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NOTES OF COMMUNITY HEALTH CARE ROUNDTABLE

Thursday, November 17, 2005

FOCUS:

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The purpose of our Community Health Care Roundtables and of our health care projects is to increase health care access that is appropriate medically, geographically, linguistically, and culturally and to improve public health. Funding for Fresno Metro Ministry's health, air quality, and hunger/nutrition programs is provided by individual donors, congregations, Vitamin Cases Consumer Settlement, The California Wellness Foundation, The California Health Care Foundation, Hewlett Foundation, The Kirsch Foundation, Kaiser Permanente, MAZON: A Jewish Response to Hunger, Roundtable Sponsors (Health Net, Kaiser Permanente, Children's Hospital Central California), Event and Activity Sponsors, and others. Thank You!

Jose Gutierrez, RN, Interim Division Manager, Fresno County Jail Medical Services – The Achievements and Challenges of Providing Jail Medical Services

Jail Medical Services are provided to adult inmates 24 hours a day 7 days a week

Good morning everyone. I've been working at the Fresno County Jail Medical Services for approximately 20 years. The Jail Medical and Psychiatric Services provide care for all of the inmates in the adult detention facilities. Probably most people do not know, but we actually have four facilities within the downtown area. We have the main jail, the north annex jail, the south annex jail, and the satellite jail. That gives us an average of about 3200 inmates in downtown Fresno. The jail Medical and Psychiatric teams provide physical and mental health care for inmates in the Fresno County adult detention facilities 24 hours a day, 7 days a week. We are there all the time. The medical and psychiatric care provided to these inmates is consistent with the community standards of care as mandated by Title 15 of the California Code of Regulations. To provide this care requires a variety of licensed personnel. These licensed medical and psychiatric personnel consist of physicians, psychiatrists, dentists, dental assistants, nurse practitioners, physician assistants, psychologists, licensed social workers, licensed marriage counselors, registered nurses, licensed vocational nurses, psychiatric technicians, medical assistants, and, of course, the office assistants, so we have a variety of personnel in order to provide the best care we can provide for our jail inmate patients and clients.

Licensed professionals provide inmates with medical screenings, primary care, minor surgery, emergency care, and mental health care

The services that these licensed professionals provide for our inmates vary. We do medical screenings, which means a full physical and treatment for whatever findings we obtained from providing the physical exam. We provide primary medical care, of course. We also perform minor surgical procedures such as abscesses and wound repairs because we do get quite a few of those. The wounds are sometimes voluntary, but most of them are supposedly accidental. They say they ran into the bed or they fell in the shower but they have both black eyes and other wounds in other parts of their body. We respond to emergencies. We also get a lot of those, and it can be anything from somebody having a cramp or a seizure to somebody who jumped from the second floor head first. We try to provide the best emergency response that we can there. The only time that we cannot take care of them is if it's too complicated, and that's why we have a contract with UMC. We send the inmates to UMC for further care when it is too critical and it cannot be taken care of at the jail. We distribute medications to all of the inmates that need them at all the different jails on all the different floors. We have calculated it a couple of times, and the amount of medication that we supply to our inmate patients is probably twice as much as Community Hospital provides for their patients. Our psychiatric department responds to mental health crises with counseling, of course. We perform suicide prevention interventions. We also provide psychotropic medications to those who need it. We're trying to push more group therapy for the inmates. We have several therapy groups for different groups of people because we have to separate different gangs, different nationalities, or different associations of inmates in order to keep them safe, so we have to break down the groups in order to be able to provide a service and still keep them from fighting with each other.

Jail Medical Services is working to provide for continuity of care when inmates are released to programs

We arrange for placement of critically mentally and physically ill inmates. Some of them we send as far as L.A. for some programs. I personally worked with what they used to call the Teenage Program here in Fresno. I worked with them making sure that the inmates get a physical and a PPD before they get released to programs to maintain the infection control in the county. One of the things that we're really looking forward to initiating is an aftercare program for mentally ill inmates. I know that this is a strong point for the mental health board. Now when an inmate is released there is no mediation between them being released and going for further treatment. We're trying to work together with the Sheriff's Department and with the mental health board and whoever wants to get involved in this so we can provide better care and not just allow them to get out of jail and not have a place to go for continuation of their care. My goal is that we can initiate a program that will prevent the mentally ill from just being released from jail and not having anywhere else to go.

