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NOTES OF COMMUNITY HEALTH CARE ROUNDTABLE

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The purpose of our Community Healthcare Roundtables and of our healthcare projects is to increase healthcare access that is appropriate medically, geographically, linguistically, and culturally and to improve public health. The Community Healthcare Roundtables are funded by The California Endowment, The California Wellness Foundation, and the donors of Fresno Metro Ministry. Additional funding for our healthcare project is provided by Saint Agnes Medical Center and Kaiser Permanente.

Laurie Primavera, Fresno Metro Ministry Overview of Children's Health Expansion Initiative

Fresno Metro Ministry has been funded for a one-year planning process to look at a Children's Health Expansion Initiative. The funding is both from First Five as well as from the California Healthcare Foundation. There are three objectives in this planning process. One is to look at doing a better job of linking children ages 0 to 18 to a medical home. The second part is to look at getting eligible kids onto Healthy Families and Medi-Cal. We have a fair number of uninsured kids who are eligible for public programs. The third part of the initiative, which is in the planning process, is to look at a privately funded product that could cover the children that are not eligible for existing programs. We started the project in January. We only have until December.

Part of the funding has been directed towards obtaining support through the Institute of Health Policy Solutions with Dr. Len Finnochio and Joel Diringer. We have a work plan and we're in the needs assessment phase. When that is completed by our consultants we will be working with them to look at several options that are applicable to Fresno County. A feasibility study will be done on each of those options and by the end of the year we will have a plan. We will not implement that plan but we'll have the plan completed. Our process includes two groups. We have a smaller planning group and on that group we have Health Net, Blue Cross and Blue Shield, Kaiser Permanente program which has the Kaiser Care for Kids program, and an

insurance program for ineligibly insured kids. Fresno County is very well represented. We have Employment and Temporary Assistance who does the Medi-Cal and outreach. We have our Community Health Department involved in that. We also have Don Pierce, who is an assistant to the County Administrator's office. Metro Ministry is also involved as well as Teresa Alvarado from Fresno Health Consumer Center, which has been one of our primary Medi-Cal and Healthy Families outreach enrollment programs. The intent is to keep it small and to work with our consultants in terms of progressing in that plan. Today you are our community coalition. We need to have four meetings with the community to both share information with you and also to obtain your input in the process.

Len Finnochio, Institute for Health Policy Solution The Children's Health Expansion Initiative

I'm here to engage your expertise since you are locals and know the Fresno community health scene much better than I do. This is the question we need to answer: If within a year or two 26,000 new children in Fresno County have an insurance card where are they going to go?

We have to do more than provide insurance plans for children. We have to find enough providers that are willing to provide the care for these newly insured children.

Data from the California Health Interview Survey (CHIS), which came out a couple of years ago, indicated that about 36,000 children in Fresno County in any given year are at risk of not having health insurance. The goal of this project through Fresno Metro Ministry is to increase the number of children who have an insurance card and increase the number of infants and children with a consistent healthcare provider. All of you know that having a card that says Blue Cross or Blue Shield or Health Net or Kaiser is often not enough. If this project works, which it will, and 26,000 kids at minimum over a set and multiple year process are insured where are they going to go?

The goal of this project is to improve outreach to enroll eligible kids into Medi-Cal and Healthy Families and to create a new plan to insure kids who aren't eligible

This project overall has the goal of insuring all kids over time and doing so by improving the outreach and enrollment infrastructure. Most children who are uninsured throughout the state are eligible already for Healthy Families or Medi-Cal, but there are about 8,500 in Fresno who are not eligible. The goal of this project is to create a new health insurance product in the county that would insure these children which would look almost identical to Healthy Families in terms of its benefit package. What will that take? There is a planning and consensus building process, which this is a part of. Of course, finding the money is the hardest part. We will have to do outreach and inreach to find the uninsured. We'll need to improve enrollment and retention. For those 8,500 children who aren't eligible for Medi-Cal or Healthy Families we will need to contract in this county with a commercial health plan or plans to provide services because you don't have a local health plan like other counties do. And we'll need to ensure an adequate network of providers.

