



PLUMAS COUNTY PUBLIC
HEALTH AGENCY

**Re-visioning Rural Healthcare Service Delivery
and Addressing the Needs
of the Underserved in Plumas County**

May 2008

Final Report

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of the Underserved in Plumas County**

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The Sierra Institute for Community and Environment partnered with the Plumas County Public Health Agency to conduct an assessment of the Plumas healthcare system. This assessment is designed to improve understanding of the healthcare system, particularly how it addresses the needs of the uninsured and underserved, and to identify ways to strengthen the system of healthcare for residents of the county. The report contains 11 key findings and 7 recommendations.

The assessment took place during the late summer and fall of 2007. A total of 23 confidential, key informant interviews took place,¹ which provide the basis for the study findings. The California Office of Statewide Health Planning and Development (OSHPD) data for the local districts was also analyzed for this assessment.

¹ Those interviewed included 6 healthcare providers, with a minimum of one from each of the four districts, and the Greenville Rancheria; 4 hospital board members, one from each of the public districts; 2 district administrators; 3 county supervisors; and 8 other individuals who are either involved in administering healthcare-related programs or services, are direct providers working with a county or related program, or are county opinion leaders. All but two interviews were conducted in person, ranging in time from 40 minutes to 2.5 hours, and averaging 1.5 hours.

INTRODUCTION

Plumas County is facing a challenge in providing community-wide access to quality health care. In light of a severe state deficit, funding for critical health and human services programs is at risk, as is the capacity of the system that addresses the scope of the county's health needs. Collectively the four² public healthcare districts and their hospitals and clinics are challenged like never before to maintain a stable system of care that meets the diverse needs of Plumas County residents.

KEY FINDINGS

1) *A significant percentage of patients are without insurance. This has implications for their own health and healthcare, the cost of healthcare, and the financial health of the districts.*

Estimates of how many patients are without public or private insurance varied from 10 percent to 40 percent, averaging roughly 25 percent. Many reported that this total appears to be increasing.

- ◆ Those patients without insurance typically do not seek care until absolutely necessary, or they may decide to forego follow-up care, and limit their children's care. In many instances, delaying needed care results in patients requiring more intervention or more expensive intervention than if they had sought it sooner. One provider said, "Every time I find someone without coverage, it's a significant issue for their care. By the time they come in, they desperately need it."
- ◆ While many patients who are without insurance pay their bills, unpaid bills threaten district fiscal health. All three districts reported in 2006 unpaid debt that totaled 12 to 18 percent of their net annual revenue.³

2) *There are multiple and complex reasons for patients going without private or public welfare insurance.*

- *Fewer employers offer health insurance or, in an effort to reduce costs and coverage, shift to catastrophic coverage.* Few ranchers, farmers, loggers, service workers, and seasonal workers have insurance through work. Some employers pay workers "off the books," resulting in no benefits. Some who offer insurance provide only high deductible or catastrophic insurance.
- *Reduced affordability of health insurance.* Some people fall between the gap between government programs and private insurance. They can't afford private insurance and their incomes are too high to qualify for full public welfare support, and the match required for partial support exceeds what they can afford.
- *Reluctance to participate in a social welfare program.* Some people are simply uncomfortable seeking help from a social welfare program, such as Medi-Cal and Healthy Families.
- *Inability to enroll, or get patients enrolled, and keep them enrolled in social programs.* One of the biggest challenges for districts is enrolling patients in Medi-Cal or other programs. Individuals don't understand (due to a literacy limitation or chemical or psychological issues), or they don't follow through on paperwork to stay enrolled. Transientness is another reason some patients don't follow up. One provider said that some patients' lives are so chaotic they can't complete or turn in paperwork. Some parents or guardians might fill out Medi-Cal forms, but if this is denied they don't pursue support through Healthy Families.^{4 5}

² Indian Valley Healthcare District faced such severe challenges that it was forced to close its hospital and clinic in 2006. (Eastern Plumas Health Care District re-opened the clinic in November 2007.)

³ Data obtained from California Office of Statewide Health Planning and Development: <http://www.oshpd.state.ca.us/HQAD/Hospital/financial/annualSData/hospAFdata.htm>

⁴ Children may receive Healthy Families support only after their family has been denied Medi-Cal.

