were 6 months up to 18 years of age, were accompanied by a parent or guardian, the parent or guardian spoke Spanish or English, and the parent or guardian was able to participate in the process of informed consent.

#### *c. Estimating Measure-of-Size*

Selection in the first two stages required for each facility a measure-of-size (MOS), that is, an estimate of weekly caseload. From LAC-DHS we obtained names and telephone numbers of administrators for each health facility in the system. We contacted the office/clinic manager and/or administrator at all facilities, verified facility names and addresses, and obtain information describing patient volume, available services and appointment schedules. The patient counts included individuals with scheduled appointments as well as “walk-in” patients. At P/PP sites we were specifically interested in counts of P/PP eligible patients (i.e., patients for whom provider would receive reimbursement from LAC-DHS based on the P/PP contract). LAC-DHS also gave us actual monthly counts of P/PP reimbursements for the previous year. From these data we derived rough estimates of weekly caseload in the clinic-types of interest, which in turn became our MOS. The estimates were necessarily approximate. Where available, we used the LAC-DHS reimbursement data for April through June 2001. Where we had to rely on estimates of facility personnel, previous experience with similar surveys prompted us to divide the counts in half. If the latter counts were in terms of total patients, rather than P/PP patients, we reduced the estimates by another one-third.

#### *d. First Stage: Facility Selection*

The 64 facilities sampled in the first stage are listed in Table 1. For CHCs, HCs, and HOCs, all facilities were selected with certainty. The sample sizes were 21, 6, and 5, respectively.

*P/PP Stratum.* We included 64 of the County’s 97 P/PP facilities in the sampling frame. These were facilities with weekly MOS greater than 49 or session-average (morning, afternoon, or evening) MOS greater than 3. Despite exclusion of the 33 small sites, we retained coverage of 93.2% of the P/PP patient population.

There was only one P/PP facility in SPA 1, so we sampled that facility with certainty. From the remaining we sampled 31 facilities using probabilities-proportional-to-estimated-size (PPES)

(Cochran, 1977). Systematic Random Sampling (Kish, 1965) from a cumulated list of facility MOS was employed for this purpose. In effect, the selection probability for the  $i$ th facility was  $P_i = 30 * WMOS_i / (\text{sum of non-certainty } WMOS_i)$ , where  $WMOS_i$  is weekly MOS for the  $i$ th facility. Before selecting, the facilities were ordered by SPA, and by size within SPA. This had the effect of implicitly stratifying by SPA, with nested stratification by size within SPA. After fieldwork began, two P/PP sites, Arroyo Vista Family Health Center and Yu Care Medical Group, ceased to serve P/PP patients and were removed from the survey.

*e. Second Stage: Facility-day Selection*

The purpose of the second stage was to randomize the schedule of visits by interview teams to the sampled facilities. This would not be a feature of most sample surveys, where respondents are encountered at a permanent location such as home or work. For PAS I and PAS II it has been necessary to randomize the field schedule because respondents are encountered at locations where they present only occasionally, and according to schedules governed in part by the weekly and monthly calendars. By randomizing our field schedule we in effect randomized our encounters with respondents whose presence at a health facility was likely more arbitrary than random.

The need to randomize the field schedule introduced another unusual feature. In a typical multi-stage survey, the selection of SSUs (secondary sampling units) would be independent in each PSU (primary sampling unit). This we could not do with schedule elements as our SSUs. For logistical reasons it was necessary to maintain a reasonably uniform work effort over the field period, and this required some degree of coordination in SSU selection from facility to facility. To accomplish this, we devised a single sampling frame to control selection of SSUs (facility-days) from all PSUs (facilities) simultaneously.

There were at least four scheduling constraints: (1) the survey would be organized as three six-week ‘waves’, separated by two-week ‘relief’ periods (during which missed facility-visits of the preceding wave could be re-scheduled); (2) field teams would visit all sampled facilities at least once in each wave, working 36 days per wave (Mondays through Saturdays); (3) visits could be scheduled for up to three small facilities (P/PPs or small HCs) on the same day, up to two facilities if one or both were moderately large, but only one facility if it was large (any HOC, or a large CHC); it was best, but not mandatory, that visits on any day be to facilities in the same general region of the County. Another complicating feature was that facilities had different schedules of operations, different days and different hours.

For selection purposes, it was easiest to view the waves as three independent samples from the same sampling frame, stratified by facility (64 levels) and day (36 levels). Accordingly, the Stage-2 sampling frame was structured as a 64-36 matrix. Each cell in the matrix was assigned a selection probability that for each facility was roughly proportional to the operating hours for that day. Specifically, for the  $j$ th day and  $i$ th facility,  $P_{j|i} = (\# \text{ of operating sessions on } j\text{th day}) / 6 * (\# \text{ of operating sessions per week})$ , where sessions are the 3-5 hour trimesters: morning (approximately 8am to 12pm), afternoon (approximately 1pm to 5pm) and evening (approximately 5pm to 9pm). A one-week segment of the frame is reproduced in the Appendix. For a given row (i.e., facility), the  $P_{j|i}$  sum to 1.0; the  $P_{j|i}$  for the total frame sum to the intended sample size, 64. If a facility typically scheduled staff meetings for a particular time slot, that

session for that facility was excluded from the frame.

The sampling problem was to select a sample that conformed to cell probabilities and to the several scheduling constraints described above. We accomplished this using the technique of Probability Lattice Sampling (Jessen, 1973; Sumner, 1973), a kind of multi-dimensional Systematic Sampling. Following the rules of this technique, (1) a set of “feasible” samples of cells, each conforming to the scheduling constraints, was designated in non-random fashion, (2) each feasible sample was assigned a selection probability,  $P_f$ , (3) then three of the feasible samples were selected probabilistically. To be “feasible” required that the set “exhaust” the frame; that is, that the sum of  $P_f$ 's for all samples that included any particular cell be equal to  $P_{j|I}$  for that cell. Thus, to conform to the  $P_f$  in selecting from the feasible set was to conform to the  $P_{j|I}$  of the original frame. To probabilistically select three of the feasible samples, we applied Systematic Random Sampling to their cumulated  $P_f$ .

*f. Third Stage: Respondent Selection*

Sampling of respondents within facilities employed Systematic Random Sampling, using pre-calculated Sampling Intervals (SIs) based on MOS and selection probabilities from Stages 1 and 2. The sampling intervals were designed so that the three stages collectively would produce self-weighted (i.e., equal probability) samples of respondents within facility-type strata within waves.

The SIs were used to prepare Assignment Sheets specific to each facility. At the facilities, field personnel were stationed at each intake point at the beginning of the day in order to count patients as they entered. On the Assignment Sheet was a series of numbers (beginning with a random start and continuing with successive additions of the SI) that designated which respondents were to be approached for screening.

The SI for the  $ij$ th facility-day was calculated as  $SI_{ij} = WMOS_i * P_{j|I} / 6 / n_i$ , where  $WMOS_i$  is estimated caseload per week for the facility,  $n_i$  is the ‘expected’ (i.e., based on MOS) number of respondents to be selected, and  $P_{j|I}$  is the Stage 2 selection probability for  $ij$ th facility-day:  $P_{j|I} = (\# \text{ of operating sessions on } j\text{th day}) / 6 * (\# \text{ of operating sessions per week})$ . For the HOC, CHC, and HC strata:  $n_i = k * 200 * WMOS_i / (\text{sum of } WMOS_i \text{ in stratum})$  where  $k$  is equal to 1.0 plus an allowance for nonresponse and re-calibration (see below) that is specific to the stratum and wave. In effect, the sample allocation for each facility-type stratum was divided among facilities in proportion to facility size. For non-certainty facilities in the P/PP stratum:  $n_i = k * 200 / 31$ . For the certainty facility in the P/PP stratum:  $n_i = k * 200 * WMOS_i * 30 / ((\text{sum of non-certainty } WMOS_i) * 31)$ .

The first wave produced fewer than the expected 200 completions per stratum, primarily because headcounts at facilities were less than expected; that is, the  $WMOS_i$  tended to be overestimated. Response rates were also somewhat lower than expected. For the second wave, stratum-specific factors were used to adjust sampling intervals downward in order to make up for the shortfalls. At the end of the second wave, we were still below target in some strata, but much less so than before. Accordingly, sampling intervals were adjusted once again before the beginning the third wave. It is important to note that re-calibration of sampling intervals was uniform within each stratum.

The size of field team for each facility was tailored to the expected interview load based on MOS and SI. It was quickly apparent that interview loads at several facilities would require field teams large enough to risk disruption to facility operations. The interviewing at these facilities was spread over two days, with the SI doubled so as to obtain a half-sample on each day. The second day for such facilities was scheduled during the ‘relief’ period at the end of the wave. Fieldwork was canceled for the third wave relief period owing to budget considerations. This had the effect of halving respondent selection probabilities for eight facilities in the third wave, and will be corrected by adjustments to the respective analysis weights.

*g. Self-Weighting*

Analysis weights have the effect of reducing effective sample size, potentially a serious problem if variation in weights is extreme. For this reason, an important goal of sample design is to produce a dataset that requires minimum weighting. This goal is met when there is minimum variation in respondent selection probabilities, at least within strata. In a self-weighting sample, the collective effect of the overall sample design is to produce an equal probability sample of respondents. In PAS II, self-weighting was designed to apply within facility-type strata within waves. This can be demonstrated by showing that the ultimate selection probabilities are constant within strata (within waves). That is, by showing that  $P_{ijk} = P_i * P_j | I * P_{k|ij} = \text{constant}$  where  $P_{k|ij} = 1/S_{ij}$  is the conditional selection probability for the kth respondent given the jth facility-day of the ith facility. For any stratum, by definition:  $P_{ijk} = P_i * P_j | I * P_{k|ij} = P_i * P_j | i / S_{ij}$ . Substituting for  $S_{ij}$  (from above):  $P_{ijk} = P_i * n_i / (6 * WMOS_i)$ . For the HOC, CHC, and HC strata, where  $P_i = 1.0$ :

$$\begin{aligned} P_{ijk} &= n_i / (6 * WMOS_i) \\ &= k * 200 * WMOS_i / ((\text{sum of } WMOS_i \text{ for all sites in stratum}) * 6 * WMOS_i) \\ &= k * 200 / (6 * (\text{sum of } WMOS_i \text{ for all sites in stratum})) \\ &= \text{constant} \end{aligned}$$

For the P/PP non-certainty sites (with substitutions from above):

$$\begin{aligned} P_{ijk} &= P_i * n_i / (6 * WMOS_i) \\ &= (30 * WMOS_i / (\text{sum of non-certainty } WMOS_i)) * (k * 200 / 31) / (6 * WMOS_i) \\ &= k * 200 * 30 / ((\text{sum of non-certainty } WMOS_i) * 31 * 6) \\ &= \text{constant} \end{aligned}$$

For the P/PP certainty facility, where  $P_i = 1.0$ ,  $P_{ijk}$  has the same value as the non-certainty sites:

$$\begin{aligned} P_{ijk} &= P_i * n_i / (6 * WMOS_i) \\ &= (k * 200 * WMOS_i * 30 / ((\text{sum of non-certainty } WMOS_i) * 31)) / (6 * WMOS_i) \\ &= k * 200 * 30 / ((\text{sum of non-certainty } WMOS_i) * 31 * 6) \end{aligned}$$

Self-weighting (within strata) was a feature of the PAS2 sample design, but in a few instances we failed to adhere to that feature. Already mentioned were the eight facilities that were ‘half-sampled’ in the third wave. In addition, the field team was supplied with the wrong SI for one site in the first wave. These events were corrected through weighting, but the overall effect on weight variation will be small.

Unbiased analysis of datasets where responses occur with unequal probabilities requires weighting. For PAS II, weights were derived as the product of three components: sampling weight, nonresponse weight, and visit frequency weight. Sampling weights account for the effects of sample design, and were calculated as the reciprocal of sampling probabilities, that is, the  $P_{ijk}$  defined above. The nonresponse weights correct for uneven distribution of nonresponse, and were calculated as the reciprocal of each respondent's probability of response, in turn estimated for adults as a function of facility type, purpose of visit, and clinic type (walk-in or otherwise). For pediatrics the probability of response was estimated as a function of facility type, purpose of visit, and sampling wave. Visit-frequency weights account for varying frequency of respondents' visits to the facilities in the sampling frame, and were set inversely proportional to number of visits to County clinics in the previous 12 months. For the overall weight, the three components were multiplied together, then rescaled so that they summed to the total number of completions (i.e., achieved sample size).

The resulting weights are appropriate for analyses relating to the headcount population (defined above). For analyses pertaining to the encounter population (also defined above), analysts should consider using weights based only on the sampling and nonresponse components, omitting the visit weights.

The use of weights reduces bias, but also tends to reduce the effective sample size. The extent of reduction depends on how the analysis pools respondents. With the three-component weights described above, for example, estimates where all adult respondents are pooled have an effective sample size that is 24 percent less than actual sample size; if adult respondents are pooled by facility type, the reduction is only 17 percent. For pediatric respondents, the reduction is 20 percent where all are pooled, and 13 percent when pooled by facility type.

#### *6. Interviews-interviewer orientation, interviewer schedules*

A total of 26 interviewers attended the training session for the Patient Assessment Survey II. The three-day training session took place February 20<sup>th</sup> through February 22<sup>nd</sup>, 2002. The first day of training was held exclusively for newly hired interviewers. Prior to this initial day of training, these new interviewers had received a packet of basic training materials that included the Survey Research Center (SRC) Interviewer Manual, a description of the PAS II project, and quick reference sheets on basic interviewing procedures, such as neutral probing techniques and refusal conversion tips. Interviewers were instructed to read these materials prior to attending the training.

The training day began with an orientation of the PAS II project. A basic description of the structure of the Los Angeles County Department of Health Services system of clinics, hospitals, comprehensive health centers, and Public/Private Partnership clinics was included. The training focused on the importance of collecting unbiased patient experiences and attitudes using the standardized screening and questionnaire materials designed for the project.

The basic concepts and ethics of academic survey research techniques were presented. Particular techniques for neutral probing were described and demonstrated through role-play examples. Interviewers were familiarized with basic interview administration such as adhering to standardized question wording, question sequence, proper recording and correction methods, and neutral probing techniques to use in the case of vague or irrelevant answers to questions. A section on asking sensitive questions and acceptable refusal conversion methods was included.

A description of University Human Subject Protection policies and procedures was presented to ensure interviewers understood their responsibilities regarding the rights of any individual approached to participate in the study. All basic skills and an outline of study procedures required for attendance at the two-day study-specific training was presented on the first day for the newly hired interviewers.

Of the 26 interviewers who completed the training, four were veteran interviewers of the PAS I survey. Ten of the 26 represented newly hired interviewers, and the remaining twelve were drawn from SRC's core interviewing staff and had at least eighteen months interviewing experience.

The entire group of 26 interviewers; including those who had been designated as site supervisors for the PAS II project attended the second day of training. This day of training was devoted to a comprehensive overview of the materials that were to be used on a daily basis by the interviewing teams in the clinics during each day of data collection. These materials included Patient Information sheets, used to inform patients of the purpose of the study and the meaning of their voluntary participation. Also included were screening forms in Spanish and English, for Adult and Pediatric patient cases, designed to determine patient eligibility to participate in the study, survey questionnaires for Adult and Pediatric cases in Spanish and English, and hand cards in Spanish and English, to be used at designated questions to prompt responses. A laminated poverty graph to assist the interviewers in calculating poverty level when asking about income was provided, as well as a laminated, color picture of various types of asthma inhalers. Other materials used on a daily basis included a brightly colored card that gave patients a brief description of the project, and SRC's 800-telephone number to call, in case the interview or post-interview could not be finished during the data collection session. Finally, the listing sheets that would be used to enumerate and select patients for screening and possible interview were presented and briefly described to the interviewers. The basic use and purpose of each material was described to orient the interviewers to the basic structure and methods of the study.

Interviewers were instructed on the second day of training on the proper techniques when approaching patients for screening. Demonstration of these techniques by experienced interviewers was conducted, followed by role-play round-robin participation by all interviewers. The role-playing progressed from handling cooperative to reluctant responses on the part of potential respondents. Proper recording techniques and procedures for following skip patterns were also emphasized.

The second day of the training also included an overview of the basic sampling procedures to be implemented to enumerate and select patients for screening. At each clinic registration area, a designated enumerator was to be responsible for monitoring incoming patients, listing them on a form provided, and then to make proper selections from the list of which patients were to be screened for eligibility to participate in the interview. Every interviewer was required to be knowledgeable of the enumeration techniques. Finally, the second day of training included a discussion by the PAS I "veteran" interviewers on their experiences on that study. This discussion aided in assuring interviewers that the task before them was survivable and could be achieved.

The third and final day of interviewing consisted of intensive practice and demonstration of interviewing techniques, using the relevant study materials. A “mock” screening and full interview was conducted to demonstrate comprehensively the flow of the interview instrument and to provide an example of the methods of administration. This demonstration by experienced interviewer and supervisory staff was followed by more round-robin practice, first with the entire group, each person taking turns, and then by separating the interviewers into groups of two, with monitoring by supervisory field staff as each team completed the tasks of screening and interviewing.

On this third day of training, the weekly schedule forms that were used throughout the study for each week’s work were presented. Interviewers were instructed to have access to Thomas Guides or comparable maps to prevent being late to clinic sites. The study design depended heavily on interviewing teams being able to begin listing patients as soon as the registration of patients began at a facility. Interviewers were to arrive no less than ten minutes before a particular clinic/facility was scheduled to open. The weekly schedule sheets provided information as to which facilities would be visited, as well as a list of the clinic types that would be open in those facilities during the time the interviewing teams were there, each clinic’s hours, address, and some travel directions to assist in efficient arrival and parking at the facility. At HOC and CHC sites, interviewers were instructed to assemble outside the facility. One or two supervisors were designated to look for the facility contact person, to alert them to our arrival and ensure our entry into each individual clinic inside these large facilities. Once approval from the facility was obtained, the site supervisors directed each clinic team to the proper room or area. Site supervisors routinely monitored the patient flow and made adjustments when necessary to the scheduled interviewer teams to ensure proper coverage; sometimes on an hour-by-hour basis at the larger sites.

Interviewers completed their training on the Friday before the first day of work on Monday, February 25<sup>th</sup>, 2002. The session ended with a discussion of appropriate attire for their work in the clinics. The interviewers were given sturdy paper folders in which to carry a day’s interviewing supplies, and UCLA-issued picture identification cards, carried around the neck on a cord prominently marked “UCLA” in blue and gold. At the end of the final day of training, interviewers were instructed to spend paid time over the weekend organizing their materials and conducting at least one practice interview with a close friend or family member for additional practice before beginning work. Interviewers were strongly encouraged to call the field director with any questions, problems, complaints, and successes throughout the study period.

## 7. Data collection

### a. Data collection

As the schedule and sampling rates were developed for each of three blocks, the schedule of interview visits was constructed and faxed to all sites (see Appendix – *Interview Schedules: Blocks I-III*). Follow-up phone calls were made by project staff 2-3 days prior to each interview visit to confirm with clinic administrators and supervisors.

Data collection was performed over a 6-month period beginning Monday February 25<sup>th</sup> at Lake Los Angeles HC and Tarzana Treatment Center – Lancaster and ending Friday July 26<sup>th</sup>. Completion of the survey was based on face-to-face interviews with patients at the facilities

included in the study. Sampling and recruitment of patients into the survey took place in the waiting room(s) of eligible intake points. For each session two to twenty interviewers were deployed, depending on the number of intake points at the facility. Typically, teams of two to five interviewers were assigned to each session at the HCs and P/PPs, with larger teams sent to the CHCs and HOCs. At the larger facilities with multiple eligible intake points, interviewers were distributed across all of the clinics being sampled. One member of the interview team at each clinic was responsible for listing patients, as they presented over the course of the session, and for implementing the patient selection procedure.

Patient selection employed Systematic Random Sampling, which in turn was implemented by means of a pre-designated list of line numbers (intervals) provided at the top of each facility/clinic listing sheet (see Appendix – *Facility Listing Sheet*). These intervals were generated using random starts and sampling intervals previously calculated for each facility in accordance with the sample design. After selection, patients were screened for eligibility. Screening for eligibility for the primary interview averaged approximately 2 minutes.

Professional interviewers conducted all screening and interviewing. The interviewers were predominantly bilingual Spanish and English speaking and most were female. A substantial number of the interviewers had worked on PAS I, and several of these were employed as site supervisors for PAS II.

Each interviewer received his or her weekly work assignment the Saturday prior to the start of the following workweek. For the purposes of this study, a workweek was defined as Monday through Saturday. The assignment packet provided the following information; the day(s) the interviewer was scheduled to work, the facility they were assigned to for that day, the clinic within the facility if appropriate, the hours of the day their shift was to cover, their co-workers on that day's facility/clinic team, the individual who would be responsible for enumerating patients, and, the designated clinic/site supervisor when the person doing the listing was not the supervisor. Listing sheet packets for each clinic within each facility were included for the person designated to do the listing on that day.

A member of the interviewing team approached patients sampled for participation in the study after the patient had registered at the reception desk. The study was introduced and explained to patients in their preferred language, including the purpose of the project and maintenance of patient anonymity. Individuals were also given an information sheet that explained the study in their preferred language. To be eligible to interview, the patient must have come to the clinic for primary care for an illness or injury or for a follow-up visit or check up. Patients coming for specialty visits, to get test results or have tests administered, to get an injection or immunization, to get or refill a prescription, to have forms filled out, to make an appointment, or to obtain other paper work were not included in the population eligible for interview.

They were then asked if they understood the study; if they had any questions; and if they were willing to participate. If patients indicated that they were willing to participate, verbal informed consent was obtained at that time. The parent or adult accompanying pediatric patients was approached in a similar fashion as described above. They were provided with an explanation of the study, and asked if they were willing to participate on behalf of the sampled child. The interviewers were very careful to tell patients that their medical care would not be affected by

their participation or non-participation in the project. Patients were informed repeatedly that their physicians would not have access to their responses, and would not be told whether or not they had participated. Every effort was made not to disrupt the flow of care.

As part of the verbal informed consent process, participants were told that they would receive a monetary incentive (i.e., \$10) if they completed both the main and post-visit interviews. Research has demonstrated that survey response rates can be optimized through the use of a financial incentive. This dollar amount was expected to serve as an incentive for patient participation, and an acknowledgment of their time, without acting as an undue influence (Willimack et al, 1995; Perneger et al, 1993; Church, 1993; Peck et al, 1981). In PAS I both patients and clinic staff indicated that the incentive served to interest people in participating in the study without influencing their responses (Diamant et al., 1999). If patients completed the pre-visit interview but not the post-visit interview, they were given a card with a toll free phone number they could call to finish the survey, and to receive the incentive.

Each facility/clinic team supervisor had access to a cell phone and/or a pager to contact the SRC Field office, and vice versa, when unforeseen problems or questions arose in the field. Site supervisors were responsible for having the appropriate facility listing sheets with that clinic's selection intervals ready at the start of each shift, and to anticipate and have ready the daily supply needs for their sites including adequate respondent incentives. Materials required for each clinic included the Patient Information Sheet specific to that facility, the proper listing forms, English and Spanish screening forms and questionnaires for both Adult and Pediatric interviews, Hand Cards for the interview, and an English/Spanish version of an 8 ½" X 11" brightly colored cardstock message that provided a brief description of the study, the sponsor, the payment of a \$10 incentive, and the SRC 1-800 telephone number to call, in the event the patient was not able to come back to the interviewers for the post-visit interview, or if they got called in for their medical visit before the main interview had been completed. The cards were intentionally printed in a brilliant color because the patients tended to hold on to their cards as they made their way through the process of their medical visit, making it easier for the interviewing staff to identify them as patients selected for an interview.

The interview took approximately 40 minutes to complete and was administered in two modules. The main module focused on the patient's prior experience with and use of LAC-DHS facilities and services during the preceding 12 months, and was usually completed before the patient saw the physician, although some patients had some interactions with nursing or office staff prior to completion of the main module (e.g., vital signs measured, asked to complete insurance forms, etc.). This module took approximately 25 to 35 minutes to complete, although it was occasionally interrupted if the patient was called in for their appointment. In this situation patients were allowed to complete the main module after their medical visit. The second module of the survey (post-visit) was administered at the conclusion of the visit, after the patient had seen the health care provider. This module focused on the patient's experience at the clinic on that day, and required approximately 5-10 minutes to complete.

#### *b. Response Rates for Individuals*

During the period of data collection over 16,000 patients were included in the head count, and of the 5,550 patients approached to participate, 2,791 were found to be eligible, 2,006 ineligible,

and 753 with eligibility unknown (mostly refusals, persons with languages other than Spanish or English, and persons on clinic sign-up lists who could not be located). Allocating the unknowns on the basis of known eligibles to known ineligibles, we estimate 3,229 (58%) eligibles. Among the eligible patients 2,521 completed the main (pre-visit) interview and were included in the final sample – our response rate therefore was 78.1%; 540 (16.7%) did not participate for a variety of reasons and 168 (5.2%) started the interview but terminated prior to completing the main interview. Forty-two percent of the patients approached were found to be ineligible, and thus were not interviewed.

Patients were interviewed on-site at LAC-DHS facilities throughout Los Angeles County, with representation in all eight Service Planning Areas (SPAs). The sample was divided among four types of facility: 639 from Comprehensive Health Centers (CHC), 574 from Health Centers (HC), 494 from Hospital Outpatient Clinics (HOC), and 604 from Public Private Partnership (P/PP) Program Clinics.

### *c. Problems Encountered in Data Collection*

The conduct of a study of this nature requires careful and precise planning, the cooperation of several unrelated groups of individuals, as well as flexibility, tolerance, and patience. Although DHS patients were being solicited for an interview at what may have been less than ideal circumstances such as feeling ill, in crowded conditions, facing long waits to see a health care professional, they were, overall, receptive and cooperative with SRC interviewers. Being too ill to be interviewed was the most common reason for refusals as opposed to hostility, mistrust, or anxiety over confidentiality. With some exceptions facility staff was generally cooperative and helpful, a fact much appreciated given the busy and sometimes crowded conditions under which many facilities operate. Interviewers performed admirably under difficult conditions and demonstrated what committed professionals they were.

The most significant problem encountered in the data collection process was of the interviewing team arriving at a facility and learning of that day's schedule being changed from what had been indicated by staff at the facility during the site visits, as well as by telephone within 2-3 days of the scheduled interviews (see Appendix – *Clinic Scheduling Changes*). It was not unusual for the team to arrive at a facility and learn that one or more clinics had been cancelled that day, and/or that one or more clinic's hours of operation had been amended from those cited the week prior to the visit, and/or that registration had been reduced to one location only or, conversely, had been split into multiple locations, and/or to find that a specialty clinic had been combined with a primary care clinic, and/or to find that mid-way through a clinic it was decided to stop taking patients for that day and refer patients to another facility or to come back the next day that clinic would be open. Successful scheduling for a data collection effort of this nature requires considerable effort in planning to ensure that all scheduled sites are covered with adequate numbers of staff, and with a staff mix that is appropriate to each facility. As described earlier, facility planning was designed to ensure that an experienced patient enumerator and/or supervisor was available, that the number of interviewers present was adequate for the expected patient flow, and that the language ability of the staff reflected the composition of the patient load at each clinic. Many of the last minute changes experienced above necessitated last minute staffing changes and often contributed to the loss of enumeration and interviews. In some cases, it was not possible to get additional interviewers to the site in time to be of help when needed. In

other cases, a shift of interviewers had to be sent home. Such events all contributed to a considerable loss of efficiency.

Of lesser frequency, but equally serious in nature, was arriving at a facility to find that clinic staff had not been informed of UCLA's visit for data collection. When such events occurred the entire team had to wait until the problem could be resolved, usually by calling the SRC Field Director who would call the facility contact and attempt to resolve the problem. On occasion, both Dr. Diamant and a representative of LAC-DHS had to intervene to resolve the problem. Each event caused the team to lose an hour or more in productive time while causing a loss in the number of patients enumerated and interviewed.

## 8. *Data Processing*

### a. *Procedures*

Numerous steps were involved in the processing of completed data. All data relevant materials required for this project went through logging, editing, coding, data entry, and cleaning procedures. All completed forms were checked in and out of secured files for each step in the series.

At the end of each facility/clinic shift, the completed enumeration sheets, screeners, and interviews were turned over to the team supervisor. Each supervisor would accumulate his or her team's completed surveys for several days. Every few days a project courier would pick up all the completed work from the supervisors and deliver it to the SRC main field office. Upon arrival in the office, the completed enumeration sheets, screeners, and interviews would be reconciled and briefly checked on accuracy for facility code, outcome code, eligibility, completeness, etc. Screeners and interviews would then be logged into a customized sample monitoring system developed using Microsoft Access and then filed in numeric order after entry. This system provided weekly sample status reports by facility.

Subsequent to logging, editing was performed. Editing involved checking each screener and interview for completeness, accuracy of response circling, branching logic, and clarity. During this process errors were noted by individual interviewer identification number. A field supervisor then reviewed these notes with that individual as a means of providing feedback on work performance and to correct any interviewer problems before they escalated. While editing, open-ended questions on the screeners and questionnaires were numerically coded. Such coding included questions such as type of specialist the patient has seen if applicable, country of birth, other County clinics the patient may have visited in the past 12 months, and converting pounds and inches to kilograms and meters.

The last step in the data reduction process was data entry. Screener and questionnaire data was entered into a Computer Automated Interview system that operated on a Unix based SUN Solaris system. The system was programmed specifically to the study instruments. Two instruments were programmed, one for adult patients and the other for pediatric patients. The programming for both instruments incorporated checks for out-of-range codes and proper branching logic. After all data were entered they were run through a variety of cleaning checks as a means of double-checking the programming accuracy. The first of these checks was to re-run all data through the CAI checks again, the second was to run frequency distributions on all variables and

look for out of range codes, or logic inconsistencies. It is possible, for example, for entry operators to back up in entry or otherwise skip around in an entry instrument and avoid coding or logic checks. This back end cleaning catches this type of error.

#### *b. Problems Encountered in Data Processing*

There were few problems with reconciliation of enumeration list, screeners, and interviews. Such problems were predominantly a situation of the enumeration sheet having one outcome indicated and the physical case actually being another outcome, most typically in the assessment of the reason for a non-interview. An example of such an occurrence would be when a patient indicated that the purpose of his or her visit was for illness or a follow-up visit, but upon further screening finding he or she had come for specialty care, or a prescription refill only and was not eligible. Sample dispositions would also change when respondents would call into SRC's 1-800 telephone number provided them to complete a partial interview or to complete the post interview.

Problems with the editing/coding process were typical of those for many health surveys. These problems do not affect the quality of the data as much as that they require more time to resolve and code. For example, the majority of DHS patients who have gone elsewhere for health care within the past 12 months, frequently did not know the name or correct name of the facility, were not clear as to the precise location of that facility, and most typically did not know if it was a County operated or affiliated facility. The coders were left to search out what and/or where the site was that was being referred to and, determine if it was a County facility. Another persistent problem was that patients often lacked the sophistication to know the type of specialist they had seen but rather would describe the part of their body or the type of illness they had that required such a visit. Therefore, the task of the coder was to associate the body area or the illness to the type of specialist that would deal with that problem. As mentioned, these problems did not so much affect the data but rather required time and labor to resolve.

#### *9. Data Analyses*

Adult and pediatric samples were analyzed separately. Univariate statistics for items are reported, and composite satisfaction scores were calculated. Bivariate analyses were performed to assess subgroup variation (i.e., gender, race/ethnicity, insurance status, facility type, service planning area-SPA and health status). Significance testing of individual items was performed using chi-square and Fisher's exact tests for comparisons of categorical variables, and Student's t-test and ANOVA for analysis of continuous variables. Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ . In some situations the results of significance tests were not available and the following is indicated, "*Note: For the following subgroup analyses the results of statistical testing are not currently available and the significance of the variation by subgroup have not been established.*"

#### *10. Presentation of findings*

Due to the large volume of data the text highlights the significant study findings, and the tables are available for further review. The tables are organized as follows first for adults, and then for children with separate tables for the bivariate analyses of the key independent variables (i.e., gender, race/ethnicity, insurance status, facility type, service planning area and health status).

Note that one 17-year-old girl qualified as an emancipated minor and completed the adult survey. For race/ethnicity the “Other” category results are presented in the tables but are not commented upon in the narrative (n=48 for adults) and n=3 for children). Among children the Asian/Pacific Islander group is very small (n=4) and the results are presented in the tables but no comparisons or inferences are made. The tables are numbered 1 through 24, with consecutive presentation of the total and subgroup results as follows for adult and pediatric patients: series “a” total and gender, “b” race/ethnicity, “c” insurance status and health status, “d” facility type, “e” Service Planning Area (SPA); for pediatric patients “f” total and gender, “g” race/ethnicity, “h” insurance status and health status, “i” facility type, “j” Service Planning Area (SPA). Results in the body of the text are reported only for cell sizes of  $n \geq 10$ . Cell sizes smaller than  $n=10$  do not allow us to draw stable inferences. However, for completeness in presenting the data, percentages and sample sizes are presented in the Appendix.

## V. RESULTS\*

### A. DESCRIBING THE POPULATION<sup>1</sup>

#### *AGE*

##### Adult

*Note: For the following subgroup analyses the results of statistical testing are not currently available and the significance of the variation by subgroup have not been established.*

The mean age of adult patients was 43.1 years (range 17 to 96). Among the adults 5% were > 65 years of age, and among women 50% were age 18 to 44. Women were somewhat older than men (43.9 years vs. 41.6 years), and on average Asian/Pacific Islanders were the oldest and African Americans were the youngest (45.3 years vs. 42.4 years). On average, patients at HCs were the oldest and patients at HOCs were the youngest (45.3 years vs. 42.1 years).

Geographically, the oldest mean age was in SPA 2 and the youngest mean age was in SPA 5 (45.2 years vs. 41.3 years). Patients in poor health had the highest and those in very good health had the lowest average age (46.7 years vs. 39.9 years).