We will need to find a workforce to provide services to kids that includes family doctors, pediatricians, dentists, nurse practitioners, physicians assistants, psychologists, and psychiatrists

The workforce that's going to take care of these kids consists of primary care physicians, family doctors, pediatricians, possibly general internists, general and pediatric dentists, and primary care nurse practitioners and physicians assistants. Fresno is a little bit below average in terms of the number of health professionals per 100,000 compared to the rest of California, but that statistic alone isn't sufficient. Just because you have fewer than average, they may on average be more likely to take Medi-Cal or Healthy Families than other places in the state. What specialists are available and where are they? We will need pediatric and dental services as well as mental health services. We also need to remember to include teenagers in this group of kids. We will need family therapists and child and adolescent psychologists and psychiatrists. Is this a sufficient list? Are there others that we need to be thinking about?

Participant question: Under specialists are you including all the referrals that would need to be made, for instance orthopedic?

Len Finnochio: Yes.

Participant comment: You could include clinical social workers, physical therapists, occupational therapists, speech pathologists, and audiologists.

Participant comment: I hope there is a role for school nurses. They can play a very vital role.

Participant question: I'm concerned about your number of children that are not covered for 12 months. When are you taking the interview for these uninsured children? If they are going home to Mexico at a certain time of the year they will be missed. Do they then have to reapply when they come back? Why don't you have a set plan for application that goes all the way through the 12 months?

Len Finnochio: For Medi-Cal there is continuous 12-month coverage for children, although that may be changing. Hopefully that won't change. For Healthy Families the family does have to pay a premium but there are advantages in that if you pay for the entire year at once you're covered for the entire 12 months. It is a problem with Healthy Families that you may drop off if you don't pay the premium and that's why any effort like this has to address retention issues and making sure families get the information they need to renew and also to pay the premium on time.

Participant comment: We also need to add optometrists, ophthalmologists, and oncologists to the list of providers.

Participant comment: We need to be able to address children with special needs such as Down's syndrome.

Participant comment: I am one of the pediatricians practicing in this community and many of us are really very concerned about the subspecialists leaving the valley. The Dermatology Department will be closing. The Department for Developmental and Mental Health already closed last year. For us as general pediatricians it's getting harder and harder to refer. Actually, some of our children have no place to go other than L.A. or San Francisco where there are waiting lists of six to 12 months. It seems like the administration at Children's Hospital is not helping us very much with keeping our subspecialists and recruiting new ones. Many pediatricians are really concerned about that. I don't know who has control over that in the community but I do think that we need help from the community to keep the subspecialists we have and maybe recruit more because there are many children that have no place to go now.

Participant comment: It's pretty well recognized that we have two epidemics in this area, asthma and diabetes. I don't see anything specific about treatment of either of those two major problems.

Participant comment: The Medical Society has a committee on community relations and Carol Rau at the Medical Society would be a very good resource for you to meet with and discuss the general parameters of your program.

Participant question: Can we include health educators on the list?

Participant comment: You might want to add as a resource health ministries and parish nursing based in congregations. There aren't a lot of them but they are growing. We also need to look at health promotion. If we think about asthma we need to look at how to prevent it and promote health. If you can keep them healthy the costs are less in the long run.

Len Finnochio: If in a perfect world every subspecialist that was needed moved to Fresno County and there were enough of each of these providers for all the new insured kids those providers still may not be interested in signing up with Healthy Families, the new Healthy Kids product, Blue Cross, or Health Net. How do we begin to scratch that surface and get these providers to accept reimbursement and deal with the health plans that would be overseeing this product? The answer is to simplify.

Participant comment: I work with UCSF Fresno Medical Education program. As you know, whether it's getting businesses to come to the Fresno area or recruiting interns Fresno is not nationally thought of as a hot spot, and that general reputation has a real impact. It's a wonderful place to live apart from the air quality but getting graduates of medical school to put Fresno high on the list as a place to do their residencies is a challenge. We need to do everything we can to promote Fresno in general and be very involved in the efforts to encourage people to come and visit. Once they're here they like it and that's what keeps physicians in the area.

Len Finnochio: Getting health professionals to areas where there is an under supply is a health policy issue that has gathered a lot of attention over the past 25 to 30 years. I would say it's going to continue to be a challenge but it's something that has to be thought of constantly when you do something like this.

Participant question: At what level would the area of cultural and linguistic competency be addressed?

Len Finnochio: When health plans are contracted through Healthy Families or Medi-Cal there are requirements in the request for proposal and for the contract. I would imagine that whatever contract comes out of this process that would be put out for bid from Blue Cross or Health Net would have many of the same requirements about cultural and linguistic competency from the providers or from their office and their staff. It is an opportunity when that RFP is developed to improve on that requirement, and so input into what that RFP looks like to address some of those issues is going to be a part of this process.

