The Marion and Polk Counties Health Access Monitoring Project

Report on Health Access for the Underserved Populations of Marion and Polk Counties

Oregon Health Action Campaign
3896 Beverly Street
Building J, Suite 6
Salem, OR 97305
(503) 581-6830
mpap@ohac.org

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Preface and Acknowledgements

The Marion and Polk Counties Health Access Monitoring Project is a joint program of The Oregon Health Action Campaign and The Access Project. Support for the data gathering and analyses used in the report were provided by The Access Project. Oregon Health Action Campaign used this information to develop the report's recommendations.

The Oregon Health Action Campaign (OHAC), a coalition comprised of 100 organizations representing over 450,000 consumers, as well as more than 2,700 individual OHAC members. OHAC has been the major voice for the health interests of traditionally underserved constituencies in Oregon for over 14 years. OHAC's mission is to empower the consumer in the development of quality, responsive health systems that allow all people to access the health care they need. OHAC accomplishes its mission through local community organizing, policy analysis, and public education.

Located in Boston, MA, The Access Project is a national initiative of The Robert Wood Johnson Foundation in partnership with Brandeis University's Heller Graduate School. The mission of The Access Project is to improve the health of our nation by assisting communities in developing and sustaining efforts that improve healthcare access and promote universal coverage with a focus on people who are without insurance.

Both Community Catalyst and Health Care For All/MA provided support to The Access Project for this study. The primary author of this report is Susan T. Sherry, a consultant to Health Care For All on health policy and community organizing. Additional contributions to this report have been provided by Jacquie Anderson of Community Catalyst, Riché Zamor of The Access Project, Ellen Pinney of the Oregon Health Action Campaign, and Allen Worters and Nicholas Herold of Health Care For All.

EXECUTIVE SUMMARY

In November 1998, the Oregon Health Action Campaign, in collaboration with The Robert Wood Johnson Foundation's Access Project, initiated the Marion and Polk Counties Health Access Monitoring Project. ***The project goal is to improve health access in Marion and Polk counties by broadening and deepening community involvement in healthcare advocacy.***

The first phase of the Project focused on gathering information and documenting the current health access situation for segments of the underserved population of Marion and Polk Counties. Key informant interviews, focus groups, community monitoring of hospital free care services and managed care plan language interpretation services were all used to gather information. This document reports the findings and recommendations from this effort.

West Salem Clinic, the Salud Community Health Center, county health department clinics, and hospital emergency rooms form the basic health access safety net in Marion and Polk Counties. As the report documents this safety net is strained and inadequate to the needs of the community and there are significant problems getting access to health care for uninsured low-income residents, Oregon Health Plan (OHP) participants, and the non-English-speaking populations of Marion and Polk Counties. The major barriers to access are in three categories:

- Lack of access to primary care, specialists, and dentists for uninsured and OHP participants is a serious problem and is exacerbated by transportation barriers.
- Inadequate and poorly communicated hospital free care policies create significant financial barriers for uninsured people.
- Inadequate language interpretation in the area's health system creates access and quality of care difficulties for the non-English-speaking population.

Oregon Health Action Campaign's (OHAC) recommendations to improve healthcare access have the common element of urging stronger collaboration among area providers, managed care plans, and community members – particularly those residents most affected by the problems. The recommendations include:

- Local providers and managed care organizations should increase their efforts to recruit primary care providers to the two-county area, obtain stronger provider participation in OHP and provide more service for uninsured residents.
- Area providers and community groups should work together to address transportation barriers and broaden services available to uninsured residents.
- Area hospitals and community representatives should work together to review and revise all aspects of hospital free care policies to ensure clarity, fairness, openness and appropriate income eligibility levels.
- OHP-contracted health plans should work with providers and community groups to expand availability of trained interpreters in all aspects of health delivery including after-hours care.

These efforts should include shared services and pooled resources whenever possible.

INTRODUCTION

In November 1998, the Oregon Health Action Campaign, in collaboration with The Access Project, initiated the Marion and Polk Counties Health Access Monitoring Project. ***The project goal is to improve health access in Marion and Polk counties by broadening and deepening community involvement in health care advocacy.*** The Project is primarily concerned with groups that are traditionally underserved by the current health care system: the uninsured, non-English speaking and low-income population.

