



Community Health Needs Assessment for Tulsa, Oklahoma

October, 30, 2003

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HealthNet

Community Access Program

Community Health Needs Assessment Final Report

**Prepared by
Community Access Program for Tulsa, Oklahoma**

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(HRSA)**

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Project Overview

The purpose of this project was to assess the health status and barriers to health care for individuals in the Tulsa area. This project was funded by the U.S. Health Resources and Services Administration (HRSA) through the Bureau of Primary Health Care (BPHC), sponsored by Tulsa Community HealthNet, and administered by the Tulsa City-County Health Department. Four sources of data were evaluated during this project: 1) Consumer surveys (**N=435**), 2) Focus groups (**7**) with providers and consumers (**N=54**), 3) Case studies with consumers (**N=64**) and 4) Health and social service provider agency interviews (**N=21**). The results and recommendations of this project are based on these four sources of data.

Interviews / Qualitative data: Qualitative data was collected from health and social service agencies, providers, and consumers in the Tulsa area. Interviews with agencies and providers, and provider focus groups were structured, following a question / answer format. Consumer focus groups and case studies followed an open-ended format of questions with the intent to generate data unique to the individual. Information for case studies came from consumers as well as from providers. The general question asked in this needs assessment was, “How do you access health care in Tulsa?” A secondary question was, “What barriers do you experience in accessing health care in Tulsa?”

Quantitative: The consumer survey portion of this project was designed based on the format of previous successful needs assessments. The two page anonymous questionnaire contained 30 questions. Before administering the survey, respondents were asked if they would like to participate in a health needs survey. All respondents included in this assessment were voluntary participants over the age of 18.

Data analysis: Descriptive and inferential statistics were derived through analysis utilizing Microsoft Excel. Qualitative data was summarized, categorized, and rank ordered when possible.

Survey sites were chosen based on an analysis of U.S. Census 2000 Data. Interviews and survey collection were conducted at various locations, concentrating on geographic areas with a high concentration of individuals at or below the federal poverty level, and thereby at risk for being underinsured or uninsured. In addition, the needs assessors attempted to geographically represent all sections of the city of Tulsa by collecting data from various zip codes within the City of Tulsa.

SURVEYS COLLECTED: 443

SURVEYS DISQUALIFIED as Incomplete or completed by persons under 18: 8

SURVEYS REPRESENTED IN THIS REPORT: **435**

SURVEY SITES:

Asian American Community Center	Dream Center	COHO members
Day Center for The Homeless	OSU – Tulsa	Kendall Whittier area
Social service case managers	Hispanic health fair	Mental Health Association
Tulsa Housing Authority sites	South Peoria area	West Tulsa HUD housing

Needs Assessment Methodology

Background:

The primary activity of the assessment portion of the Community Access Program grant was to conduct a needs assessment of the target population for primary medical, dental, and mental health care. In February 2003, the need assessors began the process of redesigning existing surveys, and developed individual semi-structured interviews for agencies, providers, and consumers. In addition, assessors determined the between methods design.

Purpose:

The purpose of this needs assessment was to identify barriers to health care for individuals in the Tulsa Metropolitan Statistical Area (MSA). This needs assessment is part of a larger GAP analysis in which community resources and capacity were assessed. This study compared agency, provider and consumer information to assess whether there are any significant differences between these groups.

Identification of the Audience for the Needs Assessment Results:

The results of this study have been disseminated to the members of Tulsa Community HealthNet, including the Tulsa City-County Health Department. In addition the results of this study will be disseminated to the Federal government (HRSA and BPHC), Oklahoma State Department Health, individual service providers and to members of the target populations and their social networks.

Statement of the Problem

Race and socio-economic status are markers to identify vulnerable groups within our population. Poverty, marginalization and poor access to health care are a few of the social factors that increase an individual's vulnerability (Healthy People, 2010).