Participant comment: The continued drop of reimbursement rates for physicians is a real big concern, especially when you come to the area of specialties. We have a very limited amount of doctors who are accepting Medi-Cal reimbursements and Medicare reimbursements to begin with. I believe currently we're under what used to be reimbursed in 1986. We've taken many steps backwards, so that is definitely going to be a concern when you're talking about addressing the issue of recruitment into this area. Even if we are attractive and we do become a hot spot those things also need to be considered. We may be able to attract doctors to this area but whether or not those doctors are willing to participate in these plans is another issue.

Participant comment: Several of the questioners have talked about the difficulties of having all these different plans that physicians may or may not be willing to accept. What's the solution to that? It just occurs to me that we really ought to get off of our chauvinistic high horse in this nation and look at what every other developed nation on this earth has done and that is to come up with some kind of single-payor plan in which all primary care givers are paid from the same source and they accept that or they go without. Whenever I mention even looking for broad outlines at the Canadian model people say, "Oh, we can do better than Canada," but they were telling me that 20 years ago and we still haven't got a plan and we still have the highest percentage of people without access in the civilized world and the uncivilized world, for that matter, and we spend more per capita than any other nation. In the last figures I saw Switzerland was next after us but it was down about 30% per capita lower than we are. If we put per capita into our program but our program were like Canada's we would finally have the finest healthcare delivery system in the world.

Diana Dooley, Children's Hospital: It is very difficult to recruit subspecialists to the area. Children's Hospital has 42 different subspecialties. We're the only children's hospital in the country that's in a rural area. It is very difficult to provide the outpatient support that we provide because of the reimbursement rates. In our outpatient clinics the reimbursement rate is \$.20 to \$.30 on the dollar. Our entire healthcare system is oriented to inpatient care and serious illnesses, end-of-life illnesses. Most of what we spend is on the acute care. Providing outpatient services is very difficult and getting primary care that prevents kids from being in the hospital is what we should be oriented to, but it's not what we are oriented to. Children's Hospital today treats more kids than it ever has at any time in the past at higher levels of acuity and with higher quality, as was evidenced by our recent award of the magnet status which will help us recruit people to this area. We are very saddened by the closures that have been required. Not only do we not have appropriate reimbursement for the outpatient services that are provided, we have by

far the lowest level of philanthropy of any children's hospital in the country. More than 70% of the children that we treat at Children's Hospital are Medi-Cal children and the disproportionate threshold for the supplemental funds is that 30%. The idea of disproportionate share programs is that you have a disproportionate share of Medi-Cal so you cost shift to commercial payors. Most hospitals are in the 30% to 40% range. We're at the 70% range so there is no place for us to cost shift to. These are some of the broader issues that all of us face in this area as we try to provide care to kids and to everybody. We have a high poverty area with very high needs, very high acuity, very low reimbursement rates, and very few providers. A lot of the kids that end up at Children's Hospital are there because there wasn't primary care, there weren't sufficient services available before they got to the serious illness that required our services. So we stand very ready. It's of note that Medi-Cal and CCS, neither of which is represented here today, are huge players in finding the answer to this problem. The point is that we should avoid finger pointing and join together to solve our problems in the Central Valley, which are enormous. They're very much bigger than identifying which subspecialists we need more of.

Participant comment: We have to put geographic accessibility on the list given our rural nature. Folks are generally going to tend to come into urban areas along with our inadequate public transportation system.

Len Finnochio: It would be great to answer every health policy challenge that all of you have addressed through an initiative to cover children. I think some of them are certainly possible, but I think we also have to be realistic. Many of the other counties that have done this have addressed some of the provider willingness issues by making sure that reimbursement was a lot more attractive than Medi-Cal and at least if not a little bit more attractive than what Healthy Families pays. The question that's going to be asked over and over again by those of us that are participating in this process is how do we begin to make a dent in the professional shortage through this initiative. How can we affect provider participation through reimbursement? One of the default questions we'll be asking ourselves is what about cultural and linguistic competence. Again, that's one of those really big health policy issues that has to be addressed in a number of different ways.

Participant question: I'm on Medicare and have a supplemental policy. How about dividing a major primary insurance provider and a supplement that will be picked up by another provider that you've listed here so that not one insurance company has to cover the whole price of everything? Maybe that could be worked out so that we have good care for the person that goes in and they don't land in our emergency services, which is the highest cost in hospital.