The jail population has the same types of medical problems that the general population has

I'll give you a little statistical information. The medical department normally encounters probably better than 300,000 inmates a year. We get approximately 205,000 inmates through booking every year, and the first person they see when they come into the jail is a nurse. We

want to make sure that they're healthy enough to be able to be in jail before we can accept them to be in the jail, and that's for their own safety. Probably most people do not know that we have this excellent and large team for medical services at the jail. We have four doctors, one dentist full time, two psychiatrists, four nurse practitioners, and over 100 nurses, half LVNs and half RNs, and we have about eight medical assistants, so we have a large staff to take care of the inmates. In 2004 we saw 182,000 inmates on sick call. The dentist saw 768 inmates for dental problems. In 2004 we sent approximately 500 inmates to the emergency room, so when we saw 182,000 and we only sent 496 to the emergency room I think we're doing pretty good there. We're not sending that many to the emergency room. One of the numbers that I did not add to these statistics is the diabetic treatments that we do because, as you know, the jail has the same people that are out in the community so they also have illnesses such as diabetes, mental health problems, high blood pressure, and kidney problems. We have about three or four patients that go to dialysis every day. We have a lot of people with wounds needing wound care and there are other encounters that we have that I did not put here because that is routine care that we do every day for them.

The Department of Behavioral Health allowed Jail Medical Services to merge their medical and psychiatric departments

As I said, we see well over 300,000 inmates a year in the jail from the medical and now the psychiatric department. As of August 15th the Department of Behavioral Health allowed us to merge the medical and the psychiatric departments at the jail, so as a nurse manager and interim division manager, right now I'm working on combining the medical and psychiatric services to provide better care for all the inmates and treat their physical and their mental illnesses together to improve their well-being. Some of the officers there are also trained in first aid, and part of that was part of my old job providing the medical training to the officers. Now the officers provide first aid if it's required or CPR. They call medical staff, but by the time medical staff responds the officer will have initiated CPR when necessary, so I think the medical and psychiatric services for the inmates are great. I think they are better than some of the services in the community, and we like to take pride in that.

Gloria Hernandez: First of all, I want to thank you and your staff for treating people as human beings. I really appreciate it. The reports I get back from people are that you guys are awesome, and I thank you for that. I'm real glad you guys are looking at discharge planning for mentally ill clients out into the community. Are you also hooking them up on diabetes, for example, hooking them up to a couple of the programs in the community so that there is consistent care when they come out? I know that often you're the one that identifies the diabetes. A lot of them don't even know about it until they get there, and so I'm wondering what the follow-up plan into the community is.

Jose Gutierrez: We don't have a specific program at this time, but I have been working in those areas. We do diagnose a lot of the inmates that never knew they were diabetics or many other illnesses that they didn't know they had. We have diagnosed cancer while they're in jail. We have diagnosed other illnesses or chronic problems like hypertension. With diabetes we do the patient teaching. I actually have videotapes in Spanish and English, and I have the newly diagnosed inmates come and sit down and put a TV there and I let them view the videotapes.

Later I review it with them to make sure that they understand and they know what diabetes is. I would like to continue on and find information on the programs that are available so we can start relating to that. I have started something like that with TB for when an inmate gets released from the jail and is under treatment because they were infected but they don't have active disease. If they get deported I have connections in Mexico, and I give the information to the patient and I notify the connections in Mexico to follow up and continue the TB treatment over there, so I think we can move towards that with diabetes, hypertension, and mental health illnesses.

Larry Gray: A few years ago they closed a lot of mental hospitals. Are there statistics to tell us how many folks are in jail that should be or could be in mental hospitals instead of jail?

Jose Gutierrez: Excellent question. I went to some of the Proposition 63 meetings and we talked about it and we determined that the largest mental health care facility in the County of Fresno is the Fresno County Jail. On average, probably at least 600 inmates at any time in the jail have mental health illnesses. We have an average of 300 inmates receiving psychiatric medications every day at the jail.

Gloria Hernandez: I have a client in there right now. I'm a patient rights advocate for mental health, and one of my concerns that was brought to my attention and psychiatrists out in the community is that he was on Abilify and was doing real good but once he got over there they put him on Risperdal and he's really decompensating. I keep hearing the word that it's a cost issue and so I'm just wondering how you all make the decision to not give him the medication that was working, or how it is now that you're in the other units, you're no longer under behavior health, that you're communicating with the psychiatrists out in the community to be sure that there's a continuum of care so he doesn't end up in Atascadero as incompetent to stand trial.

Jose Gutierrez: As a matter of fact, yesterday the medical director and myself had a meeting with a psychiatrist and we spoke about the subject. I don't think it should be money that dictates what medication a patient is getting. If the psychiatrist decides that the medication the patient is taking is not working for them, they have that ability by Title 15 to medicate the patient with what they feel is the better treatment. If you give me some information on that I can follow up on it.