Tulsa County is the second largest MSA in the state containing 16.3% of the state's total population. The Tulsa MSA has been recognized as an urban market for commerce, industry, health and social services for the 17 counties in northeast Oklahoma. It is estimated that there are 393,049 persons in the Tulsa MSA (2000 U.S. Census): 70.1% White, 15.5% African American, 4.7% Native American, and 4.7% Asian. The Hispanic population of Tulsa County has grown exponentially since 1997. Although 2000 US Census data reports 7.2% of the population is of Hispanic Origin, the actual percentage is expected to be much higher. The Oklahoma State Department of Health (OSDH, 2002) reports that ten percent of the resident births of Tulsa County in 2000 were to women of Hispanic Origin.

Oklahoma is the 8th poorest state in the nation with 41% of the state at 200% federal poverty level or less. Oklahoma is 12th in the United States for children under age 5 living in poverty, which has increased 53% since 1979 (Kaiser Family Foundation Website, 2002). Oklahoma is ranked 2nd in the United States in the number of grandparents raising children. This factor is contributed to by Oklahoma being 1st ranked in the nation in the number of incarcerated women. The unemployment rate in

Tulsa County is 6.3% (Department of Commerce, March 2003), which is a dramatic increase from 2.7% in 2000. This increase adversely affects the number of people with private insurance. At the same time, state revenues have fallen with subsequent 15-20% cuts in state agencies' budgets, which have jeopardized Medicaid eligibility for women and children.

According to the Tulsa County Profile (Tulsa City County Health Department, 2003), for individuals 18 years old and older, the three major causes of mortality and morbidity in Tulsa County are heart disease, cancer and stroke; all three have preventable lifestyle factors of diet, exercise, and stress. There is high incidence of these diseases in low-income and minority populations. Additionally, the rate of chronic obstructive pulmonary disease, accidental injury, suicide and diabetes for Tulsa County are higher than the state and national averages. These factors contribute to the decrease in life expectancy in Oklahoma by 3 years compared to the average for the nation. Infant mortality is well above the rate for the county and nation. The incidence of low birth weight in Tulsa County is higher than for the nation. Oklahoma ranks 13th in the nation in teen births. Oklahoma is the only state in the nation, which has not shown health improvements during the 1990-98 time period (ReliaStar State Health Rankings, 1998). The 2000 ReliaStar report showed improvement in only one area, accidental deaths. The Oklahoma State Department of Health (2002) reports that Oklahoma is ranked 42nd in the nation for women's health. Women in Oklahoma continue to experience high rates of death by heart disease, stroke and lung cancer.

The Oklahoma State Board of Health reports that Oklahoma ranks as one of the worst states in the U.S. for uninsured children. Immunization rates for two-year olds are 50.53% (Tulsa City-County Health Department, 2003), dramatically lower than the state average of 73% (OSDH, 2002). This discrepancy can be attributed to underreporting as well as under immunization. The Oklahoma Health Care Authority (OHCA) reports that 25% of the State's and 44% of Tulsa County's children less than 18 are enrolled in Medicaid (OHCA, June 2002). Early Periodic Screening, Diagnosis and Treatment (EPSDT) reported by the Oklahoma Health Care Authority for children less than 18 and enrolled in SoonerCare is 62% total screens received (OHCA, 2002). The last complete data analysis for 1999 (OHCA, 2000) indicate that the number of children less than 18 years old receiving at least one EPSDT service was 33% (less than one year old - 50%; 1-2 year olds - 40%; 3-5 year olds - 27%; and 6-18 years olds - 31%). Low reimbursement rates and perceived paperwork load contribute to the lack of participation (American Academy of Pediatric, Provider Survey, 2000).

One of the most significant barriers to care in Tulsa is the lack of affordable primary health care. For adults 18-64 years of age, 19% are estimated to be uninsured in Oklahoma (Kaiser Family Foundation, 2002; Families USA, 2003). Focus groups of target populations, emergency room surveys and provider surveys indicate that people who do not have health insurance and are low-income do not access traditional sites for care. They will postpone care until the condition becomes serious, at which time they seek care at an emergency room. Negative consequences of lack of health insurance on the access and utilization of medical homes have been documented in multiple

national studies (Sicker and Poorer, 2002; Uninsured in America, 2000). Additionally, the unemployment rate is 6.6% in Tulsa County (Oklahoma Employment Security Commission, March 2003), which is a dramatic increase from 2.7% in 2000. This increase adversely affects the number of people with private insurance. In addition, state revenues have fallen with subsequent 15-20% cuts in the budgets of state agencies, which has jeopardized Medicaid eligibility for women and children.

