

AN ABSTRACT OF THE THESIS OF

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Barriers for Hispanics in Oregon's Managed Care Medicaid Program.

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From February to September of 2001, a significant body of qualitative data was collected to investigate barriers for Hispanic participation in Oregon's managed care Medicaid program. As a means to investigate this topic, comments were solicited from physicians, hospital administrators, social service agencies, and low-income Hispanics through semi-structured focus groups and individual interviews. This methodology presents the reader with a rich ethnohistoric and cultural context to the local issues surrounding Hispanic under-participation in Oregon's managed care Medicaid program. Finally, through an analytical framework of critical medical anthropology, connections are drawn from local barriers to state and corporate policies.

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**PREFERRED CUSTOMERS?
Barriers for Hispanics in Oregon's Managed Care Medicaid Program**

by

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PREFERRED CUSTOMERS?
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INTRODUCTION

As national health care reform met yet another gridlock in the late 1980's, states began to design and implement alternative Medicaid delivery models. State level Medicaid reforms were made possible through a federal demonstration waiver. This waiver allows states the liberty to determine the use of federal Medicaid funds (Health Plan Administration (HPA) 1995).

Upon receiving the demonstration waiver, Oregon swiftly adopted what has come to be known as the Oregon Health Plan (OHP). The OHP is a conglomerate of several statutory elements passed over successive legislation sessions beginning in 1987 and continuing through the most recent session of 2001. The purpose of OHP is to control Medicaid spending, while expanding Medicaid coverage to significant numbers of uninsured Oregonians (HPA 1995). At the core of the OHP statutes is a prioritized list of several hundred medical conditions. Each year policymakers draw a cut off line on the list of conditions that will be covered under Medicaid based on budget projections for the upcoming fiscal year (Oregon Health Policy and Research 1999).

The OHP also includes a radical restructuring of the way Medicaid is administered: from a fee-for-service (FFS) model to managed care. In the FFS

model, doctors were reimbursed by the state for each service utilized by Medicaid patients. In contrast, under managed care, the state contracts with private insurance companies or health maintenance organizations (HMOs) to reimburse participating doctors. A flat fee is then awarded to insurance companies for every patient that enrolls in their health plan (Maskovski 2000).

The first phase of the OHP was enacted in February of 1994. At the time of implementation, Oregon had an estimated 18% uninsured rate among its 2.85 million citizens, while the unemployment rate was relatively low at 5.7% (OHPR 1999). Meanwhile, following national trends, the cost of health care was the fastest growing portion of public and private sector budgets. During this period, medical expenses were rising at four times the rate of inflation (Sultz, Kristine and Young 1997).

OHP was able to control spending and create a surplus of money to expand program coverage to more uninsured Oregonians. Within the first few years of the program, the number of uninsured Oregonians plummeted from 18% to 11%, insuring an additional 80,000. Currently, Oregon has one of the lowest uninsured rates in the nation. Nevertheless, the state is still far from its goal of a 5% uninsured rate. Furthermore, the number of Oregonians without insurance has remained stagnant at 11% for the last five years (OHPR 2000).

Although the expansion of OHP program has been successful in extending coverage to many Oregonians, there may be a disparity in program participation along ethnic lines. OHPR research indicates that Hispanics compose a

disproportionate part of Oregon's uninsured (2000). In 1998, 22% of all Hispanics were chronically uninsured and 39% were uninsured at least once in the last twelve months. This figure is especially stark considering that Hispanics experience nearly twice the rate of being chronically uninsured compared to Anglos, African Americans or Asian/Pacific Islanders in Oregon (OHPR 1998). Unfortunately, there has yet to be research that examines the number of Hispanics that qualify for the OHP, but are not participating in the program. Nevertheless, the extraordinarily high Hispanic uninsured rate in comparison to other ethnic groups in Oregon gives prudence to question the extent to which Hispanics may qualify for the OHP, but have not fully participated.

Although cultural differences and language barriers are frequently suggested, the preponderance of research in Hispanic participation in OHP focuses on financial reasons. Seasonal income fluctuation frequently raises above the income requirements at certain times of the year, thus disqualifying many Hispanic families for OHP benefits (OHPR 1995). The other prevailing hypothesis is that Hispanics typically work in blue-collar jobs and receive slightly too much income to enroll in the OHP, but are unable to afford private health insurance (OHPR 1995; OHPR 1999).

Financial considerations undoubtedly account for some of the Hispanic under-participation in OHP; however there are other cultural, linguistic, and structural factors that deserve further examination. By using in-depth interviews and participatory observations, this thesis provides an ethnohistoric and cultural

context to the local-level barriers regarding Hispanic participation in the OHP. Connections are then drawn between local level barriers and state and corporate managed care policies.

The initial research phase of this study is based on a project sponsored by the Office for Oregon Health Policy and Research (OHPR) entitled, "Options for Universal Health Care." Under the umbrella of this study, Oregon State University's Department of Anthropology's objective was asked to solicit comments and suggestions from key groups within and outside the health care system in regards to both state and employer sponsored insurance. The primary investigator was Dr. Sunil Khanna. From February to September of 2001, the research team held 16 semi-structured focus group discussions with physicians/hospital administrators, small business employers and uninsured ethnic populations in several locations throughout Oregon. Out of these interviews, this thesis included four focus group discussions with physicians/hospital administrators and three focus group discussions with uninsured Hispanics.

The second phase of the research is based on a community health needs assessment funded by Pioneer Memorial Hospital and Prineville Chamber of Commerce. The assessment occurred between July 7, and September 5, of 2001. The purpose was to evaluate both the health care resources and the residents perceived health needs in Crook County, Oregon. Data relevant to my thesis topic included four uninsured Hispanic focus groups and 40 individual interviews with doctors, hospital administrators, and social service agency workers. I additionally

chose to include participatory observation notes recorded while performing Spanish hospital translation services, assisting Hispanics with enrolling and participating in the OHP, and in various informal interactions I had with the Hispanic community in the area.

Lastly, from contacts made in Crook County, I visited Los Cruses de Varieros. This village of approximately 1,000 inhabitants is located in South Central Mexico. The purpose of this trip was to gain a historical context to my research question. From September 7 to 21 of 2001, I held two focus groups and performed five individual interviews with friends and relatives of Central Oregon Hispanic residents.

LITERATURE REVIEW

Ethnicity Defined

Recently ethnicity has begun to be recognized by researchers as a significant variable in obtaining accessible and quality health care (Trevino and Trevino 1996). Since this thesis is exploring ethnicity as a variable in OHP participation, it is important that this term is clearly defined. Yinger (1994:3) describes ethnicity as:

A segment of a larger society whose members are thought, by themselves or others, to have a common origin and to share important segments of a common origin and culture and who, in addition, participate in shared activities in which the common origins are significant ingredients.

Yinger also outlines three elements of an ethnic group: (1) the perception by others in society of differences between the group members and others relating to certain traits, religion, race or homeland; (2) The perception of these *same* differences by the members of the group; (3) The participation of group members in shared activities that are founded on their perceived common heritage or culture (1994).

The term "Hispanic" was designed by the U.S. Department of Commerce, Bureau of the Census, to refer to all individuals with ethnic origins from Spanish-speaking countries. This includes Spain, Puerto Rico, Cuba, and Central and South American countries (Mendoza 1994 in Sana-Loue 1999).

According to the 1990 census, Mexicans compose 64.3% of all Hispanics in the U.S. My field research with uninsured Hispanics consisted of an estimated 90% of Mexican-Americans. While interviewing participants, a few took offense to being labeled Hispanic. Sometimes they would correct me by saying they were “Mexican” not Hispanic. Nevertheless, this thesis conducted interviews with significant numbers of informants from other Spanish speaking countries. Furthermore, this study was interested in focusing on ethnicity rather than nationality as a variable to health care. There were also no records of nationality integrated into the participant screening process. Therefore, I have chosen to use the term Hispanic to describe immigrants from all Spanish-speaking countries.

Explanatory Models of Health

Explanatory models are described by anthropologist Peter Brown as a way to express cognitive models of illnesses (2000). Anthropologists have dedicated significant research towards documenting these models. They are important to understand because they influence peoples’ decisions to seek care, doctor-patient relations and the utilization of specific forms of care (Castro, Coe and Harmon 1996).

OHP managed care mainstreaming of Hispanic clients into private clinics and hospitals have, in many cases, created situations where physicians and patients are coming from two distinct medical paradigms. The following is a cursory description of some of the explanatory models that Hispanic Medicaid patients may

have regarding health and healing. Future chapters illustrate the barriers these explanatory models present to achieving quality, culturally competent care in Oregon's mainstream biomedical system.

George Foster (in Brown 2000:111) states, "simple one-to-one relationships between a single society and a ethnomedical system do not exist." Brown takes this stance further by stating that despite the global phenomenon of biomedicine, frequently traditional medical systems coexist along side this system (2000). It is commonplace for Hispanics, as well as most other ethnic groups, to use either or a combination of traditional and biomedical models to achieve wellness. *Hierarchy of resort* is the term used to describe the pattern of receiving health care from several different models (Brown 2000). Most Hispanics living in the United States or in Latin America have coalesced a number of the fore mentioned models with the biomedical model (Castro Coe and Harmon 1996).

As globalization continues to interlink the capacious number of ethnomedical beliefs, social scientists have now begun to categorize these groups in order to raise the level of cross-cultural understanding in the clinical setting. Foster's (in Brown 2000:116) article, "Disease Etiologies in Non-Western Medical Systems," pinpoints two basic epistemological assumptions that he believes encompass all medical models. The first general category, *naturalistic* etiologies, subscribes to the idea that disease is restrictive to illness. Usually the cause of the illness is a direct result of a phenomenon within a natural system (Brown 2000). It is commonly thought to be an imbalance or a loss of equilibrium. A few popular

natural illnesses within the Hispanic community include: "aigre or mal aire (bad air), empacho (intestinal obstruction) and mollera caida (fallen fontanelle) (Scheper-Hughes and Stewart 1983). An especially popular naturalistic explanatory model in Latin America relates to an imbalance of hot and cold in food or climatic conditions. This well documented explanatory model is described by Messer (1981: 133):

Hot-cold syndromes...view health as a balance of opposing and complementary (hot-cold) qualities and illness as an imbalance or alteration in one quality. Where such terms are used, all body conditions, food, and medicines can potentially be classified as some degree of hot cold...The general rule for health maintenance is the avoidance of the extreme of any one quality. In the event of an imbalance (illness) the procedure is to treat the person by the principle of opposites. The particular body condition is analyzed to be one or the other quality and is brought back into balance by the introduction of quantities of the opposite quality.

It is typically not apparent to the person or the doctor the specifics of how natural illnesses are contracted, nor is it of great significance. The diagnosis is also rather unimportant. The emphasis largely rests on finding a cure or a therapy to treat the illness. Lastly, the responsibility for contracting and treating illnesses primarily resides with the patient (Foster in Brown 2000).

Foster's second category, *personalistic* etiologies, are based on the notion that illness is connected to social relationships with living people, ancestors, or even spirits. Some popular Hispanic personalistic illnesses include: encono (the festering of wounds), mal ojo (evil eye), maleficio (witchcraft), melachio (melancholy), and susto (fright) (Scheper-Hughes and Stewart 1983). Illness is

perceived to be a misfortune inflicted upon an individual is intentional or unintentional action. As a result of their misfortune, magical or religious powers have acted upon them to create illness in the body. Since the causation is a consequence of social circumstances, personalistic systems search for cures outside of the individual (Foster in Brown 2000). Often the cure is rendered by reestablishing blemished relationships. There is also frequently a social component to assisting the individual in this process.

The application of the personalistic and naturalistic categories could serve as a useful tool in patient-physician dialogue within US clinical settings. Out of these conversations, there lies the possibility for further understanding between the different illness paradigms and a greater likelihood that a common goal or course of treatment can be agreed upon.

Historical-Political Background

Because most Hispanics interviewed came from Mexico, the following provides a brief historical sketch of the major Mexican migrations to the U.S. The following also notes a few of the macro-level historical events that have influenced the relationship between Mexico and the United States over the past 150 years. This historical sketch is aimed providing a context of the migratory history of Mexican Americans living in Oregon.

The U.S.-Mexican border extends 2000 miles-from the mouth of the Rio Grand River to the Pacific Ocean. The border was formed as a result of the 1848

Treaty of Guadalupe Hidalgo, which ended the Mexican War (Ehrlich, Bilderback and Ehrlich 1979). Numerous tensions between Mexico and America have come from several sources and continue into the present: Mexico's opposition to slavery in Texas and assistance to escaping slaves during the 1850's; the U.S. placement of troops in Mexico during the 1870's; the massacre of Americans at Santa Ysabel in 1916; the influx of American investors into Mexico in the 1920's; the expropriation of American-owned oil companies in Mexico by the Mexican government during the late 1930's; the introduction of U.S. agribusiness in Mexican farming during the 1940's, 1950's and 1960's, with disastrous economic consequences; the establishment and later termination of the U.S. Bracero Program; the establishment of "maquiladoras" in border areas (Ehrlich et al., 1979 Samora 1971); past and present U.S. immigration policy and the recent NAFTA agreement. All of these events have significantly influenced the relationship between Mexico and the United States and impacted Hispanics that have settled in Oregon.