Gloria Hernandez: Where do I go and look at the files now that they're no longer at mental health?

Jose Gutierrez: If you have access to the mental health records you come to the main jail, and it's on the second floor. Make sure you have your ID because we do protect by HIPAA. We take that very seriously when it comes to mental health or medical records.

Debbie: I didn't hear you comment about AIDS and its treatment in the jails and how you handle the contagiousness issue of it in such a close compartment?

Jose Gutierrez: As long as I have been in the jail AIDS has become kind of second nature. It's not as critical as it used to be. We have become better at treating it and the patients are a little

healthier. If we see that somebody is infectious, if they have open wounds or anything like that, we keep them on the medical floor. If they're newly diagnosed and they're taking medication and otherwise they are healthy, we keep them in populations where they can be with other people with similar problems.

Ray Ensher: How comprehensive is your physical examination and who determines if they need imaging or the more expensive care?

Jose Gutierrez: Initially the doctor or nurse practitioner who evaluates the health concern decides what they need to do. If it is more involved like sonograms or very expensive procedures it goes to the medical director and the medical director will decide if that is absolutely necessary or not. We have had some of those cases. As a matter of fact, with the new administration, which is me working as an interim division manager and a new medical director for about six months, the amount of x-rays being done in the jail comparing October of 2004 with October of 2005 have been reduced by about 50 percent.

Debbie: I have one more question. As an interpreter I also go to the jail a lot because I interpret at the jail. Is there any form of appeal if an inmate is not receiving the treatment that they are requesting? Apparently, when they need a treatment they need to submit some kind of a slip or something. Is there any kind of an appeal process or somebody that can be approached when sufficient time has passed and treatment has not been provided?

Jose Gutierrez: Yes. If it's an emergency, of course, they'll go to the officer and the officer calls medical staff and we either come to them or they send them to us depending on the situation. If it's something like a cold or a patient is getting sick or they have an illness that's chronic and they haven't been seen for it, they submit a medical slip requesting care for that. If they don't get a response within five days they submit a grievance, and I have each supervisor for every shift review all those grievances. That way they know if somebody is not being seen in a timely manner. Once they review those grievances they come to me personally and I review those. If the inmate is correct and they haven't been seen in a timely manner, we sustain those grievances and make sure that that inmate is seen within 24 hours of that notice.

Eddie Jessup: What is the nutritional status of folks that you see coming into the jail? Who is providing the food at the jail? Is there physical activity that begins to look at correction and prevention? You said that there is a lot of diabetes and hypertension that you see. Could you talk about the status that may be influenced by their diet and nutritional status?

Jose Gutierrez: For the majority of inmates, their health is probably the worst when they come in. At one time several years ago I made my personal legal study. When inmates came in the jail, within the first month they gained about 20 pounds. That was because they were on drugs and not eating normally when they were outside. In the last few years we provide three meals for the inmates. They may not look the best when they are served, but there is actually a dietitian that balances these meals, and we do have special diets. When the inmate comes in, right at booking we fill out a dietary form. If they are diabetic we put them on a diabetic diet and we frequently consult with the kitchen or Aramark, which is the company that supplies the food, and we make sure that they are balanced. As a matter of fact, Captain Scott Jones is the captain of

the jail, and three times every day he checks the trays that are served to the inmates for the content and the amount of food, so it's closely monitored. When it comes to exercise, there is a rotating schedule for inmates to go to what we call the yard. In the main jail it's on top of the roof. They have sunlight up there. They can go up there and exercise, run around, do sit-ups or pull ups or whatever else, but there is an exercise schedule and if any inmates require any specific care we seek to provide it.

Gloria Hernandez: I got a call yesterday from a patient in one of the facilities, not the main jail, who had been there 24 hours and is insulin dependent and had not received a meal. I did time in jail back in the 70s and I gained a lot of weight because it was mostly starch and I didn't get any exercise because I was in solitary and I was doing civil rights issues, but I'm glad things are changing and I really think a lot of it is the change of administration. I don't hear of that many cases of abuse. However, I did get a call Thursday night at my house in the jail over on Van Ness and Butler, the satellite. The mother called me around 9:30 and told me that her son had been sitting on the toilet and the guard went in because two other guys were smoking, grabbed him, started cussing him out because he was Mexican, and he ended up with bruises around his neck. In talking to mom she was trying to see her son and she was being told she couldn't see him so the lawyer made it happen and she was able to see her son. She was able to see that he was okay, and she was glad to hear that the person had been suspended until the investigation is fully conducted, but the bruises were really there on his neck. He did file a complaint. Everybody else filed complaints, and I guess they suspended the person that did it, which I'm really glad because in the old days it was just horrible to hear these cases. I'm really glad that things are looking better for the guys and the girls in there. Those of us in the community are feeling that things have gotten better in there, so thank you once again.