##### Pediatric

The age range for the pediatric sample was 6 months up to 17 years of age with a mean of 7.5 years. The pediatric age distribution was as follows: 6 months to less than 5 years (40%), 5 years to 7 years (21%), 8 years to 12 years (23%), and 13 to 17 years (16%). There was little difference in age between boys and girls; however, on average Latino children were the oldest and Whites were the youngest (7.6 years vs. 5.4 years). Geographically children with the oldest average age were in SPA 5 and those with the youngest average age were in SPA 3 (8.4 years vs. 5.9 years).

#### *GENDER*

##### Adult

Just over two-thirds (68%) of adult patients were female. Asian/Pacific Islanders were the most likely and Whites were the least likely to be female (74% vs. 61%\*). Patients at P/PPs were the most likely and those at HOCs were the least likely to be female (73% vs. 56%\*\*\*). Patients in SPA7 were the most likely and those in SPA 1 were the least likely to be female (74% vs. 64%\*). Insured patients were more likely than uninsured patients to be female (73% vs. 66%\*).

*Comments:* In PAS I women comprised 69% of the sample.

##### Pediatric

Just over half (55%) of children were female. A greater proportion of the uninsured were girls compared to the children with insurance (63% vs. 48%\*\*). Almost two-thirds (65%) of the children at P/PPs were girls compared to only 49%\* at HOCs.

*Comments:* In PAS I girls comprised 54% of the sample.

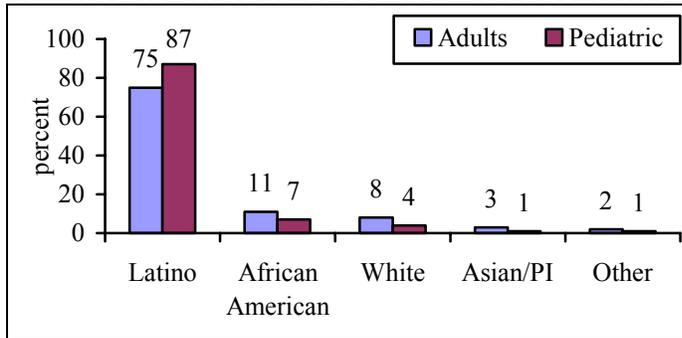
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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

<sup>1</sup> There was one girl who qualified as an emancipated minor and who completed the adult survey. For race/ethnicity the "Other" category results are presented in the tables but are not commented upon in the narrative (n=48 for adults) and n=3 for children). Among children the Asian/Pacific Islander group is very small (n=4) and the results are presented in the tables but no comparisons or inferences are made.

## RACE/ETHNICITY

### EXHIBIT 1: RACE AND ETHNICITY OF ADULT AND PEDIATRIC PATIENTS IN PAS II



#### Adult

The majority of patients at LAC-DHS sites including P/PP clinics identified themselves as Latino (Exhibit 1). The greatest proportion of African Americans was found at CHCs and the smallest proportion at P/PPs (17% vs. 7%\*\*\*), and the greatest proportion of Latinos was found at P/PPs and the smallest proportion at HOCs (80% vs. 69%\*\*\*). The greatest proportion of African Americans was found in SPA 6 and the smallest proportion in SPA 2 (28% vs. 2%\*\*\*); the greatest proportion of Latinos was found in SPA 7 and the smallest proportion in SPA 1 (89% vs. 62%\*\*\*).

*Comments:* In PAS I Latinos comprised 56% of adult patients, Whites 23%, African Americans 17% and Asian/Pacific Islanders 2%.

#### Pediatric

The majority of pediatric patients at LAC-DHS sites including P/PP clinics were Latino (87%) (Exhibit 1), although the proportion varied 94% at HCs to 78% at HOCs\*\*\*. Patients in SPA 7 were the most likely and those in SPA 1 were the least likely to be Latino (98% vs. 76%\*\*\*). In addition, there was a higher proportion of Latinos among the uninsured than the insured (91% vs. 84%\*\*), and a higher proportion of African Americans among the insured than the uninsured (11% vs. 3%\*\*).

*Comments:* In PAS I Latinos comprised 69% of pediatric patients, Whites 16%, African Americans 13% and Asian/Pacific Islanders 1%.

## IMMIGRATION STATUS

#### Adult

Sixty-eight percent of adult patients were born outside of the U.S., with females more likely than males to be non-U.S. born (71% vs. 62%\*\*\*). P/PPs had the highest and HOCs had the lowest proportion of non-U.S. born adults (75% vs. 57%\*\*\*), while SPA 7 had the highest and SPA 1 had the lowest rate (79% vs. 49%\*\*\*). For non-U.S. born patients the mean number of years living in the U.S. was 14.6 (range 1 to 60 years).

*Comments:* In PAS I 62% of adult patients had been born in a country other than the U.S.

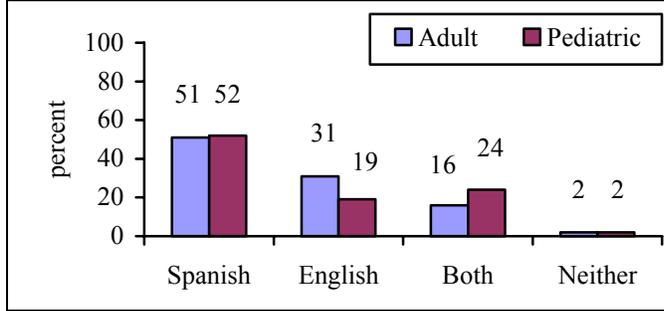
Pediatric

Three-quarters of pediatric patients were born in the United States. The 25% of the sample that immigrated to the United States had lived in the US for a mean of 4.8 years (range 0-15 years).

*Comments:* In PAS I 20% of pediatric patients had been born outside of the U.S.

**LANGUAGE\***

**EXHIBIT 2: PRIMARY LANGUAGE SPOKEN AT HOME BY ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

Women were more likely than men to indicate that Spanish was their primary language at home (54% vs. 45%\*\*\*). African Americans were the most likely and Latinos were the least likely to report English as their primary language at home (97% vs. 11%\*\*\*), although Latinos were the most likely to report both English and Spanish as their primary language at home (21%) and Asian/Pacific Islanders were the most likely to report a language other than English or Spanish (36%). Spanish was most commonly spoken at home by patients at P/PPs and least commonly by patients at HOCs (39% vs. 26%\*), and English was most commonly spoken by patients at HOCs and least commonly by patients at P/PPs (55% vs. 42%\*).

*Comments:* Eligibility for PAS I was broader than for PAS II and included people who spoke languages other than Spanish or English, although only about 2% spoke another language.

Pediatric

Fifty-two percent of the children primarily speak Spanish at home, 19% speak English, 24% speak both Spanish and English, and 2% speak other languages in their homes. The highest rate of Spanish speakers was at HCs and the lowest was at HOCs (62% vs. 45%\*), while the largest proportion of English speakers was at HOCs and the smallest proportion was at HCs (30% vs. 13%\*).

*Comments:* In PAS I, 70% of pediatric patients had Spanish as the primary language at home and 28% spoke English.

**EDUCATION**

The independent effects of education and income, as well as their interaction, on access to health care and health status have been well documented. It is important to note that this population includes some of the poorest adults and children living in Los Angeles County.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

Adult

Less than half (44%) of adults had graduated from high school, with a mean grade of regular school completed of 9.2, and a range from zero to 17 years. The mean number of years of education completed in the U. S. was 5.0 (range zero to 17 years). Men were somewhat more likely than women to have graduated from high school (50% vs. 41%\*\*\*). African Americans and Asian/Pacific Islanders had similar levels of graduating from high school and had more commonly than Latinos graduated from high school (85% vs. 31%\*\*\*). Patients at HOCs were the most likely and those at CHCs were the least likely (53% vs. 39%\*\*\*), while patients in SPA 1 were the most likely and those in SPAs 2 and 7 were the least likely (63% vs. 37%\*\*\*) to have graduated from high school. Patients in excellent health had more than twice the rate of those patients in poor health of completing high school (66% vs. 31%\*\*\*).

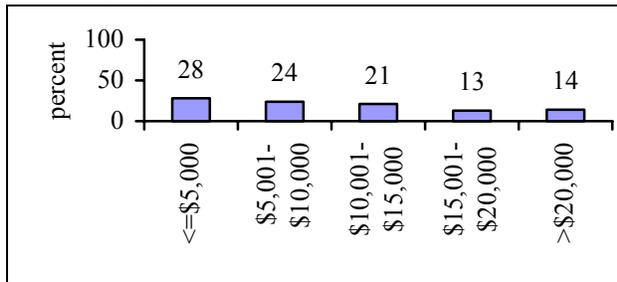
*Comments:* In PAS I, 45% of adult patients had graduated from High School.

*INCOME\**

Adult

Many medical conditions including those in this study disproportionately affect low-income adults and children. In this study, over half of adults indicated that their annual household income was \$10,000 or less (Exhibit 3).

**EXHIBIT 3: GROSS ANNUAL HOUSEHOLD INCOME FOR ADULT PATIENTS IN PAS II**



African Americans were the most likely and Asian/Pacific Islanders were the least likely to have an annual household income below \$10,000 (59% vs. 42%\*). Patients in SPA 4 most commonly and those in SPA 2 least commonly (58% vs. 44%\*), and patients who were insured were more likely than those without insurance to have an annual income of \$10,000 or less (57% vs. 51%\*).

Pediatric

Thirty-eight percent of pediatric patients had an annual household income of \$10,000 or less, which was lower than for adult patients. There was no significant subgroup variation.

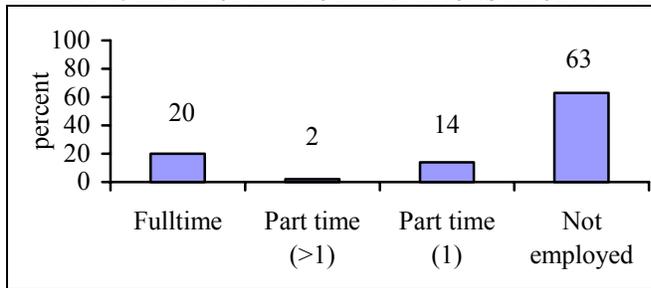
*EMPLOYMENT*

Adult

Employment status is strongly associated with income and health insurance coverage. In addition, those individuals with worse health status are less likely to be employed.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

**EXHIBIT 4: LEVEL OF EMPLOYMENT AMONG ADULT PATIENTS IN PAS II**



Men were more likely than women to have at least one fulltime job (29% vs. 16%\*\*\*), while women were more likely than men not to be employed (68% vs. 54%\*\*\*). Asian/Pacific Islanders were the most likely and African Americans were the least likely to have a fulltime job (22% vs. 16%\*\*), although Asian/Pacific Islanders were the most likely and Whites were the least likely not to be employed (68% vs. 59%\*\*).

Patients at CHCs had the highest rate and those at HCs had the lowest rate of fulltime employment (25% vs. 15%\*), while rates of being unemployed were similar across the facility types. Adult patients in SPA 6 had the highest rate and those in SPA 8 had the lowest rate of fulltime employment (28% vs. 15%\*). Adult patients in SPA 8 had the lowest rate while adults in SPA 7 had the lowest rate of being unemployed (71% vs. 58%\*\*\*). Patients who reported excellent health were the most likely and those who reported poor health were the least likely to have a fulltime job (24% vs. 10%\*\*\*), while patients in poor health were the most likely and those in excellent health were the least likely to be unemployed (80% vs. 52%\*\*\*).

Among those patients who were employed, the number of paid hours worked each week ranged from one to eighty, with a mean of 32.2. On average men worked more hours than women (35.3 hours vs. 30.1 hours), and Whites had the highest and African Americans had the lowest mean number of hours worked each week (33.5 hours vs. 30.3 hours). Adult patients in SPA 1 had the highest and patients in SPA 5 had the lowest mean number of hours worked each week (36.2 hours vs. 28.3 hours).

### *HOUSING SITUATION\**

A stable and predictable residential environment is important for many individuals with acute and chronic medical conditions. The lack of stable housing may put adults and children at risk for worsened health due to a number of factors including unsafe environment, lack of clean drinking water, limited refrigeration services, etc.

#### Adult

Four-fifths (81%) of patients lived in their own home or apartment, 14% were living in a temporary situation with family or friends and 5% were living in another setting (e.g., motel/hotel, shelter, on the street). Ninety-eight percent of respondents reported that they were able to stay in their current residential situation for the next 30 days. Women were more likely than men to live in their own home or apartment (84% vs. 76%\*\*\*), although there was no significant difference in the ability to stay at their current residence for the next 30 days.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

Latinos were the most likely and Asian/Pacific Islanders were the least likely to live in their own residence (85% vs. 64%\*\*\*), although 100% of Asian Pacific Islanders and only 94% of Whites indicated that they would be able to stay at their current residence for the next 30 days (\*\*). Adult patients in SPA 2 had the highest and those in SPA 4 had the lowest rate for residing in their own home or apartment (87% vs. 78%\*\*).

Among those adult patients who reported that they lived in their own home or apartment 18% owned their residence. Latinos were the most likely and African Americans were the least likely (18% vs. 12%\*\*\*); patients at HCs were the most likely and those at HOCs were the least likely (24% vs. 13%\*\*); and patients in SPA 1 were the most likely and those in SPA 4 were the least likely to own their residence (33% vs. 10%\*\*\*).

### *SIZE OF HOUSEHOLDS*

Assessing the size of households is important as a measure of the potential burden of resources and responsibilities that may affect access to and use of necessary health care. Variation in household composition from that which includes 2 parents and their children is believed to be a reflection of differences in cultural norms, as well as a result of difficult economic situations.

#### Adult

Forty-two percent of adults had at least one child ( $\leq 17$  years of age) living in the household, with a mean of 1.4 (range 0 to 9). Fourteen percent of adult patients had an adult who was 65 years of age and older living in their household, with a mean of 0.2 (range 0 to 10). The mean number of all people living in an adult patient's household was 3.9 (range 1 to 12).

Women were more likely than men to have at least one child living with them (61% vs. 52%\*\*\*), while men were more likely than women to have at least one adult age 65 and older living with them (16% vs. 13%\*). Latinos most commonly and Whites least commonly had one or more children living in their household (66% vs. 30%\*\*\*), while on average. Latinos had the greatest and whites had the least number of children 17 years of age and younger living in the patient's household (1.6 children vs. 0.6 children). Asian/Pacific Islanders were the most likely and African Americans were the least likely to have an adult 65 and older in their household (27% vs. 9%\*\*). Overall on average, Latinos had the greatest and Whites had the least number of people living in the household (4.3 people vs. 2.5 people). Patients who were currently insured were likely than those who were uninsured to have one or more children living in their households (68% vs. 56\*\*\*\*).

#### Pediatric

Eleven percent of pediatric patients had an adult 65 years of age and older as part of their household. Total household size varied from 2 to 12 individuals with a mean of 4.9. Overall, on average Latino and African American children had the greatest and White children had the least number of people living in the household (mean 4.9 people vs. 3.8 people).

## B. ACCESS TO CARE\*

### HEALTH INSURANCE

Health insurance is important for everyone because it provides a minimum degree of financial access to health care. However, although health insurance has been demonstrated to be a key component of accessing the health care system, millions of Americans remain uninsured for health care. Additionally, many Americans cannot afford to benefit from their health insurance due to high premiums, co-payments and deductibles. Among people who are uninsured and who have chronic medical conditions the risk for unmet health care needs is considerably elevated. To meet their medical needs many people rely on the safety net for their medical care. The safety net in Los Angeles is a loosely woven system of medical organizations that includes community and free clinics, and the LAC-DHS primary care system.

#### Adults

**EXHIBIT 5: REASONS<sup>1</sup> MOST FREQUENTLY REPORTED FOR NOT HAVING HEALTH INSURANCE BY ADULT PATIENTS IN PAS II**

	%
Could not afford/too expensive	55
Employer or spouse's employer does not offer health insurance	24
Changed their employer or lost their job	19
Not eligible due to employment/working status	11
Not eligible due to citizen/immigration status	8
Does not know where to go to apply	7
Gets medical care free	6
Not eligible due to health/other problems	4
Healthy/no need	4
Family situation changed	4
Lost public program coverage	3
Does not understand/cannot fill out the forms	2
Pays for their own medical care	1
Does not believe in health insurance	<1
Other reasons	4

<sup>1</sup>Patients could report more than one reason

Less than one-quarter (23%) of adult patients were insured at the time of the interview. While 37% of patients were employed fulltime or part-time, only 10% of their employers or spouse's employer paid for or offered health insurance coverage.

Over half (57%) of people currently uninsured reported they had never had health insurance. Uninsured patients at P/PPs had the highest rate and individuals at HCs had the lowest rate for never having had health insurance (61% vs. 44%\*\*\*). Among patients who had health insurance at the time of the interview, patients at HCs most commonly and those at P/PPs least commonly had MediCal (24% vs. 13%\*\*\*). Among those patients without current health insurance coverage 17% reported that it had been more than 12 months but less than 3 years since they were insured, 26 % reported their last coverage as more than 3 years ago, and 57% never had health insurance.

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\* Level of statistical significance is documented in the text of the results with commonly used notations:  
 \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

Among the uninsured 37% had ever applied for MediCal, and for 46% of these people the MediCal application was denied. For those people who applied to MediCal but were denied, patients reported that the denial was because their income was too high (19%); they were not eligible due to citizenship status (35%); not 65 years of age or older (9%); not 65 years of age and no minor dependents (2%), other reason (21%), and don't know (16%).

Women were somewhat more likely than men to have health insurance or coverage for health care (24% vs. 19%\*), and overall women were more likely to have MediCal (19% vs. 14%\*\*). Among the currently uninsured, men more commonly than women indicated that the reason they did not have health insurance was due to a change of employer or losing a job (22% vs. 17%\*), and women were more likely than men to attribute being uninsured to ineligibility due to citizenship or immigration status (10% vs. 4%\*\*\*). Women had higher rates of ever having applied for MediCal (43% vs. 26%\*\*\*).

African Americans had the highest rate and Asian/Pacific Islanders had the lowest rate of health insurance or coverage for health care (31% vs. 12%\*). African Americans most commonly and Latinos least commonly were covered by the General Relief Health Care Program (18% vs. 5%\*\*\*\*).

Among those individuals currently uninsured for health care Latinos had the highest rate and Whites had the lowest rate for never having had health insurance (65% vs. 14%\*\*\*). African Americans were the most likely and Latinos were the least likely to report that they were uninsured because they had changed or lost their job (35% vs. 16%\*\*\*). Additionally, Latinos most commonly and African Americans least commonly reported that their employer (or their spouse's) did not offer insurance (28% vs. 10%\*\*\*). Furthermore, Whites had the highest rate and Latinos had the lowest rate of being uninsured because they could not afford insurance (71% vs. 52%\*\*\*).

To try to understand why people might not apply for MediCal coverage we asked individuals whether each of the following might have contributed to their decision. People responded yes or no to each item. Three-fifths of patients did not think they were eligible, just over one third (37%) were afraid they would have to pay back the cost of the medical care they received; one-quarter indicated they do not like to use welfare programs; and, 17% were afraid they or someone in their family could be deported.

Among those people currently uninsured who never applied for MediCal women were more likely than men to indicate that they thought they were not eligible (64% vs. 54%\*\*), they were afraid they would have to pay back the cost of the medical care they received (40% vs. 31%\*\*), vs. they were afraid that they or someone in their family could be deported (19% vs. 1%\*).

Latinos most commonly and Whites least commonly thought they would have to pay back the cost of the medical care they receive (41% vs. 16%\*\*\*); Whites had the highest rate and Latinos had the lowest rate for indicating that they do not like to use welfare programs (44% vs. 23%\*\*). Twenty-two percent of Latinos indicated that they had not applied for MediCal because they thought that they or someone in their family could be deported, and 31% of non-U.S. born

Latinos were afraid that applying for MediCal could affect whether they could become a U.S. citizen.

Among non-U.S. born patients who were uninsured and had not applied for MediCal just over one-quarter (29%) were fearful it might affect whether they could become a citizen.

*Comments:* In PAS I 35% of adults had health insurance.

### *Pediatrics\**

Fifty three percent of parents reported that their children currently had health insurance. Parents reported a higher rate of health insurance among boys than among girls (61% vs. 46%\*\*). African Americans had the highest rate and Whites had the lowest rate of current health insurance coverage (79% vs. 38%\*\*). In addition, African American children had the highest rate and Whites had the lowest rate of coverage by MediCal (58% vs. 30%\*).

Among the reasons given for not being insured, not being able to afford health insurance was the most common response (39%), but the following reasons were also given: not eligible because of work status (16%), parents' employment does not offer health insurance (16%), not a citizen/immigration issues 13%), parent changed/lost job (12%), gets health care free (9%), lost public coverage (6%), family situation changed (6%), did not know where to go to apply (5%), and did not know how to fill application (5%). Parents at most facility types said that the primary reason their children were not insured was due to not being able to afford health insurance.

Fifty-two percent of parents said they had ever applied for MediCal for their children. The majority of parents who had not applied for MediCal felt that their children were not eligible (49%), and additional reasons included the following: 31% were afraid would have to pay back the medical care received, 29% do not like to use welfare programs, 22% were afraid that they or someone in their family would be deported. Similar reasons were given in PAS I. Among non-US born children the primary reason for not applying for MediCal or other government health care programs was fear that it would affect their children's application for citizenship (38%).

*Comments:* The percentage of parents reporting current health insurance coverage for their children has decreased from PAS I when 56% percent of parents reported coverage to 53% in PAS II, despite increased rates of insurance coverage for children statewide. It may be that once children obtain health insurance they leave the County system and seek medical from private providers.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

### *ACCESS TO THE TELEPHONE\**

The ability to make and receive phone calls is key to facilitating access to health care in terms of patients being able to contact clinics to make appointments, and to receive confirmation of appointments and changes in scheduling.

#### *Adult*

The majority of adults had access to a telephone to make and receive phone calls. Ninety-five percent of adults could both make and receive a telephone call from their residence. Women had better access than men to the telephone to both make (96% vs. 92%\*\*\*), and receive (96% vs. 92%\*\*\*) phone calls. There was some variation by race/ethnicity with Whites the most likely and Asian/Pacific Islanders the least likely to be able to make telephone calls (96% vs. 90%\*\*), and to receive telephone calls (95% vs. 89%\*) at home. The ability to make and receive telephone calls did not differ significantly by facility type, although patients in SPA 7 were the most likely and those in SPA 1 were the least likely to be able to make a telephone call from home (98% vs. 89%\*\*). Additionally, adult patients in SPAs 5 and 7 were the most likely and those in SPA 1 were the least likely to be able to receive telephone calls at home (97% vs. 90%\*). Patients in excellent health were the most likely and those in poor health were the least likely to indicate that they were able to make (99% vs. 91%\*\*), and to receive a telephone call at their residence (99% vs. 89%\*\*).

#### *Pediatric*

Ninety-four percent of households were able to receive and make telephone calls from where the child lives. There was no significant variation by subgroup.

### *PRIOR RECEIPT OF MEDICAL CARE IN GENERAL*

Prior receipt of medical care is a significant predictor for future use of medical services. Patients were asked how many times they had seen a health care provider in the past year, and where they had sought services.

#### *Adult*

In the 12 months prior to the day of the interview, 80% of patients had seen a physician for medical care. Patients had made a mean of 3.9 visits to a physician (range 0 to 90). On average, during the preceding 12 months women were more likely than men to have made a medical visit (84% vs. 71%\*\*\*), with women making more visits than men (4.3 visits vs. 3.1 visits). Asian/Pacific Islanders were the most likely and Latinos were the least likely to have made a prior visit to a physician during the year (93% vs. 77%\*\*\*), while Whites had the greatest and Latinos had the least number of visits (5.4 visits and 3.5 visits). Patients in SPA 6 had the highest rate and those in SPAs 4 and 8 had the lowest rate for having made a prior visit to a health care provider in the preceding year (87% vs. 75%\*\*). Furthermore, individuals in poor health had made the most and those in excellent health had made the least mean number of visits to a health care provider during the preceding 12 months (5.3 visits vs. 2.8 visits).

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

### Pediatric

In the past 12 months 82% of children had made a visit to a doctor or nurse. Children made an average of 4.2 visits for medical care in the preceding year (range 1 to 31), and boys were more likely than girls to have seen a physician in the prior 12 months (86% vs. 79%\*).

### *PRIOR RECEIPT OF MEDICAL CARE THROUGH THE LAC-DHS\**

One of the major differences between PAS II and PAS I was the eligibility requirement in the latter study that patients had to have made one or more visits to an LAC-DHS facility (includes P/PP sites) during the year preceding the start of the study. In this study patients were not required to have had any prior interaction with the LAC-DHS in an attempt to better understand patients' experiences within the system.

### Adult

Prior to their current visit 86% of adult patients who had seen a physician in the past year had made a previous visit to an LAC-DHS provider (includes LAC-DHS sites and P/PP sites) within the preceding 12 months (69% of all adult patients). Women were somewhat more likely than men to have previously used County medical services (87% vs. 83%\*). Patients at HCs were the most likely and patients at HOCs were the least likely to have received medical care at a County facility prior to the day of the interview (90% vs. 81%\*), while adult patients in SPA 2 had the highest rate and those in SPA 4 the lowest rate (91% vs. 81%\*). Insured patients were more likely than those who were not insured to have received medical care at a County facility within the preceding year (90% vs. 85%\*).

In the past 12 months, patients had made a mean of 4.5 visits to the facility at which they were interviewed (range 1 to 52). There was no difference by gender or race/ethnicity. Patients at P/PPs had the highest and those at HOCs had the lowest mean number of visits to the facility at which they were interviewed (5.1 visits vs. 3.9 visits), while patients in SPA 2 had the greatest and those in SPA 1 had the least number of visits (5.7 visits vs. 3.4 visits). There was no difference by insurance status, but on average patients in poor health had made the most number of visits and patients in excellent health had made the least number visits (5.4 visits vs. 3.6 visits).

### Pediatric

Of those children who had seen a physician in the past year, 89% had been seen at a County facility (73% overall). Girls were more likely than boys to have received care at a County facility (92% vs. 85%\*). In the past 12 months, children had made an average of 4.2 visits to the interview site. On average, patients in SPA 4 had made the most and those patients in SPAs 1 had made the least visits to the interview site (4.9 visits vs. 3.0 visits).

### *ACUTE ILLNESS OR INJURY*

Use of medical services for acute illnesses or injury may be an indication of episodic health care seeking, or it may be consistent with the services offered by primary care providers that includes caring for people with acute and chronic medical conditions.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

### Adult

In the past 12 months 23% of adult patients had experienced an illness or injury that required immediate medical care from a physician at a County facility (not an emergency department), and adult patients had made a mean of 2.4 visits (range 1 to 52). Among those patients seen at a County facility for an illness or injury during the past 12 months, 48% reported that they were always seen as soon as they wanted.

Men were somewhat more likely than women to have visited a County facility at least once within the past 12 months for an illness or injury (26% vs. 21%\*), although there was no difference in the mean number of visits made. Additionally, men and women were equally likely to have received care as soon as they wanted. Whites were the most likely and Latinos were the least likely to have had an illness or injury that required immediate medical care from a physician at a County facility (37% vs. 18%\*\*\*); however, on average, African Americans made the greatest and Latinos made the least number of visits (3.5 visits vs. 1.8 visits). Patients at HOCs were the most likely and those at P/PPs were the least likely to have had an illness or injury in the past year that required County clinic care (30% vs. 17%\*\*\*), although patients at P/PPs had the highest and those at HCs had the lowest mean number of visits during the preceding 12 months (2.8 visits vs. 1.8 visits).

Patients at P/PPs were the most likely and those at CHCs were the least likely to report always being seen as soon as they wanted (62% vs. 32%\*\*\*). Adult patients in SPA 4 were the most likely and those in SPA 1 were the least likely to report that they were seen as soon as they wanted (68% vs. 31%\*\*\*). Patients in poor health were the most likely and those in excellent health were the least likely to have had an illness or injury that needed medical care from a physician at a County clinic in the past year (33% vs. 18%\*).

*Comments:* PAS I had 50% of adults who experienced a non-emergent illness or injury that required medical care from a County facility in the past 12 months. This apparent decline in use is somewhat due to the variation in sampling frames between the two studies, i.e., eligibility for PAS II did not require patients to have made one or more visits to an LAC-DHS facility within the 12 months preceding the study.

### Pediatric

Fourteen percent of children had had an illness or injury that needed care right away but were not seen in an emergency department, and they had made an average of 3.1 visits to County clinics for this reason. Almost three fifths (59%) of the time they always received medical care for this reason as soon as their parents wanted. There was variation by facility type with children at HOCs the most likely and those at HCs and P/PPs the least likely to have had an illness or injury (25% vs. 7%\*\*).

*Comments:* In PAS I 39% of pediatric patients had experienced a non-emergent illness or injury that required medical care from a County facility in the past 12 months. The apparent decline in use is somewhat due to the variation in sampling frames between the two studies: 1) eligibility for PAS II did not require patients to have made one or more visits to an LAC-DHS facility within the 12 months preceding the study; and 2) children between 6 months and one year were eligible for participation in PAS II but not in PAS I.

### *REGULAR OR ROUTINE MEDICAL CARE*

Access to regular or routine medical care with a focus on preventive health care testing and counseling is an important component of primary medical care services.

#### *Adult*

In the past 12 months, 60% of adult patients had made an appointment for regular or routine medical care at a County facility. Among those patients who had made an appointment for regular or routine medical care 55% reported that they were always seen as soon as they wanted.

There was significant variation in having had a visit for regular or routine care in the past year by the following characteristics: gender (62% of women vs. 55% of men\*), facility type (67% at HCs vs. 54% at P/PPs\*\*), SPA 2 (70% in SPA 5 vs. 47% in SPA 2\*\*\*), insurance status (68% for insured vs. 57% for uninsured\*\*\*) and health status (66% of patients in poor health vs. 55% of patients in good health\*).

Latinos were the most likely and Whites were the least likely to indicate that they were always seen as soon as they wanted (58% vs. 44%\*). Patients at P/PPs were the most likely and those at CHCs were the least likely (63% vs. 46%\*\*\*), while patients in SPA 7 had the highest rate and those in SPA 1 had the lowest rate for being seen as soon as they wanted (67% vs. 33%\*\*\*).

*Comments:* In PAS I 68% of adults had made an appointment for regular or routine medical during the preceding year. This apparent decline in use is somewhat due to the variation in sampling frames between the two studies, i.e., eligibility for PAS II did not require patients to have made one or more visits to an LAC-DHS facility within the 12 months preceding the study.

#### *Pediatric*

Seventy-five percent of the parents/guardians of pediatric patients had made an appointment for regular or routine medical care for their child during the preceding 12 months, and 54% of children always received medical care as soon as their parent/guardian wanted. In the past 12 months, a greater proportion of girls than boys had an appointment made for them for regular or routine care (80% vs. 70%\*). As expected, patients with health insurance more commonly than patients without health insurance had an appointment made for them for regular or routine care (82% vs. 67%\*\*). Among facility types, rates for this type of appointment were highest among pediatric patients at HOCs and lowest among pediatric patients at P/PPs (86% vs. 64%\*\*). Uninsured patients more commonly than insured patients were always seen as soon as their parent/guardian wanted (66% vs. 47%\*).

*Comments:* In PAS I, 77% of children had an appointment made for them for regular or routine medical during the preceding year.

### *TELEPHONE CALL TO LAC-DHS FACILITY FOR HELP OR ADVICE\**

Receipt of necessary medical care may come in the form of help or advice given over the telephone, as well as medical services provided in a doctor's office or health care facility. A

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

system that allows patients to obtain medical advice from a qualified health care provider without making a visit has the potential to facilitate medical care and to increase the number of patients cared for.

### Adult

In the past 12 months 17% of adult patients had called a County clinic during office hours for medical advice or help for themselves. There was significant variation by gender (18% of females vs. 14% of males\*), race/ethnicity (Latinos 88% vs. Whites 66%\*\*\*), facility type (HCs at 22% vs. P/PPs at 15%\*), geographically (33% in SPA vs. 9% in SPA 5\*\*\*), and insurance (insured 20% vs. uninsured 16%).

Patients called a mean of 2.7 times (range 1 to 24). However, on average Whites made the greatest and Asian/Pacific Islanders made the least number of phone calls to a County facility for medical advice or help (4.0 calls vs. 2.3 calls). Patients at HOCs had the greatest and those at CHCs had the least (3.0 calls vs. 2.5 calls), and patients in SPA 3 had made the most and patients in SPA 7 had made the least number of phone calls to a County facility for medical help or advice for themselves (4.3 times vs. 2.0 times). On average insured patients had called more frequently than uninsured patients (3.4 times vs. 2.5 times), and patients in poor health had made the most calls and patients in excellent health had made the least number of calls (3.0 calls vs. 2.3 calls).

Forty-seven percent of adult patients reported always receiving the advice or help they needed. Patients at P/PPs were the most likely and those at CHCs were the least likely to have always received the advice or help they needed (55% vs. 37%\*\*\*). Among patients who had called a County facility for help or advice patients in SPA 5 were the most likely and patients in SPA 8 were the least likely to report that they had always received what they needed (82% vs. 33%\*\*\*). Patients in poor health were the least likely to indicate that they always got the advice or help they needed (36%\*).

Comments: In PAS I 31% of adult patients had called a County facility during office hours to get medical advice or help for themselves. This appears to be a significant increase from 1999 when PAS I was performed, especially in light of the differences in the sampling frames. Explanation of this increase requires further investigation of the changes that have taken place at the LAC-DHS facilities included in PAS II

### Pediatric

Just over one-fifth (21%) of parents reported having called a County clinic during office hours to get medical advice or help for their child during the past 12 months, with a mean 2.6 calls. Calling for medical advice was most common among African Americans and least common among Latinos (43% vs. 19%\*). The parents of pediatric patients with insurance were more likely than the parents of children without insurance to have called a County clinic for advice or help for their child during the prior 12 months (29% vs. 13%\*\*\*).

Of those who called for advice, 50% reported always getting the advice they needed, while the parents of children at HOCs were the most likely and those at HCs were the least likely to report always getting the help or advice they needed (67% vs. 50%\*\*\*).

*Comments:* In PAS I 29% of the parents/guardians of pediatric patients had called a County facility during office hours to get medical advice or help for their child.