Mexican immigration to the United States gradually increased right up to the great depression. During the period of 1900 through 1904, Mexican Americans represented an estimated .04% of the total immigrant influx into the U.S. However, between 1925-1929 Mexican immigration had grown to represent 15.7% of the population of immigrants. Shortly after 1929, a law was enacted in the U.S. which rendered some Mexican immigrants deportable, slowing migration temporarily.

The need for agricultural labor during World War II prompted the establishment of the Bracero Program in 1942. The program was intended to provide agricultural labor to the U.S; particularly shortage areas in California. The desire by growers to continue receiving cheap labor motivated them to advocate strongly for the continuation of this law until the early 1960's. Numerous researchers have traced the beginnings of the "illegal immigration problem" to the Bracero Program and the growers encouragement of migration into the U.S (Enrich et al.1979; Samora 1971).

Language, Acculturation and Culturally Competent Care

It is well documented that language barriers for Hispanics within the clinical setting can negatively affect access and the quality of health care (Trevino, Bruhn and Bruce 1979). Researchers have demonstrated that Hispanic patients who speak English are more likely to have a regular source of care than those who speak only Spanish (Hu and Covell 1986) and possibly be more willing to use available services (Trevino, Bruhn and Bruce 1979). Nationally, English literacy is another factor in receiving quality care, which is relatively low in the Hispanic population. Consider, less than half of the Hispanic elderly population are fully literate in English or Spanish (Cuellar 1990).

Just as there is a spectrum of English language abilities among Hispanic Medicaid clients, acculturation levels also vary within the Hispanic community. Correlatively, low-levels of acculturation have been connected to the reduced

likelihood of using hospital services (Wells et al 1989), poor oral health (Marcell, 1994) and increased likelihood of favorable prenatal health behaviors including abstinence from alcohol, drug, and cigarette use during pregnancy. Finally, high levels of acculturation have also been associated with the ability to obtain and utilize health insurance (Trevino and Trevino 1996).

The cultural background of the patient and the cultural competency of the provider can influence the effectiveness of their communication. Researchers have found that the establishment of a rapport between the patient and the physician can many times determine the quality of the visit (Roter, Hall and Katz 1988). For whatever reason, if communication barriers exist between the provider and patient, the patient may feel mistreated or misunderstood. These understandings may result in non-compliance behavior, and end in poor health outcomes (Castro Coe and Harmon 1996).

Another component to delivering quality health care to Hispanics depends on the provider's awareness and respect for Hispanic cultural values, beliefs and attitudes (Harwood 1989; Castro et al 1992; De La Cancela 1992). Significant numbers of providers view the Hispanic culture as deficit laden. Castro, Coe and Harmon (1996:11) provide an example in their discussion of Hispanic machismo.

A health provider may believe that "machismo" is a typical Hispanic male trait that serves as a barrier to compliance with medical regimens. While this may be true for some Hispanic males, this belief and a providers negative attitude toward macho males may prejudice the provider and interfere with his (or her) judgment about the treatment.

This illustration demonstrates how a negative connotation becomes attached to ethnicity and may severely limit the development of a fruitful patient-doctor relationship.

Managed Care and the Oregon Health Plan

As mentioned in the introduction, the implementation of the OHP brought about a radical restructuring of Oregon's Medicaid system: from a fee-for-service model to managed care. In the FFS system, doctors were reimbursed by the state for each individual service utilized by the Medicaid patient. Under managed care, the state contracts with private insurance companies or health maintenance organizations (HMOs) to reimburse participating doctors. In return, a flat fee is awarded to insurance companies for every patient that enrolls in their plan, regardless of how many services are utilized by the patient (Maskovski 2000).

Once receiving a contract from the state, HMOs devise their health plans that, at minimum, must cover services declared necessary from the state prioritized medical list. As an outcome of this procedure, a person enrolled in the OHP is limited to the services offered by their particular HMO plan. Contrastingly, in the FFS system, the guidelines for treating a Medicaid patient's conditions were less restrictive. For the most part, doctors had the authority to determine a medically necessary procedure (HPA 1995). The importance of this transformation is that under managed care, for profit insurance companies are now a participating discretionary body for medical service coverage along side physicians.

Another distinguishable quality of managed care Medicaid is the requirement for clients to choose between different sets of health plan coverage offered by competing HMO Medicaid contracts. Upon closer inspection however, these plans are often remarkably similar. Oregon's legislature mandated list of medical priorities that HMOs must cover, in combination with relatively low per client flat fee reimbursement, has dampened insurance companies' motivation to provide further benefits in their Medicaid packages (Andrews 1995).

The final distinguishing component of managed care Medicaid is the requirement for enrollees to choose a provider from a list of participating physicians who are currently accepting OHP clients. Except for emergencies or authorized referrals, health care is limited to a participating network of providers in accordance with health plan policies and protocols (i.e., primary health care physician referral, prior authorizations, etc.) In the former FFS system it was not necessary for the client to find a primary physician. In general, it was the hospital and the state's responsibility to match patients with a primary care physician (OHPR 2000). This thesis intends to explore the influence these structural changes in the Medicaid system have upon the Hispanic Medicaid population in accessing quality care in Oregon.

Hispanics and Managed Care Medicaid

In the last decade, numerous studies have begun to examine ethnicity as a variable regarding access and satisfaction with medical services. Still, much of

what is known about the recent managed care model is a result of studies on Anglos, middle-class populations (Tai-Seale, Freund, and Losasso 2001). The few studies that address Hispanics experience with managed care Medicaid report lower levels of patient satisfaction and access than in Anglo populations (Maldonado-Weech-Morales, Spritzer, Elliott and Hays 2001). More specifically, Hispanics describe a significantly lower satisfaction in doctor patient relationships, quality of care received, and accessibility compared to Anglo populations (Quesenberry 2000; Stable-Perez, Springer-Napoles, and Miramontes 1997).

In efforts to explain low levels of satisfaction with managed care Medicaid among Hispanic populations, the literature review suggests several social and economic contributors. First, Tai-Seale Freund and Losasso indicate in their article “Racial Disparities in Service Use among Medicaid Beneficiaries after Mandatory Enrollment in Managed Care,” that mandatory enrolment in HMO’s requires Medicaid clients to only use affiliated providers (2001). These private medical offices are typically located far away from low-income neighborhoods (Fossett 1991). As an obvious outcome, Hispanic Medicaid clients may have to travel farther to get to medical services than those with private insurance. With many Hispanic low-income families already grappling with transportation issues in their daily lives, commuting to far away clinics can potentially discourage hospital utilization.

When it comes to allocating services to low-priority Medicaid patients, prejudice and institutional racism may exacerbate ethnic disparity in service use for

Hispanic population (Fullilove 1998;Gottlieb, McCarter, and Vogel 1998; Lancet 1999). Tai-Seale, Freund and Losasso (2001:50) note, “It is conceivable that physicians may use race as an indication of potential risk factors and increased probability for missing appointments.” Risk factors such as unattended and acute medical conditions are, from the doctor’s and the HMO perspective, cost prohibitive medical treatment. Additionally, doctors are reimbursed lower amounts for Medicaid patients than for most privately insured patients. Market forces may create a type of “feet dragging” to see Medicaid patients (Wong 1998).

Hispanic managed care Medicaid patients must often contend with cultural differences and language barriers that can result in less satisfaction and poor access to health care. Valdez, Giachello, and Rodriguez-Trias (1993:534) insist, “...poor patient-provider communication and lack of cultural competence are significant barriers to high-quality care.” Given that many of these doctors have not, until recently, had Hispanic Medicaid clients in their practice, researchers raise concern over the extent to which doctors without experience working with Hispanic clients can serve this population. Before the advent of managed care Medicaid, Hispanic Medicaid populations were treated in community-based hospital with providers that typically had few cultural or language barriers (Maldonado-Weech, Moralis, Spritzer, Elliot and Hays 2001).

Although managed care Medicaid brings a for-profit industry into the daily operations of patient care, it would be naive to believe the former fee-for-service Medicaid model functioned outside of the capitalist system. Indeed, everything

from multi-national pharmaceutical companies to commercial baby food suppliers have capitalistic ventures in the FFS model (Elling in Baer 1996). Furthermore, Wong states in his book, "Medicine and the Marketplace" that FFS doctors are frequently far less altruist than they are profit motivated. FFS is often referred to as *Medicaid mills*, as doctors attempt to achieve increased profits through expediting patient consultations (1998).

Despite the capitalistic influences on the FFS Medicaid system, profit motivation is exceedingly more pronounced in the managed care Medicaid setting. The addition of for-profit Medicaid management corporations further divides physician loyalties between patients and profit. This conflict of interest forces doctors to become what Edmund Pellegrino has termed "double or triple agents" (1994). Instead of balancing self-interest profit taking and patient care as described in the FFS model, doctors must additionally integrate the HMO's interests and their share holders into health care strategies. In this light, managed care tips the scale in favor of profit taking over patient care as the over arching goal of the Medicaid system.

Managed care Medicaid supporters counter that profit motivation theoretically should result in higher system efficiency and improved customer satisfaction than the former FFS model. Similar to other goods and services, *market discipline* will force HMOs to compete for the consumer's dollar. Plans that fail to satisfy the customer at a competitive price will find themselves without enrollees (Wong 1998). Managed care supporters also argue that the profit seeking

in medicine is an economic liberty and a freedom to contract. Engelhardt and Rie assert that managed care, in general, is “ethical” because it is a product of free choice of the consumer (1988). Similarly, Waymack maintains that some of the more troubling aspects of managed care, such as cost containment measures and coverage restrictions cannot be considered to be an ethical problem because the patient has willingly consented to this system by their choice (1990). The act of participation in managed care is a conscious decision to make a trade off involving fewer health care benefits for larger monetary savings.

Although there are some apparent economic benefits to managed care, corporate efficacy and free market competition strategies often undermine community health efforts. In many cases, market competition can often stymie health care innovations (Wong 1998). For example, free market system is without incentives to be the first plan to provide culturally competent care. If the cost of cultural training of HMO staff members and providing additional translators are estimated to outweigh projected benefits, (new enrollees attracted to the plan specifically resulting from these investments) the innovation is likely to be rejected. Referring to the cost-benefit analysis of adding helpful services, one HMO executive stated openly “ I can’t pay for it if my competitors won’t pay for it” (Wong 1998:118). In these cases, minority groups or people with special needs become subject to become marginalized through market discipline.

Turning attention to the issue of profit motivation and patient preference, it is well documented that physicians often give preferential treatment in terms of

access and quality of care to privately insured patients over Medicaid recipients. The analytical model spurring most research in this area, the *two-market theory*, developed by Slone, maintains that physicians have two markets: one private and one public. Reimbursement for private insurance is significantly higher than Medicaid reimbursements. Therefore, according to this economic model, doctors will attempt to take patients in the private non-Medicaid market before attempting to secure patients in the public Medicaid market (in Wong 1998). Frequently, these physicians continue with their private practice and begin taking Medicaid patients *on the side*. Taking this economic model further, doctors routinely schedule Medicaid patients farther out, giving their privately insured patients priority (Medicaid Access Study Group 1994).

In the market-based system of managed care Medicaid, the power of the client to influence the system rests in their buying power and through their consumer choice. In theory, this buying power is supposed to cause suppliers of services to make efforts to comport consumers' wants and needs as a means to keep clients from entering another HMO. Turning attention to Oregon's managed care Medicaid system, the consumer choice is almost nonexistent. Often there is only one HMO Medicaid contract in a given area of the state (OHP 1995). Without the ability to "vote" between competing HMO's, this essentially leaves patient powerless to promote their health care interests. Wong (1998:120) argues:

The power of the marketplace to adequately enforce behavior is limited to situations in which consumers have access to high levels of information and bargaining power. By utilizing these criteria, the

level at which managed care organizations are governed, given the lack of regulatory reforms, is nowhere near the level at which patient interests are so efficiently protected.

Furthermore, in the case of the OHP, the state, not the client, has the purchasing power. The state is the actual buyer of the plan from the HMO even though consumerism is touted to be the client mode of influencing the HMO firms. HMO's are equally concerned with keeping their contract with the state. Problems arise when the state's and the clients' interests are in conflict. For example, the state often weighs efficiency over actual quality of care, while the reverse is true for the clients (Garland Hynes 1998). In these cases, the asymmetrical power and the vague consumer laws allow Medicaid patients few viable avenues to voice their complaints and create system change (Maskowski 2000).

Applied Critical Medical Anthropology

With few exceptions, American cultural anthropology's history has been almost exclusively in the domain of academia. Although there has been a long history of applied anthropology in the US, it was not until the 1970's that it began to develop significantly. Because of a kaleidoscope of social, political and economic factors, newly graduating anthropologists began to pursue jobs outside of the academy. Since then, there has been growing numbers of anthropologists working in governmental agencies, local community organizations, domestic and international businesses, and various other professions (Paredes and Higgins 2000).

