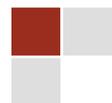

Central Oregon Health Equity Task Force Report

Findings,
Recommendations
and Supporting
Information

April 2014

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Health Equity Task Force (HETF) Members

HETF membership represents the three Central Oregon counties (Jefferson, Crook & Deschutes), as well as reflects the diversity of the community.

Sonya Littledeer-Evans, Facilitator/Consultant (Jefferson)

Marina Rodgers, Let's Talk Diversity Coalition (Jefferson)

Kate Wells, Pacific Source (Deschutes)

Elizabeth Holden, Deschutes Co. Behavioral Health (Deschutes)

Susanne Browning, Central Oregon Community Advisory Council (Deschutes)

Linda McCoy, Central Oregon Health Council, Community Advisory Council (Jefferson)

Roxana Ermisch, Health Care Interpretation/Bridges to Communication (Deschutes)

Elva Lopez, Mosaic Medical (Crook)

Denise Piza, Let's Talk Diversity Coalition (Jefferson)

Erin Tofte, BestCare Treatment/Let's Talk Diversity Coalition (Jefferson)

Jolene Estimo, Confederated Tribes of Warm Springs

Courtney Snead, Central Oregon Community College (Jefferson)

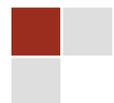
Jeff Papke, Cascades East Area Health Education Center/St. Charles Health System (Crook)

Bruce Abernethy, Bend-LaPine Schools/Central Oregon Community Advisory Council (Deschutes)

Jacqueline Hinds, Mosaic Medical (Deschutes)

Brad Porterfield, Latino Community Association (Deschutes)

Alisha Schade, Advantage Dental (Deschutes)



Task Force Overview

The work of the HETF will inform three key areas of the Coordinated Care Organization's (CCO) Transformation Plan:

Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs.

Assuring that the culturally diverse needs of members are met.

Developing a plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care and outcomes.

The HETF has developed recommendations on these key areas based upon what our priority populations in our Central Oregon communities told us. The HETF gathered this information through a variety of methods and settings, including focus groups, community forums, digital storytelling, and community outreach.

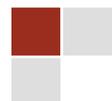
Community Engagement through Storytelling

Starting in October 2013, the Central Oregon Health Equity Task Force convened with representation from our diverse communities - representing providers, members and all three counties in Central Oregon. The Task Force created guiding questions, identified priority populations to engage, participated in Mindful Facilitation training and set out to conduct focus groups and community forums throughout the region.

We engaged communities in dialog around the following six themes:

- Language Access
- Provider and Workforce Competencies
- Linguistically Appropriate Communications
- Patient Engagement and Activation
- Access to Preventive Care
- Inclusive Environments

The HETF used storytelling as the community engagement process for this project. We know that people who experience the greatest disparities in health often have the least amount of power to influence changes in the policies, systems, and environments that impact them. Digital, multicultural storytelling is a best-practice



and culturally appropriate community engagement strategy that empowers communities to leverage their stories to create change. Personal stories are a way to bridge community members and decision makers, stimulating dialogue and fostering action.ⁱ

Our storytelling process facilitated focused dialog around areas of inequity and areas of strength. Our storytellers, despite walking in the world with much less power and privilege than most, shared from their heart and were willing to share pieces of themselves, even when painful, because they have Hope. They have Hope that their personal stories and experiences can be part of the solution towards social justice.

From these facilitated conversations, recommendations for reform were developed and are outlined in the report that follows. Several storytellers stepped forward and shared their experiences on video. The HETF facilitated the production of these digital stories in a media production that brings the first person narrative together with multimedia technology. These stories are told by Central Oregon residents who are disproportionately impacted by health disparities. These stories put a face and name to the following recommendations.

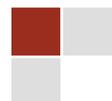
The Health Equity Task Force, on behalf of the voices we heard, call upon you our decision makers and the policy makers - to now use your power and privilege, not only to hear the voices of our community, but to put what was heard into action towards equity... and towards social justice.

Focus Groups, Interviews and Forums

One hundred and forty-six (146) community members and providers from the Central Oregon region shared their personal stories of health with the Task Force. These stories were shared in small group settings or during individual interviews. We also included the input and expertise of the 11 Task Force Members who were not personally interviewed.

It is important for readers of this report to understand:

- Community engagement is a sound method and was chosen by the Task Force to effectively engage underrepresented populations, particularly Native American and Latino/Hispanic community members, using conversations conducted in a welcoming and culturally appropriate manner.
- The project was not designed to be a statistical survey or poll, but rather a way to gain community wisdom to inform Task Force developed recommendations.
- The Task Force reflects community and agency people who serve target populations (including health care workers and providers), however, the CCO will need to determine next steps, including how it may implement change



concepts including addressing any technicalities, barriers or issues that may be involved in implementation.