#### *LEFT A COUNTY FACILITY WITHOUT SEEING A PHYSICIAN\**

Many patients have reported waiting for prolonged periods of time at a doctor's appointment. This phenomenon is not unique to the LAC-DHS, but occurs in many HMOs and private practice settings. In some cases, patients' conflicting responsibilities may not allow them to wait for extended periods of time, particularly if they had a scheduled appointment around which they made other plans.

#### Adult

One tenth of adult patients indicated that they had left a County clinic without being seen by a physician within the past 12 months. Patients most commonly reported that they had left without being seen was because it took too long/they had somewhere to go (56%), or the physician was not there/there were no appointments (27%). There was significant variation in the rates of having left a clinic in the past year without being seen by a physician by; gender women (11% vs. men 7%\*), race/ethnicity (African Americans 18% vs. Latinos 8%\*\*\*), facility type (CHCs 13% vs. P/PPs 7%\*\*), SPA (15% in SPA 6 vs. 6% in SPA 5\*), and health status (in poor health 16% vs. in excellent health 5%\*).

*Comment:* In PAS I 12% of adult patients had left a County clinic without being seen by a physician with the preceding year.

#### Pediatric

Twelve percent of parents reported that they had gone to a County facility and left without being seen by a doctor in the past 12 months. Forty-three percent reported that the reason they left without being seen was due to either a doctor not being available or no available appointments; 28% reported that the wait was too long, and 24% indicated a variety of other reasons. Within the past 12 months, 15% of children with health insurance and 8%\* of uninsured children had left a County facility without seeing a physician.

*Comment:* In PAS I 7% of pediatric patients had left a County clinic without being seen by a physician with the preceding year.

#### *REASON FOR CURRENT VISIT*

#### Adult

Over half (54%) of adult patients presented with an acute illness or injury, 42% were there for follow-up, 8% for a general checkup, 3% for a medication refill and 1% to be referred to a specialist. Women were more likely than men to indicate that the reason for their current visit was for follow-up (45% vs. 38%\*\*), while men were more likely than women to report that they had an illness or injury (57% vs. 52%\*). Asian/Pacific Islanders were the most likely and Latinos were the least likely to report that the purpose of their current appointment was follow-up (52% vs. 41%\*). There was no significant difference by insurance status. Patients in poor

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\* Level of statistical significance is documented in the text of the results with commonly used notations:  
\*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

health were the most likely and patients in excellent health were the least likely to indicate that the reason for their current visit was an illness or injury (67% vs. 43%\*\*\*), while patients in excellent health were the most likely and those in poor health were the least likely to report that they were at the clinic for a general check-up (27% vs. 2%\*\*\*).

### Pediatric

Parents reported that the reason for their current visit was primarily for an illness/injury (54%), a follow-up appointment (28%), a general checkup (20%), or immunizations (2%).

### *PATIENT WAS SEEN BY A PHYSICIAN AT CURRENT VISIT\**

Physician extenders in the form of Nurse Practitioners and Physician's Assistants are increasingly being used in certain medical settings (e.g., primary care, rural and underserved areas, prenatal care). However, it is unclear how well patients recognize whether their provider is a physician or other health care professional.

### Adult

Almost all of the patients interviewed had seen a physician (99%). Women and men were equally likely to have been seen by a physician at their current visit. African Americans were the most likely and Asian/Pacific Islanders were the least likely (100% vs. 92%\*\*\*), while patients in SPA 3 were the most likely and patients in SPA 2 were the least likely to have seen a physician at their current visit (100% vs. 95%\*\*\*). There were no significant differences by facility type, insurance status or health status.

### Pediatric

Almost all parents (99%) reported that their child had seen a doctor on the day of the interview.

### *OTHER OPTIONS FOR MEDICAL CARE*

At the time that this study was performed a majority of the Health Centers were anticipated to close. To learn more about decision-making regarding seeking needed medical care patients were asked where they would go for medical care if their current clinic were closed down.

### Adult

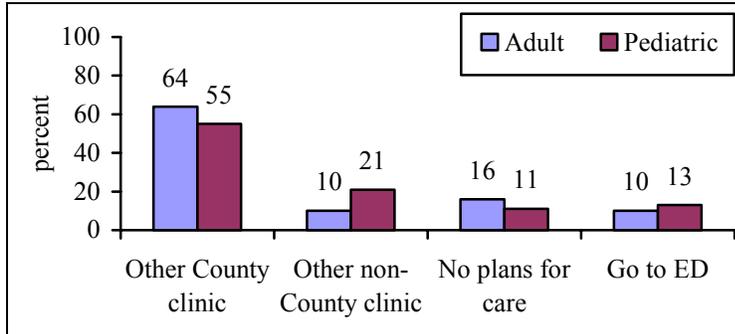
A majority of adult patients would continue to seek care within the County system (Exhibit 6) Asian/Pacific Islanders were the most likely and African Americans were the least likely to indicate that they would seek medical care at another County clinic (69% vs. 53%\*\*\*), while patients at CHCs were the most and those at HOCs were the least likely to report that they would go to another County facility if their current clinic closed (71% vs. 57%\*\*\*). Patients in SPA 2 were the most likely and patients in SPA 5 were the least likely to report that they would go to another County clinic (73% vs. 54%\*\*\*), and patients in SPA 4 were the most likely and those in SPA 3 were the least likely to report that they would go to a non-County clinic if their current clinic were to close (16% vs. 4%\*\*\*). Patients who were uninsured/uncovered for health care were more likely than those who had health insurance/coverage to indicate that they would seek

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medical care at another County facility (67% vs. 56%\*\*\*); however, insured patients were also more likely to indicate that they would go home or do nothing (7% vs. 2%\*\*\*).

**EXHIBIT 6: OTHER OPTIONS FOR MEDICAL CARE AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



Furthermore, Whites were the most likely and Latinos were the least likely (15% vs. 9%), and patients in SPA 8 were the most likely and patients in SPA 7 were the least likely to report that they would seek medical care at an emergency department if their current medical facility were to close (14% vs. 7%\*\*). Additionally, patients in poor health were the most likely to indicate that they would seek care at an emergency department (16%).

### Pediatric\*

When asked where they would go if the interview clinic site closed, a majority of parents reported that they would take their child to another County clinic. A higher proportion of the parents of girls than boys reported that they would go to another County clinic (60% vs. 50%\*) if the interview clinic site should close, while a greater proportion of boys would seek medical care from a non-County facility (26% vs. 17%\*). Latinos were the most likely and African Americans were the least likely to indicate they would take their child to another County clinic if the interview clinic site were to be closed (58% vs. 36%\*\*). Sixty-four percent of the parents of children without health insurance and 49%\*\*\* of the parents of children with health insurance reported they would seek medical care for their child at another County facility if their current clinic was closed; however, 20% of insured children and only 4%\*\*\* of uninsured children would seek care at an ED if clinic closures occurred.

Parents at CHCs most commonly and parents at HOCs least commonly reported that they would take their child to another County facility if the current facility were to be closed (60% vs. 47%\*), while 24% of pediatric patients at P/PPs and 17%\* at HOCs would seek care at a non-County clinic. However, parents of patients at HCs were the most likely and those at P/PPs were the least likely to indicate that they would turn to an ED for medical care for their child (19% vs. 7%\*). By SPA, parents in SPA 5 were the most likely and those in SPA 8 were the least likely to indicate that they would rely on another County facility for medical care for their child (71% vs. 44%\*).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

### *USUAL SOURCE OF CARE\**

Having a usual source of care (USOC) is known to improve the likelihood that people will receive necessary medical care for acute, chronic and preventive health care needs, regardless of health insurance status. Although, having health insurance makes it more likely that one will have access to a USOC. A USOC may be a person or facility that an individual identifies as the place they have gone in the past and the likely place they will go in the future for their medical care.

#### Adult

Just over half (53%) of adults reported having a usual source of care. Eleven percent of patients had been going to their usual source of care (USOC) for more than 10 years, 10% for more than 5 up to 10 years, 27% for more than 2 years up to 5 years, 21% for 1 to 2 years and just under one-third (31%) for less than one year. There was significant variation in rates of having a USOC by gender (women 59% vs. men 42%\*\*\*), race/ethnicity (Asian/Pacific Islanders 62% vs. Latinos 52%\*), SPA (61% in SPA 2 vs. 47% in SPA 5\*\*), and insurance status (insured 62% vs. uninsured 51%\*\*\*).

Women were more likely to have been going to their USOC for more than ten years (13% vs. 6%\*\*\*), while men were more likely than women to have been going to their USOC for less than one year (38% vs. 29%\*\*\*). However, African Americans were the most likely and Asian/Pacific Islanders were the least likely to be going to their USOC for 10 or more years (19% vs. 6%\*), while Asian/Pacific Islanders and were the most likely and African Americans were the least likely to be going to their USOC for less than one year (44% vs. 25%\*). Patients at HOCs were the most likely and those at HCs were the least likely to report having a USOC for more than 10 years (21% vs. 6%\*\*\*) while patients at HCs were the most likely and those at CHCs were the least likely to have been going to their USOC for less than one year (39% vs. 23%\*\*\*). Patients in SPA 5 were the most likely and patients in SPA 3 were the least likely to report going to their USOC for more than 10 years (23% vs. 4%\*\*\*) while patients in SPA 3 were the most likely and patients in SPA 5 were the least likely to have been going to their USOC for less than one year (36% vs. 18%\*\*\*).

*Comments:* It is important to reiterate that not all participants in PAS II had used LAC-DHS services prior to their current visit, while this was a requirement of eligibility for PAS I. In PAS I 67% of patients reported having a USOC, where 41% had been going to the same place for less than one year, 24% for one to two years, 18% for more than two years up to five years, 10% for more than 5 up to ten years, and 7% had been receiving medical care for more than ten years.

#### Pediatric

Overall, 73% of parents reported their children had a usual source of care (USOC). All White children (100%) and only 72%\* of African American and Latino children had a USOC according to their parents. Children with health insurance were more likely than children without health insurance to have a USOC (78% vs. 68%\*). The duration that a child had been going to a USOC is a direct result of the child's age.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

*Comments:* The rate for having a USOC among pediatric patients in PAS II is lower than that reported nationally by parents (94%).<sup>2</sup> Nationally, Whites reported the highest percentage of having a USOC with 96%, followed by African Americans 92% and Latinos had the lowest with 87%.<sup>2</sup> In PAS I, 82% of pediatric patients had a USOC. It is important to reiterate that not all participants in PAS II had used LAC-DHS services prior to their current visit, while this was a requirement of eligibility for PAS I.

### **Seeking Medical Care in Mexico**

Due to the large Mexican and Central American population in Los Angeles County, and the proximity of Los Angeles to the U.S./Mexican border we assessed the use of medical services in Mexico including visits to a physician and purchase of prescription medications. These items are new for the survey and there is no comparable data from PAS I.

#### *PHYSICIAN VISIT IN MEXICO\**

##### Adult

During the past 12 months 5% of adult patients had visited a physician in Mexico, and they had made a mean of 3.1 visits (range 1 to 24 visits). The most common reasons people reported seeing a physician in Mexico included becoming ill while visiting Mexico (42%), cheaper medical care in Mexico (15%) and that it is easier to see a physician in Mexico (11%). There was no significant variation by gender. Latino patients most commonly saw a physician in Mexico during the preceding 12 months (7%\*\*\*).

##### Pediatric

Five percent of children had seen a doctor in Mexico in the past 12 months. The reason most often given for seeing a doctor in Mexico was due to an illness while in Mexico (59%). Of note, in the past 12 months, 9% of patients without health insurance had seen a doctor in Mexico.

#### *OBTAINING MEDICATION FROM MEXICO*

##### Adult

In the past 12 months 6% of patients had bought medicine from Mexico to use in the U.S. Among those who had purchased medicine in Mexico the mean number of time they had done so was 2.2 (range 1 to 24). The most common reasons that people bought medicine in Mexico were: medicine from Mexico is cheaper than in the U.S. (44%), one can get pills in Mexico without a prescription from a physician (24%), and it is more convenient to get medicines in Mexico (20%). Latinos made a mean of 2.1 visits and patients with poor health made a mean of 2.5 visits to Mexico to purchase medications for use in the U.S. within the past 12 months.

Latinos reported that pills and medicine from Mexico are cheaper than in the U.S. (39%), one can get pills in Mexico without a prescription from a physician (24%), it is more convenient to get medicines in Mexico (21%), one can get pills and medicine from Mexico that are not available in the U.S. (19%).

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\*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

## **Specialty Care**

### *REFERRAL TO SPECIALTY CARE*

LAC-DHS retains the responsibility to provide specialty care to all patients at traditional DHS medical facilities (HOCs, CHCs and HOCs) as well as those patients at P/PPs. Specialty care services are very heterogeneous as is the level of acuity of the patients referred.

#### Adult

Over one fifth (22%) of adult patients were referred to a specialist for medical care during the past 12 months (mean 0.3, range 0 to 10). Of those people referred to a specialist 75% had seen a specialist (mean 1.1, range 0 to 10). The specialties to which patients were most commonly referred during the preceding 12 months included Ophthalmology (25%), Obstetrics/Gynecology (18%), Cardiology (14%), Orthopedics (9%) and Gastroenterology (9%).

There was significant variation by race/ethnicity, facility type, SPA, insurance and health status. Asian/Pacific Islanders were most commonly and Latinos were least commonly referred to a specialist in the past 12 months (38% vs. 18%\*\*\*). Patients at HCs were the most likely and those at P/PPs were the least likely to have been referred to a specialist in the past 12 months (28% vs. 16%\*\*\*). Among those people who were referred to a specialist, patients at CHCs and HCs were the most likely and those at HOCs were the least likely to have actually seen a specialist (81% vs. 68%\*). Patients in SPA 2 had the highest rate and those in SPA 3 had the lowest rate for having been referred to a specialist during the past 12 months (28% vs. 16%\*). There was no significant difference by insurance status for having been referred to a specialist in the preceding year; however, among those patients referred to a specialist patients with insurance were more likely than those without insurance to have seen the specialist (86% vs. 71%\*\*). In the past 12 months patients in poor health were the most likely and those in excellent health were the least likely to have been referred to a specialist (30% vs. 18%\*). Among those referred to a specialist, patients in poor health were the most likely to have actually been seen by a specialist (85%).

Among those patients who were referred to a specialist but who had not been seen, 19% reported that that no one had called to make an appointment or they had not been given an appointment and 17% reported that they could not get an appointment or the wait was too long. However, 28% indicated that they had an appointment sometime in the future. Patients without health insurance most commonly indicated that they could not get an appointment because the wait was too long (19%), other unspecified reasons (26%) or they had an appointment in the future (31%).

*Comments:* In PAS I, 30% of patients had been referred to a specialist, and 83% of these had actually received medical care from a specialist. Rates for seeing a specialist once referred appear to have decreased somewhat. The reasons are unclear at this time, but may be due to an increase in patient volume and/or a reduction in specialists available.

#### Pediatric

Fourteen percent of children were referred to a specialist with an average of 0.2 referrals (range 0 to 10), and 73% of these children actually saw a specialist (mean 1.1, range 0 to 5). In the past 12 months, children were most commonly referred to the following specialists: ophthalmology/optometry (26%) and neurology (20%).

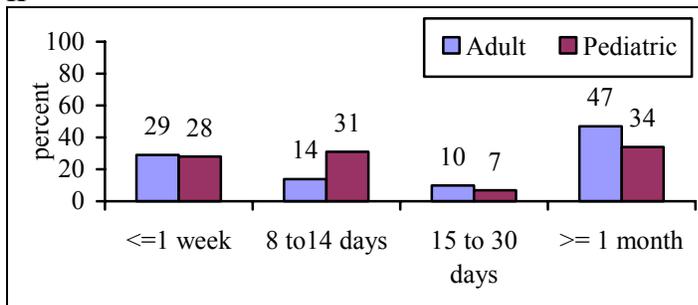
Pediatric patients at HOCs had the highest rate and those at P/PPs had the lowest rate for having been referred to a specialist in the past 12 months (23% vs. 6%\*\*\*), but there was no difference in the proportion of those children who actually received specialty care. Patients with insurance were more likely than patients without insurance to have been referred to a specialist in the past 12 months (18% vs. 9%\*\*), although there was no significant difference in the rates of actually having seen a specialist.

*Comments:* In PAS I, 15% of pediatric patients had been referred to a specialist, and 86% of those children had actually seen a specialist. Rates for seeing a specialist once referred appear to have decreased somewhat. The reasons are unclear at this time, but may be due to an increase in patient volume and/or a reduction in specialists available.

***SCHEDULING AN APPOINTMENT FOR SPECIALTY CARE\****

Delays in scheduling appointments may lead to an increased risk for complications including higher rates of preventable hospitalizations, morbidity and mortality. Some specialties may have longer waiting times than others due to patient demand, staffing, etc.

**EXHIBIT 7: SCHEDULING AN APPOINTMENT FOR SPECIALTY CARE BY ADULT AND PEDIATRIC PATIENTS IN PAS II**



*Adult*

Patients at CHCs were the most likely and those at P/PPs were the least likely to have waited a month or more for a specialty visit (58% vs. 40%\*). Two-fifths (41%) of patients thought that they had to wait too long to see a specialist.

*Pediatric*

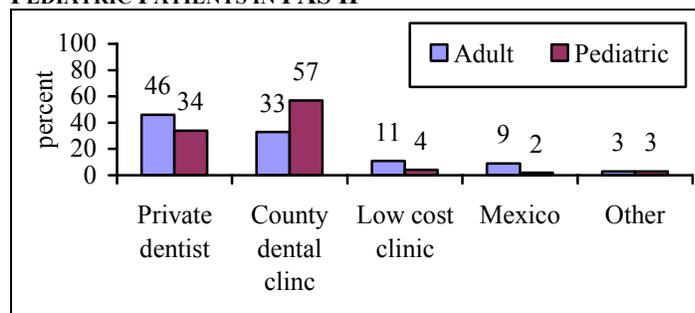
Almost one-third (29%) of parents felt that their child had waited too long to see a specialist.

**Dental Care**

Dental care even more so than medical care forms an increasing unmet need for low-income and uninsured adults, although many adults with dental insurance do not receive regular dental check-ups and cleanings. We assessed patients’ receipt of dental services for preventive and problem-specific care.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

**EXHIBIT 8: SEEKING DENTAL CARE IN THE PAST 12 MONTHS FOR A SPECIFIC PROBLEM BY ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

In the past 12 months less than one-third (29%) of adult patients had undergone a regular dental checkup, and 20% of patients had seen a dentist for a particular dental problem. During the past year women were more likely than men to have undergone a regular dental checkup (30% vs. 25%\*), as well as receiving care for a specific dental problem (21% vs. 17%\*). African Americans were most commonly and Latinos were least commonly seen for a regular dental checkup (42% vs. 26%\*\*\*), and Asian/Pacific Islanders had the highest rate and Latinos had the lowest rate for having been seen with respect to a specific dental problem (30% vs. 18%\*\*\*). Patients at CHCs were the most likely and patients at P/PPs were the least likely to report having seen a dentist for a specific dental problem during the past 12 months (24% vs. 16%\*\*). During the past 12 months, patients reporting excellent health were most commonly and those in poor health were least commonly seen for a regular dental check-up (52% vs. 22%\*\*\*). In addition, patients in excellent health were the most likely and those in fair health were the least likely to have received dental care for a specific problem (31% vs. 17%\*\*).

Women were more likely than men to have received their dental care at County dental clinics (34% vs. 29%\*), while men were more likely to have gone to a private dentist (53% vs. 43%\*). African Americans were most commonly and Whites were least commonly cared for at a County dental clinic (48% vs. 22%\*\*\*), while only Latinos had received dental care in Mexico (13%). Among those patients with a specific dental problem in the past 12 months, patients with health insurance/coverage were more likely to have received dental care at a County dental clinic (48% vs. 28%\*\*), while the uninsured were more likely to have relied upon private dentists (47% vs. 40%\*\*).

Among those people who had a dental problem but were not seen by a dentist the most common reasons included an inability to afford dental services (52%), and not having a place to go/not knowing where to go (13%). Women were more likely than men to report the reason to be that they could not afford it (54% vs. 47%\*), and Latinos were the most likely and African Americans were the least likely to report that they had gone without needed dental care because they could not afford dental services (55% vs. 37%\*\*\*). Patients in poor health most commonly and those in excellent health least commonly indicated that they had gone without needed dental services because they could not afford care (60% vs. 34%\*\*\*). For those patients who had a particular dental problem but who did not receive dental care the uninsured had a higher rate than the insured of having been unable to afford dental care (56% vs. 35%\*\*\*), as well as not having a place to go for dental care (14% vs. 7%\*\*).

Pediatric

Less than two-fifths (37%) of parents reported that in the past 12 months their child had received a regular dental check-up, and 14% indicated that their child received dental care for a particular problem (Exhibit 8). Parents of African American children were the most likely and parents of Latino children were the least likely to report a visit for regular dental care in the past year (62% vs. 36%\*).

If children needed dental care within the past 12 months, but did not get it, parents were most likely to have reported they were unable to afford dental care (19%) and that they did not know where to go for dental care (11%).

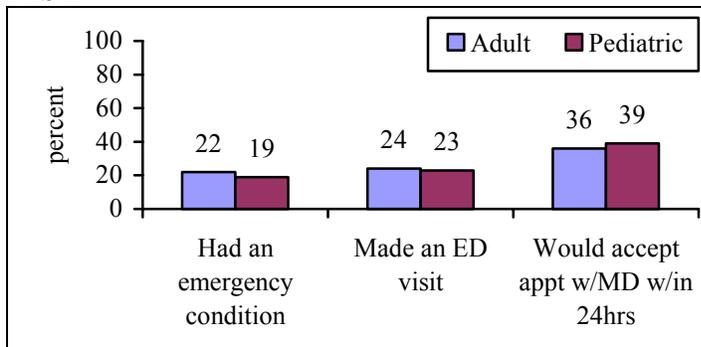
Among children age 6 to 17 just over one-tenth (11%) had missed one or more days of school in the past year because of tooth pain or dental problems. The children who missed school during the past 12 months, due to tooth pain or dental problems, were absent for a mean of 2 days (range 1 to 10 days).

*Comments:* Latinos and those without health insurance appear to have more out-of-pocket expenses for dental care.

**Emergency Department Use\***

People may seek medical care at the Emergency Department (ED) for a variety of reasons, and it is not always possible to determine whether the visit to the ED was “appropriate” based on patient report. Additionally, as primary care services within LAC-DHS decrease we may expect to see an increase in ED use. To try to determine whether some of the volume in the County EDs could be redirected patients were asked if they would consider substituting an appointment with a doctor within 24 hours rather than waiting in the ED.

**EXHIBIT 9: EMERGENCY DEPARTMENT USE IN THE PAST 12 MONTHS BY ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

African Americans and Asian/Pacific Islanders were the most likely and Latinos were the least likely to have had a need for ED services (37% vs. 18%\*\*\*), while Whites had most commonly and Latinos had least commonly sought medical care from an ED in the past 12 months (40% vs.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

20 %\*\*\*). Patients at HOCs were the most likely and those at P/PPs were the least likely to have had an illness or injury that required a visit to an ED during the past 12 months (36% vs. 14%\*\*\*), and patients at HOCs had most commonly and those at P/PPs had least commonly made at least one visit to an ED in the past 12 months (40% vs. 15%\*\*\*). Patients at CHCs were the most likely and those at P/PPs were the least likely to have gone to a County ED (67% vs. 49%\*)<sup>•</sup>.

Patients in SPA 6 were the most likely and those in SPA 4 were the least likely to have had an illness or injury that required a visit to an ED during the past 12 months (28% vs. 16%\*\*), while patients in SPA5 had most commonly and those in SPA 4 had least commonly made one or more visits to an ED in that time frame (33% vs. 18%\*\*\*). Just over one-quarter of insured patients and just over one-fifth of uninsured patients (26% vs. 21%\*) had an illness or injury in the preceding 12 months that needed emergency care, and 29% of all insured patients and 23%\*\* of all uninsured patients made one or more visits to an ED. Patients who reported poor health had the greatest proportion and those in excellent health had the smallest proportion for needing emergency medical care within the preceding 12 months (30% vs. 19%\*), although 33% of patients in poor health and only 15%\*\* of patients in excellent health had made one or more visits to an ED in the past year.

Among patients seen at LAC-DHS ED facilities, patients were seen most commonly at LAC+USC (39%), Olive View/UCLA (23%), Harbor/UCLA (21%) and King/Drew (19%). Half (50%) of adult patients reported that they were always seen as soon as they wanted, without significant subgroup variation.

In this study over half of adult patients reported that at their most recent visit to an ED they had sought medical care for a situation that they considered an emergency (Exhibit 10). Other reasons for ED use included financial and insurance issues as well as convenience.

Men and women were similarly likely to have thought that their medical problem was an emergency, but women were more likely than men to have been referred to an ED by a physician (24% vs. 10%\*\*\*), while men were more likely than women to indicate that they could not afford medical care elsewhere or did not have insurance (15% vs. 9%\*). Asian/Pacific Islanders had the highest rate and Latinos had the lowest rate for going to an ED because they thought their medical problem was an emergency (81% vs. 50%\*), while Whites were the most likely and Latinos were the least likely to report that they had sought care at an ED because they could not afford medical care elsewhere or they did not have insurance (20% vs. 8%\*). Patients in poor health were the most likely to indicate they sought care at an ED because they were brought to the hospital by an ambulance or other people (4%\*).

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<sup>•</sup> Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

**EXHIBIT 10: REASONS FOR MOST RECENT VISIT TO EMERGENCY DEPARTMENT BY ADULT AND PEDIATRIC PATIENTS IN PAS II**

	Adult (n=471) %	Pediatric (n= ) %
Felt medical problem was an emergency	53	59
Doctor advised patient to go to a hospital ED	19	14
Brought to hospital ED by ambulance/other people	14	4
Close to home or most convenient	12	9
Could not afford care elsewhere/no insurance	11	10
Couldn't get an appointment at a County clinic	7	5
Clinics closed evenings and weekends/only place to get care	6	14
Couldn't get an appointment at patient's local clinic	5	3
Regular doctor/patient's medical records are at that hospital	4	6
Couldn't get an appointment with patient's private physician	3	1
Other reason (s)	3	4
Patients could offer more than one response.		

Just over one-third (36%) of patients who were seen at any ED indicated that they would have been willing to have an appointment with a physician within 24 hours rather than go to the ED. There was no significant subgroup variation.

*Comments:* In PAS I 27% of adult patients had made one or more visits to an ED within the past 12 months. The apparent decline in ED service use probably does not reflect an absolute decrease in care seeking, but rather the influence of the differences in the sampling frames between PAS I and II.

Pediatric

Overall, 19% of parents reported that their children needed emergency department care during the past 12 months, and 23% of children had made one or more visits to the ED. Over one-third (35%) of patients at HOCs and only 14%\*\*\* of patients at other facility types had an illness or injury that needed medical care from a doctor at an ED, although patients at HOCs were the most likely and those at HCs were the least likely to have actually made a visit to an ED in the past 12 months (42% vs. 14%\*\*\*). Patients in SPA 8 had the highest and those in SPA 3 had the lowest rate of ED use (35% vs. 13%\*). In the past 12 months, children with health insurance more commonly than children without health insurance needed emergency department care (24% vs. 13%), while children with insurance were more likely than those without insurance to have made a visit to an ED (30% vs. 15%\*\*\*).

Almost two-thirds (65%) of parents reported that their child always got care at an ED as soon as they wanted. For their child's most recent visit to an ED, parents most commonly reported that they thought it was an emergency (59%), they were referred by a doctor (14%) and they could not afford care elsewhere/did not have insurance (10%). Almost two-fifths (39%) of patients would have been willing to have an appointment within 24 hours instead of going to an ED. There was subgroup variation only for gender (52% of boys vs. 28% of girls\*).

*Comments:* A substantial percentage of parents are using the ED because of convenience (i.e., clinic not open evenings or weekends, closer to their homes). Sixteen percent were using ED services because they thought they were unable to get care elsewhere (i.e., could not afford care

elsewhere, unable make appointment at USOC). Parents whose children lack health insurance may be less likely to believe that a clinic will see them without health insurance in 24 hours and thus less willing to leave the ED with the promise of an appointment in 24 hours. In PAS I 23% of pediatric patients had made one or more visits to an ED within the past 12 months. The apparent decline in ED service use probably does not reflect an absolute decrease in care seeking, but rather the influence of the differences in the sampling frames between PAS I and PAS II.

### **Hospitalization\***

Much work has been done to characterize and assess preventable and non-preventable hospitalizations. In this study we limited the items to any hospitalization and hospitalization at a County facility, rather than studying the reasons for hospitalization.

#### Adult

Twelve percent of patients had been in a hospital overnight during the preceding 12 months. Among patients hospitalized at LAC-DHS facilities, patients were most frequently hospitalized at LAC+USC (40%), Olive View/UCLA (29%), Harbor/UCLA (19% and King/Drew (14%). Women were more likely than men (14% vs. 10%\*), while Whites were most commonly and Latinos were least commonly hospitalized overnight during the preceding year (21% vs. 9%\*\*\*). Patients at HOCs had the greatest proportion and patients at P/PPs had the smallest proportion of patients who had been hospitalized overnight during the past 12 months (14% vs. 9%\*). Patients with health insurance had a higher rate than patients without health insurance for having been hospitalized one or more times during the prior year (14% vs. 11%\*), while patients reporting poor health were the most likely and those reporting excellent health were the least likely to have been hospitalized overnight (19% vs. 1%\*\*).

*Comments:* In PAS I 13% of patients had been hospitalized at least once during the prior 12 months. Hospitalization rates appear to be fairly stable for patients in PAS I and PAS II.

#### Pediatric

Overall 7% of pediatric patients had an overnight hospitalization during the past 12 months, and 77% of these patients were cared for at a County hospital. The numbers in this section are too small to allow comment on subgroup variation.

*Comments:* In PAS I 7% of pediatric patients had been hospitalized at least once during the prior 12 months. Hospitalization rates appear to be fairly stable for patients in PAS I and PAS II.

### **Unmet Need for Medical Care**

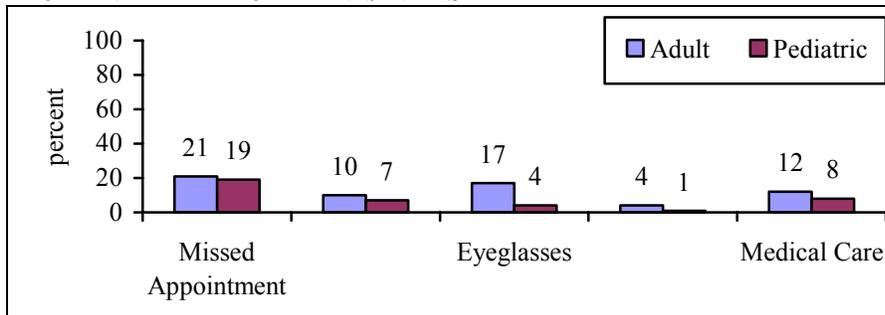
Unmet need for medical care may result in complications and worse health outcomes, included higher rates of morbidity and mortality. A lack of health insurance and low-income have been found to be predictors for greater risk of unmet need, although patients may go without various kinds of medical care for a number of reasons. In this section patients indicated whether they had gone without needed medical services during the preceding 12 months, and some of the reasons

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

why they had not received or had delayed necessary medical care. Some of these items are new to the survey and as a result there is no comparable data in PAS I.

**EXHIBIT 11: UNMET NEED FOR VARIOUS MEDICAL SERVICES DURING THE PRECEDING 12 MONTHS AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



### *MISSED APPOINTMENTS\**

#### Adult

In the past 12 months 21% of patients had missed a medical appointment. The mean number of appointments missed was less than one. The most frequently reported reasons for missing an appointment included forgetting the appointment (36%), unable to leave/miss work (19%), and no transportation (17%).

Women were more likely than men (23% vs. 18%\*), and African Americans were the most likely and Latinos were the least likely to have missed a medical appointment during the past year (37% vs. 18%\*\*\*). Patients at HCs had the highest rate and those at P/PPs had the lowest rate (27% vs. 17%\*\*\*), while patients in SPA2 were the most likely and those in SPA 5 were the least likely to have missed a medical appointment (26% vs. 14%\*\*). Patients in poor health were the most likely and those in excellent health were the least likely to have missed a medical appointment during the prior 12 months (31 vs. 16%\*\*).

Women were more likely to report that they did not have transportation (19% vs. 10%\*). Asian/Pacific Islanders most commonly and African Americans least commonly forgot an appointment (56% vs. 28%\*), while African Americans were the most likely and Latinos were the least likely not to have had transportation to an appointment (30% vs. 12%\*\*). Patients without health insurance were more likely than those with insurance to be unable to leave/miss work (22% vs. 9%\*\*).

*Comments:* In PAS I 34% of adult patients had missed a medical appointment during the prior 12 months. This apparent decline in use is somewhat due to the variation in sampling frames between the two studies, i.e., eligibility for PAS II did not require patients to have made one or more visits to an LAC-DHS facility within the 12 months preceding the study.

#### Pediatric

In the past 12 months, almost one fifth (19%) of children had missed a medical appointment. Among those that missed appointments the most common reasons given by parents were as

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follows: 36% forgot about the appointment and 25% were unable to leave/miss work, while 20% had other reasons for missing one or more medical appointments. There was no significant subgroup variation.

*Comments:* In PAS I 27% of pediatric patients had missed a medical appointment during the prior 12 months. This apparent decline in use is somewhat due to the variation in sampling frames between the two studies, i.e., eligibility for PAS II did not require patients to have made one or more visits to an LAC-DHS facility within the 12 months preceding the study.

## *PRESCRIPTION MEDICATION\**

### Adult

One tenth of adult patients reported that in the past 12 months they had needed a prescription medication but had not been able to obtain it. There was significant variation in unmet need for prescription medication by race/ethnicity (17% of Whites vs. 9% of Latinos\*\*); facility type (16% at HOCs vs. 8% at P/PPs\*\*\*); SPA (18% in SPA1 vs. 5% in SPA7\*\*); and health status (23% in poor health vs. 5% in excellent health\*\*\*).