Although applied anthropologists have found positions in wide range of work settings, there are some commonalities amongst them. The Society for Applied Anthropology Mission Statement aptly captures these similarities: “The wide application of principles controlling the relationships of human beings to one another rather than the scientific investigation of these principles (bylaws Society for Applied Anthropology:1999).” Applied anthropology thus distinguishes itself from conventional anthropology through its focus on practical research and its dedication toward solving real world problems.

Medical anthropology has been widely used in applied settings. In fact, medical anthropology represents the largest number of applied anthropologists (Brown 2000; Baer, Singer and Susser 1995). Owing to a multitude of theoretical orientations, medical anthropology can be holistically defined as the application of anthropological theories and methods to issues of health, illness, medicine, and healing (Brown 2000).

In the 1960’s and 1970’s the majority of mainstream medical anthropologists worked in either international health fields or in clinical settings such as teachers, researchers, administrators and clinicians (Singer Baer, Susser 1997). Today, applied medical anthropologists are performing a variety of jobs in the health arena. Noting the diversity of interests among medical anthropologists Kleinman (in Baer 1984:273) states:

The field of applied medical anthropology consists of a variety of differing research and teaching interests including: mental illness, chronic disease, disability, birthing, indigenous healers and healing,

practitioner patient communication and relationships, self care and lay help seeking, biomedical institutions, training of different types of health professional-nurses, family physicians, psychiatrists, pediatricians, osteopaths, public health practitioners, etc-to mention the more predominate ones.

The late 1980's marked the emergence of critical medical anthropology (CMA) as a broadly recognized subcategory of medical anthropology. There has been debate over CMA's definition and the precise theoretical orientation. However, most would be content with Baer's (1993: 299) encompassing definition: "(CMA) seeks to explain the impact of power on health status, health care and human distress in a broad range of social settings." In general, CMA posits that reality is socially constructed. These constructs often act to obscure oppressive power dynamics in political, economic, and social relationships (Brown 2000). Furthermore, these unequal power relationships are divided among class, gender, and ethnic lines. They are also characteristically antagonistic in nature, as the less powerful members of society struggle for goods and services controlled by the dominant groups of society (Baer, Singer and Susser 1997). Elling (in Singer 1989:1195) addresses this spirit or principle as it applies to the American medical system:

This perspective (CMA) understands societies as involving class conflict and see the state apparatus and medical-health systems as mediating this conflict in favor of the ruling class in capitalist societies. The historical developments and political-economic conditions are viewed as primary, with value orientations and beliefs form these fundamental conditions.

On one hand Elling is speaking to the inherent conflict in social systems, and on the other hand, he offers a common CMA critique of conventional medical anthropology's over-reliance on micro-level analysis. The fundamental error, as Singer asserts, is that conventional or clinical medical anthropologists view doctor/patient relationships as differing models of reality by both the patient and the doctor. In contrast, critical theorists like Young (in Singer 1989:1198) propose, "...the starting point for the examination of such discourse lies in the appreciation of social relations underlining and determining discourse production." In other words, the doctor/ patient relationship is not created in a vacuum. Rather these relationships represent a reality produced by a culmination of micro (e.g. patient-doctor relationships), intermediate (e.g. doctor-administrator relationships) and perhaps more importantly, macro influences (e.g. world capitalistic system).

Macro-level analysis as described by Singer and Baer is primarily concerned with the capitalist world system and its direct or indirect influence on the other levels of society (Singer and Baer 1995). The macro-level is a particular emphasis in CMA analysis because lower level social organization is produced to reinforce dominant ideology and self-interest of the most powerful macro-level organizations and institutions (Singer 1989). CMA anthropologists have long argued that biomedicine serves to reinforce political and economic ideologies of the world capitalistic system. Therefore, any analysis of intermediate or micro-level organizations of the American medical system must be first placed into the larger context of the global capitalistic order. Singer and Baer (1995:65) note:

CMA's understanding of health issues begins with analysis of the political and economic forces that pattern human relationships, shape social behavior, condition collective experiences, reorder local ecologies and generate cultural meaning, including forces of institutional, national and global scale.

Broadening the analytical scope further, CMA typically examines power relationships on a historical continuum. Observing various levels of society on a historical plane allows researchers "the grounds for an awareness of the social origins and the ideological function of such concepts as disease, medicine, and social development (Singer 1995:99)"

A clear utility of a CMA historical analysis can be found in Singer, Valentin, Baer and Jia's article "Why Juan Garcia Has a Drinking Problem" (1992). The authors use a historically based CMA analysis to explain Puerto Rican drinking behavior in Hartford Connecticut by examining the hidden social and political forces that have indirectly affected Juan Garcia's choice to abuse alcohol. Individual or micro-level analysis propagated in mainstream society suggests that Juan Garcia was simply acting irrationally and on his own. However, through an historical inspection of the unbalanced political and economic relationships between peasants of Puerto Ricans had with their native country and later in the United States the authors uncovers hidden oppressive elements in these macro-social structures that affect an individual's conduct. Juan Garcia was inextricably linked to these macro level influences that were likely to have contributed to his unhealthy drinking behavior. In the text, the authors (in Brown 2000:287) note:

The anthropological examination of drinking has failed to systematically consider the world transforming effects of global market and the global labor processes associated with the evolution and the capitalistic mode of production.

Through this holistic analysis, it becomes clear that the epidemiological concentration of heavy drinking in the Puerto Rican community in Connecticut is not a coincidence. Rather it is a manifestation of larger social struggles involving oppressive and exploitative political and historical relationships which many Puerto Rican working class families have endured under capitalism (Singer, Valentin, Baer and Jia in Brown 2000). The authors' findings were extraordinary in the sense that they acknowledged these relationships within a historical framework to contextualize normally invisible, but pervasive macro-level trends that influence individual drinking behavior. This is significant because this framework moves away from the reductionist, blame the individual mentality, towards a more holistic examination so that policy can be implemented that addresses the origins of illness.

More recently, there has been an insurgence of similar research of critical medical anthropology that is directed toward linking this theoretical perspective to applied research. The act of bridging the gap between theory and application has been termed by Singer as *praxis*. Applied CMA also recognizes an immediacy to stop current human suffering and find it unnecessary and even unethical to remain idealistic and hope for the collapse of the capitalistic system before seeking positive changes in health care. Between the band-aid solutions offered by the reformists and complete macro structure transformation, practicing CMAs tend to

work as self-described “non-reformist reformers” or what Singer (1995:88) calls “system challenging praxis.”

Sanders states two distinctive principles to system challenging praxis: enhancing democracy and eliminating mystification. To meet these requisites, applied critical medical anthropologists are characteristically advocates or “power brokers” for groups which are most marginalized within larger macro systems (Singer:1995). Critical medical anthropologist, Nancy Shepard-Hughes (1990:196), spoke to these principles when she called upon medical anthropologists to work “at the margins, questioning premises, and subjecting epistemology that represents power, political interest to opposing thinking world systems.” More recently she urged all anthropologists to take on the “idea of an active, politically committed, morally engaged anthropology” (1995:415). CMA frequently uses collaborations and coalition building between labor, ethnic, and women’s groups as their primary way of challenge to hegemony. Praxis for CMA is sometimes a daunting task, however proponents argue that real change must address the origins of health care disparity to progress towards a more humane health care system (Singer 1995 Singer, Baer and Susser 1997; Shepard-Hughes 1995).

However, praxis within CMA is not without significant challenges. Gains (in Singer 1995:85) maintains a possible contradiction between CMA’s perspective and their typical micro-level activism: “local initiatives count for naught in the alleviation of human suffering.” Meaning, if macro-level influences are the source of social injustice, it seems implausible that critical medical anthropologists will

make a difference by concentrating activities on lower-level social organization. Gains and other mainstream medical anthropologists typically work on reforming and improving the existing system (Baer and Singer 1995). Their second critique of CMA praxis is that creating a new and completely equitable system is simply unrealistic. Therefore, smaller, more obtainable goals hold the greatest utility in the fight for social justice within the hegemonic medical system.

As a response to the reformist position and Gain's comments in particular, Singer (1995:86) states in his article "Critical Praxis in Medical Anthropology" that in fact mainstream medical anthropology has not "squarely confronted the issue of power" and therefore solutions generated have been reforming but not abandoning the root causes of health problems. Addressing this issue further, critical medical anthropologist Jeff Maskovsky contends that most Medicaid studies remain limited to analyzing policy on the basis of a particular coverage goal the state has set. According to Maskovski, the fundamental error of this stance is the failure to question the hegemonic ideology, class and ethnic conflict inherent in the system (2000). This narrow scope of analysis is counterproductive to reaching a holistic understanding the American health care model.

METHODOLOGY

The initial research phase of this thesis is based on a project entitled, “Options for Universal Health Care.” This project was funded by the state Office for Oregon Health Policy and Research as a means to identify opportunities to improve the quality and efficiency of Oregon’s health care landscape. Under the umbrella of this study, Oregon State University’s Department of Anthropology’s objective was to solicit comments and suggestions from key interest groups in and outside the health care system in regards to both state and employer sponsored insurance. The primary investigator was Dr. Sunil Khanna. From February to Sept of 2001, the research team held 16 semi-structured focus group discussions around the state with physicians/hospital administrators, small business employers and uninsured populations.

In the early stages of the study, the research team identified Hispanic under-participation as a significant problem with the OHP program. This conclusion was partly based on statistical data indicating the disproportional numbers of Hispanic uninsured. This study was also influenced by the first Hispanic focus group in Eugene Oregon on March 12, 2001. In this group of 21 Hispanics, all qualified for the OHP commented that they would like state sponsored insurance, yet none had been successful in participating in the plan for any extended amount of time. Focusing on this issue, our research team began to develop open-ended questions to further explore this topic in the Hispanic and physicians/administrator focus groups

(see appendix 1.1-1.3 for focus group/individual interview sample questions). As a result, three uninsured Hispanic and four physicians/hospital administrator focus groups are included in the thesis data.

Participant contacts were established through the office of Oregon Health Policy and Research, direct community outreach, and past associates. The degree to which the research design relied on any one method varied from each site, depending on local receptivity. Actual recruitment was done by phone and by personal solicitations at local health care drop-in centers. When the participatory requirements were met, potential participants were informed about the study. If they were interested, they were given an appointment for a focus group. Lastly, participants were asked to refer other friends and acquaintances who might be interested in this study.

The focus group size ranged from six to twenty-one participants. Informed consent for participation was always collected before the interview session began. Participants were assured that their identity would not be disclosed. Within the initial stages of the interview, the interviewer verified participants' eligibility and acquired basic demographic information. For partaking in the study, all uninsured participants were given a twenty-dollar gift cash voucher. In addition, food and beverages were often provided.

Typically, one mediator conducted the interview. The mediator was responsible for tape-recording the sessions. Mediators were also required to take notes of their impressions and observations immediately following each session.

The duration of the focus group typically lasted ninety minutes. All interviews were recorded and transcribed for later analysis. The focus groups regarding Hispanic health care in the “Options for Universal Health Care” project were held in several geographical and social /political areas of the state.

After completing the “Options for Universal Health Care” study, I chose to focus on one specific area, Prineville, Oregon, as a means to more closely examine a particular Hispanic community’s experiences with OHP. I accepted an invitation to conduct a community needs assessment in July of 2001 for Pioneer Memorial Hospital in Prineville, Oregon. The project was funded by Pioneer Memorial Hospital and the Prineville Chamber of Commerce. The focus of this project was directed toward the health needs of a growing Hispanic population of Crook County. Data relevant to my thesis topic consisted of four low-income Hispanic focus groups and 40 individual interviews with doctors and hospital administrators, and social service agency workers affiliated with the OPH. I additionally chose to include participatory observation notes recorded in the process of performing Spanish hospital translation services, assisting Hispanics with enrolling in the Oregon Health Plan, and informal interactions I had with the Hispanic community in the area.

The methods used in the community needs assessment were similar to those used in the first phase of the study. To begin with, the criteria for participation were identical. Recruitment was initially through contacts made in the “Options for Universal Health Care” study and later through personal contacts made while living

in the community of Prineville. All participants were required to either sign consent forms in English or were asked for oral consent after the consent form was thoroughly explained to them in Spanish. Finally, as in the first study, all interviews were recorded and transcribed.

There were a few noteworthy differences in the data collection methodology from the first phase of the project. Uninsured participants were not given cash vouchers for their participation. While the interviews of physicians/administrator and OHP affiliated social workers were carried out in professional office settings as in the first study, the Hispanic focus groups took place in the participants' homes. Lastly, in addition to using audio recording, focus groups were also video taped.

From contacts made in Crook County, I independently researched my thesis topic in Los Cruses de Varieros- a village of 1,000 inhabitants located in South Central Mexico. The purpose of this trip was to gain a historical context to the issues surrounding Hispanic Medicaid participation. September 7-21 of 2001, I held two focus groups and performed five individual interviews with friends and relatives of Central Oregon Hispanic residents living in Los Cruses de Varieros. Before each focus group, I explained my project and requested oral consent to use the information they provided. As a measure of confidentiality, I explained to them that I would not disclose their actual names. Finally, the focus groups were also video recorded.

Sample Demographics: Ethnicity, Gender, and Geographic Location.