- This report highlights common issues as well as some locally specific issues that prevent the health system in achieving health equity for all who are served.
- This project represents an exceptional level of community engagement and empowerment, particularly with people of color and those with limited English language proficiency.
- The resulting report, based on these conversations and stories, is an opportunity to see the stories and experiences behind state and national data around health disparities and to understand why such differences in access, quality and outcomes might be occurring for these community members.

Focus groups, forums and interviews conducted:

Confederated Tribes of Warm Springs Canoe Family dinner (75 community members)

Jefferson County Relief Nursery Focus Group (3 community members)

Crook County "Books to Briefcase" Youth Focus Group (15 youth)

Jefferson County Community Forum (3 providers, 12 community members)

Deschutes County Community Forum (6 community members and non-profit reps)

Crook County Community Forum (3 providers, 8 community members)

Health Care Interpreter Focus Group (5 certified health care interpreters)

Bend Latino Community Association Focus Group (2 providers, 10 community members)

Jefferson Co. Oregon Child Dev. Coalition Focus Group (1 community member)

Individual Video Interviews with:

Shawnetta Yahtin, Warm Springs Tribal Member and Medical Social Worker

Regina Sanchez - Prineville resident and Crook Co. Health Dept. Enrollment Specialist

Joaquina Ines Rodriguez - Madras resident, wife and mother of four

Pedro Rodriguez - Madras resident, husband and father of four

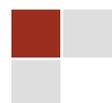
Denise Piza - Madras resident, Interpreter, LTD Coalition member and mother of four

Jessica Sanchez-Millar - Bend resident and Health Care Interpreter

Nelly Caccamo - Bend resident and Health Care Interpreter

Kirstie Morrison - Madras resident, mother of two and Warm Springs Tribal Member

Emma Smith - Warm Springs Tribal Member and LTD Coalition member



This project was also an opportunity for learning and deeper understanding around successful engagement of minority communities and vulnerable populations. For example, when attendance was minimal at the Deschutes County forum, we learned that no personal invitations were made to community members - instead area agencies laid out or posted flyers in clinics, posted the flyer on websites, and/or forwarded the email invite on to other providers. Whereas, forums and focus groups that were well attended resulted from each attendee being personally invited by someone they had worked with, were familiar with or who had reached out to them in-person.

Key Findings and Recommendations:

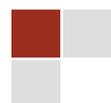
- I. Transformation Plan Element #6 Member Engagement & Communication (tailored to health literacy, cultural and linguistic needs of Latino/Hispanic and Native American/Alaska Native populations).

A. Language Access

By far, the most prevalent and consistent theme that we heard was around language access for non-English speaking members and/or Limited English Proficiency (LEP) members. Many recommendations came out of this area. Echoing consistently throughout the dialog was the need for a system's change around education, requirements, accountability and monitoring to ensure trained and certified medical interpreters are provided at every stage of care for every person who needs it.

Recommended Changes:

1. Require all clinics/providers to develop and adopt a Language Access Plan (including health literacy) by January 1, 2015.
2. Adopt and require all clinics/providers to adopt *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the National CLAS Standards) by January 2015. ⁱⁱ
3. Develop toolkits on Language Access assessment with guidelines for developing and Implementing Language Access plans (using existing best practice literature). ⁱⁱⁱ
4. Educate providers on the value of using trained and certified medical interpreters, how to work with them, and how to access them. " *Training programs for clinicians should include, as a core component, the evidence*



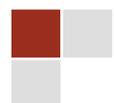
- supporting the use of trained interpreters and their impact on patient safety, quality, and satisfaction”.^{iv}*
5. Require the use of trained and certified medical interpreters (who meet the requirements specified in ORS 413.550 to 413.558, and OAR 333-002) for anyone who identifies as LEP, non-English speaking or American Sign Language.
 6. Create contracts or formal arrangements with local organizations that provide interpretation or translation services.^v
 7. Create cost-share programs to assist providers in creating in-house Medical Interpreter Certification programs.
 8. Train providers on how to bill for the use of medical interpreters.
 9. The CCO will ensure representation of LEP populations on regional CCO community advisory and governance councils.

Measurement & Accountability

10. Create a monitoring system for ensuring the service is being offered and provided - e.g.: language access audits and “secret shoppers”.
11. Ensure accountability/sanctions for providers that fail to meet standards or requirements. Possible mechanisms include tying compliance to funding, using corrective action plans, levying fines, and partnering with OHA to enforce standards.
12. Ensure incentives and rewards for providers that meet standards or requirements - e.g.; extra funding to expand, award program and publicize findings.
13. Create a best-practice sharing program. Providers that are doing it right can share “how-to” advice and outcomes with others.
14. Create, model and reinforce a mentality shift within the local health care system, that to provide anything less than full language access is unacceptable and unjust. Begin with social justice training and training on civil rights language that governs this area of health care.