The most common reasons that patients did not get needed medication were that the medication was too expensive (54%) and that the patient had no insurance (40%). Whites were the most likely and African Americans were the least likely to indicate that lack of insurance was the reason for not obtaining needed medication (56% vs. 37%\*). Patients in SPA 4 were the most likely to report that the medication was too expensive (70%\*). The uninsured were more likely than the insured to report that the medication was too expensive (60% vs. 36%\*\*\*) and that they had no insurance (43% vs. 27%\*).

### Pediatric

Seven percent of children did not get a needed prescription medicine in the past 12 months. Among those children who did not get prescription medicine, 46% of parents reported that the medication was too expensive, and 28% did not have insurance. Twenty-seven percent had other reasons to explain why they did not get a needed prescription. The sample size was too small to assess for subgroup variation.

## *EYEGLASSES*

### Adult

Almost one-fifth (17%) of adult patients reported that in the past 12 months they had needed eyeglasses but had not been able to obtain them. There was significant subgroup variation by race/ethnicity (29% of Whites vs. 15% of Latinos\*\*\*), and health status (from 29% to 10%\*\*\*).

The most common reasons that patients had an unmet need for eyeglasses were that they were too expensive (67%), and that the patient had no insurance (49%). Women had higher rates than men for reporting that glasses were too expensive (70% vs. 57%\*). Patients in SPAs 2 and 8 had the highest rates for reporting the reason they had not obtained eyeglasses was they had no

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insurance (63%\*\*). Uninsured patients were more likely than insured patients to report that the eyeglasses were too expensive (70% vs. 51%\*\*).

### Pediatric

Four percent of children did not get eyeglasses when they needed them in the past 12 months. Among the children that did not get glasses almost half (49%) of parents reported that they did not have insurance and 47% said that the glasses were too expensive.

### *BLOOD TEST OR X-RAY*

#### Adult

Only 4% of adult patients reported that in the past 12 months they had needed a blood test or x-ray but had not been able to obtain it. The most common reasons were that the blood test or x-ray was too expensive (44%), and that the patient had no insurance (42%). There was no significant difference by subgroups in frequency of unmet need for a blood test or x-ray. However, among the 4% of uninsured patients with an unmet need for these services, 45% attributed it to not having insurance, and 48% indicated that it was too expensive.

#### Pediatric

Only 1% (n < 10) of pediatric patients had not received a blood test or x-ray when they needed it. The numbers were too small to assess for subgroup variation.

### *MEDICAL EQUIPMENT*

#### Adult

Only 2% of adult patients reported that in the past 12 months they had needed medical equipment but had not been able to obtain it. The sample size was too small to assess for subgroup variation.

#### Pediatric

There were no pediatric patients who had not received medical equipment when they needed it.

### *UNMET NEED FOR MEDICAL CARE\**

#### Adult

Just over one-tenth of adult patients (12%) reported that they had needed medical care during the preceding 12 months, but had not received it. There was significant subgroup variation by race/ethnicity (20% of Whites vs. 11% of Latinos\*\*\*) and by health status (21% of those in poor health\*). The most common reason for going without needed medical care was that it was too expensive or the patient did not have insurance (54%).

#### Pediatric

In the past 12 months, 8% of the pediatric patients did not get needed medical care. Among those who had not gotten needed medical care in the past year, 63% of parents reported that the care was too expensive or they didn't have insurance, and 33% had other reasons for their child not getting medical care. Children without insurance were significantly more likely than children

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\*\*\* for p < 0.001, \*\* for p < 0.01 and \* for p < 0.05.

with insurance not to have received medical care because it was too expensive and/or they had no insurance (78% vs. 49%\*).

*DELAYED CARE*

Delays in health care may be mutable or immutable, related to individual patient barriers, structural or systemic barriers. Those barriers to care that can be changed should be identified and alternative options developed, implemented and evaluated.

**EXHIBIT 12: REASONS<sup>1</sup> REPORTED FOR DELAYING MEDICAL CARE DURING THE PRECEDING 12 MONTHS AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**

	Adult %	Pediatric %
Could not take time off work	12	7
No way to get to a medical appointment	12	6
Too sick	9	3
Had other responsibilities to take care of someone else	8	3
Had more important things to take care of	6	2
Financial reasons	4	0
Afraid to leave home because of personal safety	2	0
Other	6	5

<sup>1</sup>Patients responded yes or no to each item

Adult

Patients indicated whether in the past 12 months they had put off or delayed getting medical care for each of the following reasons.

African Americans were the most likely and Latinos were the least likely (20% vs. 10%\*\*\*), and adults in poor health were the most likely (23%\*\*\*) not to have transportation to a medical appointment. Asian/Pacific Islanders had the highest rate and Latinos had the lowest rate (16% vs. 7%\*\*\*), while adult patients in poor health had the highest rate (25%\*\*\*) of being too sick to get to their medical appointment. Women were more likely than men to have responsibilities for taking care of someone else as a reason for delaying medical care (10% vs. 5%\*\*\*). One fifth of Asian/Pacific Islanders versus 5%\*\*\* of Latinos indicated they had something more important to take care of as the reason for delaying medical care. Whites were the most likely and Latinos were the least likely (13% vs. 3%\*\*\*), and patients in poor health had the highest rate (9%\*\*\*) of indicating that they had delayed medical care during the past year due to financial reasons.

Pediatric

In the past 12 months pediatric patients had delayed or put off going to the physician for medical care for a variety of reasons (Exhibit 12).

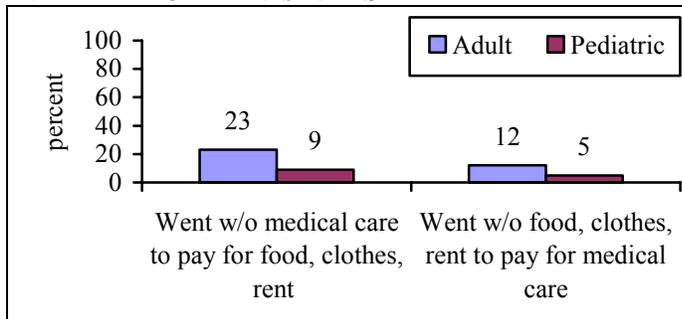
*COMPETING PRIORITIES FOR FINANCIAL RESOURCES* •

Competing priorities for financial resources are found more commonly among the low-income and uninsured, and require people to make difficult decisions in terms of prioritizing their basic needs. Patients were asked about using financial resources to pay for basic needs (food, clothing,

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rent, etc.) in lieu of obtaining medical care, as well as paying for medical care instead of basic needs.

**EXHIBIT 13: COMPETING PRIORITIES FOR MEDICAL CARE DURING THE PRECEDING 12 MONTHS FOR ADULT AND PEDIATRIC PATIENTS IN PAS II**



### Adult

In the past 12 months just under one-quarter (23%) of adult patients reported that they did not get needed medical care because they had to spend their money for food, clothing, housing, transportation or someone else’s medical care (i.e., competing priorities).

Women were more likely than men (26% vs. 18%\*\*\*), and over one-third of Whites and just over one-fifth of Latinos (34% vs. 21%\*\*\*) had experienced competing financial priorities in the preceding 12 months. Subgroup variation was also present by insurance status (25% of the uninsured vs. 16% of the insured\*\*\*); and health status (37% of adults in poor health vs. 14% of adults in excellent health\*\*\*).

In the past 12 months 12% of patients reported that they went without food, clothing, housing, transportation or someone else getting medical care to spend money for their own medical care. Patients in SPA 6 were the most likely and patients in SPA 3 were the least likely to have spent money on medical care rather than food, clothing, housing, etc (15% vs. 8%\*). Patients in poor health had the highest rate and those in excellent health had the lowest rate for having gone without food, clothing, housing, transportation or someone else getting medical care to spend money for their own medical care (24% vs. 6%\*\*\*).

*Comments:* In PAS I 25% of patients reported that they went without food, clothing, housing, transportation or someone else getting medical services to spend money for their own medical care.

### Pediatric

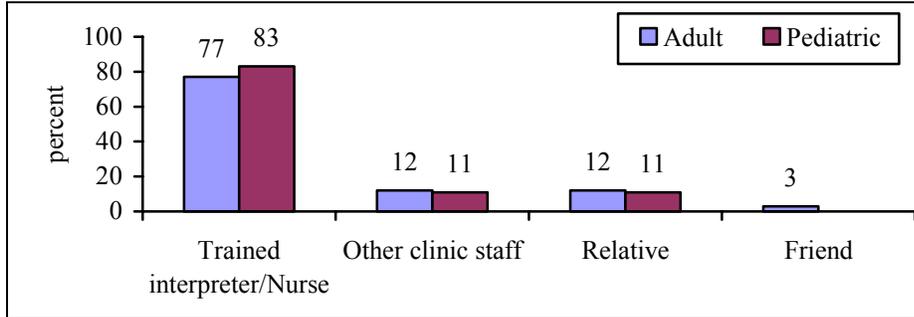
Nine percent of children had gone without needed medical care during the preceding 12 months because the money had to be spent for food, clothing, housing, transportation or someone else’s medical care (i.e., competing priorities). Within the preceding year 5% of pediatric patients had to go without food, clothing, housing, transportation or someone else getting medical care, because the money had to be spent for their medical care.

*Comments:* In PAS I 12% of pediatric patients had gone without food, clothing, housing, transportation or someone else getting medical services to spend money for their own medical care.

## LANGUAGE ACCESS TO CARE\*

Communication is important for providing and obtaining necessary and adequate medical care. Discordant language ability may lead to misunderstanding and inappropriate care. In this section the availability of interpreter services is assessed, as well as who served as the interpreter, and whether having an interpreter limited doctor-patient communication in some circumstances. This section contains items not included in PAS I.

**EXHIBIT 14: PEOPLE WHO ACTED AS INTERPRETERS FOR ADULT AND PEDIATRIC PATIENTS IN PAS II**



### Adult

Latinos were the predominant racial/ethnic group surveyed to report wanting interpreters in significant numbers. Among the 25% of Latinos who wanted interpreters in the past 12 months, 52% reported *always* or *usually* having one when they wanted one. Of Latinos who used interpreters in the past 12 months, 77% reported having trained interpreters or nurses, 12% had other clinic staff, 12% relied on relatives and 3% had friends. Thirty-nine percent of friends and relatives who interpreted for Latinos in the past 12 months were younger than 18 years of age.

Thirty-nine percent of Latinos who used an interpreter in the past 12 months reported feeling uncomfortable discussing their medical problems with their physicians due to the presence of the interpreter. The most common reasons given for feeling uncomfortable were not having confidence that the interpreter completely understood what the patient was saying (45%), and not trusting the interpreter to keep medical concerns confidential (28%).

Patients at HCs were the most likely and those at P/PPs were the least likely to report wanting interpreters in the past 12 months (22% vs. 16%\*), although there was no significant variation in interpreter availability (i.e., always or usually available) for patients who wanted them, by site of care.

### Pediatric

Among children Latinos were the predominant racial/ethnic group surveyed to report wanting interpreters in the past 12 months. Among the 29% of parents/guardians who reported wanting an interpreter (n=125), 48% reported *usually* or *always* having one when they wanted. Of the Latino parents/guardians who used interpreters in the past 12 months, 83% were trained interpreters or nurses, 11% were other clinic staff, and 11% were relatives. The relatives who interpreted to the parent/guardian were most often another child (79%) or spouse/partner (15%).

\* Level of statistical significance is documented in the text of the results with commonly used notations:  
\*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

In 38% of cases, the friends or relatives were younger than 18 years of age. Similar proportions of insured and uninsured children’s parents/guardians wanted interpreters in the past 12 months.

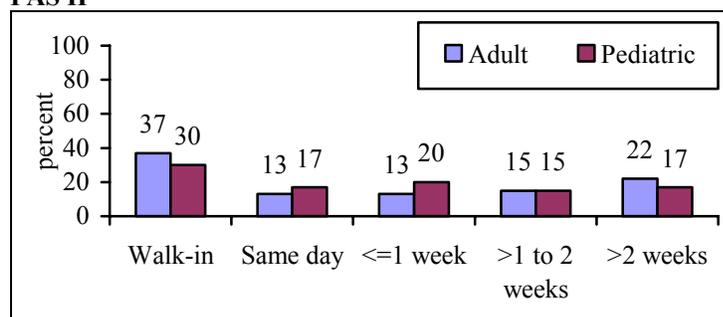
Children’s parents/guardians at HCs were the most likely and those at P/PPs were the least likely to have wanted interpreters in the past 12 months (37% vs. 16%\*\*). Interpreter availability - usually or always - did not vary significantly by type of facility or SPA.

### TODAY’S APPOINTMENT\*

In this section patients reported various aspects of their current visit (i.e., the visit on the day of the interview), including how long they had to wait from the time of scheduling their appointment, type of transportation to the appointment, travel time, waiting time at the appointment, perception of whether they waited too long at the appointment, and referral for specialty care. Patients’ experiences and ratings of satisfaction are reported in the satisfaction section.

#### SCHEDULING CURRENT APPOINTMENT

EXHIBIT 15: WAITING TIME TO SCHEDULE CURRENT APPOINTMENT FOR ADULT AND PEDIATRIC PATIENTS IN PAS II



#### Adult

Only 7% of patients had made their current appointment at a prior visit. Men had higher rates than women for making an appointment on the same day (17% vs. 12%\*\*\*) and for walking in to the clinic (45% vs. 33%\*\*\*), while women had higher rates for scheduling their appointments one to two weeks prior (18% vs. 10%\*\*\*) and more than 2 weeks (25% vs. 17%\*\*\*). African Americans most commonly and Latinos least commonly walked into the clinic without an appointment (48% vs. 34%\*\*\*), while Asian/Pacific Islanders most commonly and African Americans least commonly had scheduled their appointment more than 14 days earlier (32% vs. 20%\*\*\*).

Patients at HOCs were the most likely and those at HCs were the least likely to have scheduled their current appointment on the same day (18% vs. 9%\*\*\*), while patients at CHCs were the most likely and patients at P/PPs were the least likely to have walked into the clinic without an appointment (57% vs. 23%\*\*\*), and furthermore patients at HCs were the most likely and patients at HOCs were the least likely to have waited more than two weeks for their appointment (31% vs. 14%\*\*\*).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

Patients in SPA 4 most commonly and those in SPAs 3 and 8 least commonly made their current appointment on the same day (18% vs. 11%\*\*\*), while patients in SPA 6 most commonly and those in SPA 2 least commonly walked into the clinic (54% vs. 27%\*\*\*), and patients in SPA 2 most commonly and those in SPAs 1 and 5 least commonly had to wait more than two weeks for an appointment (36% vs. 13%\*\*\*).

Insured patients were more likely than uninsured patients to have made their appointment more than fourteen days prior (26% vs. 19%\*\*\*). Patients in poor health had the highest rate and those in excellent health had the lowest rate for walking into the clinic without an appointment (48% vs. 35%\*\*\*).

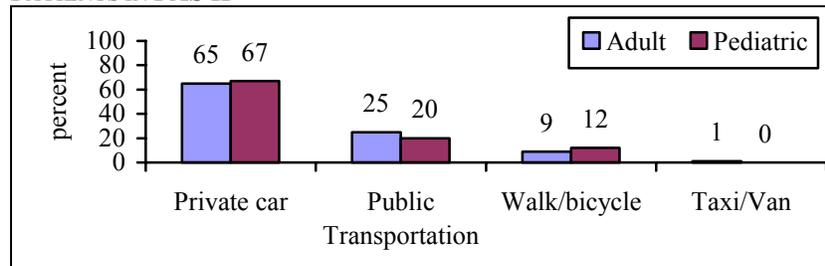
Twenty-eight percent of patients thought that they had waited too long for their appointment, with significant subgroup variation by facility type, and SPA. Patients at CHCs had the highest rate and patients at P/PPs had the lowest rate for believing they had waited too long for an appointment (37% vs. 20%\*\*\*). Patients in SPA 6 most commonly and those in SPA 8 least commonly reported that they had waited too long for an appointment (38% vs. 21%\*\*\*). Additionally, patients in poor health were the most likely and those in excellent health were the least likely to feel they had waited too long to get an appointment (32% vs. 17%\*\*\*).

Pediatric

Seven percent of patients had made their current appointment at their previous visit. Among patients who had not made their appointment at a prior visit, 48% of patients did not have appointments and either were seen as walk-ins (30%) or called for a same day appointment (17%). In addition, 20% had made their appointment within one week, 15% eight to fourteen days previously, and 17% had made their appointment more than 2 weeks ago. Eighty-one percent of parents/guardians did not think that they had to wait too long to get an appointment to see a physician.

**TRANSPORTATION\***

**EXHIBIT 16: MODE OF TRANSPORTATION TO CURRENT MEDICAL APPOINTMENT AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

Men more commonly used a private car to get to their appointment (69% vs. 64%\*\*), while women more commonly relied on public transportation (28% vs. 19%\*\*). Whites had the

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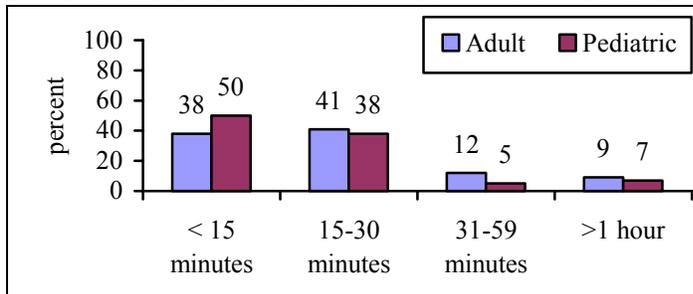
highest rate and African Americans had the lowest rate for traveling to their current medical appointment by private car (86% vs. 61%\*\*\*), while African Americans had the highest rate and Whites had the lowest rate for relying on public transportation (29% vs. 10%\*\*\*). Patients at HOCs were the most likely and those at P/PPs were the least likely to have relied on private transportation to their current visit (74% vs. 60%\*\*\*), while patients at CHC were the most likely and patients at HCs were the least likely to have used public transportation (30% vs. 16%\*\*\*). Additionally, patients at P/PPs were the most likely to have walked or bicycled to their medical appointment (13%). Patients in SPA 1 most commonly and those in SPA 4 least commonly used a private car (92% vs. 46%\*\*\*), while patients in SPA 4 were the most common and patients in SPA 1 were the least common to use public transportation (41% vs. 5%\*\*\*). Patients with health insurance/coverage were somewhat more likely than those without to have traveled by private car to their current appointment (68% vs. 64%\*). Patients in excellent or very good health had the highest rates and patients in poor health had the lowest rate (71% & 74% vs. 55%\*\*\*) for having used private transportation to travel to their medical appointment. In addition, patients in poor health were the most likely and those in excellent health were the least likely to have relied on public transportation to get to their current medical appointment (31% vs. 17%\*\*\*).

Pediatric

Children at HOCs most commonly and those at CHCs least commonly relied on private transportation (77% vs. 57%\*\*\*), while patients at CHCs most commonly and those at HCs least commonly relied on public transportation to get to the current visit (29% vs. 13%\*\*\*). Patients in SPA 1 were the most likely and those in SPA 7 were the least likely to have traveled by private car (94% vs. 43%\*\*\*), and patients in SPA 7 were the most likely and those in SPA 3 were the least likely to have traveled by public transportation on the day of the interview (33% vs. 15%\*\*\*)

**TRAVEL TIME\***

**EXHIBIT 17: TRAVEL TIME TO CURRENT APPOINTMENT - ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

Whites had the highest rate and African Americans had the lowest rate for spending less than 15 minutes to get to their medical appointment (44% vs. 36%\*\*). Additionally, African Americans had the highest rate and Latinos had the lowest rate for taking an hour or more to get to their clinic appointment (13% vs. 9%\*\*). Patients at HCs were the most likely and patients at HOCs

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

were the least likely to report that it took less than fifteen minutes to get to the clinic (50% vs. 25%\*\*\*), while patients at HOCs were the most likely and patients at HCs were the least likely to report that it took one or more hours to get to their appointment (13% vs. 5%\*\*\*). Patients in SPA 2 most commonly and those in SPA 5 least commonly could get to their clinic within 15 minutes (53% vs. 22%\*\*\*), while patients in SPA 4 most commonly and those in SPA 1 least commonly traveled one or more hours to their appointment (14% vs. 4%\*\*\*).

*Comments:* In PAS I, 35% of adult patients reported that they traveled for less than 15 minutes to get to their clinic appointment, 41% traveled for 15 to 30 minutes, while 10% had spent an hour or more getting to the appointment. It appears that overall patients may be spending somewhat less time traveling to their appointment.

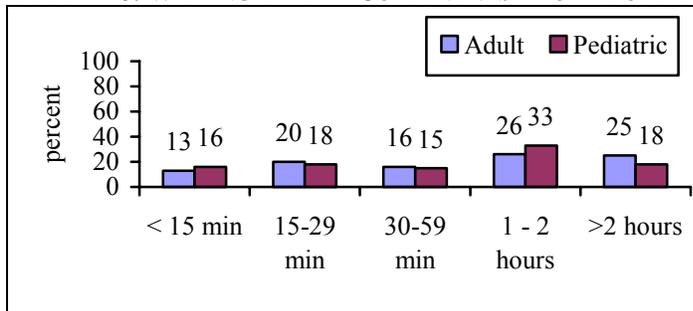
Pediatric

Patients at P/PPs most commonly and those at HOCs least commonly spent less than 15 minutes to get to their visit (61% vs. 30%\*\*\*). Additionally patients at HOCs had the highest rate and those at CHCs had the lowest rate for spending one or more hours traveling to their visit on the day of the interview (14% vs. 8%\*\*\*).

*Comments:* In PAS I, 41% of patients reported that they traveled for less than 15 minutes to get to their clinic appointment, 41% traveled for 15 to 30 minutes, while 9% had spent an hour or more getting to the appointment. It appears that overall patients may be spending somewhat less time traveling to their appointment.

**WAITING TIME\***

**EXHIBIT 18: WAITING TIME AT CURRENT VISIT FOR ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

Seventy-one percent of patients indicated that they had arrived on time for their appointment, 5% were late and 24% were walk-ins. Men had a higher rate than women (28% vs. 22%\*), and Asian/Pacific Islanders were the most likely and Latinos were the least likely to be walk-in patients (38% vs. 21%\*\*\*). Patients at CHCs and HOCs were most commonly walk-in patients (39% and 33%\*\*\*), as were patients in poor health (27%\*). Among those people with appointments, Latinos were the most likely and African Americans were the least likely (94% vs. 87%\*\*), and patients in fair (96%) and poor health (92%) were the most likely to have arrived on time for their scheduled appointment

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

For their scheduled appointment, Latinos had the highest rate and Whites had the lowest rate for waiting one or more hours before being seen for their appointment (53% vs. 37%\*\*\*). In addition, patients at P/PPs were the most likely and those at HOCs were the least likely to have been seen within 30 minutes of their scheduled appointment (39% vs. 23%\*\*\*). Furthermore, patients at CHCs most commonly and those at P/PPs least commonly waited one or more hours to be seen (66% vs. 43%\*\*). There was also significant variation by SPA: patients in SPA 3 were the most likely and patients in SPA 6 were the least likely to have been seen within 30 minutes (42% vs. 24%\*\*\*), and patients in SPA 6 had the highest rate and those in SPA 2 had the lowest rate for having waited one or more hours to be seen (62% vs. 41%\*\*\*). Results also varied by insurance status. Patients in excellent health were the most likely and patients in fair health were the least likely to have been seen within 15 minutes of the appointment (27% vs. 10%\*\*\*), while patients in poor health most commonly and those in excellent health least commonly waited for one or more hours to be seen (60% vs. 40%\*\*\*).

### Pediatric

Sixty-nine percent of children arrived on time for their current appointment. Among those children with a scheduled appointment, 16% waited less than 15 minutes to be seen for their appointment; 18% waited for 15 to 30 minutes; 15% waited for more than 30 minutes but less than one hour; and 51% of the sample waited an hour or more after their appointment time. There was variation by insurance status, with the uninsured more likely than the insured to wait one or more hours for their appointment (53% vs. 39%\*). Patients in SPA 8 had the highest rate and patients in SPA 1 had the lowest rate for having waited more than one hour after their appointment time (60% vs. 42%\*).

### *FELT THEY WAITED TOO LONG\**

#### Adult

At their current visit, almost two-thirds (63%) of patients reported that they had seen a physician as soon as they wanted. Latinos had the highest rate and African Americans had the lowest rate (66% vs. 49%\*\*\*), while patients at P/PPs were the most likely and those at CHCs were the least likely (75% vs. 51%\*\*\*) to report being seen by a physician as soon as they wanted at the current visit. Patients in SPA 2 most commonly and those in SPA 6 least commonly reported being seen as soon as they wanted (71% vs. 48%\*\*\*).

### Pediatric

On the day of the interview 67% of pediatric patients were seen by the physician as soon as their parent/guardian wanted them to be seen. Patients in SPA 4 were most commonly and those in SPA 1 were least commonly seen as soon as they wanted (81% vs. 48%\*). There was no significant difference by facility type.

### *SPECIALTY REFERRAL\**

#### Adult

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

Seventeen percent of patients were referred to a specialist at their current visit, although men were somewhat more likely than women to have been referred (20% vs. 16%\*). Patients at HOCs were the most commonly and patients at P/PPs were the least commonly referred for specialty care at the current visit (26% vs. 14%\*\*\*). There was also variation by SPA and insurance status. Patients in SPA 8 were the most likely and patients in SPA 1 were the least likely to have been referred to a specialist (22% vs. 11%\*). At their current visit patients without health insurance were more commonly and those patients with health insurance were less commonly referred to a specialist (19% vs. 13%\*\*). There was no significant difference by health status.

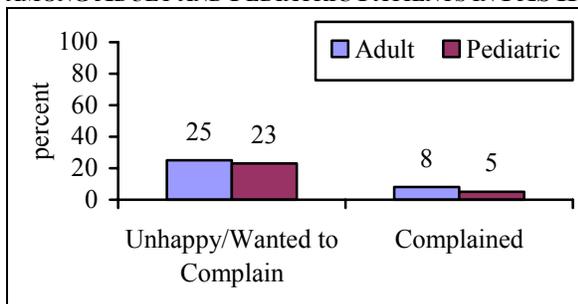
Pediatric

Nineteen percent of patients ages 12 to 17 years were referred to a specialist during their current visit. The sample size was too small to assess for subgroup variation.

**C. PATIENT SATISFACTION\***

*EVER COMPLAINED ABOUT SERVICES AT A COUNTY FACILITY*

**EXHIBIT 19: PROPORTION OF PEOPLE WHO HAD EVER COMPLAINED ABOUT SERVICES AT A COUNTY FACILITY AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

Twenty-five percent of the adults reported at some time being so unhappy with the services at a County facility that she/he wanted to complain and 33% of the unhappy ones did complain. The majority of the parents complained to clinic staff (50%) while 41% complained to the clinic supervisor, 5% called a toll-free complaint number, 2% contacted the board of supervisors or health deputies, 2% wrote a letter, and 1% used some other method. African Americans had the highest rates and Latinos had the lowest rates of being unhappy (50% vs. 20%\*\*\*). The percentage of people unhappy with services was highest at HOCs, CHCs and HCs and lowest at P/PPs (31% to 33% vs. 15%\*\*\*). The proportion of people who were unhappy with services also varied by SPA with the highest rate in SPA 6 and the lowest rate in SPA 5 (36% vs. 19%\*\*\*). The prevalence of being unhappy with services was not associated with health status.

Whites were the most likely and Latinos were the least likely to have complained about services at a County facility (45% vs. 29%\*).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

*Comments:* Overall, 6% of adult patients in PAS I had ever complained about services at a County facility.

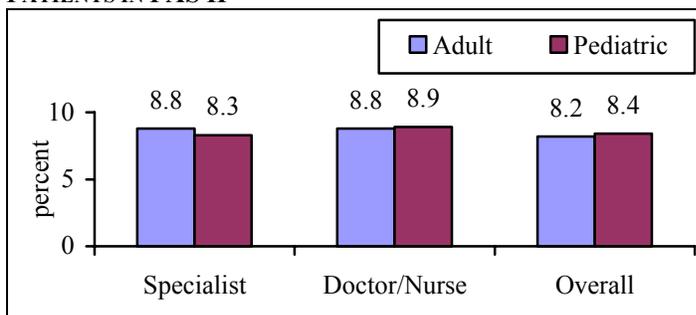
Pediatric

Twenty-three percent of the parents reported at some time being so unhappy with the services for their child at a County facility that he/she wanted to complain, and 21% of the unhappy ones did so. The majority of the parents complained to clinic staff (55%) while 21% complained to the clinic supervisor, 12% called a toll-free complaint number, 7% contacted the Board of Supervisors or health deputies, and 6% wrote a letter.

The parents of children who were insured were somewhat more likely, than the parents of children who were uninsured, to be unhappy with their child’s medical care (28% versus 18%\*).

*Comments:* Overall, 5% of parents in PAS II and 4% in PAS I had ever complained about services at a County facility.

**EXHIBIT 20: RATINGS OF SPECIALIST, CURRENT PROVIDER AND OVERALL CARE AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



*RATINGS OF SPECIALTY CARE\**

Adult

Using a scale from 0 to 10, patients were asked to rate the last specialty doctor they saw during the preceding 12 months, where 0 is the worst specialty doctor possible and 10 is the best specialty doctor possible. The mean rating for specialty care was 8.8 (range 0-10).

*Note: The significance of the variation by subgroups had not been established.*

Means by facility were highest at CHCs and lowest at P/PP (9.5 vs. 7.1), and by SPA means were highest in SPA 3 and lowest in SPA 2 (10.0 vs. 6.7).

Pediatric

Using a scale from 0 to 10, parents were asked to rate the last specialty doctor their children saw during the preceding 12 months, where 0 is the worst specialty doctor possible and 10 is the best specialty doctor possible. The mean rating for specialty care was 8.3 (range 0-10).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

*Note: The significance of the variation by subgroups has not been established.*

Means by facility ranged from 8.0 (HOC) to 8.7 (HC), and by SPA ranged from 7.8 (SPA 2) to 8.8 (SPA 8).

**Comments:** Sixty percent of adults in the 2002 National CAHPS® Benchmarking Database (n = 35,742) rated their personal physician or nurse 9 or 10 on the 0-10 scale, and 62% rated their child's personal physician or nurse 9 or 10 on the 0-10 scale (n = 47,723).

#### *RATINGS OF HEALTH CARE PROVIDERS AT CURRENT VISIT*

##### Adult

Using a scale from 0 to 10, patients were asked to rate the doctor or nurse at the clinic who saw them on the day of the interview, where 0 is the worst doctor or nurse possible and 10 is the best doctor or nurse possible. The mean rating of the physician or nurse seen at the current visit was 8.8 (range 0 to 10).

*Note: The significance of the variation by subgroups has not been established.*

There was some variation by facility type with mean levels of satisfaction highest at P//PPs and lowest at HOCs and CHCs (9.2 vs. 8.4). There was also variation by SPA with the highest levels in SPAs 4 and 5 and lowest in SPA 6 (9.0 vs. 8.2).

##### Pediatric

The mean rating of the physician or nurse the child saw today on the 0-10 scale was 8.9 (range 0-10).

*Note: The significance of the variation by subgroups has not been established.*

The highest ratings were found among patients at HOCs and the lowest ratings among patients at HCs (9.1 vs. 8.6). Additionally, levels of satisfaction were highest in SPA 4 and lowest in SPAs 1 and 5 (9.2 vs. 8.3).

#### *OVERALL RATINGS AT CURRENT VISIT\**

##### Adult

Using a scale from 0 to 10 patients were asked to rate their overall experience at the clinic they were visiting on the day of the interview, where 0 is the worst clinic possible and 10 is the best clinic possible. The mean rating of patients' overall experience at the current visit was 8.2 (range 0-10).

*Note: The significance of the variation by subgroups has not been established.*

Ratings varied by race/ethnicity and ranged from a low of 7.1 among African Americans to a high of 8.4 among Latinos. Ratings varied by facility type with the lowest ratings at HOCs and CHCs and the highest ratings at P//PPs (7.5 vs. 8.8). Additionally there was variation by SPA with the lowest levels of satisfaction in SPA 6 and the highest levels in SPA 3 (7.2 vs. 8.6). Adults in excellent health rated the experience more positively (8.7 on average) than other patients (8.0-8.3). Ratings of the overall experience did not vary by insurance status.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p < 0.001, \*\* for p < 0.01 and \* for p < 0.05.

### Pediatric

Using a scale from 0 to 10 parents were asked to rate their overall experience at the clinic they were visiting on the day of the interview, where 0 is the worst clinic possible and 10 is the best clinic possible. The mean overall experience rating at the current visit was 8.4 (range 0-10).

*Note: The significance of the variation by subgroups has not been established.*

Patients at HOCs had the highest mean rating and those at HCs had the lowest mean rating (8.6 vs. 8.0), while across SPAs the highest mean level was in SPA 4 and the lowest mean level was in SPAs 1 and 5 (8.9 vs. 7.9).

### *INTERACTION WITH CLINIC STAFF AND DOCTORS\**

Respondents reported their interactions and level of respect and helpfulness of the office staff and the adequacy of the time spent with the doctor using a level scale with three response options – completely, somewhat and not at all. Reports of interactions that “completely” met the patients’ needs are presented in Exhibit 20.

#### **EXHIBIT 21: RATINGS OF INTERACTIONS WITH CLINIC STAFF AND HEALTH CARE PROVIDERS AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**

	Adult (%)	Pediatric (%)
Patients were treated with courtesy and respect by the office staff.	86 ↓	87 ↓
Office staff were as helpful as the patient thought they should be	85 ↓	83 ↓
Health care providers listened carefully to them.	88 ↓	88 ↓
Health care providers explained things in a way that they could understand.	88 ↓	90 ~
Health care providers showed respect for what they had to say.	88 ↓	89 ↓
Health care providers spent enough time with them.	77 ↓	76 ~
Ratings were on a scale from the lowest 0 to the highest 10.		
↑ Increased compared to PAS I, ~ Unchanged from PAS I, ↓ Decreased compared to PAS I		

### *RATINGS OF WAITING ROOMS, EXAM ROOMS AND BATHROOMS*

Adult patients and parents reported on the comfort, cleanliness and privacy of the waiting rooms, exam rooms and bathrooms as appropriate. The parents of pediatric patients rated the facilities somewhat higher than adult patients (Exhibit 21).