Polk and Marion counties were chosen as the focus for this project for several reasons. Firstly, this two-county area functions as one service area for medical care with the City of Salem serving as the center for both primary and major medical care for many area residents. Secondly, these counties exhibit demographic trends that are now emerging throughout the state. For example, Marion and Polk Counties have one of the largest proportions and the most rapidly growing Latino population in the state with Hispanics twice as likely to be uninsured as non-Hispanics. At 26.6%, Marion County has the highest teen pregnancy rate in the state and is among the top seven Oregon counties in terms of infant mortality.[1] Finally, the rural and small town make-up of the two-county area is typical of many other areas of the state that are experiencing provider shortages (particularly within the Oregon Health Plan, the state's Medicaid program) and have a shortage of public transportation facilities, exacerbating health care access problems.

The Health Access Monitoring Project has three phases of activities:

- Phase One focused on gathering information and documenting the current health access situation for underserved population segments of Marion and Polk Counties. This document reports the findings and recommendations from this effort, completing this phase of the Project.

- Phase Two, now just getting underway, consists of broad-based outreach into the community so that area residents can use the information gathered during Phase One, as well as their own knowledge, to move forward on an action plan that will engage the community to work for specific health access improvements.

- Phase Three will establish a permanent Marion/Polk Community Health Advocacy effort to implement the action plan.

[1] Data provided by Children First, Portland, OR, County Data Book 1998

STUDY PURPOSE AND METHODOLOGY

The purpose of this study is to establish, as clearly as possible, what healthcare access problems exist in Polk and Marion Counties. Specifically, the Project is interested in identifying the access barriers for the low-income, uninsured, and non-native English speakers, including financial barriers, language barriers, etc. Identification of these barriers is the first step in developing a set of specific solutions that can be implemented by area health institutions, policy-makers, and community members to reduce and eliminate those barriers. The study used four different methods for gathering data:

1. **Key informant interviews:** Approximately half of eighteen interviews with health, community, and constituency leaders focused on both Marion and Polk Counties; four focused exclusively on Polk County, and four on Marion County alone. Interview questions addressed perceptions of area health needs, available area health care facilities and their language interpretation capacity, the experience of uninsured residents, and the challenges faced in meeting community health needs. (The list of key informants is provided in Appendix A.)

2. **Focus groups:** Eight people participated in each of two focus groups with uninsured residents and Spanish-speaking residents from both counties.

3. **Community monitoring of the hospital free care:** Trained community members visited three area hospitals (Salem, Valley Community, and Silverton) and sought to obtain information about hospital free care policies. Some callers sought free care information as uninsured people or relatives of uninsured people. Other callers sought the same information as part of job or volunteer duties. The monitoring focused on the availability and clarity of information about hospital free care policies, particularly from the perspective of likely users. The written policies of the three hospitals were also reviewed.

4. **Community monitoring of the language interpretation capacity of area managed care plans:** Trained Spanish-speaking volunteers used the customer service phone lines of the four Marion and Polk managed care organizations participating in the Oregon Health Plan (OHP). Callers documented each plan's ability to communicate information about the plan itself, to determine what language interpretation options were available in each plan's provider network, and to learn what after-hours interpretation capability was provided.

This report has three sections covering the topics of health access, hospital free care, and language interpretation. Each section describes specific findings and recommendations related to the section topic.

STUDY RESULTS

HEALTH ACCESS

> *"I see a lot of kids with hearing impairments because they didn't go to the doctor."*

> *"The mainstream medical system does not serve uninsured people."*

> *"There is no transportation to Salem."*

> *"There is a lack of primary care, especially for OHP patients. Doctors are not taking any new patients."*

> *"People are dropping off OHP due to the six month eligibility review. OHP enrollment happens at OHSU, but other hospitals just give out applications – they don't help people with the forms"*

> *"It's really hard for people with children who do not have cars and have to take the bus."*

The picture of access that emerges in the two counties is mixed but, as these interview and focus group quotes illustrate, low-income uninsured and OHP clients experience substantial access difficulties. Barriers to access are found within the area health and medical system as well in support systems such as transportation.