Table 1: Participants by location (total participants=146)

Location	Uninsured Hispanics	Doctors Administrators	OHP Service Agencies	Total
Crook County	47	9	11	67
Lane County Area	15	-	-	15
Linn-Benton County Area	-	6	-	6
Los Cruses de Varieros, Mexico	19	-	-	19
Portland Area	-	6	-	6
Umatilla County	6	-	-	6
Wasco/Sherman County	14	6	-	20

Table 1.2: Participants by gender (total participants = 146)

Interest Group	Women	Men
Uninsured	89	19
Health Care Providers/Administrators	9	18
Oregon Health Plan Service Agencies	10	1
Total	108	38

Table 1.3: Participants by self-identified ethnicity (total participants = 146)

Interest Group	White	Black	Asian	Hispanic	Mixed
Uninsured	-	-	-	108	-
Health Care Providers/Administrators	27	-	-	-	-
Oregon Health Plan Service Agencies	10	-	-	1	-

Study Limitations

Although this study was successful in identifying several themes related to Hispanic participation in the OHP, there are some limitations for the reader to consider. Because the largest research component was located in Prineville, many of the findings may only apply to this particular geographic area. Secondly, the relatively small sample size compared to the overall population of physicians, hospital administrators, social service workers, and uninsured Hispanics are not intended, nor should they be considered to encompass the views of these populations. In addition, the statistical data reported on the Hispanic population is probably not completely accurate. There is a wide margin of error that accompanies large surveys intended to represent hard to reach populations. The low-income Hispanic community is one such population (Berk and Schuler 1998).

This project relied heavily on focus group interviews. Despite its appropriateness for this project, there are some drawbacks. First, focus group

discussions can be highly emotional. This holds the potential for participants to polarize issues or make issues seem to be more important than they really are in their daily lives. Gender dynamics within the focus groups may influence some of the comments and may not necessarily reflect the participants' entire opinions. Furthermore, cultural differences between the mediator and the participants are likely, in some instances, to have hindered uncensored responses to the questions presented in the interviews.

Area Profiles

The first phase of the fieldwork encompassed a large geographic sample distribution throughout Oregon. Both rural and urban areas were represented. The next two phases focused on one specific area in Oregon and another in Mexico. The following area profiles note distinguishing area characteristics for the reader to consider when reviewing the finding within this thesis.

Crook County, Oregon

Located in the geographic center of Oregon, Crook County encompasses 2,983 square miles. Although Crook County has a relatively small population of 19,182, it has undergone significant growth in the last decade. Between 1990 and 2000, Crook County grew 35.9 %, far above the 15% state growth rate for the same period (Center for Population Research and Statistics 2001). The only incorporated city is Prineville. It has a population of 8,100 people and nearly double that in its

urban growth boundary (County Profiles 1998). Prineville also contains all of Crook County's medical facilities: Crook County Health Department, Pioneer Memorial Hospital and three private medical clinics.

Crook County is extremely rural. Based on the 1990 census data, 44% of the homes are primarily heated by burning wood. Those living in remote areas of the county sometimes travel up to two hours to reach medical services in Prineville. The closest freeway is two hours north and the next town traveling east is John Day, 120 miles away. The closest urban city, Portland, is over 150 miles away. Crook County is the largest geographic area not served by a four-year university in the continental United States (Prineville-Crook County Chamber of Commerce 1999).

In 2000, 93% of Crook County's total population was reportedly Anglo. The census 2000 data also maintains that Hispanics represent 5.6 percent of the county's populations; nearly double that of the 1990 census (Center for Population Research and Statistics 2001). However, a March 22, 2001 letter from the Department of Immigration and Naturalization Services asserts that the actual number of Hispanics living in Crook County is around 11% or 2000 individuals.

Los Cruses de Varieros

Los Cruses de Varieros is a village of about 1000 inhabitants approximately 200 miles west of Mexico City. It is a rural agricultural community that primarily raises corn and a strain of alfalfa transplanted from farms in Central Oregon. The

closest city Morellia, is two hours away by car. The closest health clinic is in an adjacent village 15 miles away. Electricity was not introduced into the village until 1986. Most houses are without running water. The village's only source of water is a natural spring that is located in a nearby cornfield. The heavy reliance on pesticides undoubtedly has contaminated this water source. There are two telephones in the village. Nearly all the villagers use horses as their primary mode of transportation.

In the last two decades, local market prices for the residents of Los Cruses de Varieros' cash crops have declined, while the cost of living has notably increased. This has prompted many residents to migrate to Central Oregon to live with relatives and search for better paying jobs. Today, most of the villagers that are capable of field labor are living in the United States. At the time of my visit, the inhabitants were predominately senior citizens and children. Almost all of the families are financially dependent on their relatives living in Central Oregon.

The Participants

The Uninsured Hispanic Population

This research initially intended to include self-identified Hispanics who were uninsured during the entire last year. However, after completing the first two Hispanic focus group interviews and additional statistical research, we learned that most uninsured Hispanics appear to obtain insurance sporadically throughout the

year. As a result, I expanded my Hispanic participant eligibility requirements to those who comport a pattern of intermittent coverage.

Because the OHP does not require US citizenship to receive benefits, I did not request participants to identify their nationality. However, through informal conversations, I gathered that the vast majority are first or second generation immigrants from Mexico.

There were some differences in the comments between first and second generation Hispanic participants living in the U.S. Second generation Hispanics normally had better English skills and feel comfortable speaking both languages. By contrast, first generation Hispanics often needed to speak through a translator, as most have not developed mastery in English. Second generation Hispanics were also generally more acculturated into American society. This is reflected in their comparatively higher level of knowledge about the OHP and proper utilization of services than first generation emigrants. Finally, the second generation were much more outspoken about discriminating treatment they have received and their general dissatisfaction with the OHP.

Although there are distinctions between Hispanic participants correlating to the amount of time spent in the US, the commonalities far outweigh the differences. Many first and second-generation Hispanics experience similar barriers to OHP participation- regardless of their time spent in American culture. Time spent in the US appears to only affect the degree in which a particular barrier hinders Hispanics from participation in the OHP. In sum, this sample represents a spectrum of

uninsured Hispanics, thus allows for a broader understanding of this population's overall experience with the OHP.

Physicians and Hospital Administrators

The nature of the interviews varied between interest groups. Most of the physicians and hospital administrators were unguarded in their response to the questions presented during in-depth interviews. Although many were eager to detail their views of the OPH, some were quite pessimistic about the usefulness of my research. Physicians and administrators that had a history of working with indigent Hispanic populations typically thought that either systemic or social factors were responsible for their under-participation in the OHP. In contrast to these comments were those physicians and administrators with infrequent contact with indigent Hispanic populations. They largely attributed under-participation to individual factors. For example, several physicians newly acquainted with Hispanic Medicaid clients speculated that Hispanics were not participating because they did not take the time to fill out the paper work, forgot appointments, or neglected to make the minimum payment required under the OHP.

OHP Affiliated Social Workers

Social service agency managers and workers affiliated with the OHP had their own distinguishing characteristics. Like the physicians and hospital administrators, most were anxious to express their concerns and options toward the

OHP. However, a minority of OHP affiliated workers appeared to guard against expressing their personal opinions. The responses from these participants often seemed “canned” or rhetorical in nature. It should be noted that all the service agencies interviews took place in Crook County. Therefore, their comments should be placed into the context of Central Oregon’s geographic, historical and social environment (see area description above). In Central Oregon, local agencies are just now beginning to address Hispanic issues as this population has doubled in the last ten years.

Ethnographic Methods

Hispanics that experience a high frequency of being without health insurance are often missed by larger surveys. Regarding telephone surveys, past estimates affirm that 10% of the uninsured population lack access to a telephone (Berk and Schuler 1998; Zuvekas; McNamara and Bernstein 1999). Larger surveys also frequently do not have a bilingual component and 22% of uninsured Hispanics do not speak English to the level which an interview could be conducted in English. Finally, many lack literacy skills in English or Spanish to participate in mail in surveys or written questionnaires (Zuvekas; McNamara and Bernstein 1999). Because of the language and structural obstacles listed above for this “hard to reach” population, it is difficult for researchers to accurately document low-income Hispanics’ perspectives from larger surveys that ask open ended questions and are analyzed simply by counting multiple choice responses.

The methodological features found in focus groups comport both the nature of this thesis topic and the “hard to reach” characteristics of the target Hispanic population. Focus groups have been described by Shedlin and Schreiber (1995:154) as “uniquely effective in obtaining information from hard-to-reach populations.” Inherent in focus group research is physically going to the target population and speaking with participants for a comparatively extended amount of time. This allows the investigator to make modifications to accommodate the needs of each group. For example, if it is discovered that the participants are having difficulties articulating in English, the investigator can arrange for a translator. Additionally, open-ended questions typically used in focus groups assist participants in expressing the relevant issues in a style that is meaningful to them. Speaking comfortably and in the context of everyday language, participants can convey information that likely to be difficult to disclose in other, less flexible, questionnaire research approaches.

The vast majority of knowledge gained in this study is a result of interactions between the investigator and the participants. This implies that the quality of knowledge depends on the worth of the relationship between the interviewer and the interviewee (Abma 2000). The length and depth of discussion that spawns from the in-depth interviews provide an excellent opportunity to form trustful relationships. In such cases, an atmosphere is created for a somewhat fluid exchange of ideas between the investigator and the target population.

Focus groups also provide researchers with an instrument to explore phenomena whose shapes and relationships are not extensively developed or fully understood (Stewart and Shamdasani 1990). There is a wealth of statistical data that indicate Hispanics are the most underinsured ethnic group in Oregon (OHPR 1998; 2000). Nevertheless, the specific research topic of why some Hispanics have not fully participated in the OHP remains largely understudied. Focus groups allow for open-ended discussions, which are particularly effective in recognizing and exploring unknown factors through the direction of the informants (Stewart and Shamdasani 1990).

Perhaps most importantly, focus groups can assist in gaining an emic or insider's perspective. This methodological tool is particularly apt to understand, in these cases, the participants' viewpoint, which is crucial to understanding their non-participatory behavior. To understand why some Hispanics have not obtained long-term health insurance and to create programs that are better suited for their specific needs, it is important to understand their perceptions, attitudes, and feelings regarding health and health care. The investigator captures these subsurface forms of data by engaging participants to divulge their life experiences in these issues. By being present in the focus groups in this particular research question, the researcher was able to document the emotion and feeling behind these stories that adds an extra dimension to the data that is lost on other forms of collection methodologies.

Data Analysis: Thick Description and Grounded Theory

Thick description (Geertz 1973) and grounded theory (Glaser and Strauss 1967) are the analytical guides for this thesis. Transcripts and notes from focus groups, in-depth individual interviews, and participatory observations were used in a cross-site analysis of common themes. Illustrative quotes were then selected from the data in efforts to highlight key concepts that were central to findings in the cross-site analysis.

Because of this dearth of information pertaining to Hispanic under-participation in the OHP, I did not believe it was prudent to attempt to frame theoretical perspectives and presumptuous hypotheses before gathering data. Addressing under-researched areas of study, Ken Parry (1999:89) correctly points out: "One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge." Therefore, the decision was made to create hypotheses and theory from the data produced from this study.

As another consequence of investigating this less-examined subject, the analysis needed to be inductive and explorative in nature. Matching this requisite is grounded theory. Grounded theory is a methodology that functions relatively independent of past research. The data triangulate between analysis, developing theory, and testing the hypothesis against incoming data. It is the triangulation of data that makes grounded theory an excellent self-sufficient analytic tool to research uninvestigated phenomena (Glaser and Strauss 1967).

Grounded theory was helpful in testing earlier data against incoming data, which strengthened the validity of this project's results. By constantly comparing earlier focus groups and interviews with incoming data, the project was able to verify or challenge earlier working hypotheses. Further validity was achieved by comparing interpretations of the text by multiple readers, as done in the first phase of the study. As a final point, grounded theory is dependent upon the size and diversity of the sample. The greater the size and breadth of the sample, the higher likelihood of accuracy in the findings (Glaser and Strauss 1967). Therefore, this project intentionally sought a large and varied set of participants.

Thick description is the other analytic component to this thesis. It is a process of writing detailed narratives that contextualize a situation so that the readers will respond by seeing patterns and perspectives that may even be lost on the research team (Davis 1991). Thick description is used to assist both the participants and the population they represent by voicing their own specific needs and concerns about Oregon's Medicaid coverage. At a basic level, the goal of policy is to create programs that comfortably suit the specific needs of the client. However, there appears to be a notion of a shared "culture of poverty" among policy makers (Berk and Schur 1996). This means that policy makers have a tendency to understand poverty by lumping together the diversity of people who share the same economic status into one category of people. Routinely, the specific needs of gender, race, and ethnicity are overlooked. Ignoring the differences between groups of low economic status, programs often have homogenous and

highly rigid qualities. As an outcome, a diverse population is barreled into one stringent program- regardless of their dissimilar needs. Sometime the shoe fits; many others have to go barefoot.

Thick description also provides a means to explain the contradiction between popular surface level perception of the situation and what is contesting in the lives of the uninsured Hispanic population. Oregon's uninsured Hispanic population's ethnohistories, economic struggles, perspectives of the dominant culture, and many other topics can naturally manifest itself through thick description. This type of information, presented in the words of the Hispanic population, has excellent potential to aid policy makers in understanding the complexity underpinnings behind non-participant behavior. With a richer understanding of the phenomenon, policy makers have a greater ability to create policy that both dynamic and critical in nature.