### Adult

Comfort of the exam room had higher ratings from women than men (7.9 vs. 7.6\*\*). Ratings of the cleanliness of bathrooms varied between the insured and the uninsured (9.0 vs. 8.8\*).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

Pediatric

As for adult patients, the ratings for the cleanliness of the bathrooms varied by insurance status (8.2 among the uninsured vs. 7.7 among the insured\*), although the direction of the association is the opposite of that for adults.

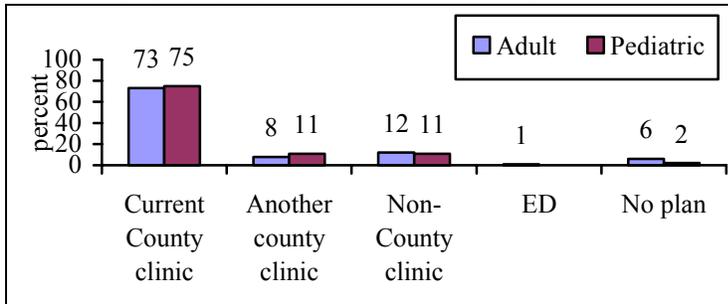
**EXHIBIT 22: RATINGS OF COMFORT, CLEANLINESS AND PRIVACY IN PAS II**

	Adult mean	Pediatric mean
Comfort:		
Waiting Rooms	7.7	8.1
Exam Rooms	8.3	8.5
Cleanliness:		
Waiting Rooms	8.3	8.5
Exam Room	8.8	9.0
Bathrooms	7.7	7.9
Privacy:		
Exam Rooms	8.9	9.2

Ratings were on a scale from the lowest 0 to the highest 10.

CHOOSING A PLACE FOR HEALTH CARE\*

**EXHIBIT 23: CHOOSING A PLACE FOR HEALTH CARE BY ADULT AND PEDIATRIC PATIENTS IN PAS II**



Adult

The majority (73%) of adults said they would be very likely to return to this clinic if they could go to any clinic for medical care. Latino had the highest rate and African Americans had the lowest rate for indicating that they would be very likely to return to their current facility 80% vs. 50%\*\*). Patients at P/PPs reported the highest and patients at HOCs and CHCs the lowest rates of being very likely to return to the current clinic if they could go anywhere for their medical care (83% vs. 62%\*\*\*). There was also variation across SPA with the highest rate in SPA 3 and the lowest rate in SPA 6 (84% and 53%\*\*\*). Interestingly, adults in excellent (68%) or very good (62%) health were less likely to report that they would return compared to other adults (74-75%\*\*).

Among those uncertain or unlikely to return to this clinic (27%), 30% would go to another County facility, 44% to other non-County facility, 5% to an emergency department, 1% to a drug store/pharmacy, 1% would do nothing, 4% did not know, and 15% would do other things.

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

Seventy-three percent of the parents reported that they would be very likely to recommend this clinic to a friend or relative who needed care. Latinos were the most likely and Asian/Pacific Islanders were the least likely to indicate that they would recommend the clinic to a friend or relative (78% vs. 41%\*). Rates were also highest at P/PPs and lowest at HOCs (85% vs. 56%\*\*\*), and highest in SPA 3 and lowest in SPA 6 (87% vs. 46%\*\*\*).

### Pediatric

The majority (75%) of parents said they would be very likely to return to this clinic for the child's care if the child could go to any clinic for medical care. Parents of girls were more likely than parents of boys (79% vs. 70%\*) to say they would be very likely to return to this clinic. Rates were highest among Latinos and lowest among African Americans (78% vs. 54%\*\*\*). This group also varied by facility type, from 66% (HC) to 84% (P/PP)\*\*\*, and from 64% (SPA 1) to 93% (SPA 5) across SPAs\*.

Among those uncertain or unlikely to return to this clinic (25%), 45% would go to another County facility, 44% to other non-County facility, 9% did not know where they would go, and 2% would go to an emergency department.

Seventy-one percent of the parents reported that they would be very likely to recommend this clinic to a friend or relative who needed care. Parents of girls were more likely than parents of boys to be very likely to recommend the current facility to a friend or relative (75% vs. 64%\*), and Latinos were the most likely and African Americans were the least likely (73% vs. 48%\*). Rates were highest at P/PPs and lowest at CHCs (82% vs. 65%\*\*), and most likely in SPA 4 and least likely in SPA 1 (86% vs. 58%\*\*).

## **D. HEALTH BEHAVIORS AND PREVENTIVE CARE\***

### **Health Behaviors**

Regular physical activity and nutritious eating habits are known to reduce the risk for many chronic medical conditions among adults and children, including obesity, diabetes, hypertension, and heart disease. However, an increasing number and proportion of adults and children in this country are inactive and overweight or obese. Additional behaviors that may put individuals at risk for medical problems include smoking, excessive alcohol use, recreational drug use and risky sexual activities. Furthermore domestic and intimate partner violence are important health risks that should be evaluated by health care providers. Children should be evaluated for appropriate developmental progress and counseling by health care providers to their parents.

### *PHYSICAL ACTIVITY- VIGOROUS*

#### Adults

Just over one-third (34%) of patients reported engaging in vigorous exercise for at least 10 minutes at least once each week. Patients participated in vigorous exercise a mean of 4.4 days each week (range 1 to 7). On the days that people exercise 56% reported being active for more than 45 minutes. There was variation in engaging in vigorous physical activity by gender, race/ethnicity, and health status.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

Men were more likely than women to engage in vigorous activity for at least ten minutes one or more times in a usual week (40% vs. 31%\*\*\*). Men and women participated in physical activity on a mean of 4.4 days, although men were more likely than women to exercise for more than 45 minutes at a time (62% vs. 52%\*\*\*). Whites reported engaging in vigorous exercise on a mean of 4.8 days and Asian/Pacific Islanders on a mean of 4.0 days. On the days that people exercise Whites had the highest rate and Asian/Pacific Islanders had the lowest rate for exercising for more than 45 minutes at a time (63% vs. 48%\*\*). Patients in excellent health most commonly and those in poor health least commonly engaged in vigorous exercise for at least 10 minutes at a time in a usual week (53% vs. 27%\*\*\*). Patients in excellent health participated in vigorous activity a mean of 5.3 days per week compared to 4.2 days per week among those with poor health status. Patients in poor health least commonly exercised for more than 45 minutes at a time (45%\*).

*PHYSICAL ACTIVITY – WALKING\**

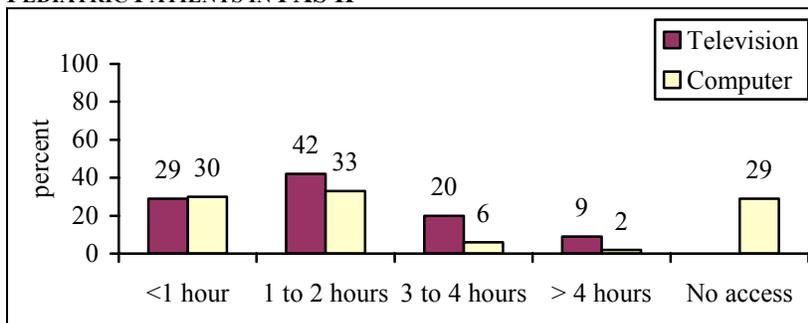
Adults

Three-quarters of patients reported walking for at least ten minutes without stopping at least once in a usual week. People walked for ten minutes without stopping on a mean of 5.2 days each week (range 1 to 7). On the days that people walked 39% reported walking for more than 45 minutes.

Men and women were similarly likely to walk for at least 10 minutes without stopping one or more times in a usual week, although men were more likely to walk for more than 45 minutes at a time (48% vs. 34%\*\*\*). Latinos reported the highest and African Americans reported the lowest mean number of days per week they walked for at least 10 minutes without stopping (5.3 days vs. 4.8 days). There was no significant difference by health status in the proportion of patients who walked for 10 minutes continuously, or in the mean number of days per week they walked for 10 minutes. However, patients in poor health were the least likely to walk for more than 45 minutes at a time (30%\*).

Pediatrics

**EXHIBIT 24: NUMBER OF HOURS PER DAY SPENT WATCHING TELEVISION OR USING THE COMPUTER AMONG PEDIATRIC PATIENTS IN PAS II**



Twenty-nine percent of the pediatric sample over the age of 5 do not use or don't have access to video games or a computer; 30% spend less than one hour a day playing video games or using a

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

computer, 33% spend 1-2 hours, 6% spend 3-4 hours, and 2% spends more than 4 hours. There was subgroup variation by gender, facility type and SPA. Boys were more likely than girls (45% vs. 24%\*\*\*) to spend 1-2 hours per day playing video games or using a computer. Patients at P/PPs had the highest rate and those at HCs had the lowest rate (42% vs. 20%\*), while pediatric patients in SPA 2 had the highest rate and those in SPA8 had the lowest rate (51% vs. 28%\*) for spending 1 to 2 hours per day playing video games or using a computer.

### *DAILY CONSUMPTION OF FRUITS AND VEGETABLES*

#### *Adults*

Participants reported eating a mean of 2.2 servings of fruits and vegetables on the day preceding the interview (range 0 to 10), when the goal for a health and balanced diet is to consume five or more servings of fruits and vegetables. The mean number of daily servings of fruits and vegetables that patients thought they should eat was 3.8 (range 0 to 10).

*Note: The significance of the variation by subgroup have not been established.*

Subgroup variation existed by race/ethnicity and health status. Asian/Pacific Islanders ate the greatest and African Americans ate the least mean number of servings of fruits and vegetables in a single day (2.6 servings vs. 2.1 servings). Patients in excellent health ate the most while patients in poor health ate the least mean number of servings of fruits and vegetables per day (2.6 servings vs. 1.9 servings).

### *CIGARETTE SMOKING\**

#### *Adults*

Just over one tenth of patients (11%) indicated that they currently smoke cigarettes every day, 7% smoke some days, and 82% do not smoke all. Women were more likely than men to be non-smokers (87% vs. 73%\*\*\*). Latinos had the highest rate and Whites had the lowest rate for being nonsmokers (87% vs. 58%\*\*\*). Patients at P/PPs were most commonly and patients at CHCs were least commonly nonsmokers (85% vs. 79%\*\*).

Among those people who smoke daily or on some days, 49% reported that within the preceding 12 months a physician had suggested that they stop smoking. In addition, one-third of people who smoked reported that at the current appointment their physician had suggested they stop smoking. There was variation among subgroups for gender, race/ethnicity and facility type. In the past 12 months women were more likely than men to have been advised to stop smoking (57% vs. 40%\*\*). Among current smokers Whites had the highest rate and Latinos had the lowest rate, during the past 12 months, to have been advised to stop smoking (78% vs. 34%\*\*\*). Patients at HCs were the most likely and those at CHCs were the least likely to indicate that at their current visit a physician had suggested they stop smoking (50% vs. 24%\*\*).

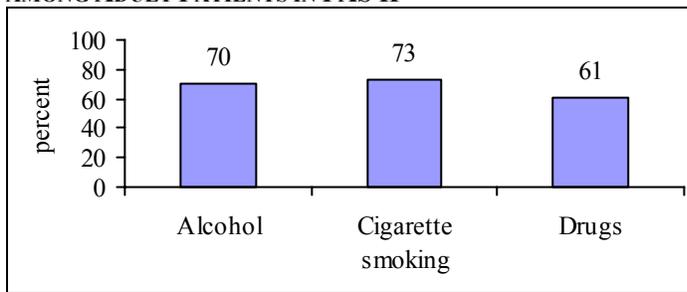
### *PHYSICIAN HEALTH SCREENING BEHAVIORS*

This section of the survey assessed physicians' screening behaviors. Patients were asked if a physician had asked them about each of the following behaviors within the past 12 months. Patients were not asked if they participated in any of the behaviors mentioned.

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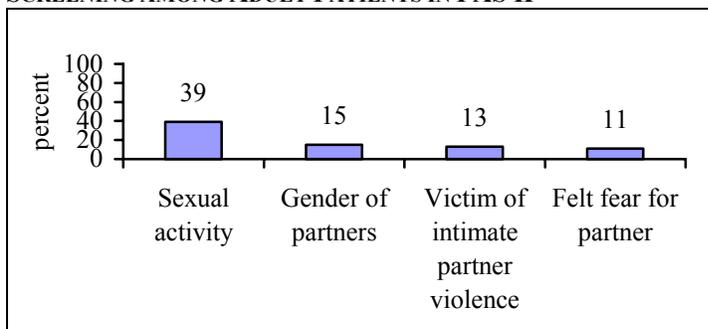
\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

**EXHIBIT 25: PHYSICIAN SCREENING IN THE PAST 12 MONTHS FOR ALCOHOL, TOBACCO AND DRUG SCREENING AMONG ADULT PATIENTS IN PAS II**



Women were more likely than men (73% vs. 64%\*\*\*), and Latinos had the highest rate and Whites had the lowest rate (72% vs. 59%\*\*\*) for having been asked by a physician in the past year whether they drank alcohol. If patients responded that they had been asked whether they drink alcohol by a physician within the preceding 12 months, they were queried as to whether the physician had questioned how much and how often they consumed alcohol. There was variation by gender with a higher rate for men than for women (71% vs. 63%\*\*); and from 50% to 75%\* by health status. Women were more likely than men to have been asked by a physician in the past 12 months if they smoked cigarettes (75% vs. 68%\*\*); African Americans had the highest rate and Whites had the lowest rate (77% vs. 68%\*\*\*); and by health status the rate varied from 67% to 80%\*. African Americans were the most likely and Whites were the least likely to have been asked in the past 12 months by a physician about recreational or illicit drug use (66% vs. 50%\*\*\*).

**EXHIBIT 26: PHYSICIAN SCREENING IN THE PAST 12 MONTHS FOR SEXUAL ACTIVITY AND DOMESTIC VIOLENCE SCREENING AMONG ADULT PATIENTS IN PAS II**



During the preceding year, women were more likely than men to have been asked about current sexual activity (42% vs. 32%\*\*\*); and, African Americans had the highest rate and Whites had the lowest rate (50% vs. 37%\*\*\*). African Americans were the most likely and Whites were the least likely to have been asked about the gender of their sexual partners (21% vs. 14%\*\*); the rate was highest at P/PPs and lowest at CHCs (18% vs. 11%\*); while the rate was highest among those in very good health and lowest for those in poor health (23% vs. 13%\*\*).

Women were more likely than men to have been asked if the patient's spouse or sexual partner had ever pushed, shoved, slapped, choked, hit, punched or kicked them (16% vs. 7%\*\*\*); while Latinos had the highest rate and Whites had the lowest rate (14% vs. 8%\*\*). Women were more likely than men to have been asked during the past year if they ever felt afraid of or threatened

by their spouse or sexual partner (14% vs. 6%\*\*\*), and Latinos had the highest rate and Whites had the lowest rate (13% vs. 7%\*\*).

### Pediatrics

In this section parents/guardians reported whether during routine medical visits the child's doctor had asked them about the following topics related to the child's behavior and development. Sixty-nine percent were asked whether the child eats fruits and vegetables everyday; 67% whether the parent puts the child in a car safety seat; 61% whether the parent had 'child-proofed' the home; and, 43% whether the child played actively at least 5 days a week. Just over two-fifths (41%) of parents/guardians indicated they had been asked if there was a working smoke detector in the home; 38% were asked how the child was doing in day care or school; 37% whether the child was sad or depressed; 31% if the child wears a bicycle helmet; 30% if there was a gun in the home; 24% if the child is exposed to violence; and only 10% were asked if their child belongs to a gang.

### **Preventive Health Care\***

Checking blood pressure is important for assessing one's risk for developing hypertension and for following the efficacy of anti-hypertensive therapy regimens.

#### *BLOOD PRESSURE CHECK*

##### Adult

Ninety-three percent of patients reported that their blood pressure had been checked at the current visit, with significant variation by race/ethnicity, facility type, SPA, and health status. African Americans and Asian/Pacific Islanders had the highest rates and Latinos had the lowest rate (97% vs. 92%\*), and patients at CHCs were the most likely and those at HOCs were the least likely (96% vs. 90%\*\*) to have had their blood pressure checked at the current visit.

##### Pediatric

Among the 6-17 year old age group 87% had their blood pressure checked at the time of the visit.

#### *ADULT CHOLESTEROL TESTING*

Fifty-six percent of patients had their blood cholesterol level checked within 1 year, 15% had their blood cholesterol checked more than one year up to 3 years ago, 3% more than 3 up to 5 years ago, 3% more than five years ago, and almost one-quarter (23%) of adult patients had never had their cholesterol checked. There was variation by gender with women more likely than men to have had cholesterol screening within the preceding three years (74% vs. 64%\*\*\*), and with men more likely than women never to have been screened for blood cholesterol levels (29% vs. 20%\*\*\*). Asian/Pacific Islanders were the most likely and Whites were the least likely never to have had their cholesterol checked (25% vs. 18%\*\*\*). Rates for cholesterol screening within the past three years were highest at HCs and lowest at CHCs (76% vs. 66%\*\*), while patients who had never had their cholesterol checked were most commonly found at CHCs vs. least commonly found at HCs (30% vs. 19%\*\*\*). Furthermore, never having had blood

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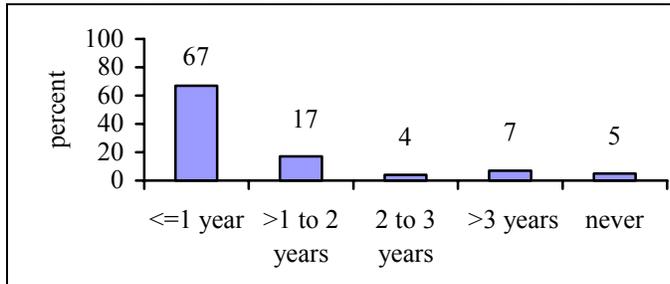
\* Level of statistical significance is documented in the text of the results with commonly used notations:  
\*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

cholesterol checked was most common among patients in very good health and least common among patients in poor health (25% vs. 18%\*).

*Comments:* In PAS I 71% of adults had had their cholesterol checked within 3 years.

**WOMEN'S PREVENTIVE HEALTH SERVICES\***

**EXHIBIT 27: CERVICAL CANCER SCREENING – PAP SMEARS AMONG FEMALE PATIENTS IN PAS II**



African Americans were the most likely and Whites were the least likely to have had a Pap smear within one year (75% vs. 63%\*), while Asian/Pacific Islanders were the most likely and Whites were the least likely to have had a Pap smear within three years (96% vs. 87%\*).

Female patients at P/PPs had the highest rate and those at HCs had the lowest rate for a Pap smear within the preceding year (72% vs. 59%\*\*\*); however, women at CHCs were the most likely and those at HOCs were the least likely to have had a Pap smear within three years (91% vs. 84%\*\*\*). Finally, female patients in excellent health were the most likely to have received cervical cancer screening within three years (94%\*).

*Comments:* In PAS I 69% of women had undergone cervical cancer screening within one year, 16% from one to three years prior, 10% more than 3 years ago and 5% had never had a Pap smear.

HEDIS Measures - Quality Compass 1998	PAS II	National <sup>1</sup>	National HMO <sup>2</sup>	State Managed Care <sup>3</sup>
	%	%	%	%
Breast Cancer screening <sup>4</sup>	79	71.2	71.8	74
Cervical Cancer screening <sup>5</sup>	88	71.3	72.1	73

<sup>1</sup> National Committee for Quality Assurance – Quality Compass 1998

<sup>2</sup> National Committee for Quality Assurance – Quality Compass 1998

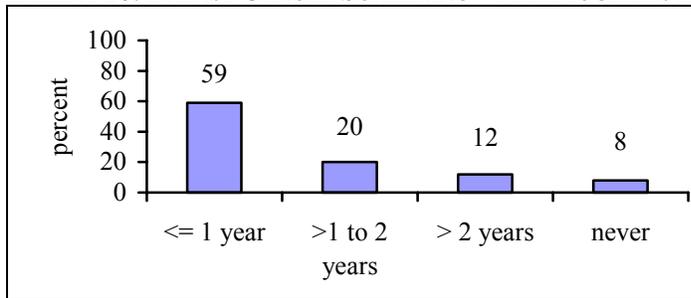
<sup>3</sup> Pacific Business Group on Health

<sup>4</sup> Percent of women age 52 to 69 who had a mammogram within 2 years (Healthy People 2000 = 60%)

<sup>5</sup> Percent of women age 21 to 64 who had a Pap smear within 3 years (Healthy People 2000 = 85%)

Latinas were the most likely and Whites were the least likely to have had a mammogram within one year (61% vs. 45%\*). Patients in SPA 5 had the highest rate and those in SPA 1 had the lowest rate for breast cancer screening within the past 12 months (75% vs. 43%\*).

**EXHIBIT 28: BREAST CANCER SCREENING – MAMMOGRAMS AMONG FEMALE PATIENTS IN PAS II**



*Comments:* In PAS I, among women age 50 years and older 65% had received a mammogram within one year, 13% more than one up to 2 years ago, 11% more than 2 years ago, and 11% had never had a mammogram.

### *INFLUENZA PREVENTION*

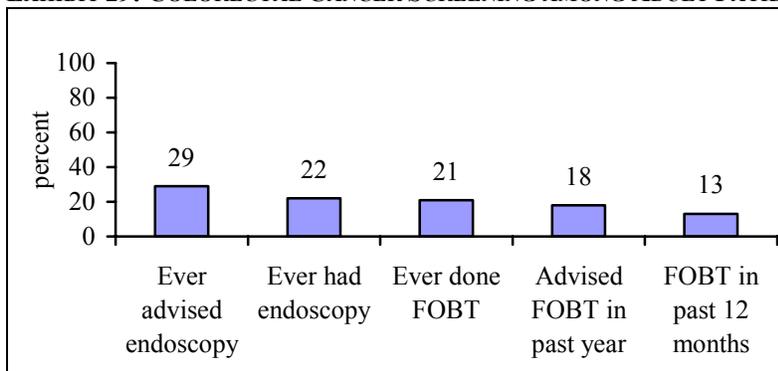
#### *Adults*

One fifth of patients had received a flu shot between the recommended time period of October 2001 and April 2002. Adults with health insurance were more likely than those without to have had a flu shot during this period of time (25% vs. 18%\*\*\*).

### *COLORECTAL CANCER SCREENING*

Colorectal cancer (CRC) is a readily diagnosable condition, with considerable treatment options and good outcomes for those patients diagnosed at an earlier stage. Unfortunately, only about one third of adults undergo regular screening for CRC. Screening may take the form of a flexible sigmoidoscopy every 5 to 7 years, a colonoscopy every 10 years, a barium enema in conjunction with a flexible sigmoidoscopy and annual fecal occult blood testing (FOBT).

**EXHIBIT 29: COLORECTAL CANCER SCREENING AMONG ADULT PATIENTS AGE 50 AND OLDER IN PAS II**



### *FLEXIBLE SIGMOIDOSCOPY/COLONOSCOPY\**

#### *Adults*

Among patients 50 years of age and older 29% had ever been recommended by a physician to undergo screening for colorectal cancer (CRC) with a flexible sigmoidoscope or colonoscope (Exhibit 29). Overall, 22% of patients 50 years of age and older indicated that they had ever

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

undergone screening for CRC. Among those patients who underwent screening for CRC 53% had a procedure within one year, 38% had been screened from more than one year up to 5 years previously, 4% from more than 5 years to 10 years ago, and 6% more than 10 years ago.

There was subgroup variation by race/ethnicity, facility type and somewhat for insurance status. Among those patients 50 of age and older who underwent screening for CRC patients at P/PPs had the highest rate and those at HOCs had the lowest rate for having had the procedure within 5 years (100% vs. 71%\*). Although rates for having had CRC screening suggested by a physician did not vary by insurance status, patients with health insurance were more likely than those without health insurance to have ever had a flexible sigmoidoscopy or colonoscopy (34% vs. 19%\*\*\*).

### *FECAL OCCULT BLOOD TESTING*

#### *Adults*

Among patients 50 years of age and older, 21% had ever done a home blood stool test (e.g., stool guaiac, Hemoccult), and 18% of patients reported that in the past 12 months they had been advised to do a home blood stool test (Exhibit 29). Among patients who had ever done a home blood stool test almost two-thirds (64%) of patients had had a home blood stool test within one year, 16% from more than 1 year up to 2 years ago, and 20% had undergone screening more than 2 years ago. There was subgroup variation by race/ethnicity, facility type, and insurance status.

African Americans were the most likely and Latinos were the least likely to have ever done a home blood stool test (35% vs. 16%\*\*\*), and African Americans were the most likely and Latinos were the least likely to have been advised during the past 12 months to perform this test (30% vs. 15%\*\*). Patients at HCs had the highest rate and those at P/PPs had the lowest rate for having had a physician recommend a home blood stool test in the past 12 months (28% vs. 12%\*\*).

### *PEDIATRIC PREVENTIVE CARE\**

Eighty-four percent of children in the sample have ever been enrolled in the WIC program. Children with health insurance were more likely than children without health insurance to be enrolled in WIC (89% vs. 76%\*\*). Children in SPA 4 were the most likely and children in SPA 8 were the least likely to have ever been enrolled in WIC (100% vs. 71%\*). Almost two-thirds (58%) of parents reported that when their child was seen for a physical exam, in the past 12 months, they were asked by a doctor or nurse if s/he was enrolled in the WIC program. Children with health insurance were more likely than children without health insurance to have been asked if they were enrolled in the WIC program (65% vs. 49%\*), as well as variation across SPAs with the highest proportion in SPA 6 and the lowest proportion in SPA 7 (69% vs. 47%\*).

Twenty-one percent of parents/guardians had ever had concerns about a problem with their child's learning or development. The parents of uninsured children were more likely than those with insurance to have ever had concerns about a problem with their child's learning or development (29% vs. 16%\*). Almost half (48%) of all parents/guardians (48%) reported that

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

in the past 12 months, when the child saw a doctor, that the doctor talked about their child’s learning development.

Fifty-one percent of parents reported that in the past year the doctor had spoken with them about their child’s hearing, speech or ability to communicate. Additionally, in the past 12 months, 20% of parents were asked how much time their child spends watching television, playing video games or using the computer.

Over two-thirds of parents (68%) reported that in the past 5 years their child had been tested for anemia, and Latino children were the most likely and African American children were the least likely to report having been tested for anemia within five years (82% vs. 66%\*).

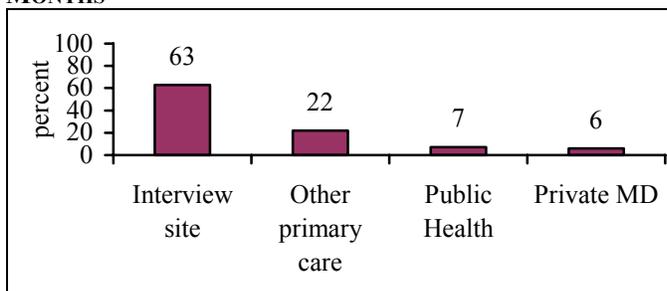
Four-fifths of parents/guardians indicated that their child’s eyesight had been tested within the past 5 years. Latino children were more likely than African American children to have had their eyesight tested (84% vs. 64%\*). Patients in SPA 7 were the most likely and patients in SPA6 were the least likely to have had vision testing within 5 years (98% vs. 66%\*).

Just over three-quarters of parents/guardians reported that their child’s hearing had been tested in the past 5 years. Boys were more likely than girls to have been tested (87% vs. 76%\*).

***PEDIATRIC IMMUNIZATIONS\****

Pediatric immunizations have been well documented to reduce the morbidity and mortality associated with many childhood illnesses. There are current at least six different vaccines that children receive, covering ten different infectious conditions, on a specific schedules for primary immunization and boosters.

**EXHIBIT 30: SITES WHERE PEDIATRIC PATIENTS IN PAS II RECEIVED IMMUNIZATIONS IN THE PAST 12 MONTHS**

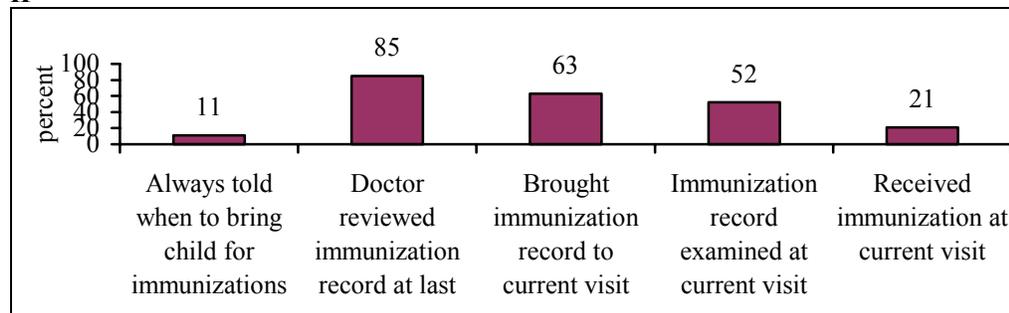


Latino children were more likely than African American children usually to have been taken to the interview site for immunizations (65% vs. 53%\*\*\*). Children with health insurance more commonly than uninsured children were usually taken to the clinic site at which they were interviewed (70% vs. 55%\*\*). There was also significant variation by facility type with the highest rate at HCs and the lowest rate at HOCs (74% vs. 48%\*\*\*), and by SPA with the highest

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

rate in SPA 2 and the lowest rate in SPA 5 (76% vs. 50%<sup>\*\*\*</sup>) for usually receiving immunizations at the interview site.

**EXHIBIT 31: DOCUMENTATION AND COUNSELING ABOUT IMMUNIZATIONS AMONG PEDIATRIC PATIENTS IN PAS II**



Seventy-two percent of parents reported that they were always told when to bring their child back for the next immunization, 11% were usually told, 11% were sometimes told and 6% were never told. African Americans were the most likely and Latinos were the least likely always to have been told when to bring their child back for more immunizations (81% vs. 71%<sup>\*</sup>). Patients at HOCs had the highest rate and those at HCs had the lowest rate (82% vs. 63%<sup>\*\*</sup>) of having been told when next to return to the clinic for immunizations.

Health care providers at CHCs had the highest rate and those at P/PPs had the lowest rate (93% vs. 78%<sup>\*</sup>) for reviewing the child’s immunization record with the parent/guardian at the most recent visit, prior to the current visit.

Twenty-one percent of children age 6-17 received immunizations at the current visit. Girls were more likely than boys to have had an immunization at the current visit (25% vs. 16%<sup>\*</sup>). Two-thirds (67%) of parents indicated that the doctor or nurse told them what to do if the child had a reaction to the immunization. Among the children that received immunizations 85% of the parents report that they were told by the doctor or nurse when their child was due for the next immunization, with significant variation by facility type: highest rate at HOCs and lowest rate at CHCs (96% vs. 72%<sup>\*</sup>).

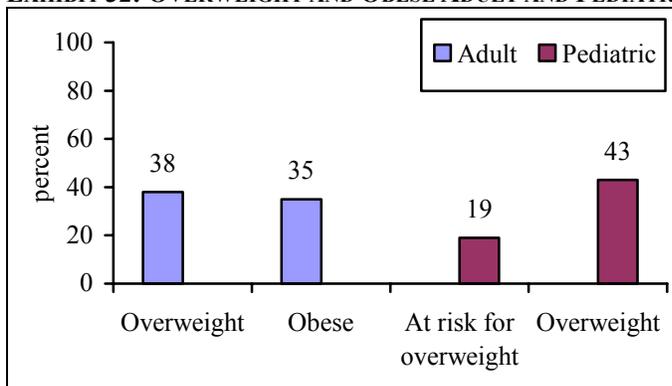
Comments: In PAS I 39% of the parents/guardians had brought the child’s immunization record to the visit.

**Body Mass Index\***

Obesity is at epidemic proportions in this country among both children and adults, giving rise to an increased risk for chronic medical conditions such as diabetes, hypertension and heart disease. Risk for obesity is based on lack of physical activity and excess caloric intake or a lack of appropriate nutritional balance in food consumption.

\* Level of statistical significance is documented in the text of the results with commonly used notations: <sup>\*\*\*</sup> for p< 0.001, <sup>\*\*</sup> for p< 0.01 and <sup>\*</sup> for p < 0.05.

**EXHIBIT 32: OVERWEIGHT AND OBESE ADULT AND PEDIATRIC PATIENTS IN PAS II**



Among children and adolescents, “at risk for overweight” is defined as at or above the gender- and age-specific 85<sup>th</sup> percentile and below the 95<sup>th</sup> percentile of BMI based on the revised CDC Growth Charts for the United States. “Overweight” is defined as at or above the gender- and age-specific 95<sup>th</sup> percentile of BMI based on the revised CDC Growth Charts for the United States.

### Adults

The mean body mass index (BMI) for the adult sample was 28.8kg/m<sup>2</sup>. Almost two fifths (38%) of patients were overweight, while an additional 35% of adults were obese (Exhibit 32). Men and women’s mean BMI did not differ significantly, although women were more likely to be obese (38<sup>th</sup> vs. 28%<sup>\*\*\*</sup>) and men were more likely to be overweight (45% vs. 35%<sup>\*\*\*</sup>). Whites and African Americans had the highest and Asian/Pacific Islanders had the lowest mean BMI (29.4 kg/m<sup>2</sup> vs. 25.6 kg/m<sup>2</sup>). The largest proportion of Latino adults were overweight (41%<sup>\*\*\*</sup>), and the greatest proportion of African Americans were obese (41%<sup>\*\*\*</sup>). Patients in poor health were the most commonly and those in excellent health were the least commonly likely to be overweight (39% vs. 33%<sup>\*\*\*</sup>), and obese (39% vs. 16%<sup>\*\*\*</sup>).