Jose Gutierrez: I'm not a part of corrections and the disciplinary actions and involvement with it. I'm there to take care of the patients. I call them patients. They're inmates, but I don't care what they're there for. I'm there to take care of their mental health and physical health. I know how it used to happen in the old days. That is not tolerated any longer, and if anybody complains of any illnesses or any injury related to being manhandled by an officer or by another inmate or falling they call us immediately and we see them immediately for those complaints.

Gloria Hernandez: One of the things that I saw on the news recently was that the violence has moved into the jail from the city streets. Is that true?

Jose Gutierrez: I'd like to disagree with that because I can tell you that the violence in the jail has decreased by 80 percent from ten years ago.

Gloria Hernandez: The news is telling us right now that the gangbangers that just got picked up went in there and took it in there. You're telling me that's not happening?

Jose Gutierrez: I'm telling you there aren't a lot of fights. As a matter of fact, there's a lot of movement that the Sheriff's Department has been doing to prevent those fights, and I've worked with them. They've been meeting for the last three months redesigning the way they classify inmates. Some of the inmates that used to be in gangs and dropped out used to be separated and they would not get any of the benefits like the gym or religious services. The Sheriff's

Department realized that they were leaving them on the side, so now they're working and creating an area where all those people who drop from gangs are going to be in one cell together as a group so they can receive all the other services that the other inmates do. I can tell you there haven't been very many large fights, and the way you're talking about there being gang fights, there haven't been any.

Gloria Hernandez: The perception out there in the community right now is that there's a bunch of violence and it's scaring the hell out of the community, and I'm really glad to hear that it's not happening.

Participant question: My son was in jail in January for driving without a license and he was in for a while. He's been in a good many times over the years. He's been very comfortable in jail. He has spent over a year of his life in Fresno County Jail. It's a sad story, but he has. However, he told me that this time he was afraid and he never had been before, and it was the gang stuff that was bothering him. That was last January. Whether his feelings about it were real I can't say, but he has had a lot of experience there.

Jose Gutierrez: Like I said, I've been working there for a long time and I have seen the changes. I have to give credit to the Sheriff's Department because they have made many changes and they have improved the situation for all of the inmates and for the staff that works there too, and the medical services and mental health services are constantly improving. One of the members of the mental health board is working on a pamphlet that's going to be put out for public information so they can communicate with us whenever they feel like it. I'm working also with him setting up a phone where people can leave a message to us and also a fax number so they can fax information that they want us to have related to their mental health or physically ill inmates. That way we can try to follow up on those things and take care of them better

Navigator Program: Rosa German, Bertha Diaz, and Hugo Ramirez - Empowering Communities for Better Health

Jeremy Hofer: For about six months Fresno Metro Ministry, Cesar Chavez Adult School, and University Medical Center have collaborated on a program called Navigators. The idea is to empower communities for better health and to make sense of our medical system and, more specifically, make sense of University Medical Center. We have with us Rosa German, Bertha Diaz, and Hugo Ramirez who will be talking a little bit more about their experience of going through this Navigator Program and some of the things that they learned there. They are now, I believe, making presentations in the community.

This program was presented in Spanish.

Debbie: I interpreted for the Navigators for about four months. I just wanted to make a comment that during the time that I worked with them what they learned over the course of the four months is that they have the right to speak up. They repeated several times the importance of having a grievance, where you take your grievances, and also what to do when asking for an interpreter, how to stand up for your rights. I found that that was the biggest lesson that was learned because the Hispanics primarily can be very humble and very patient people and don't

know that they have rights to request services and to speak up for themselves. We spent a lot of time talking about their rights for interpreters and their rights to be treated with dignity, so that's why it was repeated several times, and truly, that was a big gain for everybody.

Larry Gray: Because of the nature of having a multicultural society, how have you been able to go from Puerto Rican to Mexican to Cuban? Do you have those kinds of difficulties here in the Central Valley that they have back east?

Debbie: You mean between the different cultures?

Larry Gray: Between the different cultures in the Latino community.

Debbie: They don't see any differences.