- *Inadequate patient advocacy.* Related to the above item, many people need help understanding and negotiating the system, including filling out forms, and assuring follow through. There are an inadequate number of patient advocates, and efficiencies might be gained by improved advocate coordination.
- *Gambling on good health.* Some gamble that they will not need medical care.
- *Dental insurance coverage is worse: few have it.* A respondent pointed out that few people can afford it.

3) *Healthcare district fiscal health is threatened when self-paying patients—those with limited or no insurance—fail to pay their bills.* There are distinct differences in how administrators, board members, providers, and others view unreimbursed medical expenses, bad debt, and charity care. Hospitals report that net patient revenue is 55 to 60 percent of gross receipts.⁶ Gross receipts reflect standard medical charges—or the “rack rates”—which are higher than the negotiated or established reimbursement rates paid by insurance companies and state and federal agencies. Charges for the uninsured generally include the higher standard medical charge. “Bad debt” is the patient portion of a bill that is uncollected, which may use as its basis the standard medical charge. Uncollectible totals range from 12 to 16 percent of net revenue at the three districts according to the State (see Appendix I for a table displaying Revenue, including Revenue by Patient Category and Allowance for Uncollectible and Uncollectibles as a percentage of Net Revenue by district). One financial official mentioned that “accounts receivable” is the most important number for a district. This individual mentioned that 25 percent of the total accounts receivable for his/her district involve self-payers. Another official mentioned the payer mix as a critical measure of viability.

Regardless of how one characterizes unreimbursed charges and bad debt, the fact remains that self-paying patients are increasing, and the cost of health care for these individuals may be extraordinarily high. As one respondent pointed out, “Hard working uninsured folks pay huge amounts...” And while many of these patients pay their bills, increasing numbers can mean increased unpaid bills that threaten district solvency. One district official pointed out that Latino residents are more likely to be uninsured but, compared to other uninsured patients, are much more likely to pay their medical bills.

4) *Medicare and Medi-Cal and other state and federal program reimbursements are a vital part of the revenue base of all districts; reimbursement rates can determine district solvency.* Eastern Plumas Health Care receives 65 percent of net patient revenue from Medicare and Medi-Cal. Plumas District Hospital’s combined total is 45 percent and Seneca Healthcare District is 50 percent. A number of respondents felt that low Medi-Cal and Medicare reimbursements threatened district capability to provide services and acted as a disincentive to offering some services, but this view is not unanimously held. Denti-Cal may be the worst: one provider cited the example of hospital dentistry costing \$10,000-14,000 reimbursed at only \$1,000-\$1,500. The total dollars written off as uncollectible amounts to 18 percent of the total Medicare and Medi-Cal revenue at Eastern Plumas Health Care, where the percentage of Medicare and Medi-Cal as a portion of net revenue is highest.

⁵ Eligibility for County Medical Services Program (CMSP) was recently shifted to a three-month period of eligibility in order to reduce costs to the state for maintaining the database. This, however, shifted costs to local districts because of a) the effort required to sign people up for the program and b) revenue lost as a result of those seeking services not on Medi-Cal and not paying their bills. Cost savings at the state is incommensurate with the burden and cost shifted to county and local districts. For example, in June of 2007, CMSP county-wide enrollment was 97, compared to 315 in July of 1995. This decline has been attributed to the duration of CMSP eligibility being reduced to 3 months.

⁶ <http://www.oshpd.state.ca.us/HQAD/Hospital/financial/annualSDData/hospAFdata.htm>

The total dollars written off as uncollectible amount to 30 and 32 percent of Medicare and Medi-Cal totals at Plumas District Hospital and Seneca Healthcare District, respectively. These data make clear that securing higher Medicare and Medi-Cal reimbursement rates will significantly improve district finances, but they also suggest that concerns about low reimbursement rates to the exclusion of uncollected funds ignore something that may be easier—though not to suggest easy—to modify: patient participation in social welfare programs.

5) *While there are no “silver bullet” solutions to reducing bad debt, enrolling more people and keeping them enrolled in public programs will reduce bad debt by shifting payment responsibility to state and federal agencies.* One official pointed out that halving bad debt would double his/her district’s bottom line.