The lack of affordable mental health services is another serious barrier to care for Oklahomans. Oklahoma's estimate of prevalence of adults with a serious mental illness is based on federal guidelines from the Center for Mental Health Services published March 28, 1997 (using 1990 census data). The estimated prevalence for adults who are seriously mentally ill (SMI) is 133,898. In 1999-2000, Oklahoma served 17% of the estimated SMI population. Oklahoma's estimate of the number of children with a serious emotional disturbance (SED) is based on the Center for Mental Health Services published estimate, July 17, 1998. The number of SED children in Oklahoma is estimated to be 41,175. A recent report by the Community Health Coalition reports that Outpatient Mental Health care is "virtually unavailable."

Eastern State Hospital in Vinita was closed in 1999 by the Oklahoma Legislature and a transition plan developed. Eastern State Hospital was a state institution for in-patient mental health for Eastern Oklahoma and only one of two in the state. Over one hundred civil commitment beds were lost with the closing of Eastern State Hospital. This closing impacted an estimated two thousand clients in northeastern Oklahoma, who received in-patient and emergency detention.

Residents of Tulsa County have long suffered from high rates of alcohol, drug, and tobacco abuse. Tragically, Tulsa is an appealing central transfer and distribution point for drugs such as cocaine coming from California, Texas, and Florida. It is also a site for homegrown marijuana and methamphetamines manufactured in clandestine labs. A *Tulsa World* newspaper account cited marijuana growth as being Oklahoma's second largest cash crop and methamphetamine lab busts the largest number in the nation for 1998. In 1999, clandestine lab busts exceeded 900 for a new all time state high. The National Institute of Justice indicates that 21% of arrestees in Tulsa in July 2002 had methamphetamine in their urine. For that quarter, it was the highest in the nation (NIJ ADAM, 2002).

The Oklahoma State Department of Health reports that smoking-caused death rates in Oklahoma remain significantly higher than the average nationally. Information from the Centers for Disease Control (CDC) show that "Oklahoma is about 10 percent higher than the national rate for smoking-caused lung cancer deaths, 15 percent higher for smoking-caused coronary heart disease deaths, and 20 percent higher for smoking-cause chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema. The CDC reports that smoking costs Oklahoma \$907 million in direct medical expenditures and an additional \$1.3 billion in loss of productivity every year. *Oklahoma ranks 38th in the nation on per capita spending on tobacco prevention.* The percentage of Oklahomans who smoke increases as levels of personal income

decrease. The reduction of nicotine addiction is an area of concern according to the 2002 State of the State's Health Report, by the Oklahoma State Board of Health. A recent CDC report ranks Oklahoma sixth in the nation in the number of high school students who smoke. Approximately 42% of the state's high school students report smoking cigarettes. A shocking 21% of Oklahoma's middle school students smoke cigarettes or use other tobacco products. Without intervention, teens are following after the State's adults, who consume 112 packs of cigarettes per person a year – the 10th highest rate in the nation. The average nationally is 86 packs per person.

Dental services are almost non-existent for the uninsured and Medicaid eligible population. EPSDT (OHCA Form 416, 2000) reported 12% of the children 0-18 years of age receiving any screening and dental services (0.3% for those less than one year old, 3% for those 1 to 2 years old, 15.8% for those 3 to 5 years old, and 9.8% for those 6 to 18 years old). Twenty-one dentists in Tulsa County are listed as participating in the Medicaid program. Upon being surveyed by telephone, only 7 dentists indicated that they were receiving new patients, with an average 6-month wait for services. There is a strong and frequently expressed desire among the community for dental services that involve restorative treatment rather than extraction. During a recent interview with the director of an advocacy agency for individuals with developmental disabilities, the director remarked, " It's been so long since our clients have had dental service. Their teeth just rot in their mouth."