Participant comment: It's really important for all patients to bring in with them all of their medications to first visits, whether they're old, new, or whether they're taking them or not. Actually, medical records are really good. If you are changing physicians, if possible, get your medical records from the previous doctor that indicate whether you've had surgeries, why, why not, what diagnoses have been given, and how they've been managed. That's highly appreciated.

Eddie Jessup: I want to thank you again very, very much. I'd like to recognize Laurie Primavera for actually creating this program and training and empowering these people to work with their neighbors. I think it will make a big difference in how folks are able to get care. Thank you.

**John Capitman, Executive Director, CVHPI – The Central Valley Health Policy Institute:
What It Is and What It Does**

The Central Valley Health Policy Institute was established with a grant from the California Endowment to the College of Health and Human Services at California State University, Fresno

Thank you very much for letting me speak with you today. I really want to acknowledge Laurie Primavera who was with Fresno Metro Ministry and is now at the Central Valley Health Policy Institute, and we're very excited about that. The Central Valley Health Policy Institute was established about 18 months ago with a grant from the California Endowment to California State University, Fresno to the College of Health and Human Services. The goal of the institute, broadly, is to be of service to the Central Valley as it tackles this really amazing set of health and healthcare policy challenges in the region. We want to do that in a number of different ways. The institute is run and supervised by a regional advisory council and the advisory council has people from all over the region from Bakersfield to Stockton and from all kinds of sectors of the economy, healthcare folks, educational folks, folks involved in media, the legal sector, state government, etc. Under the direction of that regional advisory council we're involved in research, policy analysis, and technical assistance activities. We also have the Leadership Development Program, we're engaged in a number of efforts to develop research capabilities

within the Central Valley, we're making some changes in the educational offerings at California State University Fresno, and we're developing a data warehouse.

Focus groups all over the Central Valley have helped determine what the Health Policy Institute will focus on for research projects

The research and technical assistance focus of the institute was established by the regional advisory council based on doing focus groups and meetings all over the region, and we got so many suggestions about what people would like to see the institute focus on and how they'd like to see it structured. We tried to play with that a little bit and develop some foci. In terms of research and policy analysis, we're engaged in studies that we're doing ourselves that are based on the focal areas identified by the advisory committee. We've begun to enter collaborations with a number of community organizations, and we have a group this year of six health policy fellows who are Ph.D.s either with community-based organizations or at universities who are young scholars who maybe haven't done a whole lot of health policy research but show a lot of potential, and we're working with them on projects.

Three in-house projects focus on the uninsured and underinsured, the shortage of health professionals, and environmental impacts on health

The in-house projects are in three areas, uninsured and underinsured adults, health professional shortages, and environmental impacts on health. For example, in the area of uninsured and underinsured adults we did some preliminary analyses in the first couple of months that I was here in Fresno where we looked at the data on the adequacy of prenatal care in the Central Valley. These are 2002 birth records for the State of California. What they show is that the likelihood of getting the recommended series of prenatal care visits is highly dependent upon your payer source. Folks who are Medi-Cal, who are self pay, or who have other kinds of public insurance are much less likely to get an appropriate package of services. Some of the folks who are Latino, African American, American Indian, or Asian Pacific Islander are all significantly less likely to get an appropriate package of services for prenatal care. Women who are more educated are more likely to get those services. Teenage moms and moms who are immigrants but not necessarily from Mexico are also less likely to get the appropriate package of services. What's fascinating, though, is that after controlling for all those demographic differences, after putting all that aside, there are still big differences by community in the valley in terms of the adequacy of prenatal care. If you live in one of the zip codes in north Fresno you have an almost 95 percent chance of getting the appropriate package of prenatal care, but on the other hand, if you live in central Stockton your chances are about 50 percent of getting that appropriate package of prenatal services. We're trying to understand that phenomenon. It's really fascinating. We've been doing a systematic review of the published literature on prenatal services wanting to know if the patterns that we're seeing in the Central Valley are similar to those we've been seeing in other parts of the country. We're also doing a survey of prenatal care providers in those counties that are mostly in the northern counties of the region that have the worst prenatal findings for 2002 and we're analyzing the more recent data, the 2003 data, to try to get a handle on whether or not the patterns that we saw for 2002 are persistent.