“The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services” .

<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>



B. American Indian/Alaskan Native population

The Native American population in Central Oregon often encounters gaps in services that differ from the gaps encountered by other populations. In addition to health literacy, culturally responsive, and socioeconomic needs for their health care delivery, this population also faces gaps between The Indian Health Services (IHS) and specialty providers.

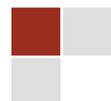
The Indian Health Service (IHS), an agency within the United States Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider for Indian people...^{vi}

Enrolled Tribal members may seek primary care service through the IHS clinic in Warm Springs. However, when patients need services that the IHS clinic does not provide (e.g. specialty care), they are referred out to non-IHS providers in Central Oregon via contract health services. Navigating this referral process is difficult because of communication between providers, records transfer, and distance. Tribal members may also seek health care outside of IHS using Medicare, Medicaid, Veterans Affairs, or private insurance. Such coverage allows them to seek primary care services at clinics other than the IHS clinic in Warm Springs. We heard from many Tribal members that they often seek services outside of the IHS clinic because wait times to get in at IHS are long, difficult to schedule and “walk-in” slots fill up fast. And for health needs after hours, the only provider open within 20 miles is the emergency room in Madras. This prompts the Tribal member population to use the ER for primary care. When the Tribal member population seeks services outside of the IHS, they face the following barriers: leaving their community for care, changing providers, encountering providers that do not know or have their history and challenging billing/insurance complexities.

Thus, even though systems are in place to ensure that our American Indian/Alaskan Native populations have coverage from both federal and state government - for whatever they should need - the gaps between these systems often result in layers of barriers and complexities that may make it more difficult to access the right care at the right time.

Recommended Changes:

1. The CCO, via the Central Oregon Health Council (COHC), will start the conversation with the Confederated Tribes of Warm Springs (CTWS) and



IHS about what strategies are needed and possible ways to better serve and meet the needs of the American Indian/Alaskan Native population in Central Oregon.

2. PacificSource Community Solutions, in its role as the lead organization in the capacity of the Coordinated Care Organization (CCO) will ensure that the American Indian/Alaskan Native population is represented on regional CCO community advisory and governance councils.

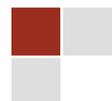
II. Transformation Plan Element #7 Diversity and Cultural Competency

A. Discrimination, Prejudice, Differential Treatment

The second theme that we heard throughout all of the stories was of differential treatment based on race, ethnicity, socioeconomic status, education level and language. Over and over again, we heard examples of how basic access to services is markedly different than it is for the dominant culture. We also heard multiple examples around how people had experienced negative assumptions, stereotypes and marginalization when they accessed services or were denied service. This key finding crosses all three of the CCO transformation plan elements 6, 7, and 8. These experiences start to create a pile-up effect of disparity for vulnerable populations. When these patients are denied basic rights to care or mistreatment while receiving care, they are not engaged in their care, they do not seek preventive care, and they may avoid the health care delivery system all together.

Recommended Changes:

1. The CCO will require all clinics/providers to create and submit an Equity and Inclusion Plan by July 1, 2015; Plans should be submitted to the CCO and must demonstrate how they meet best practice standards (National CLAS Standards).
2. The CCO will develop a toolkit on Equity and Inclusion to use to develop and assess Equity and Inclusion plans based on best practices.
3. The CCO will work with their provider networks to track data and outcomes of their Equity and Inclusion plans.
4. Starting July 2015, the CCO will require all clinic/provider staff to obtain 10 hours a year of Diversity, Equity, Inclusion and/or Cultural Humility Training.
5. The CCO will create and invest funding into pipeline programs for recruitment of bilingual, multicultural, diverse students for a medical/behavioral/dental workforce that reflects the community.



6. The CCO will actively recruit representatives of minority populations to sit on regional CCO community advisory and governance councils.

Measurement & Accountability

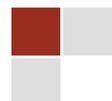
7. The CCO will create consumer quality advocate positions for each area (based on population and number of providers in the area) that reflect the community.