6) *Charity Care, designed for those without insurance, who are impoverished, and not enrolled in public programs, is generally applied after-the-fact, and the rates applied may be inconsistent with recent state legislation.* One district facility shared a written description of its charity care program; interviewees from all three districts reported their facility offered sliding-scale fees and provided discounts to impoverished patients lacking insurance. Most, however, felt that charity care was reclassified bad debt. As one board member put it, it’s a write-off, not an up front charity care program. What is unclear from the interviews and beyond the scope of the assessment is whether districts have sufficiently implemented AB 774, providing clear notification of their program and basing charity care charges on rates tied to social welfare program reimbursement rates.⁷ One district requires patients to submit the previous years’ tax records to qualify, meaning that undocumented immigrant patients are unable to participate in the program.

7) *Access to medical care is uneven in Plumas County; Indian Valley residents have been affected the most as a result of clinic and hospital closure, but over-full medical practices have resulted in patients in other districts having to wait or seek care elsewhere.*

- *There is a spatial and demographic inequality of access.* Access problems have been most acute in Indian Valley, until the re-opening of the clinic there in November of 2007, and disproportionately affected seniors, disabled, and patients lacking reliable transportation the most. Indian Valley residents still lack the quick access to emergency services that others living the county’s major communities have. Few female providers across the county have led to extended delays for those patients seeking one. Lack of transportation options, unreliable transportation, and long waits often result in individuals forgoing care until they absolutely need it.
- *Preventative, more timely, and less expensive care has suffered as a result of full practices.* Because providers lacked openings, some patients have been forced to seek emergency room service resulting in increased costs. One provider reported that instead of incurring a \$150 office visit, a patient had to go to the emergency room for services that cost \$2000.

8) *The medically indigent and uninsured access medical services in the emergency room, leading to expensive services and bills, some of which won’t be paid.* The emergency room (ER) is a preferred entry point for uninsured and underinsured. Steering people to hospital ERs is direct and indirect.

⁷ The AB 774 legislation, effective January 1, 2007, requires that every hospital have “written, understandable policies on discount payments for financially qualified patients and charity care.” In addition, it requires that hospitals “...limit expected payment for services provided to eligible patients to what it would receive from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program in which it participates, whichever is greater.”

Patients utilize the emergency room for non-emergency services because they cannot be denied, regardless of resources, and because they can't get into a provider in a timely manner. "People wait until they are more acute," said one provider. The ER may be a preferred entry point, but it is not efficacious. Patients are often worse off and require more intervention, and oftentimes more expensive intervention than they would have otherwise. Several providers reported that there appears to be a new group accessing the ER, including those who already have a primary care provider. They are seeing middle income individuals using the ER to access services because of access problems. Primary care providers do not have the capacity to meet the everyday surges in health care needs. One provider said, "People are being steered to the ER. It is the easiest point of access." In addition to more costly services, non-emergency use of the ER typically means that medical records do not follow a patient, and the patient is unlikely to be seen by a provider who knows them or their medical history.

9) *The uninsured face a different set of medical options.* Respondents were unanimous in stating that once under the care of a provider in an emergency room, insurance status or impoverishment made no difference in care. Many recognized, however, that these patients typically receive inadequate preventative care; they lack a medical home: that is, they lack a provider with whom they've developed a relationship and who maintains their medical history, including immunization and all-important allergy records, which results in some receiving unnecessary immunizations.

10) *Interpretation and translation for non-English speakers is informal at all districts.* Districts use Spanish-speaking employees or, more often, rely on patients bringing their own interpreter. Local employee interpretation is dependent on someone being available because there are no formal programs. In its participatory study of Latino healthcare, the Sierra Institute found that a very small number of patients who needed interpretation received it from a district employee. Roughly half of all patients who need an interpreter bring a minor to translate. As one individual pointed out, many providers don't know the risks and problems associated with the use of minors as interpreters. AT&T interpretation services are, in general, not used. Confidentiality issues, and an unknown level of bilingual proficiency arise with the use of informal translators.

11) *Individual districts have made Herculean efforts to survive and provide excellent medical care amidst a variety of fiscal and regulatory challenges, yet they have operated independently and competitively, which has challenged their ability to thrive.* Many of the people interviewed for this assessment expressed a genuine hope and commitment to improving the Plumas healthcare system, but identified that competition challenges development of a more seamless and comprehensive medical system for the entire Plumas community. One individual said there is not a lot of love among the four communities and medical staff and administrations, while another identified the districts as "3 or 4 bunkers with lousy profit margins." A supervisor said, "In my dozens of years here, I see the need but people don't work together to solve the problem." While skepticism exists, there also is optimism and a will to work together. As one respondent noted, "If people are genuine about their willingness to be a part of it, there's work to be done."