Thick description additionally impact the reader in ways statistical data often cannot. By using quotes from real life struggles with health care insurance, thick description can connect the reader to the situation on both an emotional and analytical level. Narratives have the ability to stimulate empathy in the reader that is typically lost when reporting abstract statistics or plain opinionated statements. Indeed, many of the greatest public health projects were accomplished by creating a relationship between those affected by the illness to the great society (Garrett 2000).

RESULTS

From the ethnographic research in this study, there emerged several new findings concerning Hispanics' participation in the Oregon Health Plan. These findings draw connections between historical, cultural and linguistic characteristics of Oregon's uninsured Hispanic population and the barriers they present to OHP participation. General themes that are addressed include: physician/patient relationships; competition within the OHP program for primary care providers; managed care market volatility and the subsequent regulatory changes; and the OHP application and renewal process. The following chapter utilizes interviewee quotations and notes from participatory observations to illustrate these findings.

Physician-Hispanic Medicaid Patient Relationships

Often Hispanic Medicaid clients have different hospital utilization patterns than what is expected from physicians in mainstream HMO hospitals (Trevino and Trevino 1996). Relating to utilization patterns, the focus group interviews indicate differing attitudes between physicians and OHP Hispanics regarding appointments. A number of physicians stated that it is the Medicaid client's essential responsibility to arrange and arrive promptly for appointments. Conversely, uninsured Hispanic participants commented that formal appointments are rarely needed in their country of origin. As a result of their past experiences, a number of Hispanics stated that appointments seem unnecessary. Many Hispanic also

remarked that when attempting to schedule appointments, hospital protocol can be somewhat confusing. Transportation and logistical issues were also indicated by many Hispanic to contribute to their missed or late appointments. The common pattern of late, missed or unscheduled appointments from the Hispanic Medicaid population have often created tensions in their relationship with their OHP primary care physician. These tensions sometimes influence physicians to drop Hispanic Medicaid clients from their patient load and consequently contribute to poor health outcomes.

My trip to Los Cruses de Varieros elucidated why Hispanics may have difficulties understanding the necessity for formal appointments required in managed care Medicaid. During my stay in Los Cruses de Varieros, I went with Armando to have stitches removed from his hand. In many private clinics for Mexico's elite, appointments are generally required. However, since Armando was going to a state sponsored hospital, he did not have to call ahead for an appointment. At the age of 64, Armando reported that he has never made a formal appointment other than for his children's baptisms. Telephone appointments are even more rare. "In this village," Armando explained "we do not have telephones in our homes. We only use telephones to speak with family members in the United States. Otherwise, if I need to speak with someone I will do it in person." When we arrived at the hospital, Armando and I took a number and waited.

As we waited to see a physician, he allowed several people with more acute or severe health problems to pass us in line. He explained that most people do not

plan their hospital visits. Even with his stitches, he was not given a specific time to return to have them removed. He decided to have his stitches removed that day because this is the only day this week the bus would pass by his town.

I noticed that Armando was becoming impatient with the long wait. I asked him what he thought about this first come, first serve system. He admitted he often gets irritated by the inevitably long wait. However, he followed up by saying that he knows that if something more serious would happen to him, others would allow him to pass them in line and see the physician much sooner.

After visiting several hospitals and clinics in Mexico, it appeared that the protocol I experienced with Armando is typical. Appointments are rarely necessary. Clearly, this system stands in contrast to the mainstream medical protocol in the United States. However there appear to be some influences of the Mexican system Armando and I visited within the fee-for-service and safety net clinics heavily frequented by low-income Hispanics in Oregon. In these systems, patients are usually required to make appointments; however, my impression is that there is more leniency for missed or late appointments than in mainstream hospitals. In the Corvallis area for example, The Sunflower House's low-income medical clinic does not have appointment-based services. In addition, when planning a safety net clinic in Central Oregon last summer, 20 percent of the daily schedule is dedicated to those who come in without appointments. In contrast, managed care hospitals are exclusively run by appointments. Those wishing to see a doctor without an appointment are often referred to the emergency room.

For Hispanics or other immigrants coming from a tradition of not having to make formal appointments, this process of scheduling can be both challenging and confusing. For the Hispanics in Central Oregon who grew up in Los Cruses de Varieros, phones were not a part of their daily lives. One Hispanic woman originally from Los Cruses de Varieros spoke about some difficulties involved with telephone appointments required in the OHP program:

One of the reasons we don't keep appointments is because I don't think we write a lot of things down. Many of us are just not in that habit. We haven't had to mark appointments in Mexico the way you have to do here. We don't write on calendars-so I think we forget a lot of times.

One Spanish translator for a medical clinic remarked:

And it is also important to us that we don't have to always make appointments to be seen. This woman came into the hospital with a baby that is sick and she cannot wait four days. She believes that they should be able to walk into the hospital with a sick baby and not be told to go to the emergency room for services and get a big bill.

Transportation issues also make it difficult for some Hispanic women to make appointments. Namely, the mainstream HMO clinics hold more conventional hours than safety net clinics or the former FFS hospitals. Therefore, Hispanic families with one car or Hispanics that are employed in jobs that do not allow time can make it not easy for many to make appointments in the managed care system.

One Physician maintained:

Hispanics are more likely to use the emergency room, which is often driven by intermittent work or childcare issues. The only time they

are available to take care of their health needs is when we are not open and the emergency room is.

In the traditional Hispanic patriarchal family, women frequently work in the home, in charge of the domestic domain. At the same time, many Hispanic households reported having only one car. Since the men usually take the family car to work, many Hispanic women are home without transportation to take themselves or possibly their children to the hospital during regular office hours.

One Hispanic woman that owned a local business in Central Oregon contextualize transportation problems to explain the high number of Hispanics that have missing or late appointments:

The husbands work long hours. So many times the women become stuck at home. They used to call me and say: 'Can you take me (to the hospital for a acute illness) or the husband would ask me for them.' They would offer to pay me.

Even though the Hispanic population generally have large support networks of friends and extended family members, several participants stated that access to other people's cars are favors that are sparingly called upon. Several participants stated that they often choose to miss hospital appointments rather than arrange a ride with someone until an illness becomes critical. Therefore, transportation for preventative health care becomes problematic. Two Hispanic women address this issue:

Maria: I see transportation problems a lot because a lot of Hispanic women don't know how to drive. They are starting to learn how to drive now, but a lot of them still don't have the vehicle.

Teresa: Some of them do-a lot of them don't.

Maria: The reason why I know A lot of women (Hispanic) would call me up to give them a ride to the hospital. The husband works long hours so many time the women become stuck at home. They used to call me and say can you take me or the husband would ask me for them. They would offer to pay me. But I saw a lot of that.

Several physicians expressed their frustrations toward Hispanic Medicaid clients for habitually missing or arriving late to appointments. One nurse practitioner, who has worked with indigent Hispanic patients in Central Oregon for ten years and in Guatemala for two years, offered some interesting insights. She believed that there should be repercussions for OHP patients that arrive late or miss appointments. On the other hand, she stated that she understands that there are many constraints on her Hispanic clients that hinder their ability to make their appointments. She said that the employment Hispanics typically hold will not liberally allow them time off from work for medical appointments. Additionally, she felt that most Hispanics have differing concepts of time than mainstream American society. She also believed that there were also dissimilar social norms regarding appointments. "In their culture," she committed, "promptness is not such an issue."

Several other physicians interpreted the high number of Hispanics that missed or were late for appointments as somewhat of an enigma. The common speculation was that Hispanics were not proactive in their health care and therefore

not terribly concerned with making appointments. Many physicians were noticeably offended by this behavior. One physician that has recently begun treating Hispanic Medicaid patients commented:

It is frustrating to me to sometimes concentrate my efforts toward a patient on the Oregon Health Plan and have them frequently miss the appointments we make for them. It is difficult to understand sometimes.

Language is another issue that frequently stifles relations between the physicians and Hispanic Medicaid patients. Several HMO sponsored Medicaid hospitals do not have bilingual interpreters for Spanish speaking patients at the front desk, nor are they available for doctor-patient consultations. Because of the deficient number of Spanish translators, language barriers are a source of misinformation, confusion and sometimes, poor health outcomes.

In several instances, language barriers within the mainstream hospital system have contributed to gender conflicts for Hispanic men. Often in Latin cultures, the male's gender role is to be strong, powerful, and in control. This is widely referred to as *machismo* (Warda 1996). Many male Hispanic participants reported a feeling of powerlessness without the ability to effectively communicate in the managed care hospital. This feeling of powerlessness has a tendency to create gender role conflicts with many Hispanic males as they lose their ability to control the situation through language. One Hispanic woman stated:

Most men still prefer to chaperone the women to the hospital and they don't like to be undermined and at the hospital they can look foolish in front of their wife and children if there aren't a lot of translators around.

It should also be noted that to have good communications in clinical settings it is important to not only have the capacity to speak Spanish, but to be aware of the cultural aspects of language. Often interpreters or physicians with excellent Spanish skills are unable to communicate with a Hispanic patient because they have a poor understanding of the patient's cultural heritage. A nurse practitioner commented on this subject:

As far as my Hispanic patients are concerned- I am bilingual- but sometimes I can't get through to them. I don't know if it is cultural or what. I just can't get through to them on certain issues. It is very very hard. Especially if they are undereducated.

A common discrepancy between the American mainstream medical system and other health care systems in Latin American countries relates to when and how people utilize services. These conflicting ideas are frequently another source of disagreement between Hispanic Medicaid patients and managed care physicians. In Los Cruces de Varieros, most of the health problems are addressed in the acute stages of illness. Even diabetics were not accustomed to regular check-ups. Several participants reported that it is also a low-priority to keep the same physician. In contrast, many physicians reported that continuity of care and regular preventative based check-ups are standards that they expect of their patients to uphold. These differing ideas of hospital utilization patterns have made many physicians wary of taking on Hispanic Medicaid patients.

One physician offered his insights regarding differing ideas of utilization across cultures:

I think the biggest one is being in a foreign land. Being unfamiliar with not only the people, but our style. Um it's strange to say that money does go with that though. Poor people of a different culture I think they are hidden away. If someone who is from a foreign culture and has the money they are going to be up at the Good Sam Complexes getting the best that they can. But the people without the money don't know what the access to service is because they are talking to their group of people they are not talking to the community generally. I think it is changing over time. This is the impression that I have been given um at a church group that I work with and just other areas that I've seen, mainly Hispanic in Corvallis, but um. Perception. They have a completely different perception of what health care is either because they never experienced it. The nice clean neat doctors visit in the hospital and all that kind of stuff or they have a very clear idea of something that is perhaps more of a spiritual or earthly, taking treasures and stuff like that. So first you have to get them in the building then you have to get them talking to you in terms of western medicine in a way they generally don't understand. Overall I think it is fine. We make it through, we get through. But as far as them continuing with their care especially diabetics, and anything ongoing. That's always a problem.

Another physician stated:

We have in our culture. All of us around this table I believe have a value or an ethic that people should have ongoing care and so forth. Education about self-examinations about the breast or whatever and being aware of hypertension and diet and exercise. Having ongoing counseling about this. Ongoing face time with a doctor or nurse practitioner. That is not necessarily the ethic, from Mexico for example, and well...It is difficult for us to understand the world the way they see it and um so it works for them. In their minds and it works for them to get episodic care., um a crisis comes up they get crisis care. And the crisis is over. And things such

as hypertension are hidden. They are silent diseases. They are just not being addressed on an ongoing basis.

The HMO's, or in this case the IPAs' ability or desire to resolve these cultural issues were questioned by a physician in Central Oregon who has a heavy caseload of Hispanic Medicaid patients:

Independent Physician Association. They administer the Oregon Health Plan for our area. Central Oregon IPA-it's like a small HMO. They are located in Bend. The providers that sit on this committee, the board of the IPA are specialists from Bend who really are not in touch with the problem we face with Hispanic indigent population in our county, or family care.

One illustrative example of the lack of cultural competency at the administrative level was relayed by a Nurse Practitioner:

They like to pay in cash and I find that difficult. The logistical plan of our organization is not prepared to accommodate this type of payment. So, I'm always having to deal with the Hispanic people and their bills.

The linguistic and cultural differences have also produced feelings of distrust and skepticism in many members of the Hispanic community in regards to the level of care they are receiving. Without effective dialogue, and a richer understanding of each other's cultural background, neutral or well-intended actions can be misconstrued as offensive. The following is an example of how poor communications lead to distrust of the Medicaid system:

Angela: (in Spanish) Like me when I catch pneumonia. I went there at one in the morning. There are two boys that had got in a car accident and everyone was concerned with them. Nobody was

paying any attention to me. I tell my daughter, why don't they check me. I am also very sick. I sat there for three or four hours. Then they gave me a shot and sent me home at six in the morning.

Interviewer: Did they explain what the shot was for?

Angela: (in Spanish) No. I was mad. I don't know how many hours was there, but I did not know how to speak that to the doctor.