These advocates will have the role of providing support and collecting customer feedback. They will perform the following tasks;

- Make follow up calls to patients after service to see how the service was.
 - Conduct on-site visits to providers to see how patients are treated.
 - Participate in on-going community engagement to hear the stories.
 - Staff a patient hot-line, able to submit feedback 24-7, in preferred language.
 - Refer situations of malpractice, civil rights or social justice needs to appropriate advocacy agencies.
 - Be visible in the community to create relationships with community.
 - Educate the patient about:
 - how to access care
 - how to navigate the system
 - services available
 - preventative health
8. The CCO will collect consumer quality reports from advocates and address providers that consistently have poor ratings/feedback.
 - Review agency's Language Access Plan and Equity/Inclusion Plan. Develop work plan to address deficiencies.
 - Financial sanctions
 - On-site training/coaching
 9. The CCO will collect consumer quality reports and reward those providers who do well. The CCO will create a best-practice sharing program. Providers that are doing it right can share "how-to" and outcomes with others.

"You get that stigma immediately right at the front desk...You feel judged... I've been on OHP before and then I've been off, and you do see a difference: in quality of services and choices you can make and coverage. When I've been on OHP, the clinics you go to are not as nice. They are dirty."

-Juniper Junction Relief Nursery focus group participant



“Cultural competency in healthcare embraces the concept of equity, with patients having equal access to quality care and nondiscriminatory, patient-centered practices delivered by healthcare providers.”

National Quality Forum’s Primary Domains of Measuring and Reporting Cultural Competency

1. Leadership
2. Integration into Management Systems and Operations
3. Patient-Provider Communication
4. Care Delivery and Supporting Mechanisms
5. Workforce Diversity and Training
6. Community Engagement
7. Data Collection, Public Accountability, and Quality Improvement^{vii}

III. Quality Improvement Plan to Reduce/Eliminate Racial, Ethnic, and Linguistic Disparities

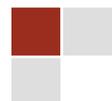
A. Health Care Billing

The next theme that was consistent for needing improvement across ethnicity, language, education and income was with medical billing; People reported a number of issues that required improvement, including:

- a) Written, electronic or telephonic communications about billing were not well geared to low health literacy levels;
- b) Billing department customer service can be unwelcoming, culturally insensitive, and unfriendly;
- c) Front line providers and billing staff delivered inconsistent communication about costs;
- d) These issues made people feel helpless because they had nowhere to turn for assistance.

Recommended Changes:

1. The CCO will create health care community workers who specialize in billing or billing advocates who are trained in billing systems, and who can help patients navigate this part of the system. Such individuals must be accessible in a patient’s preferred language.
2. The CCO will create community health plan “insurance agent”. That person is assigned to the member and is always the person they call for help/assistance (kind of like a car insurance agent). This person could develop a relationship with member, know their history, and create



- continuity for the individual so they are not passed from person to person. Some agents should be bi-lingual. The “billing advocates” mentioned above should work directly with the insurance agent to help clients.
3. The CCO will contract with a local advocacy group that is independent from providers and insurance, and solely there to advocate on behalf of vulnerable populations (including those without insurance, without education, without citizenship).
 4. The CCO will require training for billing staff regarding cultural competency, equity and inclusion annually.
 5. Billing information needs to be more user-friendly and written in terminology that is easier to understand, especially for individuals who are trying to read information from both insurance and providers. Keep billing codes in-house and not on patient paperwork. Codes confuse patients.
 6. Encourage person to person dialogue when clarification is needed; communities of color respond better to oral interaction versus letters or automated calls (which are perceived as impersonal). Many Latino/Hispanic community members do not listen to voicemail and/or return messages.
 7. Create strategies to lower cost of health care, both preventive and primary, especially for undocumented immigrants and low income. The Affordable Health Care Act in real time does not provide federal coverage, other than emergency care. Address these gaps in service and cost through Community Health Centers.^{viii}

“My bill is never in a way that I can understand easily, it is usually not accurate. And then, when I call about it, it is a fight.”

-Crook County Forum participant

B. Local Data Collection

When trying to gather data from the CCO to capture the health care experience of vulnerable member populations in Central Oregon, we found there was not much to gather. Therefore state-wide data and county specific data on health disparities was all that was available. Accurate data is required in order to determine where to focus, how to measure impact of services or lack of services, and how to evaluate whether solution strategies work.

Recommendation Changes:

1. Ensure the data collection includes most recent recommendations from the Oregon Legislature; using uniform standards for collection of data on race,



- ethnicity, preferred languages and disability status in surveys and in all services where providers collect, record or report such data. ^{ix}
2. For “Other” option, add a motivator like “Please tell us how you identify your ethnicity.”
 3. When requesting data from patients at the clinic level, explain why the data is needed to improve their overall quality of care.
 4. Access, review, and incorporate recommendations from current studies. ^x
- See appendix A.