Description of Techniques Utilized for Data Collection and Analysis:

Any one method of data collection, no matter how well employed, will not produce valid need identification. Therefore, the principle of triangulation (using multiple data collection methods such as quantitative and qualitative data and multiple data collection methods) has been employed in this study. The following summarizes the advantages/disadvantages of the data collection methods.

Advantages of Surveys:

- Reach many people in short time
- Relatively inexpensive
- Yield relevant, quantifiable data that are easy to summarize
- Anonymity may encourage honesty
- May build involvement from a Needs Assessment committee

Disadvantages of Surveys:

- Require time and skill to develop
- May have low response rates or inaccurate responses
- The respondent has no opportunity to clarify
- Restriction of responses
- May lead to unrealistic expectations

Advantages of Individual Interviews

- Build involvement and support
- Allow for clarification

- Provide relevant data
- Easier to conduct than focus groups
- May uncover information that would not be brought up in a group

Disadvantages of Individual Interviews

- Expensive in terms of time and travel costs
- Requires interviewing skills
- May be difficult to analyze and quantify results
- Those being interviewed may be self-conscious

Data for this needs assessment has been collected through interviews with individuals and focus groups, case studies, and surveys. The qualitative data derived from the individual interviews has been analyzed by themes and categories, and then rank ordered when possible. The survey was analyzed using a Likert-type scale. Triangulated, this data will provide findings of the current health needs (i.e. medical, dental and mental health) and barriers to accessing these services.

RESULTS/FINDINGS

Description of Overall Survey Respondents

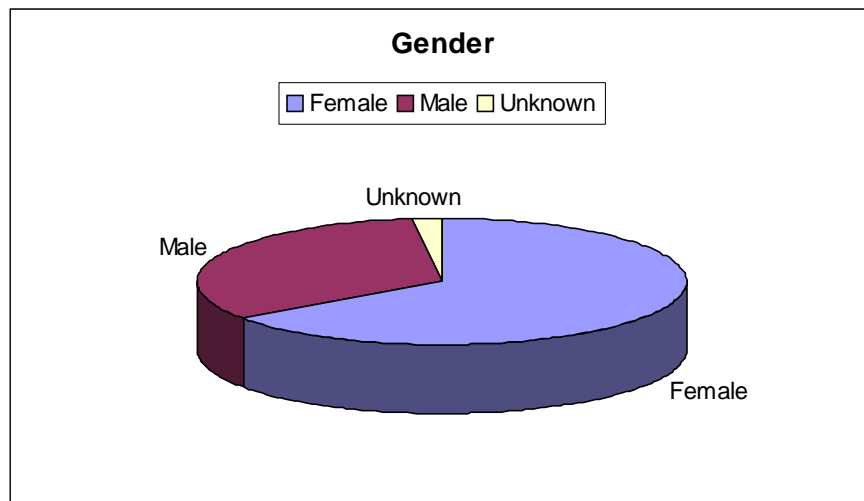
Zip Code:

74137	3	South Tulsa		74106	18	North Tulsa
74171	1	South Tulsa		74110	18	North Tulsa
74012	5	Southeast Tulsa		74130	1	North Tulsa
74120	7	Southeast Tulsa				
74133	6	Southeast Tulsa		74021	1	North of Tulsa - Collinsville
74147	1	Southeast Tulsa		74029	1	North of Tulsa - Dewey
				74048	1	North of Tulsa - Nowata
74346	1	Southeast of Tulsa		74070	3	Northwest of Skiatook
74429	2	Southeast of Tulsa		74073	3	Northwest of Sperry
74436	1	Southeast of Tulsa				
74008	3	South of Tulsa - Bixby		74126	6	Northwest Tulsa
				74127	4	Northwest Tulsa
74033	3	Southwest - Glenpool				
74066	3	Southwest - Sapulpa		74103	41	Downtown
74131	1	Southwest Tulsa		74119	29	Downtown
74132	4	Southwest Tulsa		74192	1	Downtown
74136	39	Southwest Tulsa		74102	2	Downtown
74112	5	East Central Tulsa		74104	30	Midtown
74145	5	East Central Tulsa		74135	5	Midtown
				74159	1	Midtown
74108	1	East Tulsa		74105	81	South Midtown
74128	3	East Tulsa				
74129	13	East Tulsa		74016	1	Northeast of Tulsa - Chelsea
74134	2	East Tulsa		74017	1	Northeast of Tulsa - Claremore
74146	15	East Tulsa		74055	2	Northeast - Owasso
74101	3	West Tulsa		74115	18	Northeast Tulsa
74107	16	West Tulsa		74116	1	Northeast Tulsa
				None listed	23	