As a result of these misunderstandings, hospitals can quickly build a reputation of not being good providers. One nurse practitioner commented on her experiences with this issue:

Often a negative experience at a health facility is conveyed by the patient to other members in the community, thus perpetuating a snowball effect of negative opinions about the facility. This becomes a major barrier to health care access, particularly for the uninsured non-white patients.

One other physician remarked:

The word of mouth becomes...[an] effective medium to actually convey your services and [the] kind of help that is available. What if one person who actually become[s] the mouthpiece for one particular health center...this person, is, because of cultural differences and linguistic differences ends up having a terrible experience at a health facility. This person goes back to the community and provides a view of the center, which is not rosy and there you have created one of the major barriers.

Another example of how informal networks within the Hispanic community have spread misinformation based on cultural or linguistic misunderstanding within managed care Medicaid was noted by an anesthesiologist in Central Oregon. The story pertains to a potential lawsuit her hospital was mitigating. A low-income Hispanic woman that did not have English language skills came into the hospital

for a prenatal check-up. The medical staff brought into the patient's room an instrument that she perceived to be a tool used to perform abortions. When the doctor reached for the instrument, she screamed and had her husband escort her out of the hospital.

For a period of time after the incident, there was a dramatic drop in the number of Hispanic patients who patroned the hospital. The anesthesiologist believed it was a result of this misunderstanding. As a response to this incident, the hospital hired an interpreter. This interpreter, which happened to be a Hispanic woman, reported that within the Hispanic community there were many negative rumors about the hospital. In the nurse's opinion, these rumors were "outlandish and simply untrue." She said that dispelling these rumors was a difficult and slow process. She believed that the trust of the Hispanic community had been lost because of cultural and language misinterpretations from both the hospital and the Hispanic community.

Hispanic compliance to the doctors' recommendation are hindered when supporting agencies are unable to perform culturally competent tasks. Often Hispanics would drop into the multicultural office at Pioneer Memorial Hospital in Prineville to ask what was written on the prescription because the pharmacy did not have bilingual services. This language barrier created doubt in many Hispanics to the extent the pharmacy was capable of prescribing the correct pharmaceutical.

Lastly, there is a general uneasiness many Hispanic reported experiencing in HMO sponsored hospitals. Language and cultural competency are factors, but

there was also a lack of Hispanic informal networks linked to the HMO sponsored hospital that, in the past FFS system typically provided. FFS hospitals were often liaisons between the formal health and social service sector and the informal networks in the Hispanic community. One physician addressed this issue:

When I was in Seattle, the residency program had three safety net clinics (Comparable to FFS clinics, in that, they only treat indigent populations) that we were affiliated with. And what struck me was that it is more than just another place to get healthcare. They were really committed partnerships. There was one homeless clinic in the Pike Market. If you go and sit down in the waiting room, you see that this is their community center. It was not just a place to access health care: it was an anchor for their lives. People worked very much in partnership with the community and with social services. The Chinese Clinic in the Chinese District of Seattle is full of Asian languages, and you get a sense that this is part of their social life in addition to a place where they might get health care. I think safety net clinics are providing more than just access to healthcare, they are providing, perhaps a way of thinking about health in a larger cultural context. It address some of the isolationism or the loneliness or the affiliation that understanding that it is okay to use herbal medicines because everybody else in the waiting room is doing the same thing. They are vibrant experiences even though , from the ivory tower of academic medical center, it always felt like “oh that’s them providing free care.” But there is something more to it than that. There is something we have failed to do in our insured healthcare funded sites that we need to think about.

Competition

The privatization of Oregon’s Medicaid system has created a fundamental shift in health care responsibilities. Managed care Medicaid is derived from a philosophy that views Medicaid enrollees as customers in a free market system (Maskovski 2000). This means that if customers do not get what they need or expect, it is not the fault of the state or the private sector. The clients are assigned

the responsibility of getting their needs met by asserting their *purchasing power* by choosing a participating HMO provider within the managed care system. However, the state is the actual purchaser of the plan. Moreover, the “choice” Medicaid clients are given is often between two plans furnished by the same HMO. This raises serious doubt to the extent OHP clients can influence managed care policy through consumerist principles.

Instead of market forces creating improved quality of care for the Medicaid client through competition, in many situations, they are partially responsible for creating an undercurrent of inter-client competition for finite slots in the OHP program. For Medicaid clients, this is significant because primary care physicians are the gatekeepers to OHP covered health care services. Without a primary care physician, it is very difficult to access health care in the managed care Medicaid program, except in emergent situations. Many Hispanic Medicaid clients reported numerous difficulties securing and staying enrolling with a primary care physician. This has caused some Hispanics to discontinue participation in the OHP.

The following section describes several market factors that explain why Medicaid patients are not as profitable as privately insured clients, thus influencing many physicians to accept only the minimum quota of OHP clients. One physician addressed the pressure to “streamline” private sector practices by minimizing Medicaid patient load:

I have been fascinated with many patients in my new practice with ordinary diseases who are referred to me because I am at a university. It is socially expectable to direct patients here, from three

or four hours away to get primary care. And their physicians have said, "I'm not an expert in Fibromyalgia. I am not an expert at caring for chronic fatigue." Of course. Nobody is; because there is little you can do but meet with the patient frequently, offering your time and support. Reimbursement is quite low for psychosomatic pain, or chronic pain. We have an incredibly disproportionate share of these patients here...I think this is a growing trend, and I very strongly believe that it is evidence that physicians are feeling the pressure to streamline their practices with patients who are more financially ideal for their practice. Because they have simplified illness cases, they can be seen only sporadically and they have the line diagnosis.

Physicians participating in OHP are required to meet a quota of Medicaid clients they must have in their practice. As discussed in the literature review, on average, Medicaid clients take longer to treat and require more testing and educational training than private insured clients (Wong 1998). Furthermore, these extended physician/patient consultations are significantly less profitable than private paying HMO clients. Often physicians exceed their quota of clients, but not to the extent that they meet the demand for their services. One physician addressed this issue:

One of the challenges for the primary care physicians all across the state is when you bring them together for these conferences on access and justice is that while many physicians would like to do slightly more care for the uninsured or OHP patients, they are within groups or organizations or they themselves are fearful that if you throw the gate open you will be drowned. There is no way to just do your fair share and not be completely overrun by the desperate need out there and the fact that others are not doing their fair share. The fear is growing as I see it from our statewide conferences, not lessening. There used to be a sense, in some places like Medford, Oregon that we cared for our own. As two competing health systems have come in there, there is a lot less of that, and the uninsured rates are higher in Southern Oregon as a result. You start to see how they

had a wonderful system (the former FFS system) where they coordinated with referrals to doctors so that they shared the distribution and tried to relieve the sense that if you open the door all will be drowned.

Another physician reported:

I actually have the highest amount of OHP patients in the county right now, and I am not taking any more. I think everyone else is at their limit or at least near their limit of OHP patients. So new OHP patients don't have anywhere to go in the community. Right now in our clinic, there isn't room for more than a dozen or so OHP patients. So that is a huge problem. I think all the other clinics in town are similar.

In managed care Medicaid, hospital services are accessed through primary care physicians. It is the client's responsibility to obtain a primary care physician. However, the high demand for primary care physicians from the Medicaid enrollees has created an undercurrent of competition for the limited OHP slots available in any particular physician's patient load. A number of Hispanic participants made it clear that having a primary care provider was a priority to them, but they have had minimal success obtaining one.

Interviews from both Hispanic patients and physicians indicate that Hispanics often have special linguistic and cultural needs that require more time and resources than other Medicaid clients. As a result, Hispanics are typically not considered preferred *customers* by physicians. In these cases, market forces can be considered a contributor to many Hispanic Medicaid patients being displacement from their primary care physician. Commonly Hispanics that become displaced

from their primary care physician face several barriers to obtaining another OHP sponsored physician willing to accept them into their practice. This chain of events driven by market forces result in many Hispanics discontinuing their participation in OHP.

One Physician pointed out other issues inherent in the for-profit Medicaid program:

Unfortunately, the way the Oregon Health Plan is structured the Medicaid patients become the burden of the hospital and the providers who want to do the service, who want to provide the care. But we are just barely staying afloat here. Because of the extra time and resources it takes to treat the Hispanic OHP clients they have unfortunately put a tremendous strain on our hospital.

One Hispanic woman commented:

In my case, I took my son to the hospital because he was very sick and all they gave me was a little cup of syrup to give to him. It seemed like the doctor didn't even care too much. They have so many patients. They care about doing something else.

The following is an account of one Hispanic woman's experiences attempting to access health care. The story illustrates how profit motivation in HMO sponsored hospitals sometimes interferes with patient care. In addition, this narrative highlights the lack of Medicaid client consumer power as a means to voice grievances they may have toward the managed care system.

While working at Pioneer Memorial Hospital, I met a Hispanic woman I will call Flavia. Flavia repeatedly contacted the hospital for an appointment to see a physician about her stomach pains. However, her citizenship was undocumented

and therefore she only qualified for emergency room coverage through Medicaid. She stated she could not afford to pay out of pocket for a medical examination. A nurse heard of her situation and agreed to see this woman pro bono. The nurse quickly diagnosed her stomach pains as an “appendix on the verge of erupting.” According to the nurse, it was only a matter of time before it ruptured, putting the woman at a serious health risk if it was not removed immediately. Meanwhile, Flavia was reporting significant pain and was unable to work.

The nurse explained the situation to the surgeon, who was the person who could perform the operation, but the specialist initially refused to see to see Flavia. The nurse informed me that surgeons that are used to scheduled operations are often times weary of increased emergency procedures from the Hispanic Medicaid population. These physicians often comment that the emergency operations are medically risky, time consuming, and displace scheduled appointments from private paying customers. In return, surgeons and HMO companies are offered meager reimbursements for these emergency procedures.

Because Flavia was an undocumented OHP emergency cardholder, the OHP guidelines dictated that the surgeon would not normally be reimbursed for the procedure until the appendix ruptured. Furthermore, the surgeon did not have any time in his schedule for the procedure. The nurse was persistent and the surgeon finally agreed to perform the procedure for Flavia at the expense of the hospital. Afterwards, the surgeon refused to speak with the family about the operation and postoperative home care, even though it is standard practice for this type of

operation. In addition, although there was ample number of hospital beds available, the surgeon sent Flavia home from the hospital that day. Again, standard procedure is to allow the patient to recover overnight at the hospital. Flavia was experiencing nausea as her family helped her out of the hospital. Meanwhile, the nurse reported that the surgeon was irate, and that he was pushed out of his already busy schedule to perform the operation. She said it was not this specific case that angered him. Rather, it was the accumulation of having to make these types of concessions for undocumented Hispanics on a regular basis.

Flavia and her family later reflected on this experience. Flavia said she felt that the migrant Hispanic community has been singled out to receive the “poorest treatment under the OHP.” She also said she felt an incredible amount of frustration that she has no way to influence the system and create policy changes that would improve the quality of care undocumented Hispanics receive.

In Central Oregon, where this took place, there is only one physicians association that has contracted with the OHP. Only having one group providing services is commonplace in the OHP. There is a growing trend of consolidation in the private sector contracts with OHP. Consider, in December of 1995, HMO Oregon alone enrolled 41% of the Medicaid eligible population. By the middle of 1996, five of the plans covered more than 70% of all the Medicaid clients. In October 1996, OMAP discontinued contracting on a partially-capitated basis (OHPPR February 1999). Without a competing group sponsoring the OHP, Flavia

cannot vote with her consumer power and therefore has little influence over the health plan she receives. This scenario is typical in the rural areas of Oregon.

Turning attention to primary care physicians' role as the gatekeeper to access medical care in managed care Medicaid, the finding suggests that this has created several difficulties for Hispanic Medicaid patients. Instead of physicians competing for OHP clients through better service and quality of care, the client demand for the finite OHP patient slots has effectively allowed physicians their choice of Medicaid patients. The interviews have elucidated that many physicians' patient preference is chiefly based on economics. As stated earlier by one physician regarding patient preference, "...patients who are more financially ideal for their practice are preferred."

Many Hispanic participants remarked that even after they obtained a primary care provider, they were later dropped from the physician's patient load. One physician commented that most doctors attempt to streamline their practices by dropping Medicaid "trouble patients" (meaning, patients that take up too much of the physician's time, or miss appointment or do not comply with treatment regimens) from their patient load. In numerous conversations, participating physicians singled out Hispanic Medicaid patients and hospital administrators as fitting the mold of the aforementioned "trouble patient."

Once dropped from an OHP primary care physician, the client faces a series of bureaucratic obstacles to regain access to health care. Unlike the former FFS model, it is the client's responsibility to seek out other physicians who will take on

an already deemed “trouble patient.” Although these clients are still enrolled in the OHP, no particular physician has an obligation to serve them. Several Hispanic reported that it becomes a difficult task to find a physician within a HMO that is taking OHP clients and is willing to accept a client that has already been dropped by a colleague.