Other Findings and Recommendations

Populations at Risk for Low Health Literacy:

- Elderly (age 65+) - Two thirds of U.S. adults age 60 and over have inadequate or marginal literacy skills, and cannot read or understand basic materials such as prescription labels.
- “Minority” populations
- Immigrant, non-English speaking populations
- Low income - Approximately half of Medicare/Medicaid recipients read below the fifth-grade.
- People with chronic mental and/or physical health conditions
- Low educational attainment

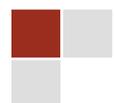
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A. Language Access & Linguistically Appropriate Communications

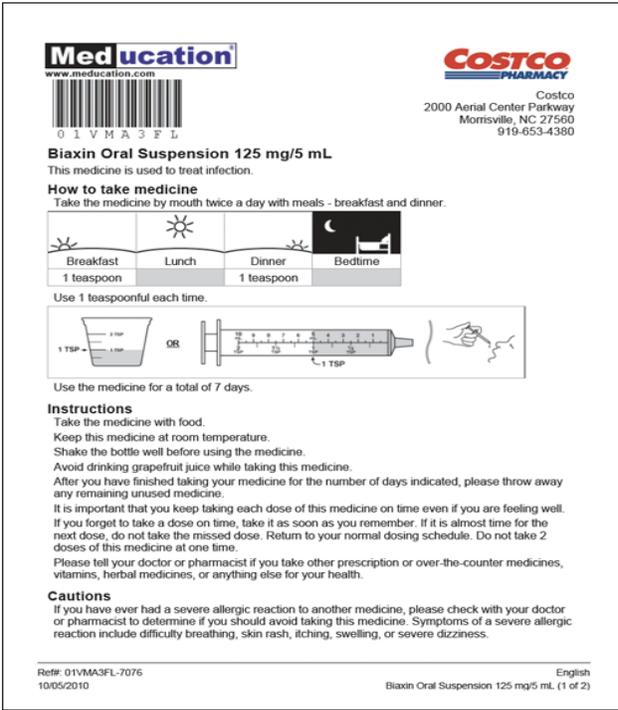
1. Often, there is no bilingual staff at pharmacies or when prescription/medication directions are given. In addition, even with the English speaking population, it was often shared that no one explains how filling a prescription works (cost, pharmacy, payment).

Recommendation:

- Spanish speaking populations want/need interpreter services for pharmacy and prescription related services.
- Require use of Certified Health Care Interpreters for LEP patients.
- Inform providers which Pharmacies can print labels in Spanish and that Rite Aid offers telephonic interpreting.
- Implement standardized software for pharmacies and providers to use that address both the language and literacy of patients, such as the



- **Meducation Software that offers medication and discharge instructions at a good reading level for health literacy and currently in 15 languages.**^{xii}



Health Literacy

Universal Medication Schedule - concrete, visual representations of times of day and the amount of medicine to be taken each time

Pictograms - reduce dosing errors

Concise Instructions - one line per instruction

Targeted reading level: 5-6th grade

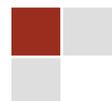
Visual spacing to reduce cognitive overload

xiii

“In 1964, Congress passed Title VI of the Civil Rights Act. This law prohibits discrimination and ensures that federal money is not used to support health care providers - including pharmacies and pharmacists - who discriminate on the basis of national origin. Title VI says:

No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The U.S. Department of Health and Human Services (HHS) and the courts have applied Title VI to protect national origin minorities who do not speak English well.” ^{xiv}



2. There is a major lack of Spanish speaking staff or use of interpreters in the hospital and Emergency Department (specifically in Jefferson County). Many participants reported experiencing incorrect billing, especially when they are on OHP. Yet, because of the language barrier the Spanish speaking population has great difficulty calling and getting help with billing issues. Most reported that, if they can find transportation, they will attempt to seek services in neighboring counties, rather than in their own community in Jefferson County.

Recommendation:

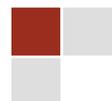
- Have Spanish speaking staff available at all times.
- Require the use of Certified Health Care Interpreters for LEP patients, including for billing department communication with patients.
- Suggest telephonic and video remote services as a back-up.

One study compared the functional health literacy (FHL) of Spanish- and English-speaking adult patients in a suburban emergency department (ED). They found the majority of Spanish-speaking subjects have less-than-adequate FHL. Self-reported reading ability and years of school completed appear to predict FHL and may be clinically useful. Due to the disproportionately low level of health literacy among Spanish-speaking patients demonstrated in this and previous studies, future efforts should focus on developing programs that improve health literacy by providing this population with oral translations and pictorial and video instructions.^{xv}

3. The Spanish speaking population reported that often their health care appointments are cancelled, rescheduled or are scheduled several weeks out because no interpreter is available or a provider failures to arrange for an interpreter.