Len Finnochio: Health plans, did you hear that? For the health plans that would probably come to the table in this county, Blue Cross, Health Net, maybe Kaiser, the challenge is also yours. How do you structure a product in this area that addresses provider sufficiency issues as well as cultural and linguistic sufficiency issues? It's ultimately your dollars and who you contract with and the attractiveness of the program to the providers that's going to make them willing to participate, so the challenge is yours as well.

Participant question: In addition to policy issues that are internal, which is what we're looking at here, I'd like to know more about the potential for impacting policy on a statewide level and

how universal coverage for children that takes place at a county level will impact the willingness of our legislators to look at the bigger picture and take up their responsibilities.

Len Finnochio: The statewide California First Five Commission is investing up to \$46.5 million in this. California Endowment is going to invest \$50 million. The Packard Foundation has invested. The goal of a number of big foundations over the next three years is to do what is necessary at the local level to get near universal coverage for children all the while thinking through the policy strategy to make this happen in Sacramento three or four years from now, so that is certainly part of this larger process. It's one foot in the county and one foot in Sacramento.

Janice Milligan, Health Net: Everyone in this room has an opportunity to help the health plans by telling us exactly what it is you need from us to bid on this product. Whether it's Health Net or Blue Cross or Kaiser or Blue Shield the challenge for us is that the benefit structure hasn't been delineated. One of the big challenges right now that confuses almost everyone is that the benefit structures are different depending on what kind of Health Net you have based on who the payor source is. That's one of the first big challenges that you all have to look at and ask the health plans to remedy as a product. What we're talking about here is universal healthcare coverage for children. If we're going to have universal healthcare coverage for children here in Fresno we need to make it universally accessible, and the only way you can do that is to take away some of the differences. There are still huge gaps between Healthy Families and Medi-Cal both as benefit packages and in the way you access those programs, so we need to start thinking about it and you've got a year to do it. It seems to me that this is an opportunity to take a look at an RFA that would address that so that the providers who are providing this healthcare don't have the horrible confusion of trying to sort out everything from whether or not this child is eligible for a vaccine under this program to simple things like co-pays. You really have to take a look at that here in Fresno so that the health plans can come and answer those RFA questions in a way that's going to meet the needs of people here in Fresno, especially the children.

Len Finnochio: I think that's a great challenge to this initiative overall and the steering committee and the coalition members who are going to participate in figuring out what that benefit package looks like and what Fresno can afford. In other counties they've come up with pretty much a Healthy Families comprehensive benefit package and I think that's the goal for this initiative as well.

Participant question: Is there a plan that covers undocumented children? I work in the rural areas and they end up in the emergency room most of the time because there's nothing that will cover them.

Len Finnochio: The goal of this initiative is to cover all children including the undocumented.

Participant comment: There is a new Kaiser program that is for children who are not eligible for any other subsidized program, and those are the undocumented children. It will not meet all the need but there will be maybe 500 slots.

Joel Diringer, Institute for Health Policy Solutions
Health in the Heartland: *The Crisis Continues* Study

This is an abbreviated discussion of some of the findings from the Health In the Heartland report that was presented in February. If you want a copy it's available on the web at this point and there are also printed executive summaries.

Health in the Heartland: The Crisis Continues is a study that looked at over 50 different health and demographic indicators and used these data to compare the valley to the State of California and compare valley counties with each other

The authors of the report are myself and Dr. Kathy Curtis from Fresno State, Cheryl Paul, and Danielle Deveau. It was a project that was done jointly with the Central Valley Health Policy Institute and myself and it was funded, like many things in this room, by the California Endowment. It was a year-long study looking at four major areas in the San Joaquin Valley on demographics, health status, health access, and also some health policy issues. It was an update to a report that I did in January 1996, so it was an eight-year update called Health in the Heartland: The Crisis Continues. What we looked at was over 50 different health and demographic indicators from four major sources: The 1990 and 2000 census to get some trend data, the 2001 California Health Interview Survey, which you may be familiar with by now, significant Department of Health Services data from the county health status profiles as well as birth certificate data, and lastly, the Office of Statewide Health Planning and Development (OSHDP) both on provider issues and also hospital discharge rates for certain diseases. What the report does is compare the valley as a region to the state as a whole, compare counties within the valley, and it also does some community-level analysis.