There is increasing recognition of the need to consolidate districts and affiliate with partners, possibly regional partners. One individual said, "We are not going to have the resources unless we intelligently partner." As an example of a nascent movement, Seneca Healthcare District has launched a partnership with Renown Health, which is providing a chief executive for Seneca's operation. Eastern Plumas Health Care District is in the midst of negotiating a relationship with Renown as well. Separate from Renown, and like Plumas District Hospital, Eastern Plumas has received considerable

support to advance digital technology. Plumas District Hospital is also connecting with a number of districts in the region. What remains is improving the will and capacity to partner within the county.

RECOMMENDATIONS

1. *Improve coordination and partnerships among Public Health, Social Services, and other agencies and organizations in Plumas County to increase the number of people enrolled in no or low cost health insurance. Coordinate existing efforts aimed at improving participation in Medi-Cal and other public programs.* The Public Health Agency is probably the best entity to take the lead in securing or coordinating funding and supporting outreach coordinators that are involved in referrals and providing assistance with the public benefits application process. Key coordinator challenges involve educating patients about the importance of follow up and helping ensure that qualifying patients retain program eligibility. Coordinators could also educate providers and support staff about local, state, and federal programs, including qualification criteria.⁸ Coordinators could be linked to districts, family resource centers, or some other community entity, and conduct home visits.

2. *County agencies, community organizations, and districts need to re-examine ways of working together.* For example, agencies and others might work closely with the school district to tie sign-ups for Medi-Cal and other programs to free and reduced lunch enrollment (the Sierra Institute is exploring opportunities). Outreach coordinators could work with the school district to sign families up as a part of free and reduced lunch participation and through medical screening programs. These types of changes cannot be accomplished without the infrastructure support in funding and program design.

3. *A collaborative effort involving the Public Health Agency and clinics and hospitals should review and update charity care programs throughout the county to assure compliance with AB 774.* Issues such as language and literacy access should be examined. Program descriptions in English and Spanish need to be offered. The Public Health Agency or a local collaborative might be established to monitor and assess the financial impacts of charity care programs and to help assure compliance does not exacerbate bad debt or worsen district fiscal conditions. Increased patient education about charity care can help decrease district bad debt.

4. *Districts and Public Health need to explore ways to increase provider availability and access and increase patient understanding of the implications of using the emergency room for primary care.* Eastern Plumas Health Care District's opening of the Greenville Clinic addressed a critical access issue in Indian Valley. However, delays in seeing a provider due to limited provider availability (particularly female providers) still exist across the county for various reasons. These delays along with non-emergency patients accessing services in emergency rooms need to be assessed to help identify and address impacts. Increased patient education could aid in the reduction of true personal and district costs of accessing the emergency rooms for non-emergencies. Resources need to be secured and focused on prevention, managing chronic disease, and ensuring access to health services.

5.a) *Districts triaging patients visiting emergency rooms and directing non-emergency patients to clinics is a good practice that should continue, along with data collection to identify patient education needed and ways of reducing unnecessary emergency room use.* b) *Examine other models that utilize public health clinics to do "front line" work to determine how to more effectively serve patients.* For example, building on the primary care provider health and the First Five program, more well-baby clinics could be offered by the Public Health Agency. c) *Convene a collaborative of the*

⁸ A model for this may be the trained Healthy Families "assisters," a program that ended when it lost funding.

Public Health Agency and districts to identify ways to improve preventative and primary care and reduce the financial burden on the districts.

6. *Develop a network of trained and paid medical interpreters and translators coordinated by Public Health or Social Services, or develop a link to programs reliably offering these services. Consider the use of telemedicine or similar video technology to offer face-to-face translation service.* The Sierra Institute is currently working with a variety of community and county partners to identify cost-effective means for training interpreters and providing interpretation and translation services.

7. *Residents, providers, districts, and the county need to support the nascent movement towards a countywide and, potentially, a regional model.* There is emerging administrative and district support. This can be deepened and extended through additional work with others, exploration of diverse alternatives, and abandonment of the one district one facility model, in order to ensure long-term viability and more seamless and improved Plumas healthcare services.

CONCLUSION

This study of the Plumas healthcare system demonstrated there exists a genuine interest and commitment among providers, administrators, and others to provide quality healthcare to the entire Plumas County community. There are, however, systemic institutional barriers to overall system effectiveness and, in some instances, efficacious patient care. The underserved and uninsured in particular face unique barriers that limit their options and medical care.