Almost one third (32%) of patients reported that a physician had told them they were overweight or advised them to lose weight; overall only 12% of patients indicated that someone from a physician’s office had helped them to lose weight. Women were more likely than men to have been told by a physician that she was overweight or should lose weight (36% vs. 23%<sup>\*\*\*</sup>), and additionally women were more likely than men to have received some assistance to lose weight from someone at a physician’s office (14% vs. 10%<sup>\*</sup>). Patients in poor health had the highest rate and those in excellent health had the lowest rate for having had a physician tell them that they were overweight or needed to lose weight (43% vs. 6%<sup>\*\*\*</sup>), and patients in poor health had the highest rate and those in excellent health had the lowest rate for having received help or assistance to lose weight from someone in a physician’s office (16% vs. 5%<sup>\*\*\*</sup>).

*Comments:* Almost three quarters of the adult sample had an elevated BMI and were at risk for weight related medical conditions such as diabetes, hypertension and heart disease.

### Pediatrics

Among children and adolescents, “at risk for overweight” is defined as at or above the gender- and age-specific 85<sup>th</sup> percentile and below the 95<sup>th</sup> percentile of BMI based on the revised CDC

Growth Charts for the United States. “Overweight” is defined as at or above the gender- and age-specific 95th percentile of BMI based on the revised CDC Growth Charts for the United States.

Approximately 43% of the children surveyed (age 12 to 17) were overweight, while 19% were at risk for being overweight. Forty-four percent of Latino children were overweight. Children in SPA 2 had the highest rate and those in SPA 4 the lowest rate of being overweight (60% vs. 27%\*\*).

*Comments:* Over two-thirds of children were at risk for being overweight or overweight according to age adjusted height and weight charts.

### **Use of Prescription Medications**

A significant proportion of people in this country use prescription medications, with the highest rates among individuals with chronic medical conditions. Additionally, the cost of pharmaceuticals is increasing, adding further expense to caring for low-income and uninsured patients.

#### Adults

Almost half (47%) of patients reported that they had taken a prescription medication during the preceding four weeks. Patients used a mean of 2.8 prescription medications (range 1 to 25). In the past four weeks Whites were the most likely and Latinos were the least likely to have taken a prescription medication (71% vs. 42%\*\*\*). African Americans took a mean of 3.2 prescription medications while Whites took a mean of 2.6. Patients at HCs had the highest rate and those at P/PPs had the lowest rate for having taken a prescription medication during the preceding four weeks (58% vs. 43%\*\*\*). The mean number of prescriptions used was highest at HCs and lowest at P/PPs (3.1 prescriptions vs. 2.5 prescriptions). Patients in poor health had most commonly taken one or more prescription medications during the preceding four weeks (60%\*\*\*). The mean number of medications used in the past four weeks was highest for patients in poor health and lowest for patients in excellent health (3.9 medications vs. 1.9 medications).

Among patients using prescription medications almost three quarters (71%) reported that a physician or nurse had always explained the reason for taking the medications. Asian/Pacific Islanders were the most likely and Whites were the least likely (78% vs. 53%\*\*\*) to report this. In the past 12 months 97% of patients taking prescription medications reported that they always understood the directions for taking the medication. Patients in poor health were the least likely to always understand the directions for taking medication (92%\*).

#### Pediatrics

In the past four weeks, 29% of the pediatric sample had taken or used any medicine for which a prescription was needed, with a mean of 1.5 medications (range 1 to 7). Children with health insurance were more likely than those without health insurance (34% vs. 23%\*\*), and children at HOCs had the highest rate and those at P/PPs had the lowest rate for using a prescription medication in the past four weeks (41% vs. 19%\*\*\*).

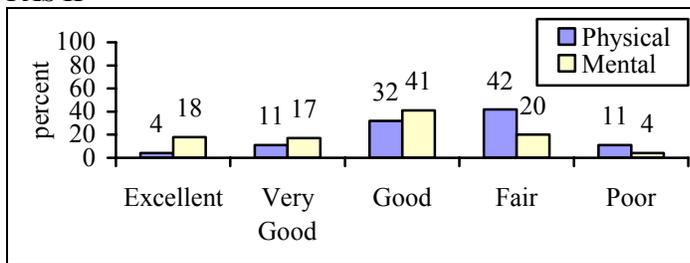
Seventy-eight percent of parents reported that in the past four weeks the doctor or nurse always explained the reason the child was taking a medication. The parents of girls were more likely than the parents of boys to report that the doctor or nurse always explained the reason for taking the medicine (88% vs. 66%\*\*). Ninety-seven percent of parents reported understanding the directions for taking the child’s medication.

## Health Status\*

### Adult

Health status among adults was assessed in two ways. First, using a single item adult patients were asked to rate their physical and mental health on separate five-point scales: excellent, very good, good, fair and poor (Exhibit 29).

**EXHIBIT 32: SELF-RATED PHYSICAL AND MENTAL HEALTH USING A SINGLE ITEM AMONG ADULT PATIENTS IN PAS II**



Second, we used the SF-12 (Short Form-12). The SF-12 is a survey developed to measure physical and mental health through the use of a total of 12 items. Summary scores are generated separately for physical and mental health. Higher scores correspond to better health. The mean score for physical health among adult patients in this sample was 42.8, and the mean score for mental health was 49.7. The mean scores for physical and mental health in the general US population are 50 with a standard deviation (SD) of 10. Hence, this sample scored about 0.7 SD below the general US population on physical health and equivalent on mental health.

*Note: The significance of the variation by subgroups has not been established.*

Males and females (43.2 vs. 42.6) had similar SF-12 physical health scores. SF-12 physical health scores were highest for Asian/Pacific Islanders and Latinos and lowest for African Americans (44.4 vs. 41.4); highest in SPA 4 and lowest in SPA 5 (44.0 vs. 41.4); and, highest at P/PPs and lowest at CHCs (44.0 vs. 41.4). The uninsured had slightly higher physical health scores than the insured (43.0 vs. 41.9).

*Note: The significance of the variation by subgroups has not been established.*

SF-12 mental health scores varied across facilities and were highest at P/PPs and lowest at HCs (51.1 vs. 48.5), as well as varying across SPAS with the highest score in SPA 2 and the lowest score in SPA 8 (50.7 vs. 48.5).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

*Comments:* In PAS I 6% of adults rate their overall health status as excellent, 15% very good, 30% good, 41% fair and 9% poor.

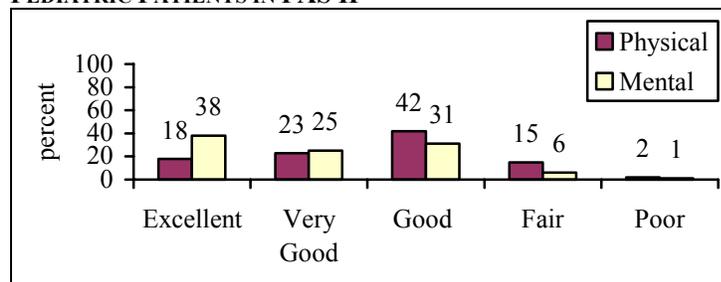
<b>EXHIBIT 34: COMPARISON OF SF-12 SCORES: PHYSICAL AND MENTAL HEALTH COMPOSITE SCORES</b>		
	Physical Health Mean (S.D.)	Mental Health Mean (S.D.)
United States <sup>1</sup>	50.1 (9.9)	50.1 (9.4)
Clinical Diagnosis <sup>2</sup>		
Sub-threshold	43.7 (11.5)	44.4 (19.2)
Lifetime	45.8 (10.6)	41.0 (10.6)
Major depression	47.6 (11.5)	37.4 (12.1)
Dysthymia	42.7 (11.9)	38.2 (11.7)
Double depression	45.6 (10.9)	32.0 (9.8)
<b>PAS I</b>	<b>37.2 (6.6)</b>	<b>47.2 (11.7)</b>
<b>PAS II</b>	<b>42.8</b>	<b>49.7</b>

<sup>1</sup>Ware, Kozinski & Keller (1995); <sup>2</sup>Sugar CA, et al. (1998)

As seen in Exhibit 30, these scores were lower than those for the general U.S. population (Ware 1995, Lundberg 1999), and somewhat comparable to people with serious physical illness (Sugar 1998, Ware 1998), although higher than for PAS I. This apparent increase in SF-12 scores is probably due to the variation in sampling frames between the two studies (i.e., eligibility for PAS II did not require patients to have made one or more visits to an LAC-DHS facility within the 12 months preceding the study).

Pediatric

**EXHIBIT 35: PARENT/GUARDIAN-RATED PHYSICAL AND MENTAL HEALTH USING A SINGLE ITEM FOR PEDIATRIC PATIENTS IN PAS II**



Children missed a mean of 2.7 days from school due to sickness or illness. On average, boys missed more days than girls from school (3.1 days vs. 2.4 days). Ratings of excellent mental health appear to vary by facility type with the highest rate at CHCs and the lowest rate at P/PPs (46% vs. 35%\*).

The Peds QL™ is a modular instrument for measuring health-related quality of life (HRQOL) in children and adolescents ages 2 to 18 years old (Varni et al, 2001). The Peds QL 4.0 Generic Core Scales consists of 23 items applicable for healthy school and community populations, as well as pediatric populations with acute and chronic health conditions. The Peds QL 4.0 Generic Core Scales encompass: 1) Physical Functioning (8 items), 2) Emotional Functioning (5 items), 3) Social Functioning (5 items), and 4) School Functioning (5 items). The survey comprises four age-specific variations of the same instrument that can be consolidated and analyzed by the specific subgroups of interest.

**EXHIBIT 36: PEDIATRIC QUALITY OF LIFE**

<b>Study</b>	<b>Total Score</b>	<b>Physical Functioning</b>	<b>Psychosocial Functioning</b>	<b>Emotional Functioning</b>	<b>Social Functioning</b>	<b>School Functioning</b>
PAS II	83.93	85.43	83.04	79.87	87.12	79.90
Varni et al. (2001) <b>Chronically III</b>	74.22	73.28	74.80	73.05	79.77	71.08
Varni et al. (2001) <b>Acutely III</b>	80.42	81.81	79.56	78.82	83.58	74.74
Varni et al. (2001) <b>Healthy</b>	87.61	89.32	86.58	82.64	91.56	85.47

The mean total score for children was 83.93, 85.43 for physical health, 83.04 for psychosocial health, 79.87 for emotional health, 87.11 for social functioning and 79.90 for school functioning. As seen in Exhibit 32, these scores fall in between those scored by healthy children and acutely ill children in a study using the same instrument among children recruited from a variety of pediatric health care settings (these included private physicians' offices and specialty clinics).<sup>1</sup>

There was significant variation among pediatric patients in PAS II by gender, race/ethnicity and facility type. Boys scored higher than girls (87.27 vs. 84.36\*), and Latino children scored the highest and African Americans scored the lowest (84.26 vs. 81.17\*) on physical functioning. Whites scored the highest and African Americans scored the lowest in school functioning (87.71 vs. 72.34\*). Children at CHCs had the highest score across all categories, whereas those at HOCs scored the lowest (\*).

*Comments:* The variation by facility type may be explained because it is possible that more chronically ill children access care at HOCs versus all other facilities.

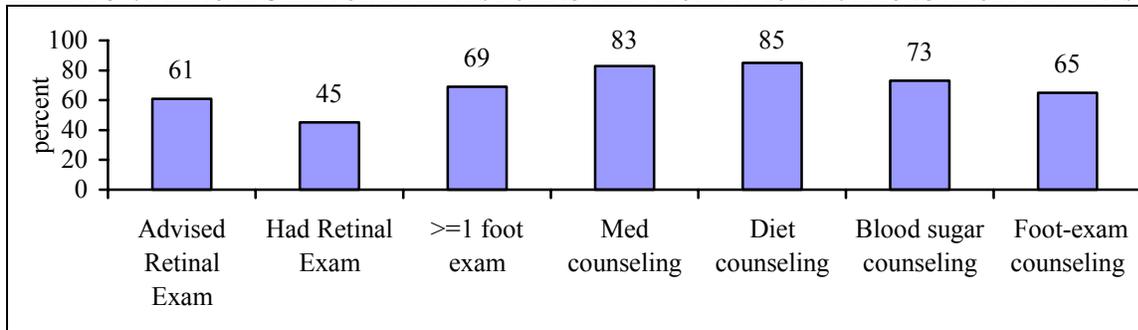
**F. QUALITY AND PROCESSES OF CARE FOR CHRONIC ILLNESSES\******QUALITY OF CARE FOR DIABETES (ADULTS)***

Diabetes is an increasing health problem that currently affects approximately 17 million adults and children nationwide, although an estimated 5.9 million people who have the condition remain undiagnosed. The prevalence of diabetes among U.S. adults (age 18 years and older) increased by 50% between 1990 and 2000. Those individuals who have diabetes but remain undiagnosed are at further elevated risk for the multiple medical complications associated with diabetes including but not limited to chronic renal failure, heart disease, blindness, and amputation. Quality of care guidelines for diabetes focus on optimizing glycemic control and reducing the risk for diabetes related complications.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

**EXHIBIT 37: MEDICAL CARE FOR DIABETES DURING THE PRIOR 12 MONTHS AMONG ADULT PATIENTS IN PAS II**



Currently the prevalence of diabetes in the general population, nationwide and in California, is estimated at 5.9%, with significant variation by age and race/ethnicity. In this sample of patients in care, about 16% (n=318) of adult patients reported ever being diagnosed with diabetes mellitus. Patients at Health Centers were the most likely and those at P/PP clinics were the least likely to have diabetes (26% vs. 13%\*\*\*). Eighty-two percent of patients with diabetes received some sort of pharmacotherapy, but only 26% of these were receiving insulin (with 81% receiving oral hypoglycemics). About two-thirds of patients with diabetes were checking their blood sugar at home. Whites were the most likely and African Americans were the least likely to be using an oral medication (95% vs. 52%\*\*\*), while African Americans were the most likely to be using insulin (48%\*).

There were no major changes in the quality indicators from the previous survey (PAS I), though there was a small trend toward lower scores for indicators involving patient education (Exhibit 33). Eighty-nine percent of patients with diabetes had undergone blood cholesterol testing in the past three years.

Whites were the most likely to have undergone a dilated eye exam in the past year (58%\*). Asian/Pacific Islanders were the most likely to have had at least one foot-exam during the preceding year (94%\*). There were only modest differences by facility type, with patients at HCs having the highest and patients at P/PPs the lowest rate of receiving dilated retinal exams (51% vs. 41%\*), and patients at HOCs with the highest rate and those at P/PPs with the lowest rate for receiving nutritional education (90% vs. 78%\*).

Among patients with diabetes, African Americans had the highest rate and Whites had the lowest rate for having blood cholesterol checked within the past three years (99% vs. 87%\*). Patients at HCs were the most likely and those at CHCs were the least likely (99% vs. 84%\*), and patients in SPA 1 were the most likely and those in SPA 6 were the least likely to have had a blood cholesterol test within three years (100% vs. 81%\*). Patients in very good health were the most likely and those in poor health were the least likely to have had a cholesterol test within 3 years (95% vs. 79%\*).

Significant variation at the SPA level was present, with SPAs 2 and 8 having the greatest proportion and SPA 4 having the smallest proportion of patients with diabetes who check their blood sugar at home (80% vs. 46\*\*); and SPA 5 having the greatest proportion and SPAs 6 & 7 having the smallest proportion of patients who had a physician perform at least one foot exam in the past 12 months (83% vs. 57\*). Counseling regarding dietary intake was received most

commonly by patients in SPAs 2 & 3 and least commonly by patients in SPA 4 (94% vs. 62\*). Latinos were the most likely and Whites were the least likely to have always had their diabetes medicine during the past 12 months (93% vs. 62%\*\*).

*Comments:* In PAS I 20% of patients had a known diagnosis of diabetes mellitus. There were no major changes in the quality indicators from the previous round of data collection (PAS I), though there was a small trend toward lower scores for indicators involving patient education. The proportion of patients who received a dilated eye exam in the preceding 12 months in PAS I was 48%, as did the proportion advised to get such an exam (69%). Almost two-thirds (59%) had received at least one foot-exam during the preceding year. Ninety-six percent of patients had received medication counseling, 91% had received dietary counseling, 92% blood sugar counseling, and 68% counseling regarding performing foot exams at home.

#### *PATTERNS OF CARE FOR HYPERTENSION (ADULTS)\**

Hypertension is an independent risk factor for stroke, heart disease and end-stage renal disease. It currently affects a majority of patients above the age of 50, although there are multiple drugs available to treat this condition.

Twenty four percent (n=484) of adults reported a diagnosis of hypertension. Similar to PAS I, there was significant variation by race/ethnicity. African Americans had the highest rate and Latino/Latinos the lowest rate of hypertension (41% vs. 20%\*\*\*). Patients at HCs had the highest and those at CHCs had the lowest rate (34% vs. 21%\*\*\*), while patients in SPA 2 had the highest and those in SPA7 had the lowest rate (32% vs. 17%\*\*). Insured patients were more likely to have a diagnosis of hypertension than uninsured patients (28% vs. 23%\*\*). Patients in poor health had the highest and those in very good health had the lowest rate of hypertension (35% vs. 18%\*\*\*).

Due to the lack of variation in the findings, most of the quality measures used in PAS I were not assessed in PAS II (e.g., the frequency of BP measurement). Instead, we report on patterns of care for hypertension. Few patients with diagnosed hypertension were untreated (11%), and most patients with hypertension were receiving pharmacotherapy (72%). Among those patients with hypertension who were taking medication, 84% always had their medication during the past 12 months. Patients who did not always have their medication reported the following reasons among others: lack of insurance (28%) medications too expensive (25%) and lack of perceived need (23%). The sample size was too small to assess for subgroup variation.

*Comments:* In PAS I, 34% of patients had a known diagnosis of hypertension.

#### *QUALITY OF CARE FOR CONGESTIVE HEART FAILURE (ADULTS)*

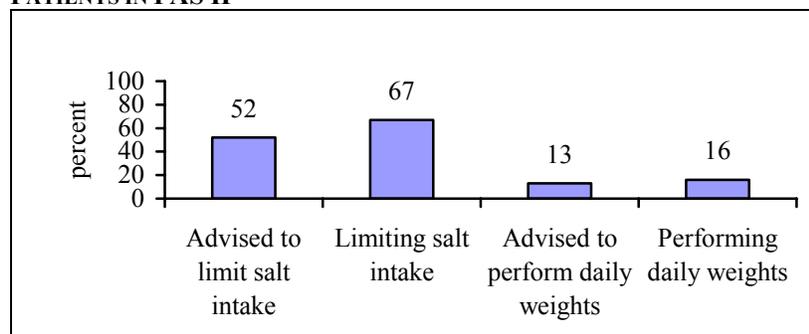
Only 60 (3%) of sampled patients had a diagnosis of congestive heart failure (CHF). The burden of CHF was spread fairly evenly across facility types and SPAs. Two-fifths (40%) of patients were taking a diuretic (i.e., water pill) and 86% of patients always had their medication for CHF.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

The quality indicators for CHF centered on patient education activities: limiting salt intake and weighing oneself daily (Exhibit 33).

**EXHIBIT 38: MEDICAL CARE FOR CONGESTIVE HEART FAILURE WITHIN THE PAST 12 MONTHS AMONG ADULT PATIENTS IN PAS II**



*QUALITY OF CARE FOR ASTHMA/REACTIVE AIRWAY DISEASE\**

Adults

Nine percent of adult respondents reported that a physician had diagnosed them with asthma. Whites were the most likely and Latinos were the least likely to report a diagnosis of asthma (25% vs. 5%\*\*\*).

Asthma severity can be estimated by applying the 1997 National Heart Lung and Blood Institute (NHLBI) criteria for persistent asthma based on symptom days. Adults who wheeze or have shortness of breath every day are classified as having severe persistent asthma, those with symptoms a few days a week would have moderate persistent asthma and mild persistent asthma would include those with symptoms about twice a week. And those with symptoms only a few days a month would be classified as having mild intermittent asthma. Fifteen percent of the adults who had been diagnosed with asthma never had wheezing or shortness of breath, 24% a few days a month, 13% less than 1 day a month, 7% had symptoms once a week, 19% a few days a week, and 22% every day. Just over one-fifth (21%) of adult patients with asthma always cough when they do strenuous activities or run, 15% usually cough, 37% sometimes cough, and 27% never cough. The sample size was too small to assess for subgroup variation.

Beta agonists were the most common treatment (51%) followed by inhaled steroids (15%), and only 13% of adults were using a spacer or facemask with their medication. All Asian/Pacific Islanders were using a beta-agonist while less than half of African Americans use this type of medication (100% vs. 45%\*). Patients in fair or poor health (60% and 58%) were more likely than those in good health (45%) to be using this class of medications.

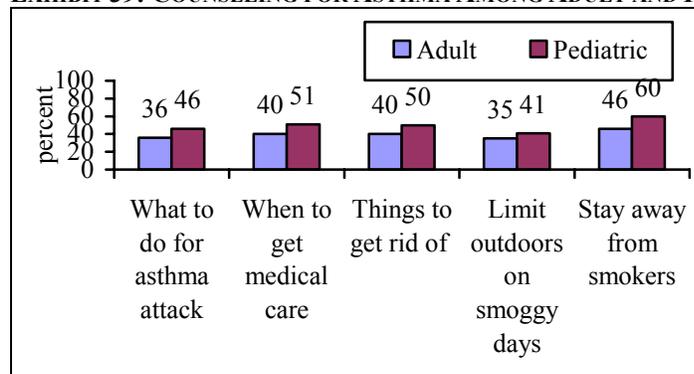
In the past 12 months, 11% of the adults with asthma used at least one course of oral steroids. Of note, in the past 12 months one-third (33%) of the adult sample went without their asthma medications. During the prior 12 months Whites and African Americans had twice the rate of Latinos for having gone without their asthma medication in the past year (37% vs. 18%\*\*\*).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

During the past 12 months, 17% of adults with asthma had sought medical care at an ED for problems related to this condition; 6% had been hospitalized overnight in the past year; and the average respondent had missed less than a day of work or school in the past year due to the disease.

Adult patients with asthma were counseled by physicians about what to do for an asthma attack; when to seek medical care; things to get rid of at home; limiting activities outdoors on smoggy days; and avoiding cigarette smoke (Exhibit 39).

**EXHIBIT 39: COUNSELING FOR ASTHMA AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**



Latinos were the most likely and Whites were the least likely (54% vs. 27%\*\*\*), while patients at CHCs were the most likely and those at HOCs were the least likely (55% vs. 31%\*) to have been told by the doctor when to get medical care right away for their asthma.

Men were more likely than women to have been told by their doctor to get rid of things that make their asthma worse (52% vs. 37%\*); Latinos the most likely and African Americans the least likely (45% vs. 38%\*); and patients at CHCs were the most likely and those at HOCs were the least likely (58% vs. 29%\*\*). Patients at CHCs were the most likely and those at HOCs were the least likely to have been told by the doctor to limit outdoor activities on a smoggy day (48% vs. 23%\*).

Latinos were the most likely and African Americans were the least likely (52% vs. 43%\*), and patients at CHCs were the most likely and those at HOCs were the least likely (61% vs. 27%\*\*\*) to have been told by the doctor to stay away from people who smoke because of their asthma.

Pediatrics

Ten percent of the parents/guardians had ever been told that their child had asthma, and 8% reported being told that their child had wheezy bronchitis or reactive airway disease. Variation was present in asthma rates by insurance status and type of facility. Insured children were more likely than uninsured children (14% vs. 4%\*\*\*), and pediatric patients at HOCs were the most likely and those at CHCs were the least likely to have ever been told they had asthma (18% vs. 10%\*\*\*).

Asthma severity can be estimated by applying the 1997 NHLBI criteria for persistent asthma based on symptom days. Children who wheeze or have shortness of breath every day are

classified as having severe persistent asthma, those with symptoms a few days a week would have moderate persistent asthma and mild persistent asthma would include those with symptoms about twice a week. And those with symptoms only a few days a month would be classified as having mild intermittent asthma. Thirty-one percent of the pediatric sample never had wheezing or shortness of breath, 20% less than 1 day a month, 27% a few days a month, and 22% had wheezing at least once per week. Twenty-two percent always cough when they play or run, 5% usually cough, 55% sometimes cough, and 18% never cough. The sample size was too small to assess subgroup variation.

Beta agonists were the most common treatment (49%), and 59% of children were using a spacer or facemask with their medication.

In the past 12 months, 25% of the children with asthma used at least one course of oral steroids. Of note, in the past 12 months 19% of the pediatric sample went without their asthma medications.

Just over one third (34%) of children with asthma had sought medical care at an ED for problems related to this condition during the past 12 months; 13% were hospitalized over night; and over half (53%) of children with asthma had missed one or more days of school in the past 12 months (mean 5.4 days - range 0-90).

In the past 12 months 46% of parents were told by their child's doctor what to do in case of an asthma attack, and 51% of parents were told by their child's doctor when to get medical care right away for their child (Exhibit 39). The parents of pediatric patients at CHCs were the most likely and those at HOCs were the least likely to be told when to get medical care for their child if s/he has problems related to asthma (64% vs. 55%\*). In the past 12 months 50% of parents were told by their doctor to get rid of things that make their child's asthma worse; and 41% of parents were told by their child's doctor to limit outdoor activities on a smoggy day. In the past 12 months 60% of parents indicated that their child's doctor discussed staying away from people who smoke around their child. Parents of male children with asthma were more likely than parents of female children to have been told (78% vs. 43%\*\*). Twenty-five percent of pediatric patients with asthma got a flu shot between October 2001 and April 2002.

*Comments:* In PAS I 6% of children had a diagnosis of asthma

#### *PATTERNS OF CARE FOR HYPERCHOLESTEROLEMIA (ADULTS)\**

Elevated cholesterol levels are known to increase the risk for heart disease in the general population, and even more so for people with additional risk factors such as diabetes, hypertension, obesity and smoking. Cholesterol levels should be checked approximately every three to five years for patients not at risk for co-morbidity and more frequently for individuals with diabetes, hypertension and cardiovascular disease.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

Hypercholesterolemia was reasonably common in the sampled population of patients. About 23% or 462 respondents reported that a physician had diagnosed them with the condition. The diagnosis was more common in women than men (25% vs. 19%\*\*), and for health status the highest rate was among patients reporting poor health and the lowest rate among those reporting excellent health (35% vs. 13%\*\*\*).

Only 14% of patients reported no treatment for their hypercholesterolemia. Two-thirds were following a diet and exercise plan and 41% were taking medications. However, African Americans had the highest rate and Latinos had the lowest rate of no treatment to lower cholesterol (24% vs. 11%\*\*), while P/PP patients were the most likely and patients at HOCs were the least likely to be on a diet and exercise regimen (76% vs. 56%\*\*). One-fifth of patients with poor health status were not receiving any treatment for this condition.

#### *PATTERNS OF CARE FOR DEPRESSION (ADULTS)\**

Depression is under-diagnosed in this country among all populations of patients. It has potentially life altering effects on quality of life and performance of daily activities, and may have a disproportionate effect on low-income uninsured patients because of limited access to mental health care.

Twelve percent of patients in this sample had been told by a provider that they had depression. Whites were the most likely to receive this diagnosis and Latinos were the least likely (28% vs. 10%\*\*\*).

Among diagnosed patients, 57% had been referred for counseling, although almost half (48%) of counseled patients felt the number of counseling sessions they had received was insufficient. Reasons for discontinuing counseling were often financial (45%).

Two thirds (66%) of depressed patients had been prescribed medicine. White and African American depressed patients were more likely than Latinos to have received pharmacotherapy (79% vs. 60%\*\*). Patients at P/PPs were the most likely and those at HCs were the least likely to have been prescribed medications (76% vs. 44%\*\*).

#### **G. FOOD SECURITY**

Low-income individuals are at particular risk for not having adequate nutritional resources, mainly due to inadequate financial resources. Even with access to food in general, people may be limited in their ability to obtain healthy and nutritious food options, and may consume whatever food is available in lieu of going hungry. Lack of access to food may have particular implications for people with diabetes as well as growing children.

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\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

**EXHIBIT 40: FOOD INSECURITY DURING THE PRECEDING 12 MONTHS AMONG ADULT AND PEDIATRIC PATIENTS IN PAS II**

	Adult (%)	Pediatric (%)
Often the food they bought just didn't last and they did not have money to get more.	7	31
Often they could not afford to eat balanced meals.	8	30
Often they or someone in their household had cut the size of a meal/ skipped it entirely because there was not enough money for food.	16	7
Often they ate less because there was not enough money for food.	18	7
Often they were hungry but did not eat because they could not afford enough food.	13	6
They had used free community food programs.	14	13

Adults\*

Among those patients who cut the size of their meal or skipped food (Exhibit 35), 31% reported that it happened every day or a few days a week. Men were somewhat more likely than women to have been often unable to afford to eat balanced meals (12% vs. 7%\*\*\*). Whites were the most likely and African Americans were the least likely to report that often they could not afford to eat balanced meals (17% vs. 6%\*\*\*). Whites most commonly and Latinos least commonly indicated that within the past 12 months the patient or someone in their household had cut the size or entirely skipped meals because there was not enough money for food (27% vs. 15%\*\*\*). In addition, White were more likely than Latinos to have eaten less in the past year because there was not enough money for food (33% vs. 15%\*\*\*). Furthermore, Whites were more likely than Latinos to have been hungry in the past 12 months, but not to have eaten because s/he could not afford enough food (24% vs. 11%\*\*\*). Of note, African Americans most commonly and Latinos least commonly used free community food programs (25% vs. 12%\*\*\*).

Patients in SPA 4 most commonly and patients in SPA 7 least commonly reported that they or someone in their household had cut the size of a meal or skipped it entirely because there was not enough money for food (22% vs. 11%\*). Among those patients who cut the size of their meal or skipped food patients in SPA 5 were the most likely and those in SPA 3 were the least likely to report that it happened every day or a few days a week (41% vs. 10%\*\*\*). In the past 12 months patients in SPA 6 had the highest proportion and those in SPA 1 had the lowest proportion of patients who ate less because they felt there was not enough money for food (23% vs. 12%\*). In the past 12 months, patients in SPA 1 most commonly and those in SPA 2 least commonly used free community food programs (22% vs. 9%\*).

The insured and the uninsured were equally likely to have someone in their household who had cut the size of their meal or skipped it entirely because there was not enough money. However, patients who were uninsured were more likely to have done this almost every day or a few times a week (34% vs. 19%\*).

\* Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for p< 0.001, \*\* for p< 0.01 and \* for p < 0.05.

Patients in poor health had the highest rate for having purchased food in the past 12 months that often did not last and they did not have money to buy anymore (13%\*\*\*). In addition, patients in poor health were most commonly and those in excellent health were least commonly unable to afford balanced meals (58% vs. 27%\*\*\*). Patients in poor health had the highest rate for having to cut the size of a meal or to skip it entirely because there was not enough money for food (35%\*\*\*). Additionally, patients in poor health were hungry but did not eat because they could not afford enough food (27%\*\*\*) and used community food programs (24%) more than two times the rate of other patients.

### Pediatrics<sup>•</sup>

Variation by facility type was seen with 41% of the parents of patients at HCs and 24% of the parents of patients at P/PPs reporting that often the food they bought just didn't last and they didn't have money to get more\*. Fifty-three percent of patients in SPA7 and only 14% in SPA2 reported that often their food didn't last\*\*\*.

Variation by facility type was seen again with 44% of patients at HCs and only 20% at P/PPs reporting that often their household could not afford to eat balanced meals\*\*\*. Forty-eight percent of the parents of patients/guardians in SPA7 and only 16% of the parents/guardians of patients in SPA8 reported that often their household could not afford to eat balanced meals\*\*\*. Among those families who had cut the size of a meal or skipped it, 62% had to reduce or skip meals a few days a month, 23% a few days a week, and 16% less than once each month.

Thirteen percent of families used a free community food program to feed their children, in the past 12 months. Parents of children with insurance were more likely than those without insurance to use a free community food program (16% vs. 10%\*). Twenty-three percent of children seen at HCs and 7% seen at P/PPs used a free community food program during the past year\*\*.

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<sup>•</sup> Level of statistical significance is documented in the text of the results with commonly used notations: \*\*\* for  $p < 0.001$ , \*\* for  $p < 0.01$  and \* for  $p < 0.05$ .

## **DISCUSSION**

The PAS II is the second, large-scale, comprehensive, patient assessment of the medical care provided through the Los Angeles County – Department of Health Services, and is unusual in its size and scope. The PAS II continues the important information gathering and data analysis that began with PAS I assessing patient report with respect to their medical care: access, receipt, unmet need and satisfaction.

### ***Cultural Diversity among the LAC-DHS population***

The composition of the respondents in this project reflects the cultural diversity that exists among residents of Los Angeles County, and the need to consider the impact of cultural variation on access to and use of health care through the LAC-DHS. Patients were predominantly Latino, low-income, limited education, immigrant, non-English speakers and for a portion had an unpredictable housing situation. Of note, adult and pediatric patients varied somewhat by race/ethnicity, income and immigration status.

### ***Access to Health Care***

The Institute of Medicine's Committee on Monitoring Access to Personal Health Care Services defines appropriate access to health care as "the timely use of personal health services to achieve the best possible health outcome" (IOM, 1993). Previous studies have found and confirmed that uninsured adults are more likely to delay seeking care than those who are insured (Ayanian et al., 1993), and they are less likely to be referred by physicians for other health services (Mort et al., 1996). Optimizing access to needed health care is important for multiple reasons. Delayed receipt of medical care may result in more serious illness for the patient, increased complications, a worse prognosis, and longer hospital stays (Epstein et al., 1990; Adler et al., 1993). Individuals without a usual source of care are at increased risk for not receiving age and condition-appropriate preventive services (Weissman et al., 1991; Lambrew et al., 1996). Health insurance coverage, employment, household income and residential status continue to be associated with an individual's ability to obtain needed medical care (Freeman et al., 1990; Hayward et al., 1988; Himmelstein et al., 1992; Wood et al., 1991; Mort et al., 1996). However, many other factors also need to be considered (Himmelstein et al., 1995). Models explaining use of health care services suggest that other factors enable or impede an individual's ability to obtain medical care. These include health beliefs, cultural practices, language barriers, social networks and contacts, and the availability and accessibility of medical care in the community (Andersen, 1995).