Fresno is higher than the rest of the state in chronic disease rates. It is about the same as the rest of the state in suicide rates. And we are better than the state in immunizing children.

How are we doing here in Fresno? In looking at 54 indicators Fresno County is doing worse than the state on 28 out of 54. Fresno is doing better than the rest of the state on 14 and similar to the state on only 5. So which ones are where Fresno is below the state average? I should say just because you're below the state average doesn't mean the state average is good. It just means compared to your benchmark you're doing lower than that. The first one, which we just talked about, is availability of providers. The health status of residents when asked how they rate their health status is lower here than in the state. Indicators of maternal and infant health such as infant mortality, low birth weight, and access to prenatal care are lower. Screening for cervical cancer utilization is a bit lower here. Chronic disease rates, which I think, unfortunately, you all know, are higher here. Diabetes, asthma, and coronary heart disease are all higher here than they are on average in the state. The incidence of chlamydia is very high. Binge drinking is higher here. People that say that they drink is actually lower than the state average, but of those who drink there is more binge drinking, that is, people who drink five or more drinks at a single sitting. And lastly, the rate of motor vehicle deaths is about double the state rate. Where are we similar to the state average? Child obesity is one area. About 20% of children ages 6 to 20 are obese. It's the same as the state but it doesn't mean it's good. Suicide rates are fairly similar.

People who indicate that they have a usual source of care is the same as the state and those who say that they delayed care due to inability to pay is about the same, so there are some paradoxes in there in that if you have higher uninsured and less access to providers why is it that everyone says that they have a usual source of care and don't delay care? Where are things better in Fresno compared to the state? One is in the rate of avoidable hospitalization. What we did here was look at ambulatory care sensitive diagnoses. These are hospital discharges for certain conditions that can be better treated on an outpatient basis, things like asthma and diabetes. It's a marker for availability of primary care because these are conditions that are generally treated on an outpatient basis. You're also better than the state on coronary heart disease deaths, not the incidence of heart disease but deaths from heart disease. Cancer deaths are lower. Housing costs are much lower here than they are in the rest of the state and that actually makes more income available for health services for a family. Alcohol use, as I said, is somewhat lower here, but not binge drinking. Tobacco use, surprisingly, is a little bit lower here. The rates of T.B. and AIDS, HIV are also lower here. Immunization rates are a bit higher. You're probably at 96% or 97% of kids getting immunized. The percent of the eligible population that is in fact enrolled in food stamps is higher here than in the rest of the state.

About one-third of kids in Fresno are under the poverty level. We have a high youth population here, and we have a low wage-earning population that can support the growing elderly and youth populations.

We'll look at some of the demographics here. About one-third of kids here are under the poverty level, which is even higher than the valley and much higher than the state. Also, about one-third of the adult population has no high school education, which is also higher than the rest of the state. Also, one-third of families in the census said that their dominant household language is Spanish. About one-third of the population are 18 or under, which is a bit higher than the rest of the state, so there is a larger percent of youth population. Corollary to that is the fact that the 25 to 44 population, the wage-earning population, is much smaller here and actually decreased as a percentage of the population between 1990 and 2000, so you're losing your wage earners that can support the growing elderly and the growing youth population.

Fresno County has fewer primary care providers per 1000 people, 30% fewer dentists, and about half as many mental health providers than the State of California

Fresno County has about 15% fewer primary care providers per 1000 people. These are data from the UCSF Center for Health Professions from 2000. There are about 30% fewer dentists. There are probably half as many mental health providers in Fresno County than in the state and even fewer than in the valley as a whole. Most of Fresno is designated HPSA, which allows access to over 60 federal programs that have to do with health workforce and other access programs. There are very few areas that have been designated dental HPSAs, and that's a problem. I believe almost the whole area has been designated a mental health HPSA.

Forty percent of children in Fresno County are on Medi-Cal or Healthy Families. Any cuts in Medi-Cal will disproportionately affect this county because we rely on it more.