The Health Policy Institute is doing a survey to begin to understand what is happening in terms of primary care as a result of the shortages in healthcare professionals

Everybody has talked about the health professional shortages in the Central Valley. We know that although we actually have about an average number of primary care physicians, we're way low in terms of specialty physicians and we have shortages of nurses, PTs, OTs, and radiologists. All of that has been talked about a lot. What hasn't been talked about a lot is what difference that makes in the capacity of primary care providers to meet the needs of their clients. What are the things the primary care providers are having to do to accommodate the fact that they have these problems of professional shortages? What does that mean in terms of the quality and the adequacy of care? We're doing a survey beginning with the federally qualified health centers and moving on to the rural health centers to try to understand what the providers are doing and what's happening in primary care in the region as a result of these professional shortages.

The institute is also working with California State University, Fullerton, to develop a model of the health and economic consequences of air pollution

In the area of environmental impacts on health we're working with California State University, Fullerton to develop an economic model of the consequences of air pollution for health and therefore for the economic well-being of the region. A similar model was developed for Southern California and it was really influential in a lot of the debates that they've had there about influencing pollution. We're also really interested in areas of asthma education and have been working with a couple of groups. If a kid misses school because of asthma it's a big deal. It loses money for the school and it hurts the kid's ability to move forward in their education. We don't know why kids miss school. We only know that they're absent. Almost all of the school systems in the valley just carry absence data but we don't know reasons for absences and so it's hard to say what the real financial costs are, for example, to the school systems, of kids having asthma and therefore missing school. We're working with a number of groups about how we can have that data available.

The Health Policy Fellows are working on several projects related to health and healthcare in the Central Valley

The Health Policy Fellows are an amazing group. VaNee VanVleck, an economics professor at Fresno State, is developing a simulation model of how utilization patterns and payer mix patterns influence the financial well being of hospitals in the valley. As you know, many of the small hospitals in particular but even some of the larger ones are facing severe financial problems. We can easily say, "All we need to do is increase Medi-Cal rates or transfer more people from fee-for-service Medi-Cal to Managed Care Medi-Cal and that kind of problem will go away." We need a model that lets us make some estimates of what those kinds of consequences will be. Some of our preliminary work and work from other communities suggests that the financial well-being of hospitals won't really improve that much unless we can really also influence utilization patterns. There's some interesting work there. Another example is working with the VA on care for post-traumatic stress syndrome patients. The VA serves literally thousands of PTSD patients in the Central Valley through a network of community-based mental health providers that they have almost no ongoing contact control of. PTSD is an area where there has

been enormous development recently in terms of appropriate treatment regimens. Here's an opportunity to work with this big system of providers to improve quality of care and yet there are a bunch of structural barriers to doing it. Those are some examples of some of the work that the fellows are doing.

Three other examples of groups that CVHPI is collaborating with are Corcoran District Hospital, the small community of Home Garden, and University Medical Center

We've gotten started on a number of collaborations. We've been working with the Corcoran District Hospital on their diabetes project. Corcoran District Hospital serves a small community in Kings County of about 20,000. More than half the population is in prison, which is pretty interesting. Diabetes is a huge issue in Corcoran, so we've been working with them on the development of an approach that addresses both the delivery system and providing more support to families as they deal with a family member who has diabetes. Home Garden is another small community in Kings County just outside of Hanford. We're helping them with a community needs assessment. They have a population of 1763 and they want to interview everybody. I think that's great, so we'll see what we can do. We recently submitted with University Medical Center a proposal to explore Breast Cancer Navigators. A lot of the work that I'd done prior to coming to Fresno had been exploring racial ethnic disparities in breast cancer and other kinds of cancer care. The thing that's really amazing is that the disparities arise not so much in terms of people participating in screening. Screening rates have really come to be not quite equal but close to equal across racial ethnic groups in this country, and even across insurance status groups most women are getting screening. What fails and where we see huge disparities arising is what happens after screening, and so we are hoping with this Breast Cancer Navigator Program to understand why women end up not completing the package of diagnosis and treatment for breast cancer and then what can be done to facilitate their access.

The Health Policy Institute is constructing a data warehouse that will contain all available data coded by zip code for the whole Central Valley

Finally, we have the data warehouse under construction. The data warehouse will accumulate all of the available secondary data that's coded at the level of the zip code for the whole Central Valley, so we'll be able to say for each zip code demographic characteristics, hospitalization patterns, and emergency room patterns. That's the warehouse. We're starting to put that together. We ought to have some data available from that in the next few months and we'll be able to respond to specific data requests. If you're working on a proposal, if you're trying to find out which community has the biggest problem with x, y, or z, we'll be able to at least point to some of the available data that can pinpoint many of those issues. The Central Valley Health Policy Institute is sponsoring a conference on December 1st, and this will be presentations of a lot of the proposals and project ideas that I've just been sharing in much more detail talking about how potential collaborators with us throughout the region, potential funders, and others can shape our work to make it as responsive as possible.