### ***Coverage for Health Care***

It is well documented that lack of health insurance is associated with decreased receipt of routine care (Holl JL, 1995), lower rates of immunizations (Himmelstein DU, 1995) and less access to neonatal intensive care for low birthweight infants (Bronstein JM, 1995). In addition, increased levels of cost sharing have also been shown to decrease receipt of needed care, especially among low-income populations (Health Insurance Experiment). In the NHIS, health insurance status was related to every access-to-care indicator and people without health insurance were the most likely to have an unmet need for health care and to lack a usual source of care (Weissman et al., 1994). Other research has shown that the lack of health insurance acts as a major barrier to receipt of needed health care services (Freeman HE, 1990; Adler NE, 1993, Hayward RA et al., 1988).

Findings from PAS II indicate that rates of insurance for adult and pediatric patients are low, and even among a sample of low-income patients, health insurance still has a significant impact on access to and receipt of health care. The majority of adults who were uninsured had always been uninsured, and did not appear to have much chance of obtaining health insurance. Immigrants to the U.S. perceived barriers to obtaining insurance that included a lack of eligibility and a fear of repercussions. However, a number of County programs are in place which strive to alleviate the financial burden of obtaining health care (Ability to Pay – ATP, ORSA) and programs that provide health care services to adults and children who are uninsured such as the General Relief Health Care Program as well as contracts with other safety net providers through the Public Private Partnership Program.

At the State level there has been an emphasis on enrolling children in the Healthy Kids/Healthy Families program, although this impact is not demonstrated by the findings in this study. Nationally 88% of children are reported to have health insurance. According to reports from the 2001 California Health Interview Survey, 86% of children had health insurance for the entire preceding 12 month period. However, LAC–DHS takes care of a disproportionately large uninsured population. This racial/ethnic variation in health insurance rate is different than what is seen in the State of California where African American children have the highest proportion of health insurance coverage at 96%, followed closely by White children with 95% and only 81% of Latino children with health insurance. Current health insurance among the pediatric sample in this study is predominantly MediCal (47%).

Ten percent of the responses given for not being insured were due to not knowing where to apply for health insurance or not knowing how to fill out the application. This underscores the need for community outreach workers to help parents of eligible children apply for health insurance coverage. There is still more to be done to educate the public about MediCal (and Healthy Families), eligibility, and to ease their fears about immigration consequences for their children and families. Additionally, it would be useful to find out why children in this population are losing their public coverage (16% overall). If the State reinstates quarterly status reports for parents, which has the potential to affect children, even more children stand to lose health insurance coverage.

#### *Access to Telephones*

There was significant subgroup variation for the ability to make and receive telephone calls at one's residence. This has an impact on an individual's ability to call for medical advice or help, as well as making medical appointments and being notified about changes to their appointments or reminders of the appointments. In fact, 8% of adult and 7% of pediatric patients had missed an appointment because they had forgotten about it.

#### *Prior Use of Health Care - Medical Visits*

A majority of adult and pediatric patients included in this sample had made one or more visits to a health care provider in the 12 months preceding the interview, and of those patients most of them had previously been seen at a County facility. However, there were some patients who reported visits to both County and non-County providers. Patients in this sample appear to have made as many if not more visits for health care in the past year than patients in other samples, although they appear to be seeking medical care from multiple sources.

In the past 12 months, more than half of patients were seen for acute illness or injury as well as for regular or routine care, with some variation between adults and children and by subgroups. At the level of the current analyses, it is difficult to know whether those patients who reported an acute illness or injury sought episodic care or whether they were seen at a USOC. These rates are dissimilar to other patient samples with higher rates of acute illness or injury and lower rates for regular or routine care. It will be important to assess the prior use of services between the 68% of patients who had used LAC-DHS services during the preceding year and the 32% who had not.

A significant issue is the perceived role of LAC-DHS with respect to the type of medical care that will be provided. Will there be an emphasis on caring for people with chronic medical conditions, providing episodic care for acute illnesses and injuries, or ensuring that age and gender appropriate preventive health care services are received. With decreases in funding available to the County and a potential increase in the patient population relying on LAC-DHS for medical care, a focus on attracting and retaining insured patients might be considered (e.g., MediCal).

#### *Prior Use of Health Care – Telephone Calls*

Less than one fifth of adults and just over one-fifth of the parents of pediatric patients had called a County facility for help or advice. This rate is considerably lower than patients in Managed Care plans, and demonstrates an apparent decrease from PAS I. Overall, patients at LAC-DHS facilities do not appear to have an expectation that they can call for help with less than half of adult patients and half of parents reporting that they had always received the help they needed. The explanation for the decline in rates of calling a LAC-DHS facility for help may be somewhat related to patient perception of decreased services through LAC-DHS during the recent and ongoing budgetary challenges, as well as including the 32% of patients who had not received care through the LAC-DHS during the preceding 12 months.

A system that allows patients to obtain medical advice from a qualified health care provider without making a visit has the potential to facilitate medical care and to increase the number of patients cared for.

#### *Left a County Facility without Seeing a Physician*

One tenth of adult patients and over one tenth of pediatric patients had left an LAC-DHS facility without seeing a physician, most commonly because the wait was too long. There was variation by gender, race/ethnicity, facility type, SPA and health status. This variation may indicate an intolerance or inability to wait for prolonged periods of time to obtain medical care in a non-Emergency Department setting. The establishment of systems that reduce waiting time may alleviate part of this issue. For example, more individual appointments could be scheduled, rather than relying on block appointments; or patients could be notified about changes in clinic staffing or the rescheduling of clinics or appointments.

#### *Patient Perceived Alternative Options for Medical Care*

If the facility at which they were receiving health care were to permanently close, 10% of adults and 13% of children would rely on Emergency Department services. This finding has considerable implications for the ability of EDs to function to provide emergency care. Even currently, there is a perception by many that a significant portion of ED care is non-emergent.

Additionally, a majority of patients indicated that they would seek medical care from another County facility, demonstrating their significant reliance on the safety net. There was significant subgroup variation including by health insurance: where two-thirds of uninsured patients would continue to rely on the County for their medical care. It would be interesting to analyze this data looking specifically at the clinics that closed in 2002 after data collection was completed.

### *Usual Source of Care*

The evidence supporting the importance of having a usual source for health care is extensive (Newacheck et al., 1996; Weissman et al., 1994; Lewis et al., 1996; Berk et al., 1995; Lambrew et al., 1996; Himmelstein et al., 1992). One of the initial goals of the Medicaid Demonstration Project was to increase access to primary care services within the LAC-DHS network. This goal was to be met through a restructuring of the LAC-DHS network throughout LA County.

Just over half of adults and a little less than three-quarters of pediatric patients at primary care clinics (i.e., general internists, general pediatricians and family practitioners) were able to identify a specific clinic or physician as their usual source for health care. These results are somewhat lower than those from national samples, and among patients enrolled in private insurance plans. In addition, these estimates may be somewhat elevated, and may represent some degree of sampling bias as the patients included in this study were by definition (i.e., based on the sampling frame), users of primary care services through the LAC-DHS. Nevertheless, one may interpret these findings to indicate that it is possible for low-income patients who rely on a County health system to have a usual source for health care where they can have their acute, chronic and preventive health care needs met.

A little less than three-fifths (58%) of adult patients reported that they had received care at their USOC for two years or less. This finding may indicate that a greater number of patients are seeking primary care services through the LAC-DHS as a result of the restructuring (i.e., the implementation of the PPP program and the prior expansion of HCs) and the implementation of new programs. However, with the recent contractions of the DHS primary care network that occurred after the completion of data collection for this study these findings may no longer be accurate. Among pediatric patients the rate for having a USOC was lower (73%) than national data (94%).

Additional analyses of interest should focus on USOC among those people previously receiving medical care through the LAC-DHS, and those who were new to the system, with further subgroup analyses between the two groups.

### *Seeking Medical Care in Mexico*

Overall, we found very low rates for seeking medical care in Mexico. Five percent of adult and pediatric patients had received medical care while in Mexico, most commonly because they had become ill while visiting. Additionally, six percent of adults had purchased medications in Mexico with almost half of those people reporting that medicine in Mexico was cheaper than in the U.S.

The perception that large numbers of people in Los Angeles County seek medical care in Mexico, either as a visit to a physician or in the purchase of prescription medications does not appear to be supported by the findings from this study. However, patients do appear to seek

prescription medications from Mexico because of the lower cost more commonly than they seek low cost medical care, and this is a study of patients already received medical care where their medications are often provided by the County.

### *Specialty Care*

Twenty-two percent of adults and only 14% of children had been referred to a specialist during the preceding 12 months. Ophthalmologist/optometrists were the most commonly referred to specialties for both adult and pediatric patients. However, it is not clear from this survey whether patients were seeking evaluation of concerns related to visual acuity or if there were specific eye-related issues.

Only three-quarters of adults and children actually saw the specialist they were referred to. In some cases, people had an appointment and were still waiting to be seen, but for many the wait was too long or they never could make an appointment. This is probably a reflection of the volume of specialty care need that LAC-DHS faces, with limited resources including specialty providers. Overall, patients are very accepting of the time delays. However, the length of time that patients reported waiting for their most recent visit to a specialist appears somewhat comparable to wait times within other systems of care (e.g., Managed Care, Academic Medical Centers, VA).

It will be important to assess wait times for a specialty appointment by the individual specialties as some referrals may be more urgent than others. Further analysis of the data may provide more specific information with respect to delays for particular specialties for both adults and children.

### *Dental Care*

Rates for receipt of dental care were very low among both adults and children, with 29% and 37% respectively having received a regular dental checkup within the preceding 12 months. National trends among low-income populations have shown similar findings, i.e., low use of dental care. Even among those with dental coverage a similar finding is observed. An analysis of 1995 data, the most recent data available according to the researchers, from 27 state Medicaid programs showed that thirty-four percent of children enrolled in Medicaid fee-for-service plans had visited the dentist in the preceding year.

Only one-third of adult patients but over half of pediatric patients with a particular dental problem had received their care from a County dental facility. Financial barriers were the most common explanation for not receiving dental care. Of note, 11% of children age 6 to 17 had missed one or more days of school in the past year because of tooth pain or dental problems.

### *Emergency Department Use*

Almost one-quarter of adults and almost one-fifth of children in this sample had sought medical care from an Emergency Department at least once during the preceding 12 months, the majority of whom were seen at County EDs. Patients in this sample appeared to use the emergency department at higher rates than patients in other samples. For those patients who had sought medical care from an ED, over half thought their medical problem was an emergency, however there were still many people who chose to obtain medical care at an ED for convenience or financial reasons.

Programs have been developed to try to alleviate the volume of patients seeking medical care at EDs, some of which have focused on providing patients with other options for receiving the health care that they want. In this study, 36% of adult and 39% of pediatric patients would have been willing to have an appointment to see a physician within 24 hours, rather than going to an ED. This finding supports the potential for LAC-DHS to develop and/or expand systems that are currently in place to divert and re-direct non-emergent patients from the ED into ambulatory care settings.

Further work needs to be done to assess the current situation in the EDs, especially after the clinic closures of 2002 and the recent reduction in funding to the P/PP program.

### *Hospital Use*

Twelve percent of adult and 7% of pediatric patients were hospitalized one or more times during the preceding year. The majority of these patients were hospitalized at a County facility. The closure of County hospitals would predictably result in the hospitalization of former patients at private hospitals in the County. However, patients may defer hospitalization if they do not think they can pay for the services. These types of delays have previously been demonstrated to result in worse outcomes because of the increased severity of illnesses at the time of presentation.

## **Barriers to Health Care**

### *Unmet Needs*

This study highlights the existence of significant barriers to needed health care that LAC-DHS patients continue to experience. A significant proportion of the sample reported that they had not received needed medical care one or more times during the previous year, and had been unable to obtain prescription medications and eyeglasses. In this survey, adults had higher rates than children for experiencing unmet health care needs, almost certainly related to the variation in rates of health insurance coverage. Among adults and children an unmet need for eyeglasses may result in a reduced ability to function, including employment and participation in school. Additionally, lack of prescription medication may lead to complications of acute and chronic medical conditions that result in worse outcomes and may be more costly from a financial perspective.

There was significant variation by race/ethnicity, facility type and SPA as well as health status. The findings of unmet need from PAS II are higher than rates from the 2001 California Health Interview Survey (CHIS). However, the samples are not comparable as CHIS is a population-based survey of households and PAS II was a survey of health care users. Further analyses that stratify patients in CHIS or the 2002 Los Angeles County Health Survey by users and non-users of medical services, income and insurance status and then compare the findings to PAS II will be useful.

### *Missed Appointments*

Approximately one fifth of adult and pediatric patients had missed one or more medical appointments in the preceding 12 months, with 36% in both samples reporting that they had forgotten the appointment (8% and 7%, respectively). The rate of missed appointments for adults declined from 34% in PAS I and for children it declined from 27%. The explanation for the decreased rates of missed appointments is not available based on the data from this survey,

however one might postulate that system changes were implemented during the time between the surveys to lower the rate of missed appointments. Based on respondents' comments in PAS I, these changes might include, but not be limited to reminder phone calls and specific appointment times rather than block appointments. However, patients faced other mutable barriers that caused them to miss medical appointments including transportation issues, work/employment issues, and other responsibilities.

At many of the LAC-DHS facilities the system used to schedule patients assumes a very high rate of patients who do not present for their appointments ("no shows"). It would seem more efficient from a planning perspective, as well as with regard to the provision of needed and appropriate care to patients, if systems could be implemented that would reduce the "no show" rate. Over 90% of patients reported that they could both make and receive phone calls, so the development and implementation of some type of telephone reminder system might be a possibility. It is true that thousands of patients are seen at LAC-DHS facilities (including P/PPs) every day, so implementation of a telephone reminder system might be a challenge, but it would prove less expensive and most likely more effective than mailed reminders. We suggest that LAC-DHS study whether reminder systems are used at individual County facilities, and if so, how effective they are in reducing the "no show" rate. Based on data from study a majority of adult and pediatric patients have direct access to telephones. A review of State and National programs might also indicate the use and effectiveness of reminder systems for a public health system.

#### *Competing Financial Priorities*

In some instances, patients did not receive needed health care because the money they had was needed to pay for food and clothing. This is an example of competing priorities, to which low-income people are particularly vulnerable (Gelberg et al., 1997; Gelberg et al., 1996). Not surprisingly, among this low-income sample of patients, financial barriers to care were not only experienced by the uninsured. Adult patients in this sample had higher rates than pediatric patients for experiencing competing priorities. Patients not only went without medical care to pay for their basic needs, but over one tenth of adults gave up basic needs to obtain medical care.

#### *Delayed Care*

Delays in receipt of necessary medical care may lead to the development of further complications and increased severity of disease, which may in turn lead to higher costs for medical care: to the patient, the system, or both. Patients in this study appear to have experienced considerable delays in their receipt of health care attributable to both mutable and non-mutable causes. Inability to take time off work and transportation continued to be significant causes of delayed care, as was also evident in PAS I.

#### *Transportation*

A lack of transportation, and long distances to travel from home to medical facilities have previously been demonstrated to act as significant barriers to health care (Berk et al., 1995). In this sample, two-thirds of adult and pediatric patients used private transportation to get to their medical appointment although there was some subgroup variation. Reliance on private transportation may be at risk if the cost of gasoline is high, while some people who rely on public transportation may find the services not to be convenient, or they may be affected by changes in bus routes, construction and work stoppages. At some County facilities vans were

available to transport patients between different locations, but this service has been considerably decreased.

A relatively small proportion of the sample reported spending an hour or more traveling to their medical appointment. However, these findings may have changed with the closure of health centers throughout the County leading to fewer locations at which to receive medical care and longer distances to travel.

### *Language Access to Care*

Language can form a significant barrier to receipt of necessary health care, from the point of making an appointment to registering and interacting with the health care provider. Lack of language congruence can lead to unmet needs or even inappropriate medical care. Findings from the Access Project show that uninsured respondents with limited English proficiency (LEP) who have access to an interpreter have strikingly better experiences in a wide range of areas, including ability to understand medication instructions, ability to get financial assistance to pay for care, and overall satisfaction with their health care encounter, compared to those who did not have an interpreter.

In this study Latinos were the predominant racial/ethnic group to indicate that they had wanted interpreters during the preceding year. For the 25% of Latino adult patients who wanted one, only half indicated that an interpreter was always or usually available to them. Even then, for those patients who had an interpreter 15% had relied on friends or relatives, and 39% of these were under age 18. Having an interpreter did not guarantee that patients would be willing to speak about all of their health concerns. Almost two-fifths of adult patients reported feeling uncomfortable discussing their medical problems with the physician due to the presence of the interpreter.

The variation by facility type in rates of wanting an interpreter was interesting. Adult and pediatric patients at P/PPs were the least likely to have wanted an interpreter, although there was no significant difference in the availability of interpreters by facility type. As P/PPs had a higher rate of immigrant patients, this may reflect a greater capacity for Spanish speaking patients at P/PPs than other types of facilities. Note that since this survey was only administered in English and Spanish, we are unable to assess the need for interpreter services of patients speaking other languages.

Additional analyses that could further inform LAC-DHS about the impact of interpreter services within this system would include focusing on those patients who indicated Spanish to be their primary language and to stratify receipt of medical care, including preventive health care services by access to an interpreter. Further analyses should look at those patients who reported discomfort discussing medical issues with an interpreter present, and the person who served as the interpreter.

### **Ratings of Care**

Approximately one-quarter of adult patients and the parent/guardian of pediatric patients reported that at some time they were so unhappy with the services at a County facility that they had wanted to complain, which 33% of adult patients and 21% of parents did, although there was racial/ethnic variation with White adult patients the most likely and Latino adult patients the least likely to have complained. Over three-quarters of patients or parents had complained to clinic

staff or to the clinic supervisor, only a small proportion had used the telephone complaint number (5% of adults and 12% of parents). This may reflect a greater degree of comfort speaking with clinic staff, and/or a lack of knowledge about the telephone complaint number.

On a scale of 0 to 10, where 10 is the highest rating the rating for specialty care was 8.8 for adult patients and 8.3 for pediatric patients with apparent variation by facility type and SPA. The mean rating of the doctor or nurse seen at the current visit was 8.8 for adult patients and 8.9 for pediatric patients, again with apparent variation by facility type and SPA. Finally, the overall rating of satisfaction from adult patients was 8.2 and 8.4 among pediatric patients with apparent variation by facility type and SPA. However, the variation by SPA may be a reflection of the distribution of types of LAC-DHS facilities throughout the County.

These ratings are not dissimilar to those from PAS I and reported in the National CAHPS Benchmark Data. It appears that patients in the LAC-DHS have comparable levels of satisfaction to patients in Medicaid managed care plans, and somewhat higher than patients in commercial managed care plans.

### **Health Behaviors**

Regular physical activity and nutritious eating habits are known to reduce the risk for many chronic medical conditions among adults and children, including obesity, diabetes, hypertension, and heart disease. However, an increasing number and proportion of adults and children in this country are inactive and overweight or obese

#### *Physical Activity*

Only one third of adults reported engaging in vigorous exercise for at least 10 minutes at least once each week, although three-quarters of patients indicated that they walked for at least ten minutes at least once in a usual week. Of those 75% of patients almost half walked for more than 45 minutes at a time. These findings indicate that patients are not as active as they should be to reduce their risk for chronic conditions. While it is true that this is a population of patients in care, many of the conditions they suffer from could potentially be alleviated to some degree or better controlled through regular physical activity and a balanced diet that could lead to necessary weight loss. Physicians, nurses and other health care providers need to spend time with patients advocating regular physical activity. At a societal level adequate facilities need to be available, including neighborhoods that are safe to walk around during the day and at night.

Children and adolescents appear to be spending a large proportion of time watching television or using the computer. While there are educational programs on television and available for the computer, children are increasingly inactive. This inactivity may put them at elevated risk for becoming overweight with a resultant risk for obesity related conditions as previously mentioned – diabetes, hypertension, and cardiovascular disease. Further emphasis needs to be made by health care providers, as well as by educators to increase the level of physical activity among children and adolescents.

#### *Body Mass Index*

Obesity is at epidemic proportions in this country among both children and adults, giving rise to an increased risk for chronic medical conditions such as diabetes, hypertension and heart disease.

Risk for obesity is based on lack of physical activity and excess caloric intake or a lack of appropriate nutritional balance in food consumption.

Over two thirds of adults in this study were either overweight or obese. This finding is somewhat higher than rates in the national or state population. Only a small portion of patients reported being told by their health care provider that they were overweight, and an even smaller proportion had received assistance or counseling from someone in a doctor's office to help them lose weight. Additional analyses could focus on those adults that are overweight and obese to assess their receipt of counseling from a physician about their weight and weight loss assistance. Approximately 43% of the children surveyed (age 12 to 17) were overweight, while 19% were at risk for being overweight.

It is also important that healthful eating and physical activity are supported and facilitated at the community level, and if necessary with the assistance of local and State legislation. There are currently some work-based programs in place to increase the level of physical activity among adults in Los Angeles County, but there should be an even bigger push. The health care dollars that are spent on conditions associated with obesity are increasing for adults as well as children.

#### *Consumption of fruits and vegetables*

Participants reported eating a mean of only 2.2 servings of fruits and vegetables on the day preceding the interview, while the mean number of daily servings of fruits and vegetables that patients thought they should eat was 3.8. These levels are both well below the suggested goal of five or more servings of fruits or vegetables in a day for a health and balanced diet. The cost and availability of fresh fruits and vegetables may be contributing to the paucity of fresh produce in people's diets. Studies have indicated that when people have ready access to markets, and when the stores carry reasonably priced produce and other healthful food options that people are more likely to purchase these items and to prepare them for their families.

Coordination with neighborhood planning and development organizations to attract and bring in large chain supermarkets and farmer's markets would provide people with healthier food options than are currently available in many parts of Los Angeles County. In addition, restaurants with healthy food options are often more difficult than fast food options (high calorie/high fat) to find in some areas.

#### *Smoking*

Cigarette smoking is closely associated with multiple acute and chronic medical conditions. Studies have demonstrated that counseling by a physician to stop smoking is one of the most effective interventions.

Smoking rates among patients in PAS II were lower than expected with over four-fifths of patients reporting that they had never smoked. This is a change from PAS I, and the reason for the apparent decline in smoking rates is not readily evident. Nevertheless, among those patients who smoked daily or only on some days, less than half had been advised by a physician in the past year to stop smoking, while only one-third of patients had been counseled about smoking cessation at the current appointment.

## **Preventive Health Care**

Age and sex specific preventive services are recommended for the general adult and pediatric populations, as well as condition specific screening and preventive services. Items were included in the PAS survey to measure receipt of preventive health care services by adults and children for two reasons: 1) to act as a baseline measurement of preventive health care services provided through the LAC-DHS, and 2) to compare the receipt of services to other patient populations. A very important opportunity to consider is the use the information that was collected in this survey to develop and implement interventions to improve the receipt of health care. The effects of these interventions can then be measured and the effectiveness of the intervention assessed over time. For example, the rates for receipt of these services could be re-measured in 1-2 years after an educational intervention for providers and patients had been developed and implemented.

### *Physician Health Screening Behaviors*

We assessed physician screening behaviors for alcohol, smoking, recreational drug use, sexual activity and gender of sexual partners, and risk for domestic or intimate partner violence. Rates of screening varied widely from asking about cigarette smoking (73%) and alcohol use (70%), to sexual activity (39%), gender of sexual partners (15%) and risk for violence (13%).

These are all behaviors or experiences that may contribute to health status. Some of these personal behaviors are modifiable such as smoking, alcohol and drug use and physicians should take the opportunity to counsel patients about the health risks associated with them. Sexual activity can be a risk to health through the transmission of sexually transmitted diseases, survival sex, or unintended pregnancy. Clinicians should be asking all patients about their sexual activity to determine those at elevated risk.

Domestic or intimate partner violence is far more prevalent than many health care providers think. Additionally it is not limited to low-income individuals, but the concomitant health risks of being poor may do so. County services are available, although many hesitate to use them out of fear for themselves or a child.

### *Women's preventive care: Cervical & Breast Cancer Screening*

Studies in the literature have shown that women with poor health and chronic medical conditions are at increased risk for not receiving age-appropriate preventive health services including Pap smears and mammograms (Kiefe et al., 1998). In addition, low-income, minority women have been shown to be at greatest risk for morbidity and mortality due to breast and cervical cancer. The reliability of patient self-report for the receipt of cervical cancer screening has been validated in the literature (Bowman JM, 1991).

Women's receipt of preventive services including Pap smears (88% within 3 years – 85% in PAS I) and mammograms for women  $\geq 50$  years of age (79% within 2 years – 78% in PAS I) were above the goals reported in Healthy People 2000 (85% and 60% respectively). Only 5% of women had never had a Pap smear; and 8% of women  $\geq 50$  years of age had never had a mammogram. We did find that there was significant variation between the four different types of facilities and the eight different SPAs.

In this sample, women of color were more likely than White women to have undergone screening for cervical cancer (i.e., Pap smear within 3 years) and breast cancer (i.e., mammogram within 2 years for women age  $\geq 50$ ). These findings vary from those of previous studies (Vernon et al., 1985; Mandelblatt et al., 1995; Pamuk et al., 1998; O'Malley et al., 1997) and may be due to the existence of multiple programs in LA County through which un- and under-insured women receive these services. Studies in the literature have described how women with poor health and chronic medical conditions are at increased risk for not receiving age-appropriate preventive health services including Pap smears and mammograms (Kiefe et al., 1998). We plan to assess this effect in future analyses.

### *Influenza Prevention*

One fifth of adults had received a flu shot during the appropriate season, however, more important analyses will focus on receipt of a flu shot among those patient populations that are at increased risk for morbidity and mortality related to influenza. Specifically, rates of flu shots among adults 65 years of age and older, patients with diabetes, and patients with asthma should be assessed.

### *Colorectal Cancer Screening*

Colorectal cancer (CRC) is a readily diagnosable condition, with considerable treatment options and good outcomes for those patients diagnosed at an early stage. Unfortunately, only about one third of adults undergo regular screening for CRC. Screening may take the form of a flexible sigmoidoscopy every 5 to 7 years, a colonoscopy every 10 years, or a barium enema in conjunction with a flexible sigmoidoscopy and annual fecal occult blood testing (FOBT).

Rates for CRC screening among the adults age 50 years and older was lower than national averages, and lower than other patient populations. These low rates may easily be explained for flexible sigmoidoscopy and colonoscopy, which are only performed for diagnostic purposes with in the LAC-DHS system. However, annual FOBT is inexpensive, and significantly underused in this population.

### *Pediatric Immunizations*

Immunizations protect children from serious infectious diseases and are considered an important marker of the adequacy of preventive care. Incomplete immunization levels may also indicate an adequate number of well-child visits. The goal of Healthy People 2000 is for 90% of children to have completed the recommended immunization series of 12 vaccines by age 2.

The majority of children were receiving their immunizations at the facility where the interview took place, while less than one-quarter reported going to other primary care sites. Only 7% reported using public health facilities. Based on the results it appears that some review is taking place on the part of health care providers to assess whether children are up to date on their immunizations, although only 11% of parents reported always being told when to bring their child in for immunizations. The explanation for this may be that health care providers are not explicitly telling parents when to bring their children back, but are scheduling return visits at the appropriate time. One fifth of children had received an immunization at their current visit. Due to the complications of collecting the immunizations and date they were received in PAS I, this aspect of the study was not repeated.

Parents should be encouraged to have immunization records for their children, and to bring them to all medical appointments. To achieve the goal of Healthy People 2010, there should be continued strengthening and expansion of existing public health outreach programs. In this way, parents can be informed of the available County facilities in their communities that offer affordable and accessible immunization programs, especially in areas with more limited services.

### **Health status and Quality of Life**

Only 15% of patients reported their health status as excellent or very good while 24% reported fair or poor health. Comparison with published SF-12 scores indicate that patients in this sample have overall worse physical and mental health status (Lundberg et al., 1999; Sugar et al., 1998; Ware, et al., 1995; Wu et al., 1997). The findings in this study indicate that adult patients who reported poor health were more likely to have made a visit for medical care, although many people in poor health still reported considerable barriers to receipt of needed health care.

The intersection of poverty and lack of health insurance puts both adults and children at risk for poor health. In an ideal world social services would include health insurance as well as ensuring access to necessary and appropriate health care, safe housing, adequate and nutritional food as a start. Integration of services within the County might lower the risk for poor health that many low-income and uninsured individuals face.

### **Quality and Process of Care**

#### *Quality of Care for Diabetes- Adult*

Diabetes is a major cause of morbidity and mortality; and medical care for diabetes accounts for almost 15% of national health care expenses (Javitt et al., 1995). Diabetes is known to be more prevalent among Latino/Hispanics than among Whites (Cowie et al., 1997). The development of standardized quality of care indicators for diabetes includes a focus on ophthalmologic/retinal care, foot care, blood pressure control, glycemic control, and cholesterol (Beckles et al., 1998; DCCT 1993). We found that patients in this sample received comparable quality care for diabetes with patients in other sample populations (Mayfield et al., Brechner et al., 1993; Beckles et al., 1998). Nationally as well as locally, compliance with quality of care indicators for diabetes is lower than optimal, and should be the focus of patient and provider education.

We did not find racial/ethnic variation in the prevalence of diabetes in this sample of patients in care. However, there was variation by facility type. A majority of patients with diabetes were using one or more types of medication, although Whites were the most likely to be using an oral medication and African Americans were the most likely to be using insulin. Additional analyses might study the type behavioral and pharmacologic treatment that patients with diabetes are receiving based on their BMI.

Patients with diabetes within the LAC-DHS system appear to be receiving diabetes related care at rates similar to that provided in other health care settings. For example, data from the National Committee for Quality Assurance (NCQA) are reported as the mean percent of quality indicators performed across plans surveyed in their 2001 review (*The Health Plan Employer Data and Information Set - HEDIS*). An average of 48% of patients with diabetes received a dilated eye exam in the past year and 76% of patients with diabetes had a blood cholesterol test in the past year according to HEDIS.

### *Patterns of Care for Hypertension - Adult*

Hypertension is a major cause of morbidity and mortality among adults, especially African American. Complications resulting from poorly controlled hypertension include heart disease, stroke, kidney failure and blindness. The prevalence of hypertension in this sample was higher than that of national samples of patients in care. This emphasizes the need for appropriate care among low-income adults who are at increased risk for not receiving regular care and worse health status (Townsend et al., 1982). However, the apparent decline in the prevalence of hypertension is probably a reflection of the changes in the sampling frame from PAS I to PAS II.

### *Quality of Care for Asthma*

#### Adult

The National Institutes of Health Guidelines for the Diagnosis and Management of Asthma has two major goals: 1) to prevent recurrent exacerbations of asthma and 2) to minimize the need for emergency department visits or hospitalizations. Current NIH guidelines recommend that patients with persistent asthma, mild ( $\geq 2$  isolated episodes of wheezing per week), moderate (daily symptoms) or severe (continual symptoms), receive daily long-term medications for disease control (e.g., inhaled steroids). Inhaled steroids are not used for acute exacerbations but rather inhaled short-acting beta2-agonists (e.g., albuterol, etc.) are the medications of choice and are classified as “rescue medications”. Systemic steroids (e.g., prednisone, prednisolone, etc.) are used as rescue medication only when the exacerbation is moderate to severe. One of the limitations in interpreting the use of medication in our sample is that we did not have clinical parameters (e.g., spirometry or peak flow meters) to rate the severity of asthma, although we did have items that measured severity and frequency of symptoms.

Among adults Whites were the most likely and Latinos were the least likely to have asthma or reactive airway disease. This may be explained by the variation in smoking rates in this sample, as well as nationally, or that some of the Latinos in this sample had not had prior access to health care services. Without access to health care, one cannot be diagnosed.

Over half of adults were using a beta agonist, but only 15% were using an inhaled steroid. Based on the proportion of patients who had persistent symptoms of asthma (22% everyday and 19% a few days a week), these patients appear to be under treated. This may be a reflection of one or more of the following: lack of knowledge on the part of providers, availability of medications and patient adherence. Adults at CHCs were the most likely to have received asthma related education. If there are standardized education programs or curriculum on asthma for providers and/or patients at these sites, they might be distributed to other facilities.

#### Pediatric

According to the 1998 National Health Interview Survey (NHIS), 8.7 million (12%) U.S. children under the age of 18 have been diagnosed with asthma. Nationally, African American (16%) children were more likely than White (12%) or Hispanic children (10%) to have ever been diagnosed. In this LAC-DHS sample of children in care, 24% African American children and 9% of Latino children had asthma. African Americans in PAS I also had the highest prevalence.

Significant progress in medical outpatient management has occurred and hospitalization can frequently be avoided (Lieu et al., 1997). As a result, hospitalization for asthma is a potential marker of the adequacy of primary care as high rates may indicate inadequate outpatient

management and/or an increase in the severity of illness. The Healthy People 2010 goal for pediatric asthma is for no more than 1.73 asthma hospitalizations per 1,000 for children 0-18 (Healthy People 2010).

The majority of pediatric patients were using only a beta-agonist inhaler, with only 6% using an inhaled steroid, while 25% of children had been on a course of oral steroids at least once during the preceding year. These findings may indicate inadequate or inappropriate asthma care due to poor patient (and parent) education, and a lack of understanding about the appropriate use of steroid inhalers (they are not to be used as “rescue medications” but rather for long-term prevention/control purposes). In addition, these findings may reflect physician’s lack of knowledge regarding the use of inhaled steroids as the standard of care of pediatric patients with persistent asthma and patients’ inability to obtain the medication due to financial and other barriers. Furthermore, over one-third of pediatric patients with asthma had made a visit to an ED during the past year, with a mean of just over one visit per year.

Health care providers are educating parents and patients at rates of 43% to 73%, although only one-quarter of children with asthma had received an influenza injection during the flu season.