The number of uninsured children in Fresno at the time of the CHIS survey was about 26,000. It's actually higher when you ask how many have been uninsured in the past year. The number of uninsured eligible for Medi-Cal or Healthy Families is about two-thirds or 17,500, which leaves 8,500 children who are ineligible either because their income is too high or because of their immigration status. The Children's Health Expansion Initiative hopes to take care of all the uninsured kids by either getting them onto available programs or creating new opportunities for coverage. When you look at the percent of uninsured children Fresno is about the same as the valley and just a little bit higher than the rest of the state. About 10% of children do not have health insurance. About 69% are eligible for Healthy Families or Medi-Cal. That's a little bit lower than in the state or in the valley and that's probably accounted for not by higher income here but by a larger undocumented population. Forty percent of kids in Fresno are on Medi-Cal and/or Healthy Families. This is based on the CHIS data, which is a survey, so the number may actually be somewhat higher. It's a much higher percent than in the state, and that's important. Just remember that any cuts in Medi-Cal will disproportionately affect this county because you rely on it more heavily and then realize that every dollar in Medi-Cal generates about \$2.38 as it ripples through the economy with its multiplier effect. Job-based coverage, children who receive coverage through their parents' jobs, is much lower here. It's less than half of the rest of the state, which is almost 60%.

Besides educational status one of the greatest indicators of poverty and being uninsured has to do with the immigration status of a child's parents

One of the most important issues that's driving a lot of this has to do with the percent of children in immigrant families in the valley. If one or both parents are immigrants themselves CHIS looked at it as an immigrant family, so 44% of children in the valley are in a family with one or more parents who are immigrants themselves. U.S.-born children with U.S.-born parents have the lowest rate of uninsured at 10% and poverty at 16%. At the other end of the spectrum, when you look at undocumented immigrant children 60% are uninsured and 78% are in poverty. Even U.S.-born children, children who are citizens, are intensely affected in both their poverty status and their rates of insurance by one of their parents being an immigrant. If you're a U.S.-born child and you have an undocumented parent you have about double the chance of being uninsured and probably four times the chance of being in poverty. As you know, it's very common to have mixed families where perhaps the father is documented and the mother is not, one of the siblings may be, some may have green cards, and some may have no legal status. This is important as we look at the Children's Health Expansion Initiative and it's also important as we look at the health status of children to realize that besides educational status probably one of the greatest indicators of poverty and being uninsured has to do with the legal status of their parents.

North Fresno and Clovis have the highest access to healthcare in the valley compared to all the rest of Fresno, which has the lowest access to care

Right in Fresno City, right where we are, is where the worst access to care is as opposed to North Fresno and Clovis, which has the highest access. The rural areas are also moderately low access or low ranking and then as you get further into the mountain areas you're having better access, at least in the way we've measured it. Way at the bottom was all of Fresno except for

North Fresno and North Fresno is 10th best, and they are right next to each other. In the report we've actually taken these rankings and related them to some of the demographics. Some of the associations have to do with income status, Spanish-speaking population, reliance on public benefits, and percent of single-parent households. So what can be done? We need to look at the diverse populations in the valley and particularly in Fresno. The multicultural aspect of the population here is very important when looking at any of the health programs. Having done farm work for a long time I tend to think of all immigrants as Latino, but that's not true here in Fresno. There is a whole range of immigrant communities and many more Hmong are coming in the very short term. We also need to target resources to those communities with the greatest needs and that has to do with going back and trying to do some mapping and looking at what specific needs there are in particular communities as opposed to thinking that one size fits all for every community.

We need to maximize state and federal funds and minimize the use of our local resources by making sure kids who are eligible for Healthy Families and Medi-Cal get enrolled

What is the idea of maximizing the use of state and federal funds? If two-thirds of your uninsured kids are eligible for but not enrolled in Healthy Families and Medi-Cal that means you're paying for them with local resources. It's your local hospital, your local doctors, and your local clinics that are providing care for the uninsured and it's affecting their bottom line. If you get the uninsured on the other programs you draw down federal and state dollars. Don't forget it's two-thirds federal dollars on Healthy Families, one-third state dollars, and it's 50/50 on Medi-Cal. You want to replace your local resources, which are far more limited, with federal and state resources. That's an important thing and it's also an economic driver if you want to look at it as just an economic issue for the valley. We need to enhance prevention and education efforts.