Addressing some of the findings and implementing recommendations in this report is relatively straightforward. For example, helping patients qualify and stay enrolled in Medi-Cal and Healthy Families and other public programs is an important way of directly helping patients that, at the same time, contributes to district fiscal health. While this is not to suggest it will be easy, there are a variety of agencies and groups that are interested in providing services to improve program enrollment. Increased and more formalized use of interpreters and translators, a current project of the Sierra Institute involving a variety of local partners, is underway and will improve healthcare for Latinos and possibly other underserved groups. Addressing other systemic barriers and underserved and uninsured patient needs is less straightforward. For example, enhanced patient education and more public information and outreach about charity care and sliding scale programs will help underserved and uninsured patients but, at the same time, have the potential to compromise already thin district bottom lines. Addressing the needs of the uninsured and underserved cannot be done in a vacuum. Attention must be paid to the short- and long-term capacities of local districts and local agencies while addressing the needs of these residents.

There remains ample room and need for additional collaborative work. The county and Public Health Agency can establish a commission of experts to examine the findings and recommendations in this report, identify those recommendations that might be easiest to implement, and identify key issues that might have been missed and ways these issues might be addressed. This commission will likely prove most important where options are less clear and systemic institutional barriers more substantive. Even for these more difficult—seemingly intractable—issues there are agencies and groups with ideas and interest in launching pilot projects that will provide benefit to the Plumas community. Pilots can offer powerful lessons for Plumas County, as well as rural areas elsewhere. Pilot efforts should be embraced for the learning opportunities they represent, but most of all for the opportunity they represent for identifying ways to more effectively address the diverse medical needs of the underserved and uninsured in the Plumas County community.

APPENDIX I

District Revenue, Deductions, Net Patient Revenue, Allowance for Uncollectibles, and Uncollectibles as a percentage of Net Revenue for Fiscal year 2006 (July 1, 2005 to June 30, 2006).

	EASTERN PLUMAS HEALTH CARE	INDIAN VALLEY HOSPITAL	PLUMAS DISTRICT HOSPITAL	SENECA HEALTHCARE DISTRICT
Gross Patient Revenue	\$32,291,317	\$4,152,254	\$32,213,834	\$15,537,302
Deductions from revenue	\$13,875,882	\$1,269,933	\$14,446,868	\$6,265,548
Net Patient Revenue	\$18,415,435	\$2,882,321	\$17,766,966	\$9,271,754
Allowance for Uncollectibles	(2,212,881)	(294,028)	(2,417,984)	(1,493,459)
Uncollectibles as a Percent- age of net revenue	-12.02%	-10.20%	-13.61%	-16.11%

APPENDIX II

Programs available for low-income uninsured who are not eligible for Medi-Cal due to residency status or incomes above the federal poverty line

- Family Planning, Access, Care, and Treatment (PACT) program for women to 55 and men to 60. It is for sexually transmitted disease treatment and family planning.
- County Medical Services Program (CMSP), for county residents 21-65. It requires a Medi-Cal application and can be difficult to obtain.
- Healthy Families is for those under 300 percent of poverty level.
- Kindergarten Roundup is a screening program, but follow up is difficult with many.

Primary and preventative care offered for uninsured clients beyond Emergency Care and births

- Kindergarten roundup.
- Immunization program and TB screening offered by the Public Health Agency.
- Women, Infants, and Children (WIC).
- Healthy Smiles dental program.
- Child Health and Development Program (CHDP) that one provider said is an excellent but underutilized program because it is complicated, cumbersome to bill, and the provider has to talk to the mother. The program is designed to screen patients and get those who need services to specialists. Providers don't use it much or know it well.
- Early Breast Cancer Detection Plan (EBCDP) is an excellent state program that is also underutilized. Paperwork shuffle is extraordinarily cumbersome. A provider said the program tracking tool is not useful because one has to keep track of a lot of things a clinic doesn't normally do.
- Another provider mentioned the State of California matching funds through case management programs such as Linkages (for patients 18-60) and Multi-Purpose Senior Service Program (MSSP). Even though Plumas County is part of the official program area, it receives little to no service because of its distance from Chico and the cost inefficiency of serving the county. These programs provide flexible money to do what providers feel is needed.