#### *Mental Health - Patterns of Care for Depression*

Depression is under-diagnosed in this country among all populations of patients. It has potentially life-altering effects on quality of life and performance of daily activities, and may have a disproportionate affect on low-income uninsured patients because of limited access to mental health care. The lack of receipt of mental health services may be an indication of the barriers to receipt of needed care in LA County as well as other individual and societal perceptions that act as barriers to care. The very high rates of depressive symptoms in this patient population seem to indicate a need for the expansion of mental health services throughout LA County.

#### **Food Security**

Low-income individuals are at particular risk for not having adequate nutritional resources, mainly to do inadequate financial resources. Even with access to food in general, people may be limited in their ability to obtain healthy and nutritious food options, and may consume whatever food is available in lieu of going hungry. Lack of access to food may have particular implications for people with chronic medical conditions as well as growing children. Significant proportions of both adults and children in this sample were at ongoing risk for not being able to obtain adequate food. In fact, pediatric patients appear to be at higher risk than adult patients for not having access to adequate food, including nutritional options. Adult and pediatric patients appeared to be using food kitchens at similar rates.

#### *Limitations*

As in all surveys based on interviews our results were subject to self-report bias. Specifically since patient self-reports of service utilization were vulnerable to reporting errors, reliance on this approach is susceptible to mistakes in the screening procedure, including both false negatives and false positives, and reporting errors about the sites where care was received; such errors can lead to biased results in comparisons. However, we tried to reduce the potential for these errors by having interviewers who were fluent in two languages; by constructing lists

including the names and addresses of all LAC-DHS facilities; and by designating specific time periods during which care could have been received.

#### *Lessons learned in the performance of this study*

An early concern in the development of this study as it was for PAS I, was the reliance on patient volume information, the validity of which was questionable. The composition of the final patient sample in this study, including stratification by type of facility, indicate that the initial estimates of patient volumes at the facilities and within each of the sessions did not vary greatly from the original profiles. However, this was aided by statistical weighting techniques that were used to adjust for non-responders (non-response weights) and variation in volume within and between facility types (sampling rates). More reliable information at the outset of the project would allow for greater confidence in interpreting the differences among and between facilities.

A post-project survey of the interviewers who had participated in the PAS study revealed that almost all of the interviewers had enjoyed their participating in the project and that they felt that the questions that were being answered were important in assessing the health care provided through the LAC-DHS. Many interviewers suggested that the administrators and staff at the sites needed to pay better attention to the interview schedule. This last comment was due to the fact that although the interview schedules were faxed and mailed to the clinics at least a week in advance (more commonly 2-4 weeks in advance), and that multiple follow-up calls were made to each of the clinics reminding staff of an upcoming visit, problems still arose such as when a group of interviewers arrived at a usually very busy clinic to find that the session had been canceled more than a week previously, or when on multiple occasions a nurse refused to allow the interviewers to start interviewing at the beginning of a session because the clinic administrator had not apprised the staff of the visit. Many of these problems were anticipated, and methods put into place to alleviate their affect; nevertheless, improved communication and cooperation of the facilities would make the performance and outcomes of this study even more successful and useful.

#### **Conclusions**

On the whole the results of this survey indicate that patients LAC-DHS primary care clinics receive care that is appropriate according to national guidelines and comparable to other patient populations. The continuation of the Public Private Partnership Program (P/PP) appear to have increased patients access to and use of necessary and appropriate health care. We draw this conclusion based on patients' reports about where they receive their medical care; the comparisons of care provided by the different facilities; and the levels of patient reported satisfaction. However, there still appear to be areas in the provision and receipt of health care by patients through the LAC-DHS that can be greatly improved. This study provides important information for the development and implementation of programs that provide health care to vulnerable populations, as well as developing ongoing processes of data collection and evaluation to assess the impact and effectiveness of the programs.

#### **Acknowledgments**

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## PATIENT ASSESSMENT SURVEY II

### Fact Sheet: Describing the Population

**Key findings:** Patients receiving primary care services from LAC-DHS facilities:

- ◆ are racially and ethnically diverse
- ◆ are primarily Spanish speakers
- ◆ are low-income
- ◆ are primarily unemployed
- ◆ have good access to telephones
- ◆ have very low rates of health insurance
- ◆ report poor health status

#### **Background**

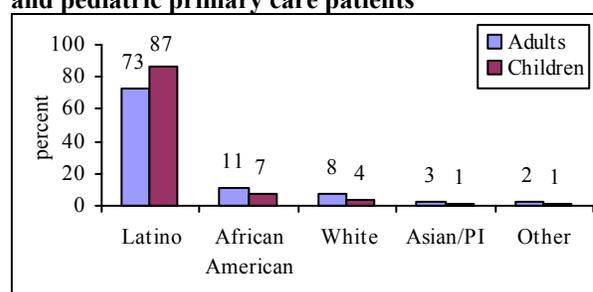
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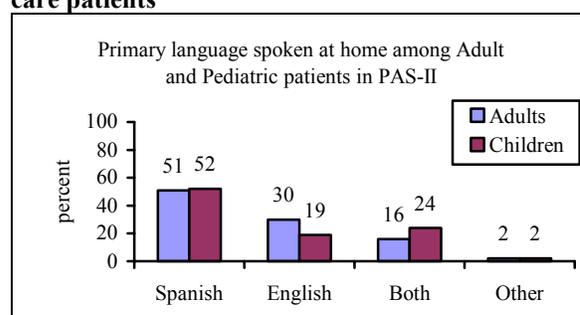
**Findings:** The majority of patients at LAC-DHS sites, including P/PP clinics, identified themselves as Latino (**Figure 1**), with a higher proportion of children who were Latino than adults. Just over two-thirds (68%) of adult patients were female, as were just over half (55%) of pediatric patients. Sixty-six percent of adult patients were non-US born, as were 25% of pediatric patients.

**Figure 1: Race/Ethnicity among LAC-DHS adult and pediatric primary care patients**



Half of patients reported Spanish as the primary language at home (**Figure 2**) while almost one-third of adults and almost one-fifth of children spoke primarily English.

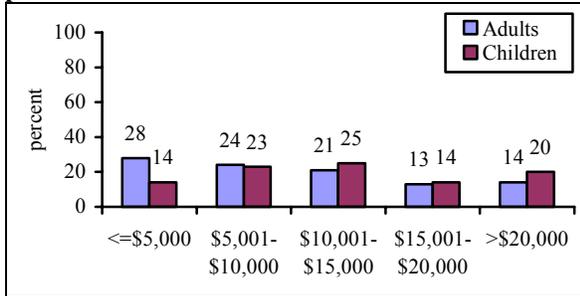
**Figure 2: Primary language spoken at home among LAC-DHS adult and pediatric primary care patients**



Less than half of adults (44%) had graduated from high school. Over one-half of adults and just under two-fifths of children had an annual household income of \$10,000 or less (**Figure 3**). Among adult patients only 18% had at least one full-time job, 15% had one

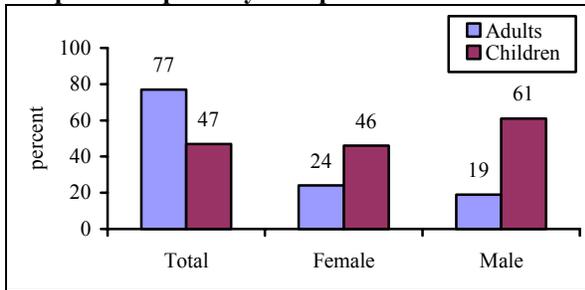
part-time job, 2% had two or more part-time jobs, and 65% were not employed.

**Figure 3: Gross annual household income among LAC-DHS adult and pediatric primary care patients**



Less than one-quarter (23%) of adults were insured at the time of the study, and just over one-half (53%) of children (Figure 4).

**Figure 4: The uninsured among LAC-DHS adult and pediatric primary care patients**

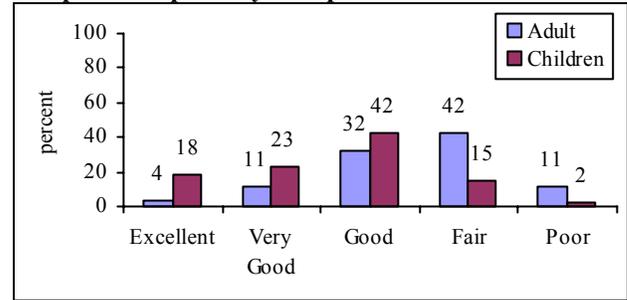


Four-fifths of adult patients lived in their own home or apartment; 15% were living in a temporary situation with family or friends; and 5% were living in another setting (e.g., motel/hotel, shelter, or on the street). Of note, 96% of adult respondents reported that they were able to stay in their current residential situation for the next 30 days.

The ability to make and receive phone calls is important in facilitating access to health care in terms of patients being able to contact clinics to make appointments, and to receive confirmation of appointments and changes in scheduling. The majority of adults and children (≥94%) have access to a telephone to both make and receive phone calls.

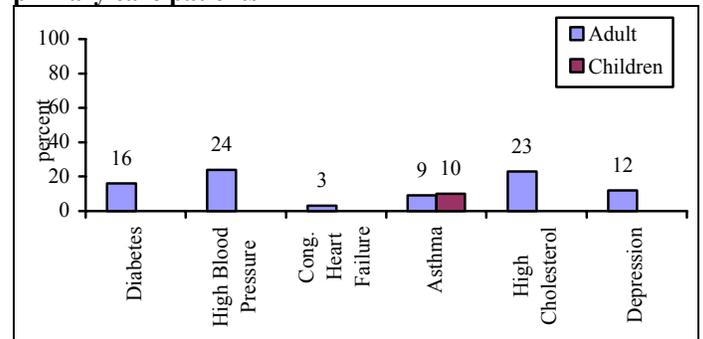
Adult patients had high rates of fair or poor health status (Figure 5).

**Figure 5: Health status among LAC-DHS adult and pediatric primary care patients**



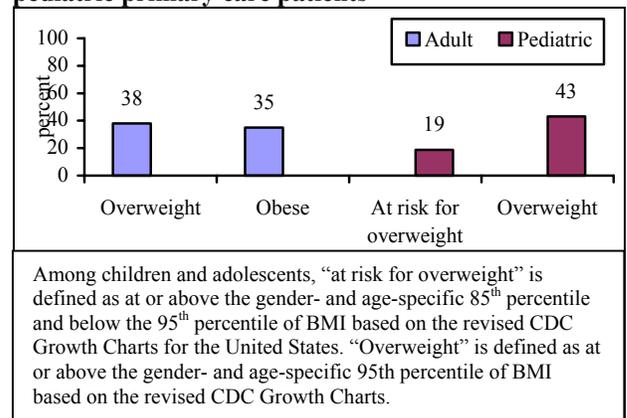
The rates of common medical conditions were comparable to other populations of patients in care (Figure 6).

**Figure 6: Prevalence of common chronic medical conditions among LAC-DHS adult and pediatric primary care patients**



Almost three-quarters of adult and two-thirds of pediatric patients had an elevated body mass index (BMI).

**Figure 7: Overweight and obese adult and pediatric primary care patients**



## PATIENT ASSESSMENT SURVEY II

### Fact Sheet: Patient Satisfaction

#### Key Findings:

- ◆ Overall, patients receiving medical care at primary care clinics through the LAC-DHS reported relatively high ratings.
- ◆ A majority of patients would choose to continue receiving care from LAC-DHS
- ◆ A majority of patients would recommend LAC-DHS services to family and friends.

#### Interactions with Staff and Physicians

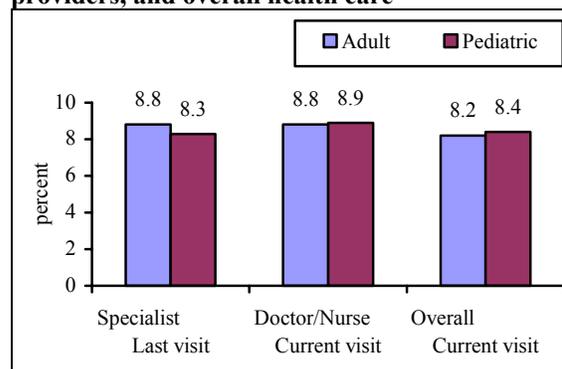
Patients and the parents of pediatric patients reported on their interactions with the clinic staff and health care providers on the day of the interview. The findings indicate that a large majority of adult patients and the parents of pediatric patients felt their needs and/or expectations were met completely (*Exhibit 1*). Of note, adult patients and parents were least likely to report that they felt providers had spent enough time with them or their child.

**Exhibit 1: Interactions with staff and physicians**

	Adult %	Pediatric %
Patients were treated with courtesy and respect by the office staff.	86	87
Office staff were as helpful as the patient thought they should be	85	83
Health care providers listened carefully to them.	88	88
Health care providers explained things in a way that they could understand.	88	90
Health care providers showed respect for what they had to say.	88	89
Health care providers spent enough time with them.	77	76

Patients and parents rated the specialist they had seen most recently, the doctor who saw them at the current visit and their overall impression of the medical care at their current visit (*Exhibit 2*).

**Exhibit 2: Ratings of specialists, primary care providers, and overall health care**



Ratings were on a scale from the lowest 0 to the highest 10.

Adult patients and parents rated the comfort, cleanliness and privacy of the facilities. Ratings did not vary by facility type.

**Exhibit 3: Ratings of comfort, cleanliness and privacy.**

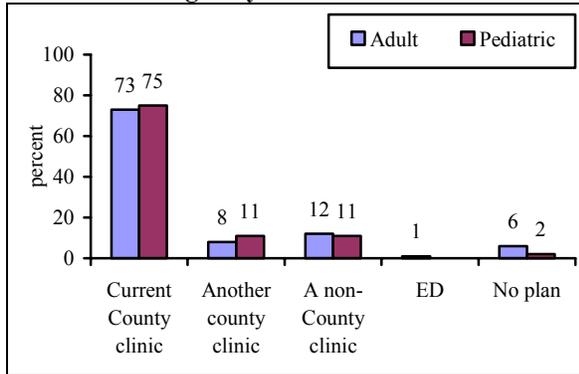
	Adult mean	Pediatric mean
Comfort:		
Waiting Rooms	7.7	8.1
Exam Rooms	8.3	8.5
Cleanliness:		
Waiting Rooms	8.3	8.5
Exam Room	8.8	9.0
Bathrooms	7.7	7.9
Privacy:		
Exam Rooms	8.9	9.2

Ratings were on a scale from the lowest 0 to the highest 10.

The majority of adult patients and the parents of pediatric patients reported they would return to the current facility if they could go anywhere for medical care (*Exhibit 4*). Smaller proportions of patients would choose to go to another County facility, a non-County facility or an ED. However, 6%

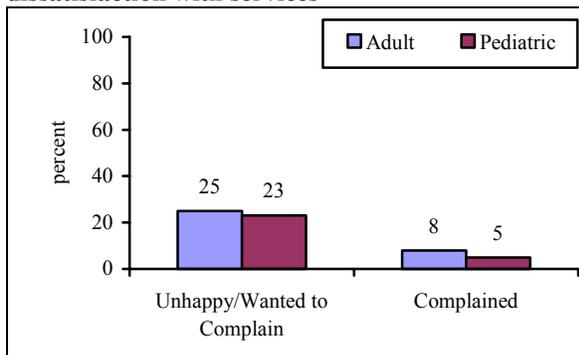
of adult patients and 2% of parents did not have a plan for where they would seek medical care if given the opportunity to go anywhere.

**Exhibit 4: Where patients would seek care if they could choose to go anywhere**



A majority of adult patients (73%) and the parents of pediatric patients (71%) indicated that they would be very likely to recommend the clinic they were visiting on the day of the interview to a friend or relative who needed medical care.

**Exhibit 5: Desire to report and reporting dissatisfaction with services**



One quarter of adult patients and a slightly smaller proportion of the parents of pediatric patients reported at some time being so unhappy with the services at a County facility that s/he wanted to complain (Exhibit 5). Overall 8% of adult patients and 5% of parents were unhappy with services and complained.

Among those patients and parents who had complained, the majority had complained to clinic staff (50% and 55%), while 41% and 21% of adult patients and parents respectively, complained to the clinic supervisor, 5% and 12% called the toll-free complaint number, 2% and 7% contacted the board of supervisors or health deputies, 2% and 6% wrote a letter, and 1% used some other method.

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## PATIENT ASSESSMENT SURVEY II

### *Fact Sheet: Quality And Processes of Care for Common Medical Conditions*

#### **Key Findings:**

- ◆ Comparable rates of diabetes care – although not optimal.
- ◆ Over one-quarter of adult patients had ever been diagnosed with depression.
- ◆ Most patients with high blood pressure were treated.
- ◆ Adults and children were counseled about asthma.
- ◆ Unmet need for medication among adult patients with chronic medical conditions.

#### **Diabetes**

Sixteen percent of adult patients had diabetes. Diabetes is an increasing health problem that currently affects approximately 17 million adults and children. Quality of care guidelines focus on optimizing blood sugar control and reducing the risk for diabetes related complications. Eighty-two percent of patients with diabetes were using some type of medication, although only 26% of these patients were using insulin.

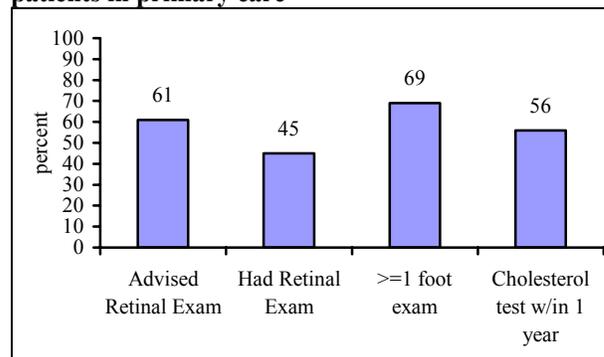
Complications for diabetes include blindness, kidney failure, amputation due to non-healing ulcers and heart disease. To reduce the risk for these conditions people with diabetes should undergo regular screening tests.

Three-fifths of patients with diabetes had been advised to have a dilated eye exam, but overall less than half of patients had done so (*Figure 1*). Less than three-quarters of patients with diabetes had received at least one foot-exam during the preceding year.

In the past 12 months, adult patients with diabetes had received counseling about: the need to take their medications and taking them properly (83%), diet and nutrition (85%), the need for good blood sugar

control (73%), and performing regular foot exams (65%).

**Figure 1: Diabetes care among LAC-DHS adult patients in primary care**

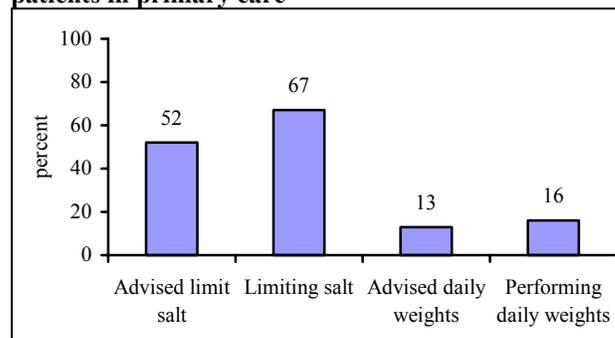


#### *High Blood Pressure*

Almost one-quarter (24%) of adult patients had high blood pressure. Few patients with diagnosed hypertension were untreated (11%), and most patients were using medication (72%). Among those patients with hypertension who were taking medication, in the past year 84% always had their medication. Patients who did not always have their medication did not have insurance (28%), and reported that medications were too expensive (25%).

#### *Congestive Heart Failure*

**Figure 2: CHF care among LAC-DHS adult patients in primary care**



Only 3% of adult patients had congestive heart failure (CHF). Two-fifths (40%) of patients were taking a diuretic (i.e., water pill) and 86% always had their medication for CHF. The quality indicators centered on patient education activities: limiting salt intake and weighing oneself daily (*Figure 2*)

*High Cholesterol*

Almost one-quarter (23%) of adult patients had a diagnosis of high cholesterol. Almost two-thirds (64%) of patients had modified their diet and increased their level of physical activity, and 44% were taking a cholesterol lowering medication.

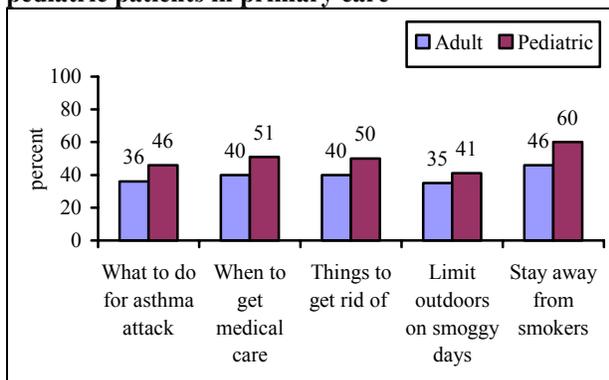
*Asthma – Adult & Pediatric*

Almost one-tenth (9%) of adult patients had asthma. Among adult patients with asthma over half (51%) were using beta-agonists and only 15% were using inhaled steroids. Only 13% of adults were using a spacer or facemask with their medication.

One-tenth of pediatric patients had asthma. Among pediatric patients with asthma just under one-half (49%) were using a beta agonist and 59% were using a spacer or facemask with their medication.

Both adult and pediatric patients with asthma had been counseled about treating asthma and reducing symptoms (*Figure 3*).

**Figure 3: Counseling for asthma among adult and pediatric patients in primary care**



*Mental Health Care – Depression*

Just over one-quarter (28%) of adult patients had ever been told by a physician that they had depression. Two-thirds (66%) of patients with a history of depression had been advised to go for counseling, although only one-half (51%) reported they had received enough counseling. Over three-quarters (77%) of adult patients had been treated with a prescription medication; however, 21% of patients were not able to get their depression medication during the past year.

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## PATIENT ASSESSMENT SURVEY II

### *Fact Sheet: Access to Health Care*

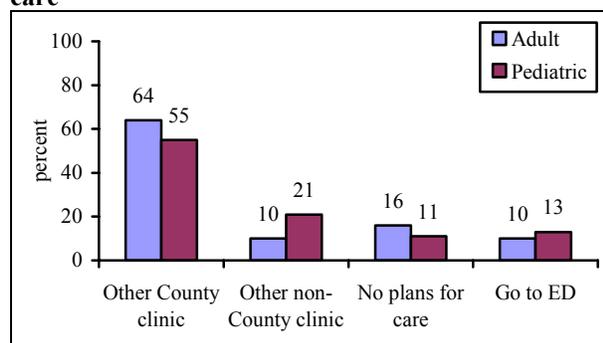
#### ***Key Findings:***

- ◆ If LAC-DHS clinics closed:
  - ◆ a majority of patients would continue to rely on County facilities.
  - ◆ 10% of adult and 13% of pediatric patients would go to an Emergency Department (ED).
- ◆ Only 23% of adult and 53% of pediatric patients had insurance.
- ◆ Almost one-quarter of patients had used ED services in the past year.
- ◆ Over one-third of adults and children would take an appointment with a doctor within 24 hours rather than go to an ED.
- ◆ 10% of adults and 7% of children did not get a medication that was prescribed to them.

#### ***Plans for Medical Care***

At the time of the study, eleven Health Centers were anticipated to close. Patients were asked where they would go for needed medical care if their current clinic were permanently closed. A majority of adult and pediatric patients would continue to seek care within the County system (*Figure 1*).

**Figure 1: Places patients would go if facility was closed and the patient needed medical care among LAC-DHS adult and pediatric patients in primary care**



#### ***Health Insurance***

Less than one-quarter (23%) of adults were insured at the time of the study, as well as just over half (53%) of children. Over half

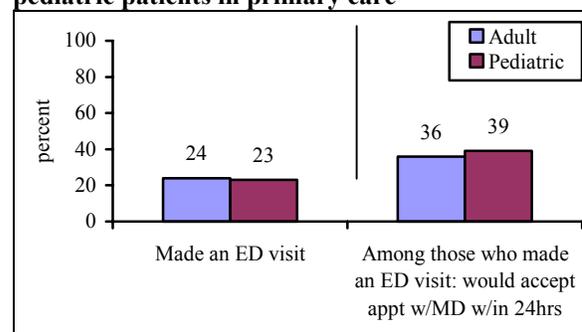
(57%) of adults who were uninsured had never had health insurance (44% of all adults), and only 37% of uninsured adults had ever applied for MediCal. Among the uninsured who had not applied for MediCal, three-fifths did not think they were eligible; just over one-third (37%) were afraid they would have to pay back the cost of the medical care they received; one-quarter do not like to use welfare programs; and 17% were afraid they or someone in their family could be deported. Among non-US born children the primary reason for not applying for MediCal or other government health care programs was parents' fear that it would affect their children's application for citizenship.

#### ***Usual Source of Care***

Just over one-half of adult patients (53%), and almost three-quarters (73%) of children had a usual source of care.

#### ***Emergency Department (ED) Use***

**Figure 2: Emergency department (ED) use within the past 12 months among LAC-DHS adult and pediatric patients in primary care**



Just under one-quarter (24% and 23%) of adult and pediatric patients had sought care at an emergency department during the preceding 12 months (*Figure 2*). Thirty-six percent of adult and 39% of pediatric patients would have been willing to take a scheduled appointment with a doctor within 24 hours rather than visit the ED.

Over one-half of adult and pediatric patients reported that their last visit to an ED was for a situation they considered an emergency (*Figure 3*). Other reasons for ED use included financial and insurance issues as well as convenience.

**Figure 3: Reason for most recent visit to an emergency department (ED) among LAC-DHS adult and pediatric patients in primary care**

	Adult <sup>1</sup> %	Pediatric <sup>1</sup> %
Felt medical problem was an emergency	53	59
Doctor advised patient to go to a hospital ED	19	14
Brought to hospital ED by ambulance/other people	14	4
Close to home or most convenient	12	9
Could not afford care elsewhere/no insurance	11	10
Couldn't get an appointment at a County clinic	7	5
Clinics closed evenings and weekends/only place to get care	6	14
Couldn't get an appointment at patient's local clinic	5	3
Regular doctor/patient's medical records are at that hospital	4	6
Couldn't get an appointment with patient's private physician	3	1
Other reason (s)	3	4

<sup>1</sup>Totals more than 100% because patients could provide more than one response.

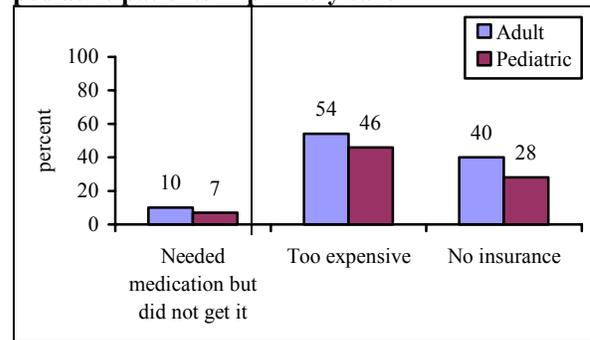
Interpreter Services

One-quarter of adults and 29% of the parents/guardians of pediatric patients had wanted an interpreter during the past year.

Unmet Need for Prescription Medication

Not being able to obtain needed medical care may result in worse health outcomes. Patients were asked if they had needed a prescription medication in the past 12 months but had not been able to obtain it (*Figure 4*). One-tenth of adult and 7% of pediatric patients had not been able to obtain needed medication, mainly for financial reasons.

**Figure 4: Unmet need for prescription medication in the past 12 months among LAC-DHS adult and pediatric patients in primary care**



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# PATIENT ASSESSMENT SURVEY II

## Fact Sheet: Preventive Health Services

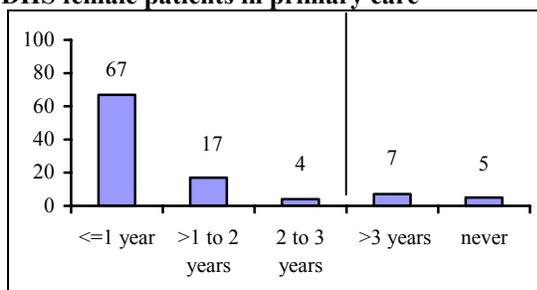
### Key Findings:

- ◆ Comparable rates of cervical and breast cancer screening with other patient populations
- ◆ Low rates of colorectal cancer screening
- ◆ Physicians screened patients for tobacco, alcohol and drug use
- ◆ Only 1/3 of smokers were advised to quit at their current visit

### Cervical Cancer Screening-Pap Smear

Two-thirds of women had undergone cervical cancer screening within one year, and 88% had undergone a Pap smear within 3 years (*Figure 1*).

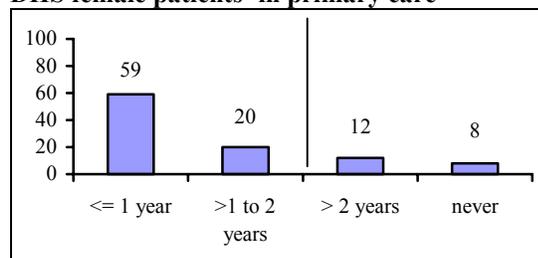
**Figure 1: Receipt of a Pap smear among LAC-DHS female patients in primary care**



### Breast Cancer Screening-Mammogram

Almost three-fifths of women ages 50 years and older had undergone a mammogram within one year, as had an additional 20% within 2 years (*Figure 2*).

**Figure 2: Receipt of a mammogram among LAC-DHS female patients<sup>1</sup> in primary care**



<sup>1</sup>Women ages 50 years and older

Women in LAC-DHS received cancer screening at rates comparable to other patient populations (*Figure 3*).

**Figure 3: Cervical and breast cancer screening among LAC-DHS female patients in primary care: comparisons to other samples**

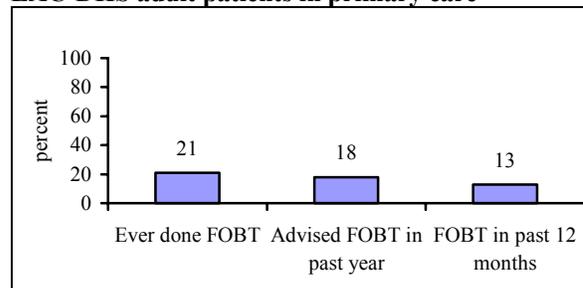
	LAC-DHS	2002 LACHS <sup>3</sup>	State Managed Care	National HMO
	%	%	%	%
Pap smear <sup>1</sup>	88	82	73	72
Mammogram <sup>2</sup>	79	76	74	72

<sup>1</sup> % of women ages 21 to 64 who had a Pap smear within 3 years  
<sup>2</sup> % of women ages 52 to 69 who had a mammogram within 2 years  
<sup>3</sup> Los Angeles County Health Survey (population-based survey)

### Colorectal Cancer Screening

Among patients 50 years of age and older, 29% had ever been advised by a physician to undergo lower gastrointestinal endoscopy (flexible sigmoidoscopy or colonoscopy). Overall, only 22% had ever had either of these procedures. Only one-fifth had ever done a home blood stool test (FOBT: fecal occult blood test). Overall, only 18% of patients reported being advised to do an FOBT in the past 12 months, and overall, only 13% of eligible patients had an FOBT within the preceding 12 months.

**Figure 4: Colorectal cancer screening among LAC-DHS adult patients in primary care**



<sup>1</sup>Adults ages 50 years and older  
 FOBT=Fecal Occult Blood Test

### Cholesterol Screening

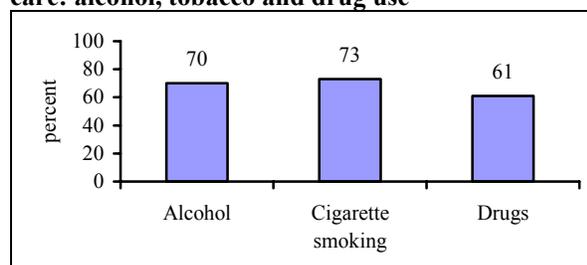
Seventy-one percent of patients had their blood cholesterol level checked within 3 years, 3% more than 3 up to 5 years ago, 3%

more than five years ago, and almost one-quarter of adult patients (23%) had never had their cholesterol checked.

### Physician Assessment of Patient Health Risks

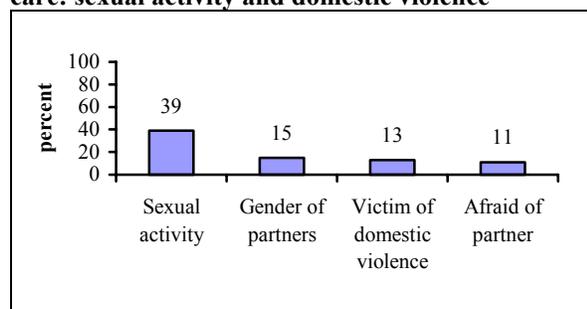
In the past 12 months, almost three-quarters of patients had been asked by a physician whether they used alcohol or smoked cigarettes (Figure 5). Only three-fifths (61%) of patients were asked whether they used recreational drugs.

**Figure 5: Physician assessment of patient health risks among LAC-DHS adult patients in primary care: alcohol, tobacco and drug use**



Less than two-fifths of adult patients had been asked if they were sexually active and overall, only 15% of adult patients had been asked about the gender of their sex partners (Figure 6). In the past 12 months, a doctor had asked less than one-seventh of patients if a spouse or intimate partner had physically harmed them, or if they were afraid of their spouse or intimate partner.

**Figure 6: Physician assessment of patient health risks among LAC-DHS adult patients in primary care: sexual activity and domestic violence**

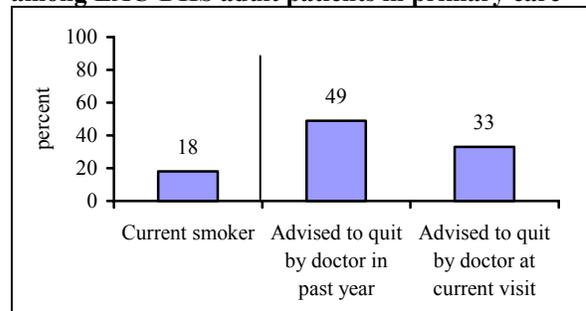


### Cigarette Smoking

Just under one-fifth (18%) of patients smoked every day or some days. Less than

one-half (49%) of these had been advised during the prior year to stop smoking, and only one-third had been counseled at the current visit.

**Figure 7: Cigarette smoking and cessation advice among LAC-DHS adult patients in primary care**



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