*The leadership program is a group of about 30 people in the community
who are seen as emerging leaders*

The Leadership Program is a ten-session, year-long program. We have about 30 people participating this year. We'll be recruiting for a new cohort come early winter, the second cohort. Leaders come from all kinds of organizations. We've used the language that they're emerging leaders. They're not necessarily the top person in their organization, but they're people who have a lot of potential and interest. We have journalists, lawyers, and political folks. I'd love to come some time and just talk about that program in particular.

*CVHPI is willing and able to help organizations who have developed proposals and
project ideas with obtaining some of the data that they need*

We definitely have done a lot of and are quite willing to do a lot more of helping organizations as they develop proposals and project ideas and reports to identify available information. Deb Riordan, who is working with me, and Marlene Bengiamin are both just fabulous at culling through the existing data to try to see if we can tell you a story. We may not be able to get you new data in a minute, but we can certainly help you find what's out there, and we're very open to developing collaborative projects and working with different groups on options as they come up. You can contact us by calling me or Laurie at 228-2150.

Gloria Hernandez: I volunteer on a case that involves 23 women, multi-language, Hmong, Cambodian, Laotian, and Mexicans, and out of the 23, four of them have breast cancer. They used to work with plastics making sprinklers. I just find it odd that out of the 23, four of them have had breast cancer. I realize your study is going to target zip codes, and I'm just wondering if that doesn't go far enough. Maybe it should target industries. That's one suggestion. The other one is I realize that asthma and all this other stuff is important, but I deal with mental illness and I see a lot of meth-related mental illness and I'm just wondering if that's something that you are thinking about tracking as the connection to the community, the breaking up of families, the high crime, etc.

John Capitman: I'm very, very interested personally in substance abuse and behavioral health issues. One of the projects I brought with me from Boston and it continues at the institute is a national survey of primary care providers to see what they're doing in terms of working with young people around screening and treatment for substance abuse. One of the big problems right now is we have these two separate systems of treatment, and largely people in the primary care system aren't trained, aren't prepared, don't have the vehicles, and don't have the referral sources. Why screen somebody if you can't then do anything? So we want to find out a little bit about what the current practices are. I've talked with Community Health Centers in Madera County and also in Bakersfield about expanding their services in terms of behavioral health. I think it's a hugely important issue. As far as the industrial concerns, we'd love to make some connections with the various groups working around occupational safety issues in the valley. I think there are a whole bunch of them. The ones that come up in agriculture I think are perhaps most dramatic, but across a number of industries there may be opportunities to do research. California has this huge problem with disability payments. California pays more in disability dollars than any state in the country even proportionally. Some of that is connected to the

problem of the uninsured. We end up having people get more hurt at work in part because they haven't had primary care and they've been at risk in one way or another and then that increases disability services, so there is a lot of interest in how we can think about connecting employment-based, safety-related coverage and primary care insurance.

Eddie Jessup: I personally am really interested that you're doing the zip code analysis because of, for instance, the Brookings Institution report that we have the concentrated poverty that is so clear, and particularly because as we look at doing interventions in areas, I'm thinking on the obesity/hypertension/diabetes continuum, the funding for that, and hopefully from the data that you are looking at that, doing an environmental intervention where there are many sectors that are addressed would help us in terms of delivering services and changing the environment and health outcomes for people if we know that a geographic area is under served and is really impacted by health disparity. Could you talk about that at all?

John Capitman: At the risk of being argumentative, I think that this whole recent discussion of the zip codes with concentrated poverty is a little bit of a distraction. When you look at rural sections of the Central Valley there's enormous poverty. It's not concentrated because they are rural areas, and yet the proportions of folks living in poverty is very high, so if we just say the problem is because we've got these concentrations, no, the problem is that we have very high poverty rates. If the Central Valley were a separate state it would be about 20th in population, it would be middle of the pack in land area, and it would be the poorest state in the nation, poorer considerably than Mississippi in terms of average income. Tulare County and Kings County are among the poorest counties in the nation, so when we talk about concentrated poverty, the whole region is a region of concentrated poverty and so I feel like that kind of causes a little bit of a distraction. The communities in Fresno that are most impacted in terms of concentration of poverty also are environmentally perhaps most impacted and they're created by histories of racism and classism and oppression, but if we just get the discussion focused on those neighborhoods we're going to miss the larger set of causes that creates both those neighborhoods and the rural poverty.