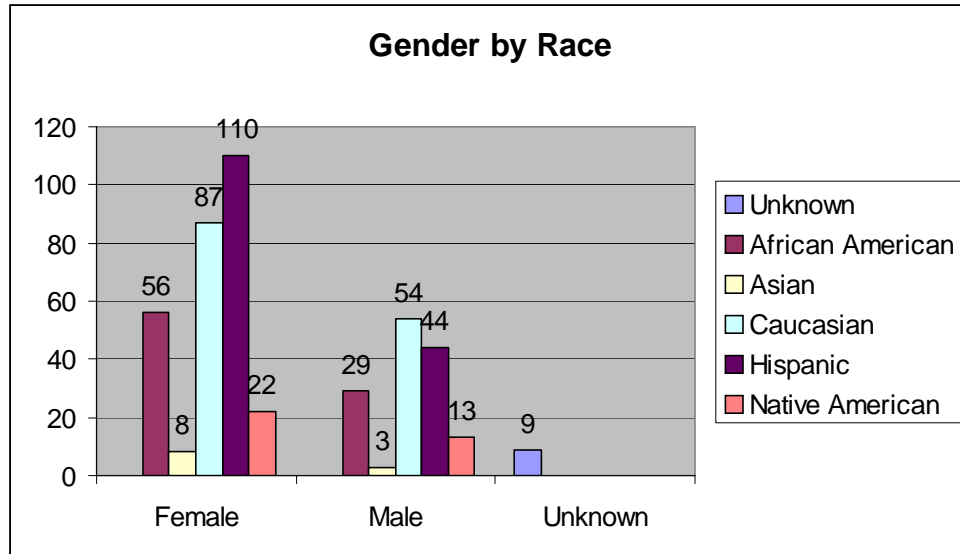
As evidenced above, all geographic areas of Tulsa are represented in the assessment.

Gender, Age, Race/Ethnicity:

	Overall	African American	Asian	Caucasian	Hispanic	Native American
Female – 18-19	13	4	0	2	6	1
Female – 20-29	93	22	2	31	32	6
Female – 30-36	69	14	0	13	38	4
Female – 40-49	54	6	1	19	21	7
Female – 50-59	32	8	3	12	7	2
Female – 60-82	16	1	2	8	3	2
Female – Age not given	6	1	0	2	3	0
Total Female	283	56	8	87	110	22
Male – 18-19	2	0	0	2	0	0
Male – 20-29	30	4	2	5	16	3
Male – 30-39	40	8	0	14	14	4
Male – 40-49	42	11	0	18	9	4
Male – 50-59	18	5	0	8	5	0
Male – 60-82	9	1	1	5	0	2
Male – Age not given	2	0	0	2	0	0
Total Male	143	29	3	54	44	13
Age not given	4	0	0	1	3	0
Race / Age / Gender not given	5					
TOTAL	435	85	11	142	157	35
	100%	19.8%	2.6%	33.0%	36.5%	8.1%



Women represented 65% of individuals participating in the survey.