**Stefan Harvey, California Center for Public Health Advocacy
New Diabetes Data Regarding Children and Health Disparities**

The California Center for Public Health Advocacy did a study using diabetes death data from the Department of Health and fitness gram data from the California Department of Education

It's a great opportunity for me to talk to you about a new study that the California Center for Public Health Advocacy recently completed. I'm delighted to have the opportunity to tell you about the study because I hope it provides you with yet another tool to use and a somewhat unique tool as you work to try to affect public policy specifically in Sacramento. We at the California Center for Public Health Advocacy used two sources of data to conduct this study. The first was death data that the Department of Health Services collects and the second data source was the fitness gram data that the California Department of Education collects as required by law. As you may know, 5th, 7th, and 9th graders are tested for fitness. We looked at the death data from 1996 to the year 2000 and we analyzed this data in somewhat of a unique and different way inasmuch as we looked at diabetes deaths by state legislative district so we have a diabetes death rate for each of the 80 assembly districts in California and each of the 40 senate districts.

Thus, you will have a tool to use with your assembly representatives as well as your senators in Sacramento. We now know the diabetes death rate by state legislative district so no member of the California Assembly can say to any of us, “Well, that’s interesting data, but that’s for Fresno County,” or that’s interesting data because that’s for the 19th Congressional District.

Across the 80 assembly districts in the State of California there is considerable variation in the range of diabetes death rates per 100,000 residents

What did we find when we looked at the diabetes death data across state legislative districts? First of all, we adjusted the death data by age and by ethnicity. In some legislative districts there are more Latinos, for example, than in other legislative districts. Having adjusted the death data for race and age we found the following five principle findings from our study. The first is that across legislative districts in California there is considerable variation in the death rate. If we look at the 80 assembly districts the range was from 40.6% to 158.4% diabetes deaths per 100,000 residents, which is a considerable range across those 80 assembly districts.

Diabetes death rates are particularly high in the Central Valley region

The second finding is that the highest diabetes death rates were concentrated in three regions in the state, and it will probably not surprise any of you in this room that the Central Valley was one area in the state where the diabetes death rates were particularly high. The other two regions were Los Angeles County and the southwest area of San Bernardino County. If we look specifically at the three assembly districts that include a portion of your county all three of those assembly districts were among the highest in the state. We divided both the assembly districts and the senate districts into quintiles. All three assembly districts that incorporate part of Fresno were in the highest quintile and the same was true of the senate districts.

There is a correlation between a legislative district having a high diabetes death rate and that same district having a high prevalence of overweight and unfit children

We also asked the question of whether there was a correlation between legislative districts where there was a high diabetes death rate and those legislative districts where there was a high prevalence of overweight and unfit children going back to a study that we released in the year 2000 which looked at the fitness gram data. We found that there was a correlation, and those assembly districts that had a high percentage of diabetes death rates were often those assembly districts and likewise senate districts that had a high prevalence of unfit and overweight children. That led us to a conclusion that there are conditions in these communities, in this case conditions in legislative districts, which are contributing both to overweight and unfit children as well as a high diabetes death rate and that finding reinforced our interest in working on policy issues that affect the nutrition and physical activity environment.

Diabetes death rates are highest among the African American, Latino, and American Indian communities

Our fourth finding was that the diabetes death rates were highest among certain communities in California, again not surprising. These are the African American community, the Latino

community, and the American Indian community. For example, while the diabetes death rate for the 31st Assembly District for all residents was 108.5% per 100,000 individuals, the death rate for African Americans in that district was higher than that at 179.1% and Latinos was 149.3% per 100,000.

The diabetes death rate statewide increased every year from 1996 to 2000

The fifth finding of our study was that the diabetes death rate on a statewide basis from 1996 to 2000 increased every year. This is a disturbing fact. There is national data that indicates that of children born in the year 2000 one-third of them will develop diabetes in their lifetime.

The California Center for Public Health Advocacy worked with a panel of experts in California to come up with a set of policy recommendations to address the need to prevent and delay the onset of diabetes as well as manage the disease

As a part of the study there were policy recommendations that were put forth. We worked with a panel of experts across California on this study. Dr. Phyllis Preciado of your community was among those experts who advised us. They came up with a set of policy recommendations which addressed both the need to prevent and delay the onset of diabetes as well as recommendations to manage the disease. There were a series of recommendations that addressed the need to create healthy nutrition and physical activity environments in California. Our contention, and I suspect you all feel the same way, is that one of the reasons we see an increase in the prevalence of diabetes, particularly among children in California, which then is resulting in an increase in the number of Californians who are dying from diabetes-related consequences, is the overweight and obesity epidemic. Our efforts from a policy standpoint are to try to change the nutrition and physical activity environment. Many of the recommendations put forth in this policy brief address those environments and how to change them. I wish that were an easy proposition, but I think changing the nutrition and physical activity environment in California is about as daunting a task as ensuring that every California child has health insurance. But like you all in the room, there are many of us in California who are going to spend as many years as it takes to change those two environments. The final set of recommendations addresses the need to place particular emphasis on those communities in California from an ethnic standpoint as well as a geographic standpoint that are hardest hit by the diabetes epidemic. There are 22 recommendations included in this policy brief.