Eddie Jessup: I agree with you on all of that. However, as we begin to do interventions to change that and we have so little infrastructure in order to make those changes, if we're addressing such a large issue of poverty how do we do it so we actually get to doing something and have an impact when there's so little in the way of resources to begin to do that? In addition to your discussion on lack of access to services, how do you begin to determine so that it's not too little that is spread out too thinly?

John Capitman: I'm not sure I can answer that. I do think that health disparities are not just the result of problems of access. They're also the result of unequal care once people get into the system. It's not the same thing as access. The kinds of issues that I think you're working on in terms of having people make sure they get what's their due when they're in the health system, those issues are not really the same thing as access. They're the next step, the quality of care, so I think that that makes a difference and I think the conditions of living in poverty also in and of themselves influence health outcomes. I absolutely agree with the contention that addressing some of the central health policy challenges we have involves not only changing the health system but also addressing some of the conditions of poverty.

Participant question: You mentioned the increase in disability costs, and I suppose caseload would be part of that. It strikes me that there may be a possibility of increased disability costs being correlated to a weakening of enforcement of OSHA. Is there any data linking OSHA to disability and making that comparison? I'm just thinking it would be helpful if we wanted to try to get increased enforcement of OSHA back to where it was initially, and our legislators or officials are going to need some ammunition. For data access that's just one point that might perk somebody's interest.

John Capitman: I think you're right, and that would be great.

Gloria Hernandez: I find what you guys are doing is fascinating because I remember having to fight for the cancer registry back in the 70s because of pesticides and when Cesar took the battle to the boycott I was pissed off because we should have been organizing farm workers. If I would have known back then what is foresight of how people woke up and realized that pesticides have caused a lot of these illnesses...I just think you guys are way ahead and I congratulate you and I welcome you and I thank you.

Participant question: (Inaudible).

John Capitman: Because we have a shortage of health professionals, we also have a shortage of response to some of those acute care needs, all of which creates this complex mix which holds down reimbursement and makes it harder to go forward in terms of meeting those needs. That's a very complicated idea. I think it's something we all need to understand more about and sort out, the idea that the current mess is an interplay among shortages of professionals and low rates of insurance and adequacy of insurance. I think that that's a huge central kind of thing. I think costs of healthcare are out of control, and not because of utilization but because of pure costs, and I think that that makes all the rest of the conversation much harder. It makes it much harder to figure out other ways of getting more people insured and we just always have to talk about that. The third major issue is really about what I would call culturally humble, culturally appropriate care. I'm not comfortable with the notion of cultural competence because I don't think I can become an expert on somebody else's culture. That whole idea is troubling to me, but I think that in our society we have endless evidence that people are not consistently treated respectfully in the healthcare system, and I think that that's true here.

Debbie: I just wanted to comment in support of the Navigator Program that many of the issues that you just mentioned, those three top issues that you're addressing, we addressed also in the Navigator Program, and I'm thinking that we probably worked hand in hand with you more than we were even aware of. We spent probably over two hours talking about the importance of not going to emergency care for day-to-day influenza and things like that. We addressed that very issue, and something that they talked about today, actually, was the importance of having a doctor and not going to emergency care for that kind of thing. We also talked about the interpreters and cultural competency and sensitivities. I just wanted to let you know that the Navigator Program is working very closely with what you're doing as well as trying to spread the word to the community leaders to spread the same message.

John Capitman: Thank you.

Laurie Primavera: I've only been with the Health Policy Institute for six weeks. I'm the associate director. I just want to give a perspective. John is a nationally renowned researcher, and for those of us that are advocates it's sort of like, big deal. What's data? What's research? But John really comes published and well recognized nationally. What I've seen him do in nine months is incredible as far as helping support you, the advocates, to do that action. John has created this leadership program which Yolanda Reeves is in and several others. He has created a fellowship program, and significant for me as a graduate from Fresno State times two, he's really raising the bar for graduate application in terms of research. That's not an easy thing in terms of building the program and working directly with at least 20 to 30 individuals. He has me writing an abstract and that will take him three months to sort through. As the associate director I'm not the researcher. My job is to communicate and talk about how the research connects and really makes a difference in terms of the action in the community, and I would say that I think John has done a really great job of highlighting some of those things. We need you as partners, just as you were talking about with the Navigator Program. Carmen Arambula, who actually made, worked, created the curriculum, and taught the Navigator Program, and Robin Gonzales at University Medical Center will be presenting at the December 1st conference. Just keep in mind that our job is to support you with the data that you need for advocacy to test out new models of care, but we really need your ideas and your support.