This is a time of change and upheaval in health care. Many of the changes underway can leave health institutions and providers increasingly isolated from the communities they serve, especially from underserved segments of the community. Some successes in improving access around the country have been achieved by focusing attention on the community benefits obligations of area health institutions' health plans as a way to strengthen both access and collaboration.[2] In some instances, state policymakers have an important role to play in helping to address locally identified access issues. Above all, resolution of many of the health access issues identified through this Project will require a strong commitment from local health institutions and community groups to work together in concerted and well-planned initiatives.

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[2] Community benefits are the unreimbursed goods, services, and resources provided by health care institutions, including health plans, that address community-identified health needs and concerns, particularly those of people who are traditionally uninsured and underserved.

KEY FINDINGS ON HEALTH ACCESS

The key findings on general health access issues in Marion and Polk Counties are as follows:

- There is a severe shortage of primary care providers in Polk County so that OHP participants and the uninsured must routinely leave the area to obtain care. While there are more providers in Marion County, they are operating at maximum capacity. As a result, at least periodically, OHP participants and the uninsured are unable to access primary care in Marion County.
- The West Salem Clinic is a major provider for OHP and uninsured residents in both Marion and Polk Counties. Due to constant capacity constraints, West Salem must periodically close intake of new clients.
- The county health department clinics are also at capacity and are often called upon to provide services beyond their charter of maternal and child care such as primary care to adults -- most often for Hispanic women who first came to them for maternal and health care.
- All community members and providers interviewed stated that there was a shortage of primary care access for OHP participants. Only the Oregon Medical Assistance Program (OMAP) stated that they had no indication of OHP primary access problems in the Marion and Polk Counties. There are, however, strong indications that access for OHP patients in these localities may not meet the OMAP's own standards by failing to provide comparable time, distance, and appointment access as available to non-OHP patients.
- Salem Hospital opened an urgent care clinic, built medical office facilities and recruited family practice physicians for the facilities. The physician practices filled immediately. Despite high use of the urgent care clinic, there has been no commensurate reduction in emergency room use, suggesting continuing unmet needs for more family physicians.
- There are many currently uninsured residents eligible for Oregon Health Plan (OHP) and Children's Health Insurance Plan (CHIP) coverage, but not enrolled. Under-enrollment is particularly high in the Latino community. Inadequate information at the community level and fears about enrollment jeopardizing legal status appears to account for the low enrollment rates.
- Transportation to health care providers is a major access barrier particularly because so many people outside of Salem and West Salem must leave their own communities to obtain care.
- Dental access for low income and uninsured people is a significant problem since only a few dentists in the two counties accept OHP patients and, with no dental school in the area, there is no clinic option available as in many major metropolitan areas throughout the country.
- Mental health services, including both crisis and community-based care, are widely perceived as inadequate.

OHAC'S RECOMMENDATIONS ON IMPROVING HEALTH ACCESS

Recommendations in the area of improving health access are as follows:

- Area providers and managed care plans should seek to recruit stronger provider participation in OHP and in serving uninsured residents. Programs to provide primary care and other medical services to uninsured residents should be developed as part of hospital and managed care plan community benefits.

- Area managed care plans, hospitals, and providers should work to expand primary care capacity, particularly in Polk County. Expanded capacity in both counties should be extended to all OHP participants and to the uninsured.

- Area hospitals and managed care plans should minimally comply with the Voluntary Community Benefits Reporting Guidelines developed by the Oregon Association of Hospitals and Health Plans. The guidelines suggest community involvement in identifying community health needs and in designing programs to respond to these needs. Area hospitals should pursue this approach.

- Community groups and area providers should collaborate to expand community-based outreach for existing health access programs with particular attention to the unique needs of the Latino community.

- Area providers, managed care plans, and community organizations should explore collaborative approaches to improving medical transportation for Polk County communities. Such service should receive consideration as a potential community benefit by hospitals and managed care plans.

- Community groups should work with the Oregon Medical Assistance Program (OMAP) to determine whether OMAP standards for primary care access are being met. If these standards are not, then OMAP should work to assure that area managed care plans meet access requirements.