Household Income per month:

	Overall Average	African American	Asian	Caucasian	Hispanic	Native American
\$0 - \$199 / month	23.4%	4.6%		12.0%	3.4%	3.4%
\$200 - \$499 / month	9.2%	3.9%	0.2%	1.1%	3.2%	0.7%
\$500 - \$999 / month	22.5%	4.6%	0.9%	8.5%	7.1%	1.4%
\$1,000 - \$1,999 / mo	21.8%	3.0%	0.7%	3.9%	12.9%	1.4%
\$2,000 - \$2,999 / mo	4.8%	0.2%	0.5%	2.3%	0.7%	1.1%
\$3,000 + / mo	2.8%		0.2%	1.8%	0.7%	
Not listed	15.4%					
Total	100.00%					

Household Status:

Single	36.8%
Separated / Divorced	32.2%
Married	20.0%
Widowed	2.1%
Live-in Partner	6.0%
Blank	3.0%
Total	100.00%

Number of people living in household:

1	22.8%
2	19.5%
3	15.6%
4	13.1%
5	10.6%
6	5.5%
7	1.6%
8	1.8%
11	0.2%
12	0.5%
13	0.2%
Not listed	8.5%
Total	100.0%

Primary Language:

Cantonese	0.2%
Chinese	1.1%
English	66.0%
Hmong	0.2%
Spanish	31.3%
Vietnamese	0.7%
Not listed	0.5%
Total	100.00%

Secondary Language:

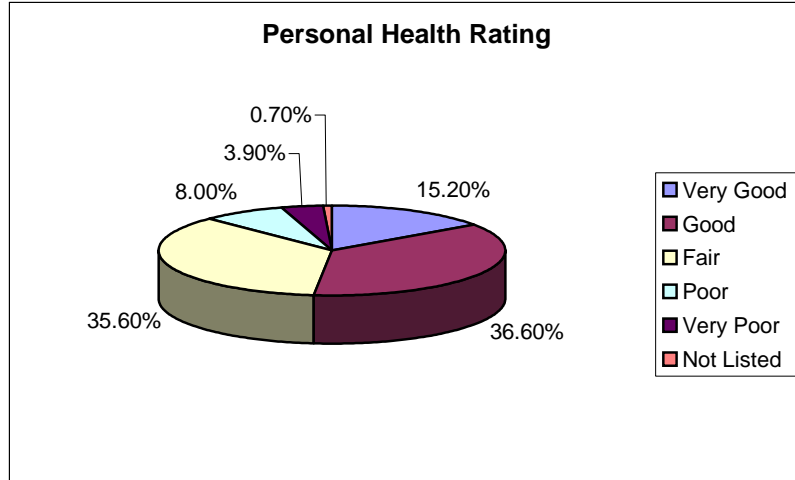
Cantonese	0.2%
English	9.2%
Farsi	0.2%
French	0.2%
German	0.7%
Korean	0.2%
Portuguese	0.2%
Russian	0.2%
Spanish	6.9%
Vietnamese	0.5%

Education:

Grades 1-6	10.1%
Grades 7-9	12.9%
Grades 10-12	30.8%
GED	8.5%
Some College	16.3%
2 Years of College	9.2%
4 Years of College	3.9%
More than 4 Years of College	3.9%
Not listed	4.4%
Total	100.00%

How would you rate your health?

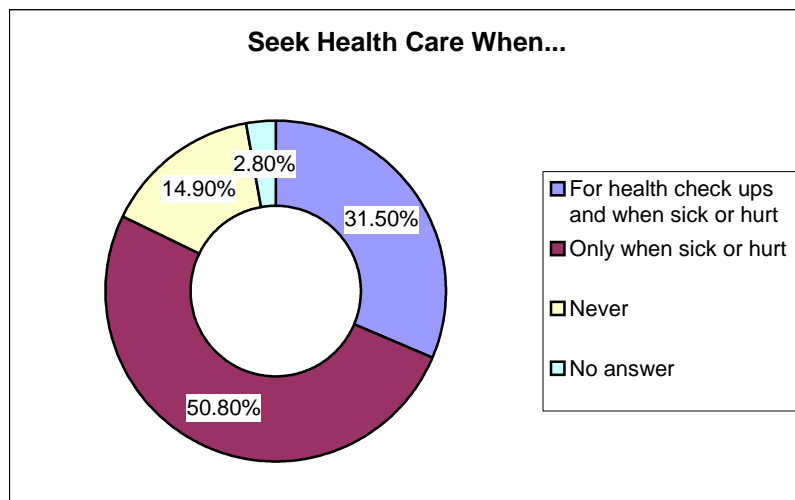
Very Good	Good	Fair	Poor	Very Poor	Not Listed
15.2%	36.6%	35.6%	8.0%	3.9%	0.7%



When do you go to the doctor?