Recommendations:

- Require training for providers on scheduling interpreters ahead of time, making this a priority, and on how to work with professional interpreters.
- Require regular audits and monitoring when appointments have been rescheduled at least twice for language access issues.
- Require staff making referrals to mention language needs to outside offices receiving referrals.



Oregon's Health Care Interpreter (HCI) Program oversees the HCI Registry and the qualification and certification of health care interpreters as specified in Oregon Law (ORS 413.550 to 413.558, and OAR 333-002). The program also advocates for policies to ensure culturally and linguistically accessible services; supports HCI professional development, and staffs the Oregon Health Care Interpreter Council.^{xvi}

- L**ack of English fluency is an independent Predictor of:
- Poor control of chronic disease
 - Reduced health care use
 - Poor quality of primary care
 - Absence of a regular source of care
 - Lack of continuity of care
 - Lack of patient satisfaction
 - Poor quality patient education and understanding of their disorder^{xvii}

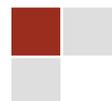
4. There is a misconception/misunderstanding about the use of professional Health Care Interpreters; when to use them, how to work with them and whose responsibility it is to provide/schedule them.

Recommendations:

- Impose clear requirements, procedures, and training for providers on their responsibility to provide Interpreters for LEP clients, especially if they receive federal dollars.
- Train providers on how to bill for this service.
- Create a public registry of providers that are in compliance with providing, scheduling and paying/billing for interpreters and make it available in all languages and formats for the region.

“They think it takes longer with an interpreter, they feel it takes twice as long. No, no - it doesn't take twice as long. It's a misconception...if it's a professional interpreter it doesn't take twice as long. If it's not, it will because they are trying to figure out what to say and how to say it, right? But if it's a professional interpreter it doesn't take twice as much. It's more accurate, more efficient and the chances to miss a diagnosis are less.”

- *Deschutes County Medical Interpreter focus group participant*



5. Many providers still do not have their written material in Spanish, including take home instructions. This is not only problematic when the client needs the material in their own language and can read in their own language, but even for those who may be illiterate, they still would like someone at home, who will be able to read it to them in their own language, versus having to translate it and getting it wrong.

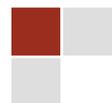
Recommendations:

- Require providers to provide all written health care materials in the client's own language, particularly Spanish for residents of Central Oregon.
 - Translation of health care documents must be done by certified translators (not bilingual staff/persons).
 - Train staff to look for resources that already have translated materials: National Institutes of Health/Medline Plus; Doctors.org; many basic intake forms and consents can be found translated on the internet; tailor for each agency.
6. There are still providers that use bilingual staff or patient family members to interpret health care information for the patient. Despite having access to Professional, Certified Health Care Interpreters, some providers still do not understand the difference and the inequitable impact this can have on the patient and their health outcomes.

Recommendations:

- Conduct training immediately to educate providers on the difference between being bi-lingual and being an interpreter and the inequity that is created by not using or providing a professional interpreter.
- Require the use of professional interpreter for every health care appointment for LEP patients.
- Impose clear sanctions for providers who do not comply with this requirement.

Physicians treating patients with Limited English Proficiency (LEP) who have access to and who use the services of trained interpreters report significantly higher quality of patient-physician communication than physicians not using these services.^{xviii}



B. Provider & Workforce Competencies

1. The client and the client's family's cultural understanding/beliefs of mental health issues often differs from the views held by Western Medicine practitioners, often ending in misdiagnosis, fear of sharing symptoms/issues, or not seeking services.

Recommendation:

- Providers, especially mental health providers, need knowledge about the beliefs/values/customs of the populations they serve and should consider this context in developing the treatment plan.

2. Young people, whose parents can't advocate for them, feel that their providers do not believe them when they self-report symptoms, pain levels, or need help.

Recommendation:

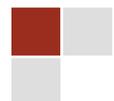
- Hire advocates that understand both youth and the health systems.
- Make available accessible feedback venues for youth or young adults.
- Hire providers that specialize in working with teen/young adult population.

3. There is a stigma associated with being on OHP. People shared their experiences of differential treatment by providers and billing agencies, especially if they had experienced private insurance before.

Recommendation:

- Require training for providers and staff on the impact of differential treatment.
- Encourage OHP to build relationships with providers to diminish stigma and continually explain coverage options.

4. Several community members shared that often times when scheduling health care appointments, including dental, if they have public insurance they are only given selected times or openings for appointments with no other alternatives. This feels like differential treatment and that not having



private insurance equates to less opportunity for appointments and schedule options.