- Area providers, managed care plans and community groups should work together to develop a plan to improve dental access for low-income residents. Such a plan might include recruitment of dentists, establishment of dental clinics, and support for improved state-level OHP dental reimbursement rates.

- Area providers, managed care plans and community groups should collaborate in seeking state-level policy changes that would improve resources for and management of mental health services.

HOSPITAL FREE CARE

> *"I didn't eat some of the time because of my medical bills."*

> *"A lot of times people I know won't take their kids in to the hospital if they are sick because they don't have insurance and it would cost too much money."*

> *"Some people have what are huge hospital bills for them --- $2,000 to $3,000. Collection agencies are frequently used. This creates credit problems for people and then they end up homeless, or in very poor housing, which just makes their health worse."*

> *"Four years ago I collapsed on the floor. I had a pain in my stomach for a long time and I just let it go because I had no health insurance. I had cervical cancer. They did the surgery and my bills come up to $15,000. It took me three and one-half years to pay it off. I didn't have to pay for my chemo - I went eight times. They gave me a doctor to see on a regular basis and I didn't have to pay for it"*

As these quotes from study subjects show, the cost of medical care influences the timing and level of care that the uninsured and underinsured seek and that it also reverberates in other aspects of their lives.

Hospital free (charity) care[3] is a critical part of the health care safety net for uninsured and underinsured people. As the number of uninsured people grow, this safety net is more important than ever to more area residents. The hospital is the most important element of the safety net, especially in communities without enough health care providers. How easily the community and potential users of free care are able to find out about the availability of hospital free is a basic measure of access for uninsured residents. The actual hospital free care policies in terms of income eligibility and application procedures is another measure of the adequacy of the safety net.

The study showed that, while Polk and Marion Counties have a safety net of free and reduced-cost hospital care, the policies and their application are inconsistent and, most importantly, are applied with inappropriately-set income standards so that too many patients are left with bills they cannot afford to pay. This can lead to bad credit ratings that hurt other aspects of their lives.

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[3] Free care, or charity care, is care provided a hospital for people who show they cannot afford to pay for care; hospitals do not expect to be paid for these services. Some hospitals provide free care for a portion of hospital bills when patients can pay some, but not all, of the cost. Bad debt is different from free care. It means services for which the hospital expects payment but never receives it. Bad debt is usually from insurance companies or individuals not paying bills. Hospitals expect to be paid for bad debt, so they use collection efforts to obtain payment.

KEY FINDINGS ON HOSPITAL FREE CARE

The study findings concerning hospital free care policies and practices are as follows:

- While uninsured people delay seeking care because of inability to pay, they do ultimately seek and obtain care at area hospitals and are confident that they will not be turned away from these institutions. Hospital employees are fully aware of local institutional policy that no one is turned away and communicate this clearly to the public.

- In no instance, was a caller to area hospitals able to obtain a complete definition of the hospital's free care policy, either written or verbal. In many cases, the amount of information provided seemed to depend upon the status of the caller with uninsured callers received the least amount information about actual free care and payment plans.

- However, the public and many hospital employees have little or no knowledge of hospitals' actual free care policies. In many instances, community members are told that while they will not be turned away, but that there is no free care available -- only payment plans. Even those patients who receive sliding scale coverage do not understand the process or policies that determine the sliding scale.

- Many uninsured patients are placed on payment plans. While patients express their appreciation of this institutional flexibility, many struggle to comply with these payment plans. When uninsured patients are unable to meet payments, they are subjected to collection action. Such action harms credit and, thereby, compromises their ability to meet other basic life necessities. Several informants cited bad credit resulting from their inability to keep up with hospital payment plans as a contributing factor to their substandard housing situation.

- The free care policies of area hospitals do not seem to accurately reflect patient ability to pay as indicated by an increase in their bad debt relative to free care. The shift from free care to bad debt conforms with the experience of uninsured people who seem to have much greater experience with payment plans rather than with free care. (The rise in bad debt has moved one hospital to review its free care policy. One area hospital officer acknowledged that uninsured people likely to be eligible for free care were not receiving it, but there was no acknowledgement that the institution's own policies and procedures merited evaluation because of this problem.