Private Sector Volatility and Hispanic OHP Participation

Private sector volatility in the managed care Medicaid market has resulted in constant policy changes, which have filtered down to a complex and constantly altering set of rules and responsibilities for OHP clients. Since the beginning of managed care Medicaid in 1994, a revolving door of HMO companies have contracted with the state. The high turnover in HMO contracts are largely due to the fluctuating profitability of providing health care for Medicaid patients. When the market dictates low or no profitability for managed care Medicaid, HMO firms promptly exit the market and dissolve their contracts with the state. With each new contract comes a new set of company regulations that the client must successfully navigate to receive care. Those clients lacking skills to adjust and understand the constant and substantial regulatory changes have generally dropped out of the program. Many Hispanics are particularly vulnerable to managed care Medicaid volatility due to language barriers and their general unfamiliarity with the managed care system.

In the initial phases of the OHP, the HMO delivery system included 16 fully capitated health plans (FCHPs), four partially capitated physician care organizations (PCOs), and five dental care organizations (DCO's). Office of Medical Assistance Programs (OMAP) also contracted with 317 primary care case managers (PCCMs) to manage services in these areas without managed care plans. In 1999, managed care was available in 28 of 36 counties (OHPPR February 1999).

In OHP's brief history, several HMOs have discontinued participation or greatly reduced the number of counties they cover. Some closed their Medicaid books altogether, arguing that the payment schedules were too meager to be financially sound. Other companies maintained that the market was too flooded with competition. Still HMO companies stated that the requisites for participation in the OHP was too complex or cumbersome (OHPPR February 1999). One clear trend was that as many plans exited, a few began expanding their coverage markets. This resulted in a concentration of plan enrollment and a reduction of market competition. Of the four plans that had been working as PCO's, two changed to FCHP's, one consolidated with another plan, and one terminated participation (OHPPR February 1999).

The chart below, "Fully Capitated Health Plan Market Changes 1994-1999," illustrates the nature of the private sector's participation with the OHP. It is important to keep in mind that with each change in management comes a different regulatory system for managing OHP clients. Furthermore, it is the responsibility

of each client to understand and comply with these administrative changes. Often Hispanic Medicaid patients who are unfamiliar with HMO operations and/or lack English skills have significant difficulty responding to policy changes. Consequently, policy changes have made it difficult for Hispanic, in particular, to continue participation in the OHP.

Table 2.0 Fully Capitated Health Plan Market Changes 1994 – 1999
Oregon Health Plan Policy and Research February 1999

County	02-01-94	10-01-94	10-01-95	10-01-96	10-01-97	10-01-98	01-01-99	No. of Changes
Benton	6	6	5	5	4	4	4	2
Clackamas	11	11	11	7	7	7	7	1
Clatsop	4	4	4	3	2	2	2	2
Columbia	3	4	2	2	4	4	4	3
Coos	3	3	1	1	1	1	1	1
Crook	1	1	1	1	1	1	1	0
Curry	1	1	1	1	2	2	2	1
Deschutes	1	1	1	1	1	1	1	0
Douglas	2	2	2	2	2	4	4	1
Gilliam	0	0	0	0	0	0	0	0
Grant	0	0	0	1	1	1	1	1
Harney	1	1	1	1	1	1	1	0
Hood River	2	2	2	2	1	1	1	1
Jackson	5	6	5	7	6	5	5	5
Jefferson	1	1	1	1	1	1	1	0
Josephine	3	3	4	4	4	4	4	1
Klamath	2	2	2	3	3	2	2	2
Lake	0	0	1	1	1	1	1	1
Lane	5	5	5	3	3	3	3	1
Lincoln	0	0	1	1	1	0	0	2
Linn	5	6	4	4	3	4	4	4
Malheur	2	2	2	2	1	1	1	1
Marion	6	6	6	4	4	4	4	1

Table 2.0 continued.

Morrow	0	0	2	2	2	2	2	1
Multnomah	12	12	10	7	7	7	7	2
Polk	6	6	6	4	4	4	4	1
Sherman	0	0	0	1	1	1	1	1
Tillamook	0	0	0	0	0	0	0	0
Umatilla	3	3	3	3	3	2	2	1
Union	3	3	3	3	1	0	0	2
Wallowa	2	2	2	2	1	0	0	2
Wasco	2	2	2	2	1	1	1	1
Washington	11	11	10	7	7	7	7	2
Wheeler	0	0	0	2	1	2	2	3
Yamhill	6	6	6	5	5	6	6	2

The following is a conversation among physicians on the subject of the constantly changing insurance coverage for OHP clients.

Dr. Stevenson: It (universal health care) would at least allow us to avoid the patchwork of ever changing regulations that different insurance companies have for reimbursement... People will call and say “Do you take such and such insurance?” And part of me thinks “well I don’t know, what we are taking this month. Last month I was taking this and this. You’ll have to call our business office.”

Investigator: It keeps changing?

Dr. Rose: Oh Yea.

Investigator: Why does it change so much?

Dr. Rose: Because the hospital negotiates costs and fees with different insurance companies and when they have reached some satisfactory contract with them then we can take them. If the contract changes or falls out, we have a disagreement with them, then we can no longer see the patient under the contract.

Dr Stevenson: And it makes it sound like we don’t want to see patients anymore, instead our insurance has changed our contract.

Many other physicians interviewed held similar views regarding the private sector's volatility and its interference with the continuity of care a patient receives. For the Medicaid client, each transition of HMO affiliation means they must seek out another OHP sponsored HMO physician that is willing to take on a new patient. In Central Oregon, for example, this is a very difficult task. While conducting research in the area between June and July of 2001, all physicians had filled their quota of OHP clients and only a few were accepting more OHP patients. For the Hispanic Medicaid clients, the unfamiliarity of the procedure to solicit these new physicians coupled with possible language barriers makes this task especially difficult.

One Hispanic woman explained her frustration after a HMO contract with her local hospital dissolved:

Laticia: I went to the hospital, but I knew I had the Medical (the Oregon Health Plan) to pay for it. Then when I get my sister to take time off from work to take me to the hospital, I found out that they don't take Care Oregon there anymore. I was about ready to get surgery on my hand, but then they said no. And they would not do it. Hermiston hospital does not take Oregon Care now. I didn't know what to do. I thought I would be covered in Hermiston. So I said to myself "Now what?" A few months later a friend told me that they were accepting medical in Pendleton (about 30 miles away). I went to my welfare case manager and he arranged to get my surgery done there.

Investigator: Where did you get diagnosed at?

Laticia: In Hermiston.

While Laticia was successful in eventually accessing medical care, her story highlights how private sector volatility affected patient-physician continuity, delayed needed medical attention, and did not provide a clear avenue to

successfully switchover to another primary care physician. Once Laticia found a new physician, she was forced to once again adjust to that particular HMO's policies and regulations.

OHP Enrollment and Renewal Process

Hispanics encounter numerous difficulties in the OHP enrollment and renewal process. Frequently, OHP requires information that many Hispanics feel uneasy about reporting. Secondly, several participants stated that the Spanish translation of the application is awkwardly worded and hard to understand. Moreover, a significant number of Hispanic families are illiterate and have difficulties obtaining agency assistance in filling out the forms. Assistance through various social service networks exist; however many of these agencies have not reached a level of cultural competency such that the Hispanic community feels comfortable patronizing these offices. Finally, the renewal process does not account for the high mobility of migrant Hispanic workers, nor the fluid nature of a typical migrant household. The combination of these factors has made the OHP application and renewal process linguistically confusing, structurally challenging, and culturally insensitive.

Several Hispanic Medicaid clients reported having comparatively lower formal educational backgrounds than the mainstream public. I witnessed in Los Cruses de Varieros the low education levels many residents received before migrating to Central Oregon. According to one informant in Los Cruses de

Varieros, most children do not finish sixth grade and many cannot read a Mexican newspaper. For the people of Los Cruses de Varieros, education is poorly funded and not well supported. Most are rarely confronted with situations that require them to read or write. A trip to the state sponsored hospital, for example, only requires a signature.

The importance of this education gap is that lower levels of education negatively affect Hispanic Medicaid clients' ability to correctly file for the OHP application. The application process requires both reading and writing skills. Without these skills, potential Medicaid clients must rely on others to process and renew their applications. While there is a widely recognized need for OHP affiliated agencies to provide assistance to persons attempting to apply for the OHP program, many agencies are not at a level of cultural competency to effectively help Hispanic individuals.

One OHP affiliated social worker stated:

We have had an overall increase in Hispanic population, but just in the last two years, our office has seen a dramatic increase in the number of Hispanic clients we see. One reason is that in the past two years we have had a Spanish interpreter. The Hispanic community now comes in the hours she works. Our interpreter has made a big difference in reaching the Hispanic populations....I think that there was probably a stigma of being a "white" agency before we had a translator. When they saw that we were interested in their needs and ready to help them, we saw the major increase.

As discussed in the above quote, the employment of a Spanish translator was an excellent way to reach out to the Hispanic population. Frequently translators are mediators of cultural conflict between the service agency

administering the OHP and the Hispanic population. One Hispanic woman spoke about her experiences in an OHP affiliated agency:

I worked at the health department for a while and that was when Connie was running it and she really didn't understand the culture. And it frustrated me-but she learned a lot from them you know. And they learned from her. As a matter of fact, when I said Mexicans don't liked being called Hispanic that's one of the things we kind of ran into because I would come in and Connie was walking through one day and they have a form that you fill out and it says to cross out your nationality and it would say white black and whatever-but no Mexican and so they don't like that and so I said don't check it if you don't think you are Hispanic and Connie came out and said "wait a minute she says: "You fill out Hispanic." And I said they aren't claiming to be Hispanic they feel they are Mexican. She said "can I talk to you in my office?" And she said to me " you don't call them Mexicans. That is not how you call them. And I said I wasn't trying to be derogatory-that is just what they want to be called. So I kind of got in trouble for that. Well a week later, the same people came back. And Connie made them fill out another form. So finally I asked them. Aren't you Hispanic? Isn't this the box you should mark. And they flat said "no! We are Mexican." And that is what we prefer to be called. I got in a lot of trouble over that for calling them Mexican people. They were very offended that Connie told me not to call them Mexicans. So we had a meeting. I had the people come in and I said to Connie " now these people are going to explain to you that they are not Hispanics they are Mexicans. And so she said "interesting." I think that they (the Mexicans at the meeting) felt comfortable in speaking up because I speak Spanish and I look Mexican. I don't think they would have spoken up to any social worker.¹

The following are participatory observation notes recorded at a local OHP affiliated agency:

A woman just moved up from California last week looking for some cash assistance and to enroll in the OHP. While I was their waiting to assist a Hispanic friend, the woman broke down and began crying

¹ See p. 6 for an explanation of the use of the term "Hispanic" in this thesis.

in frustration: "No one can understand me here" she said. As far as I could tell the entire agency was White and no one spoke Spanish. She had been waiting for over an hour and she appeared to be the only one client in the office for the majority of that time. The caseworker did not understand her needs. When I asked her why she was not being assisted, she said they were discriminating against her because she is Mexican.

In many cases, fully literate Hispanics are also confused by the OHP application. I assisted several literate Hispanic residents with the application translated into Spanish. The language that is used was reported to be unfamiliar and awkward. As a consequence of the linguistic confusion, applications are commonly rejected for missing or inappropriate information, thus further discouraging OHP participation.

Selecting a provider is a particular puzzling area of the application. One OHP associated social worker remarked:

Again, now I'm going back to the situation Latinos face... There is a lot of paperwork involved in enrolling for OHP. There is a lot of small writing when you get your application packet. The forms, and the cards have a lot of things to choose. In fact, what is really interesting is that they have to choose a provider, like you have to choose a dental provider if you get on the plan. It's confusing to me and it is extraordinary confusing for the Latino population. I have called and said "Well, can you send us some information on who your providers are so we can pass it on to the patients. They don't know who to choose." "Well, they can choose this company or this company but that is it. You have to choose one, but you can't have any information on the plan until you have choose, then we will send you some information." How do you make a choice then? Just pick a name? It is really complicated.

Another Hispanic man stated:

There are a lot of problems with the Oregon Health Plan. For example, I have filled out the application two times and I still have not received anything back.

A Hispanic woman offered her experience with enrolling in the OHP:

I was four months pregnant and I didn't have a job at that time. I tried to find work after that I could do while I was pregnant. I was six or seven month and I was working at Pizza Hut and it was getting heavy work. I started bleeding at work so I quit. I applied at first and I was denied because they said they didn't get enough information. I did send them the whole information, but they said I didn't. So I had to reapply again. Nothing happened. Then I talked to my caseworker and they redid it through the computer, so I didn't have to fill out another application.

Beyond the confusing nature of the OHP form, the renewal forms that are required to be completed every six months have made it extremely difficult for some segments of the Hispanic Medicaid population to continue their participation. Typically, a renewal form is mailed to the client requiring an update on the original application every six months. If the form is filled out correctly, meets the eligibility requirements, and is returned within 30 days, the client will receive OHP benefits for another six months. Although the renewal application is in both Spanish and English, a common complaint is that the English version is indiscriminately mailed to most Spanish speaking OHP clients.

Another commonly reported problem is that because Hispanic migrant clients are continually moving and the conventional system of mailing the OHP renewal application is frequently unsuccessful in reaching this population. As an

outcome, their coverage frequently lapses and they must resubmit an entirely new OHP application to regain OHP benefits.