Recommendation:

- Streamline scheduling across members; all patients should have equitable opportunities to access services and appointments when it is convenient and timely for them.
5. Diverse population members often shared stories of times their children needed care and providers made assumptions about the patient's fitness to parent/care for their children. These assumptions/stereotypes materialized in comments providers made to the patients using terms such as neglect, unfit, and child welfare involvement. Such treatment made patients not want to return for services or seek services elsewhere.

Recommendation:

- Require training on topics of inclusion, diversity, and equity training for providers to dismantle stereotypes, assumptions and exclusion.

"A provider is going to be good or bad in any language. In their native language or in their second language - that's just who and how they are. We cannot change that...you just do your job and try to help so the communication doesn't break down and everything is understood. You cannot change him."

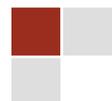
-Deschutes County Medical Interpreter focus group participant

C. Patient Engagement and Activation

1. Cost of health care was a recurring theme that we heard from all populations, but most particularly among the uninsured. Individuals developed an overall mistrust of the system when they did not understand the cost of care upfront and then later went into debt because of the cost of the care they needed. This experience played a key role in individuals not seeking care later because of not having the means.

Recommendation:

- Outreach efforts need to be increased in Central Oregon to educate vulnerable populations about the Affordable Care Act and Cover Oregon.



- These outreach efforts need to be relationship based, presented in the communities of these populations, by staff who represent the population, in the language of the individuals, and with as much cultural humility as possible.
2. Fear of retribution or further mistreatment keeps vulnerable populations from speaking up, giving feedback or complaining about services/care.

Recommendation:

- Provide a safe, anonymous, easy to access, language appropriate way to give feedback about services.
3. Health Care service delivery for vulnerable populations should be first about creating relationships, trust, history with the family, and respect for cultural differences.

Recommendations:

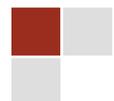
- Assist providers to be able to take time to meet with families and treat/inquire about more than just one issue at an appointment. Usually much more is going on and it is all related.
4. Programs that were strength-based and focused on the community or family getting involved seemed to inspire people more often than individually based programs. Community members felt a sense of support and belonging when they became involved in a program to improve their health that involved their family or community.

Recommendation:

- Invest in engagement and activation programs that target families and communities and that create a support network within these contexts.
5. When trying to engage diverse communities, methods that work in the dominant culture are not effective (flyers, e-vites, etc.). Instead, personal relationships, personal invitations, and connections are required first. Once that is established, diverse communities will engage because the personal connection is what is valued first.

Recommendation:

- Engage diverse communities by what is valued and important to them, not the system or institution.



D. Access to Preventive Care

1. Families do not have anywhere to go for services after hours except the emergency room (Jefferson County). Some will go to Bend when they have or can find transportation.

Recommendation:

- Provide 24-hour access to clinics or non-emergency centers.
2. School based health care services worked as an engagement model for children and their parents for preventive care. When this connection was good, community members reported stronger connections to school and ease of access for health care for their children. Delivering preventive and other services in non-traditional medical/dental environments is a best practice.

Recommendation:

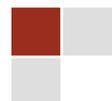
- Increase school-based health centers and/or health screening days at schools.
- Invest in community programs that coordinate/provide such services at schools.
- Create, encourage and invest in school-based health centers and/or health screening days for low income, rural schools, and communities.

E. Inclusive Environments

1. All of the Spanish speaking individuals we interviewed talked about the importance of having someone that spoke their language at the location where they received health care services in order to create a welcoming environment. In addition, people of color shared that seeing materials, signs, pictures and posted information in their own language and/or representing them also helped them feel at ease and welcomed.

Recommendation:

- Set a standard for any provider that serves LEP populations to have bi-lingual staff to greet and communicate with patients in their own language.



- Encourage providers to provide and post written information in the languages of those they serve and train them on how this creates a welcoming environment and can improve patient engagement.
- Provide training and best practice for office/clinic décor that reflects the population that is being served – e.g. health information specific to Native Americans, preventive information in 5-6th grade reading level, pictograms, Spanish materials, and pictures and art that represent the local cultures and the diversity of the community.

“I think they do pretty well trying to get the Spanish speaking people to come in and feel welcomed and receive them with speaking Spanish, having the materials there in Spanish, and also not just having everything in English hanging up on the walls but there’s other languages as well or not just white babies hanging around, there’s all cultures.”

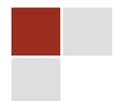
-Crook County forum participant

2. All of the community members spoke about feeling welcomed when providers and receptionist staff were kind, smiled, professional, respectful, and genuinely interested in them and wanting to help. Many spoke of providers taking the time to listen to them. Providers heard and valued their stories and the patient’s insight about what was going on with them in relation to the rest of their life. Even when the language of the patient differed from the provider, the patient still felt welcomed and that the provider was trying to help if they demonstrated these characteristics.