OHAC's Recommendations on Hospital Free Care

Recommendations to improve the substance and dissemination of hospital free care policies are as follows:

- Area hospitals should work with community representatives, particularly low-income uninsured people, to review and revise all aspects of hospital free care policies to ensure clarity and fairness. Policies should clearly define eligibility income levels for free care and partial free care sliding scale provisions. Income levels should be set realistically so that most recipients of partial free care are able to comply with their payment plans. Policy provisions should include:
    - ✓ Written policies with clear and consistent eligibility standards
    - ✓ Notice to the community including postings and outreach
    - ✓ Simple, language appropriate applications with reasonable documentation requirements
    - ✓ An open, respectful and timely decision-making process with review due to changed financial circumstances
- Information about free care policies should be communicated broadly throughout the community and within the hospital including ongoing training for hospital employees.
- State policymakers should consider establishment of a standard definition of free care and basic requirements for provision of free care by all hospitals so that there is a level playing field among all Oregon hospitals.

LANGUAGE INTERPRETATION

> *"I'd love to see one Spanish advice nurse for all the doctor practices."*
>
> *"Salem Hospital Social Services are great to clients and around interpretation needs."*
>
> *"The community has historically operated on the principle that the Latino population is a transient population. This is part of the community's self-image even though it is not true."*
>
> *"The language barrier is in the way of everything. There are disputes about whether it is a client or provider responsibility to arrange interpretation. It takes an enormous effort to even schedule an appointment for an earache. By the time you add up the patient's request being rejected by the provider, then the patient calls us, then we call the health plan, then we push the health plan which often wants three days notice to arrange interpretation, then we say that is inadequate – plus there are all the call-backs associated with this – it is hard to get beyond the language barrier."*

The capacity to communicate effectively is fundamental to delivering quality health care as these study quotations reiterate. This reality is recognized in both federal Civil Rights law and in the regulations governing the Oregon Health Plan. Managed care plans and providers who contract with the OHP are required to have adequate language interpretation capacity. These OHP requirements are especially important since OHP is (or could be) a major source of health insurance coverage for many Latino children and families. The need for adequate language interpretation extends from the task of selecting a managed care plan to scheduling provider appointments to after-hours care. The ability of area providers to meet the needs of non-English speaking residents is fundamental to meeting the health care needs of these area residents.

The study showed that language interpretation service in Marion and Polk Counties are generally good within the hospitals and clinics, at least for Spanish, which constitutes the major non-English language. Outside this environment, the level of service provided is significantly less good, often impeding the effective communication of critical medical information.

KEY FINDINGS ON LANGUAGE INTERPRETATION

The key findings on interpretation services for the non-English-speaking seeking health care in Marion and Polk Counties are as follows:

- The safety net clinics of West Salem and Salud and the county health departments have bilingual staff and excellent language interpretation capacity making these sites important sources of care for Spanish-speaking residents.
- Salem Hospital has excellent language interpretation capacity with trained interpreters on staff. It can still, however, be challenging for non-English speaking patients to obtain the interpretation support they require over the entire course of their treatment. The smaller hospitals of Silverton and Valley Community have limited interpretation capacity and, therefore, rely on untrained employees or phone interpretation services.
- Outside of the safety net clinics, health departments, and Salem Hospital language interpretation services are inadequate. Most physician practices, including those serving OHP clients, do not have any language interpretation arrangements. For example, a major pediatric practice advice line does not have any Spanish-speaking staff. Clients are often asked to bring their own interpreters. It can be difficult for clients to even set up appointments -- sometimes requiring two or three phone calls, a process that is made even more difficult when the client does not have a home phone.
- Even for those practices that arrange for interpretation services, two to three days notice is often required to set up such appointments – clearly inadequate for urgent care situations. A number of practices rely solely on the limited Spanish language skills of physicians and their staff, regularly causing patients to leave without necessary medical information. Most disturbingly, the providers who used this approach were unaware that there was any problem with their interpretation services.
- The customer service departments of OHP managed care plans are able to assist Spanish-speaking callers during business hours with basic administrative information. Of the three managed care organizations serving Marion and Polk Counties, one has bilingual customer service staff and the remaining two use phone interpretation services.
- Care Oregon is able to assure OHP enrollees of access to Spanish-speaking physicians or interpretation services including for after-hours care. However, other managed care plans were unable to make such assurances. These other plans informed callers that hospital emergency rooms would be their only option for after-hours care that required a language other than English.
- Many of the managed care plan and physician practice situations described above are not in compliance with OHP contract requirements. It is also of note that OHP-contracted managed care plans do not, for the most part, reimburse providers for the cost of interpretation services nor do they provide any centralized coordination for interpretation services.