The California Center for Public Health Advocacy is tracking about a dozen bills in Sacramento that address the nutrition and physical activity environment

A handful of the policy recommendations are now being pursued through state legislation. I know many of you are involved in legislative action in Sacramento. We hope that these findings will be useful to you in your efforts in Sacramento. In closing let me invite you to join a network of advocates across the state with whom we work primarily via e-mail. We would be delighted on an ongoing basis to provide you information on what is going on in Sacramento with regard to about a dozen bills that address the nutrition and physical activity environment. There are a dozen bills that we are tracking and not only providing information to our network but also

asking for their participation and assistance in ensuring that the California legislature passes specific bills.

Rev. Walt Parry: Why is this not just a personal choice issue?

Stefan Harvey: Our feeling is that the environment is so intent on convincing us to eat unhealthy foods and be sedentary that we've got to address this from an environment standpoint.

Rev. Walt Parry: And what are the issues in schools related to both activity and food?

Stefan Harvey: On the physical activity front the issues in California schools are not enough physical education or in some cases no physical education at all. On the food front when we go to California public schools and see the environment in terms of the food that's being sold and promoted not to mention the advertising that is going on in our schools we see that significant changes have to be made there.

Participant comment: In terms of improving nutrition environments I do not see a recommendation listed here related to breast feeding. I think that is a piece that's missing because all the research indicates that formula use leads to higher rates of obesity and diabetes. We've been talking about school and junk food, and my description of formula is junk food for babies. When we look at the data for our community around the breastfeeding rate we also have the lowest breastfeeding rates in this community.

Stefan Harvey: Thank you for pointing out that omission. Interestingly enough, while it is not a recommendation, one of the 12 bills that we are tracking is SB 1275, a bill that's been introduced by Senator Ortiz, which is a breastfeeding promotion bill in that it will get at the marketing of infant formula in hospitals.

Participant comment: You mentioned physical education in schools being reduced. A lot of our extracurricular activities that schools usually provided like band, dance, the arts, etc. kept our children busy and when you eliminate those things our children get home from school earlier, they don't have the evening and weekend activities, and so then they're sitting in front of the T.V. eating. We parents who are concerned sign up our children in different extracurricular activities at city recreation departments, but there are so many children who can't access those things and so then they're sitting in front of the T.V. doing nothing.

Participant comment: In Fresno Unified we have so many students that are on free and reduced lunches. Because of the guidelines that we're required to follow by the federal government it is challenging for us to provide a nutritional meal that will be acceptable to multicultural students.

Stefan Harvey: That comment makes me state the obvious, which is in addition to working locally and at the state level in order to be successful we also have to work nationally.

Edie Jessup: I'm Edie Jessup and I work with Fresno Metro Ministry on the Hunger and Nutrition Project. For the last eight months a group has been working on a proposal to the

school board on a healthy school environment policy and we will be going to the school board with that request for a committee to be appointed and within three months a policy recommendation on food and physical activity in the schools. I have it available if you're interested in seeing it. If you're interested in endorsing it before I go to the board I would be happy to take your endorsement or your agency's endorsement.

Rev. Walt Parry: I want to mention the Kaiser Permanente Child Health Plan. There are several things to remember regarding that. First of all, it's primarily for two different groups. One would be undocumented children because they are not eligible for Medi-Cal or Healthy Families. Secondly are those children whose family's income is from 250% of poverty to 300% of poverty because they're not covered under Healthy Families or Medi-Cal. The first thing, though, is to always check to see if a child is eligible for Medi-Cal or for Healthy Families. As we know, approximately two-thirds of the children that do not have health insurance in Fresno County are eligible for either Healthy Families or Medi-Cal, so that's step one. If the answer is no or if the child is undocumented then the next step is to look at this Kaiser plan. Both Fresno Metro Ministry and the Fresno Health Consumer Center can assist you related to getting and filling out applications. We should all be trying to think of specific individuals or groups to target in order to try to extend health insurance to a number of the children in Fresno County.