Recommendation:

- Train providers on what is and how to provide inclusive, welcoming environments and the value of cultural, family centered, and patient engaged care.

A review of 13 clinical trials found that when doctors were given training to hone their people skills, patients typically fared better in their efforts to lose weight, lower their blood pressure or manage pain. The new review focused on fairly "general" skills -- such as maintaining eye contact with patients, and listening without interrupting. Health providers...were randomly assigned to either stick with their usual care or have some kind of training on patient interaction... focused on building "warmth" and empathy... others taught providers specific techniques, like "motivational interviewing".^{xix}



3. Community members identified interaction with billing departments for health care services over and over again (across race/ethnicity and language) as an interaction where community members felt disrespected, and poorly treated. They reported a lack of clear communication and a feeling that they had nowhere to turn for help.

Recommendation:

- Require training for billing department staff around inclusion, cultural competency, and welcoming environments.
 - Improve how billing is explained in written materials that are sent home; use non-medical jargon, explain billing/insurance codes, use language and literate appropriate wording, and make available a non-automated help line.
4. There are many providers and clinics that are doing it right; they provide language access, understand how to work with diverse populations and create inclusive environments for all they serve.

Recommendation:

- Learn from these providers, replicate what they are doing right and create a roadmap/example for others.

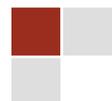
Moments of Impact and Learning

A dental provider was at a discussion table when a Latino man shared his impactful story of receiving dental care. The man was moved and empowered by being heard by a provider and the provider was moved by being trusted with this story.

A hospital manager was at the discussion table when experiences were shared about receiving hospital services. Collaborative recommendations came out of the discussion.

After evening discussions, a table of Latino/Hispanic community members, feeling very empowered to stop inequitable services, all volunteered to share their stories on video in the hopes to be part of the change.

After being interviewed on video, several community members became emotional. When asked why, they shared that they have never been asked for input or about their experiences. This opportunity to help create change and improvement for services for them, their families and communities impacted them deeply and gave them hope.

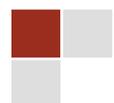


Conclusion

One aspect of social justice is health care policy and system reform that includes a focus on equity, inclusion and eliminating disparities. Underserved and underrepresented populations that have historically been excluded from access to the power and resources afforded to the dominant culture experience the impact of such oppression; they have higher rates of disease, lower health outcomes, lower quality of health care, lower life expectancy and less access to health care services. We know such disparities and inequities have much less to do with individual choices and are much more about the social, economic, and physical constructs that have been built around us.^{xx}

We believe that communities have the ability to solve their own problems and that sharing our personal stories is an act of civic engagement. Underrepresented and underserved community members are not traditionally connected to their larger community institutions, especially around policy issues. Engaging these populations is not only a strategy to raise awareness of the personal impact of inequity, but also to give these members of our communities a voice and the ability to advocate on their own behalf, which leads to social justice.^{xxi}

We hope that the stories and recommendations contained in this report aid the CCO, its provider network and the legislatively mandated CCO committees and councils in the region to begin to create environments and policies in Central Oregon that counteract the disparities and inequities in our health care systems and services, resulting in optimal health for all members of our communities.



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<http://www.hhs.gov/ocr/civilrights/clearance/exampleofapolicyandprocedureforlep.html>
- ^{vi} <http://www.ihs.gov/aboutihs/overview/>
- ^{vii} NQF, Endorsing a Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report, Washington, DC: NQF; 2009.
- ^{viii} National Immigration Law Center <http://www.nilc.org/immigrantshcr.html>
- ^{ix} <http://gov.oregonlive.com/bill/2013/HB2134/>
- ^x <http://www.imiaweb.org/resources/disparities.asp>
- ^{xi} SAMHSA-HRSA Center for Integrated Health Solutions, "Improving Quality and Access to Integrated Care for Racially Diverse and Limited English Proficiency Communities". July 16, 2013. www.integration.samhsa.gov
- ^{xii} <http://www.pgsi.com/>
- ^{xiii} <http://www.pgsi.com/>
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- ^{xvi} Oregon Health Authority, Office of Equity and Inclusion.
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- ^{xviii} Hornberger JC, Gibson CD, Wood W, Dequeldre C, Corso I, Palla B, Bloch DA. Eliminating language barriers for non-English-speaking patients. Medical Care 1996;34:845-56.
- ^{xix} HealthDay News. (2014, April 10). A Doctor's 'People Skills' Affects Patients' Health. Retrieved April 13, 2014, from http://www.healthfinder.gov/News/Article.aspx?id=686670&source=govdelivery&utm_medium=email&utm_source=govdelivery
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