OHAC's Recommendations on Language Interpretation

Recommendations in the area of the availability and capacity for interpretation for non-English speaking health care consumers are as follows:

- OHP and OHP-contracted managed care plans should work with community members to establish stronger monitoring of interpretation capacity among managed care plans and to improve their capacity.

- OHP-contracted managed care plans should facilitate physician access to trained interpreters through establishment of centralized systems and reimbursement.

- Managed care plans should ensure accessible after-hours care for non-English-speaking clients. Initial steps might include establishment of a Spanish-speaking nurse call-in line that could be shared among managed care plans and physician practices.

- Physicians contracting with managed care plans should consider negotiating for greater plan support for interpretation services including appropriate reimbursement and centralized systems for obtaining interpreters.

- The OHP should increase capitation rates to cover the cost of interpretation services. This increase should be accompanied by stronger monitoring of interpretation requirements.

- Area hospitals, managed care plans, and physicians should explore collaboration with each other, including pooling of resources, to expand the number of bi-lingual/bi-cultural employees and trained medical interpreters with stable employment. Such an approach might include a shared interpreter pool.

CONCLUSION

The major conclusion to be drawn from the first phase of this Project is that health access for the traditionally underserved populations in Marion and Polk Counties requires strengthening. The existing safety net is strained and the mainstream medical system has not responded adequately to pressing community health needs. It is hoped that the findings in this report will spur an in-depth examination of how all segments of the health system and community can work together to respond to documented health access needs.

Many of the issues identified in this report, such as the need for language interpretation due to changing demographics or shortages of primary care providers in rural areas, are not unique to Marion and Polk Counties. These are issues in many other Oregon communities. However, Marion and Polk Counties have some unique assets to bring to addressing these problems: (1) a financially strong major hospital without any immediate competitive pressures that is in a unique position to offer leadership; (2) an increasingly active consumer engagement from within underserved populations can offer critical insight and wisdom in designing responses to identified need. This is a time of change and upheaval in the health system in Oregon and in the Nation as a whole. Communities and local providers have a major stake in shaping the direction of this change. The first step to influencing the shape of change is deeper collaboration within the community and among local health institutions.

As noted throughout this report, a major part of the solution to identified access problems lies at state and national policymaking levels. Adequate reimbursement for primary care, language interpretation and dental services; maintenance of outreach for existing access programs; and continued support for coverage programs for the uninsured are all part of the state and national policy arenas. Strong collaboration among area providers and community groups to advocate for more effective and specific state and national policies to improve access provides the best means to shaping public policy in the face of growing community need.

APPENDIX A – KEY INFORMANTS

The key informants who provided information concerning health access in Marion and Polk Counties in support of this study are show below with their affiliated organizations:

Sandy Abrams, Mid-Willamette Valley Senior Services Agency

Steve Bowles, Valley Community Hospital

Kathleen Dowling, Salem Hospital

Julie Fitzgerald, Dr. Climer, Silverton Hospital

Valerie Freeman, Salem Hospital

Lorraine Heibert, Polk County Health Department

Lynn Martin, West Salem Clinic

Elena Pena, St. Patrick's Church

Sandra Peterson, Healthcare Business Education

Carmen Ramirez, Salud Medical Center

Dr. Lou Rios, private practice

Patti Vega, Marion County Health Department

Kathryn Weit, Developmental Disabilities Council

Mary Tippen, Woodburn Medical Clinic

Joel Young, Oregon Medical Assistance Program

Jacqueline Zimmer, Oregon Association of Area Agencies on Aging and Disabilities

Ramon Ramirez, Pineros y Campesinos del Noroeste