The following is a conversation involving public health officials and a health care administrator in Central Oregon:

Beth: You constantly have to be sending them (OHP affiliated agencies) information- which is probably helpful to them as a way to up-to-date information. But at the same time, it can discourage participation. Because the offices will generally call you tell you that you are missing a paper or something like that so maybe on that level it's just um overwhelming in that sense and they (Hispanic Medicaid clients) just let it go.

Cynthia: They are also mobile. I know the addresses- we update the forms every six months, but even in-between this time you will try to contact them for addresses or something and they will have already moved.

Steve: Yes. That's a big barrier.

Beth: So if they get a notice that they need more information to maintain their Oregon Health Plan it's going to another address and they never get it.

Hispanic migrant workers often face further difficulties with the structure of the OHP income requirements. The formula OHP uses to determine financial eligibility is to average the last three months of the total household income. For migratory workers, their income levels fluctuate radically throughout the course of a year. In some crop seasons, migratory laborers household income rises above the income requirements for total family income, while other seasons they may be well within the eligibility qualifications. One social worker asserted:

One of the issues I have found with the Latino community is: A. They do not know enough about the Oregon Health Plan. They do tend to let their cards, once they get it, their coverage lapses because they do not understand what they have to do to keep them active. B.

Their income will go up. They will get one good job in the fields for a month on a farm, all of a sudden they have too much money for that month-but they don't have enough money in the rest of the eleven months. Or very little money; they are scraping by. And this cycle does not give them any consistency in care with a provider.

Another issue for migrant Hispanics applying or reapplying for Medicaid benefits relates to the OHP policy that includes all household incomes to determine financial eligibility. In many low-income Hispanic households, the number of household incomes frequently changes throughout the course of a year. In many migrant Hispanic homes, relatives and friends stay for short periods. A number of Hispanics reported that when they filed the application there were too many income earners to qualify for the program. They had to apply again after some occupants moved out of the home. Meanwhile, others qualified initially, and then later were rejected because the number of occupants had since risen. In sum, the structure of the OHP requirements present significant barriers for many Hispanic households that have a continual influx of residents.

Beyond the issue of the highly fluctuating total Hispanic household income, there is further uncertainty about whether each income earner contributes substantially to the household welfare. OHP appeared to create the income earner formula based on the traditional American nuclear family, where all income earners dedicate their funds toward household welfare. However, many of the comments collected from Hispanic uninsured individuals raises doubt to the extent each household income earner contributes to total household health and welfare. These

households typically have a constant flow of friends and relatives staying for varying periods. Although many people may live in one home, their economic contributions to the household may be minimal in some cases and substantial in others. A number of Hispanic participants reported that a significant portion of their income is sent to relatives in Mexico or living elsewhere in the United States. It appears that many of the assumptions about household income are inconsistent with the findings in this thesis and may mislead OHP officials into believing there is more money that can be designated to health care than actually exists, particularly within Hispanic households.

The final theme that emerged was that the type of questions that is asked on the OHP application conflict with many of the Hispanic participants' value placed on privacy and autonomy within the public arena of American society. Several Hispanic participants believed that the application asks too many personal questions. These questions raised suspicion and fear that immigration officials will use this information against them. As stated earlier, undocumented persons are able to receive emergency medical coverage from the OHP. This population is especially leery of devolving information about themselves or other members of their household that could jeopardize their ability to live in the United States. For instance, the application requires the applicant to list every person living in their household as well as report their immigration status. Buried in the stack of literature that accompanies the application is a line that states the OHP will not reveal information provided by their clients. However, this is not highlighted in the

application process. Furthermore, many reported they do not trust the government enough to believe this statement.

CONCLUSIONS

Managed care Medicaid has mainstreamed clients into hospitals and clinics that, in the past, were almost exclusively the domain of private paying or privately insured patients. Before the advent of managed care Medicaid, Medicaid populations were treated by community-based providers that were generally familiar with the cultures and languages of their patrons (Maldonado-Weech, Moralis, Spritzer, Elliot and Hays 2001). To a large extent, physicians and hospital administrators in the former FFS Medicaid system chose to treat indigent populations (Maskovsky 2000). However, with the advent of the OHP, physicians that affiliated with a particular OHP contracted HMO are required to take on an ethnically diverse Medicaid population along side their privately insured patients. Equally significant is that many Hispanic Medicaid clients find themselves traveling out of their community-based clinics and into frequently unfamiliar mainstream hospitals for the first time. These newly formed doctor-patient relationships have been reported by several physicians and Hispanic Medicaid patients as unsatisfactory.

This thesis suggests four primary sources of tension between physicians and Hispanic Medicaid clients: (1) Language barriers have created miscommunication, confusion between physicians and some Hispanic Medicaid patients; (2) The pattern of late or missing appointments by many Hispanics conflict with the schedule oriented mainstream hospitals; (3) Episodic and

emergent patterns of seeking medical attention from many members of the Hispanic community disagree with regular and preventative visitations preferred by physicians; (4) Gender conflicts arise for many Hispanic men while attempting to navigate an unfamiliar medical system. Collectively, these factors contribute to an environment prone to misinterpretations, confusion and cultural insensitivities in Oregon's health care system.

Another theme that emerged was the influence HMO private sector market competition has on Hispanic Medicaid participation. With the advent of OHP came a fundamental shift from state to private sector management of Medicaid clients. Consequently, market forces within the private sector health care industry have had a profound effect on the nature of health care delivery for Medicaid patients.

Private sector market factors frequently influence physicians to limit OHP patient load, thus instigating a competition for the finite OHP patient slots available. Because of the high demand for OHP physicians, doctors can often dictate whom they will provide medical care to and whom to release for someone else to treat. Almost all physicians interviewed described that the Hispanic population as comparatively less cost efficient than other Medicaid clients because of their patterns of emergent utilization, missed or late appointments and/or language barriers. In several cases, these traits discouraged physicians from accepting Hispanic clients into their practice. Without a PCP, access to medical care becomes severely limited. Without a viable avenue to access care, many

Hispanic OHP clients that are unable to secure a PCP have dropped from the OHP program.

Volatility in the private sector HMO market and the recent merging of managed care sponsored Medicaid corporations have also had a negative impact on OHP Hispanic participation. The privatization of Medicaid through managed care adds an additional layer of private sector administration. These administrative rules and regulations vary from corporation to corporation. The rules are often difficult to navigate and confusing for Hispanics that are unfamiliar with managed care.

In the short history of the OHP, a significant turnover of HMOs. With each corporate turnover, OHP clients must familiarize themselves with the specificities of the new managed care company's rights and responsibilities. For the Hispanic Medicaid client, the most significant challenge to HMO turnover is finding another primary care physician. Many Hispanic participants described obtaining a new primary care physician as a large bureaucratic obstacle that sometimes resulted in their discontinued participation in OHP.

Finally, the OHP application and renewal process has additional bureaucratic barriers for Hispanic participation. Many Hispanics believe the OHP forms, printed in either Spanish or English, are awkwardly worded and confusing. Several Hispanics commented that the forms require excessively personal information about the applicant as well as other members of their household. These participants feared this information could be used by the government for

immigration purposes. Although there is extensive governmental assistance for application and renewal procedures, these agencies frequently lack the linguistic or cultural competency to effectively serve the Hispanic community. These deficiencies frequently result in an under-utilization of OHP services by eligible Hispanic Oregonians.

Due to the recentness of the OHP program, as well as the overall lack of national research on Hispanic participation in managed care Medicaid, this thesis should be considered a preliminary study. Although several topics were explored, this thesis also identified several other areas of interest that could be addressed in future research. Specifically, 1) The informal communication networks within the Hispanic community and possible strategies to link these networks to the OHP affiliated agencies and hospitals; 2) Hispanic utilization patterns between the OHP hospitals and local safety net clinics; 3) OHP Hispanic compliance issues; and 4) Hispanic payment strategies for OHP fees.

RECOMMENDATIONS

- The state should fund safety net clinics, that is, a broad range of local, nonprofit organizations and government agencies that share the common mission of providing medical services to vulnerable populations experiencing barriers to health care, as an alternative to the Oregon Health Plan.
- Political pressure needs to be placed on Oregon Health Plan sponsored HMOs to comply with existing laws that require translation services in all Oregon Health Plan sponsored Hospitals.
- Renewal of the Oregon Health Plan should be extended from every six months to a yearly basis.
- Medicaid sponsored HMOs should be required to provide ongoing training in cultural competency for its physicians and hospital administrators.
- When an HMO discontinues participation in the Oregon Health Plan, they should be required to assist their Medicaid clients' transition to another Medicaid sponsored HMO.

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APPENDICES

Appendix 1

FOCUS GROUP GUIDE FOR HEALTH ADMINISTRATORS/PROVIDERS

Welcome

Ask group members to come in, make a name tag, read and sign the “informed consent” form, read and sign the “cash voucher” form (if applicable), and take a seat.

Introduction

Facilitator: I’d like to thank you for taking the time to be with us this evening. I’d like to introduce those here and myself (also introduce other project personnel present). My name is _____, and this is (mention the names of other project personnel). We are conducting this focus-group study for the State of Oregon on options for universal health insurance, we do realize that we need to learn from your experience. We want to know what you think, what you feel about the issues of universal health insurance. We have specifically designed this focus group to seek your input on this and related topics.

START THE TAPE RECORDER HERE

[At this point, go around the room and have people say their name and something about themselves.]

Facilitator: Now that we are a little bit more familiar with each other, let us proceed with our focus-group session. In order to facilitate the discussion, we have prepared a set of questions. I will start the discussion by asking you to comment on a series of questions. Here is the first question.

1. Please provide a general profile of the patients (clients) accessing health services from your organization. Discuss how your patients generally pay for health care cost.
2. What is the rough percentage of uninsured patients at your clinic/facility? How does your clinic/facility handle the uninsured patients?
3. What barriers do your patients (clients) face in accessing health care?
4. What is the status of safety nets in your community? What can you tell us about the quality of care provided at the safety net clinics?
5. The Oregon Health Plan began enrolling participants in February 1994. How has the health care landscape changed since then?
6. During the 1990's, the percentage of uninsured Oregonians fell. But for the last three to five years, the percentage has not changed. Any thoughts about this? What, if anything, should Oregon do? What concerns might you have? What advice would you give to the State of Oregon?
7. Is universal coverage/access in Oregon a realistic goal to be working toward? What do you think about the idea that all Oregonians should be guaranteed some level of health care?
8. Is there a public health angle to be considered here when thinking about the uninsured? How would that play out in decisions to provide universal health coverage? [Expand upon data-based decision making, focus on prevention, community-level care, etc.]
9. What is your opinion regarding the strengthening of the safety net (improve access, not insurance coverage) in Oregon?
10. In your view, how should health care be financed? [Expand upon choices in terms of individual contribution, employer contribution, employer-employee cost sharing, taxes, etc.]

Facilitator: At this point we are going to review the issues we have discussed today. The facilitator briefly summarizes the topics that were discussed and provides opportunities for more additions and/or revisions.

Facilitator: We are planning to do other similar focus group interviews. Please take a moment and think about what we might ask them that we have missed. What should we be sure to ask them?

Thank you very much for sharing your thoughts with us today.

Appendix 2

Uninsured Focus Group Questions

1. What are your main concerns about your personal and family health insurance coverage? [Expand upon topics such as, affordability, current occupational status, etc.]
2. How does having health insurance rank among your other daily concerns? How important is it compared to take home wages? Does it effect your decision to apply for or leave a job?
3. How often and from where have you accessed health care in the last six months? What kinds of illnesses did you or your family experience?
4. How do feel about the quality of safety net clinics? OHP sponsored hospital? What does each have to offer? What does each lack?
5. Were you enrolled in any health insurance program in the last six months? If yes, why did you disenroll? If no, why not?
6. What other barriers besides have you faced in accessing health care as uninsured individuals.
7. Why do uninsured individuals not participate or disenroll from public health insurance programs for which they are eligible?
8. Have you ever been offered employee-sponsored insurance? Did you except? Why or why not?
9. What do you think about co-pays versus co-insurance? What sort of barriers do each create? What is the financial reality of these options for you?
10. What is an adequate benefit package for OHP? Are too few services covered? Are out of pocket expenses too much?
11. What do you think about the idea that all Oregonians should be guaranteed some level of health care? [Expand upon issues such as priority groups for health coverage – infants, small children, pregnant women, etc.]

12. In your view, how should health care be financed? [Expand upon the choices in terms of individual contribution, employer contribution, employer-employee cost sharing, taxes, etc.]

Appendix 3

Community Needs Assessment
Physician/Public Health Worker Interview GuidePioneer Memorial Hospital
Prineville OR 97754

1. In terms of age, sex, and ethnicity: what are the populations you are serving? How have these populations changed-what are some trends among your client demographics?
2. What are the services that you provide?
3. Are there underserved populations in this community in respect to health care? Who are they? Why do these gaps in service exist?
4. In your opinion, what type of health related services are needed to augment the existing system?
5. In your opinion, what is the most effective and efficient way(s) of delivering these services.
6. Do you think that the addition of a safety net would increase access to vulnerable populations in Prineville?
7. What are some advantages to the creating a safety net clinic? What are some pitfalls?