For health check ups and when sick or hurt	Only when sick or hurt	Never	No answer
31.5%	50.8%	14.9%	2.8%

Over fifty percent of respondents go to the doctor only when they are sick or hurt, which indicates few respondents go to the doctor for routine check-ups. Approximately 15% never go to the doctor even when they are ill or hurt. With 50.8% of respondents only going to the doctor when they are sick and or hurt, walk-in and/or urgent access at more flexible times is needed to provide options other than accessing health care in a hospital emergency room.



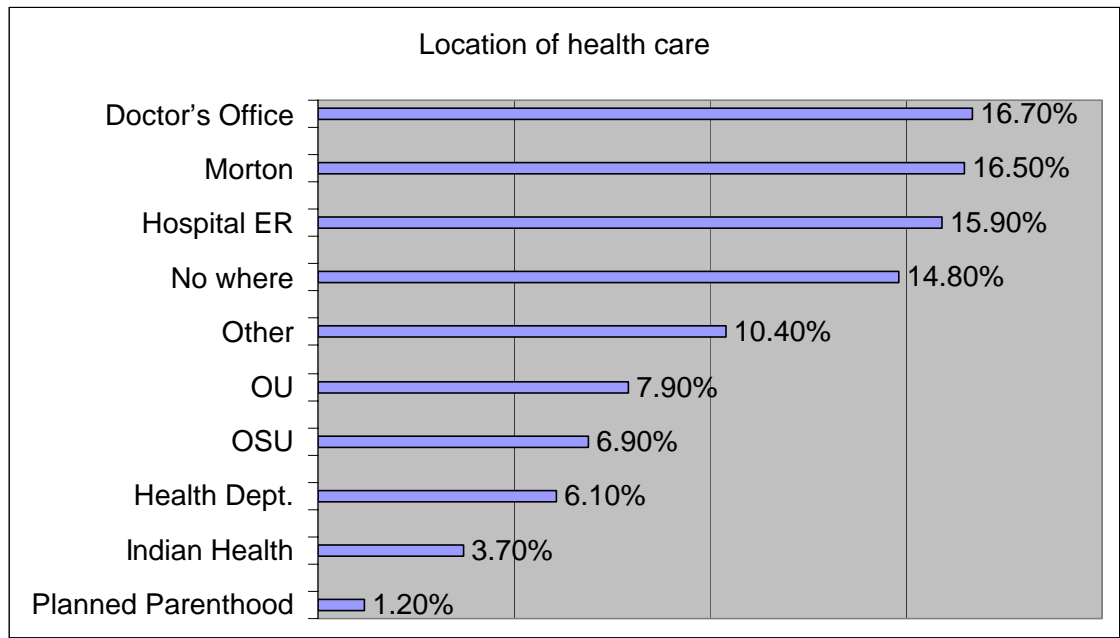
Where do you go when you are sick or in need of a health check up?

OU	OSU	Indian Health	Health Dept.	Morton	Planned Parenthood	No-where	Hospital ER	Doctor's Office	Other
7.9%	6.9%	3.7%	6.1%	16.5%	1.2%	14.8%	15.9%	16.7%	10.4%

Organizations listed in the “Other” category include Family & Children’s Services, area free clinics, the nurse clinic at the Day Center for the Homeless, the Veteran’s Administration clinic, Neighbor for Neighbor, and Associated Centers for Therapy.

NO primary health care provider: Almost 16% of respondents utilize the ER to access primary health care, and 14.8% of respondents reported they had no where to access health care. ***Combined, these two groups indicate over one third of the respondents do not have a medical home for primary health care.***

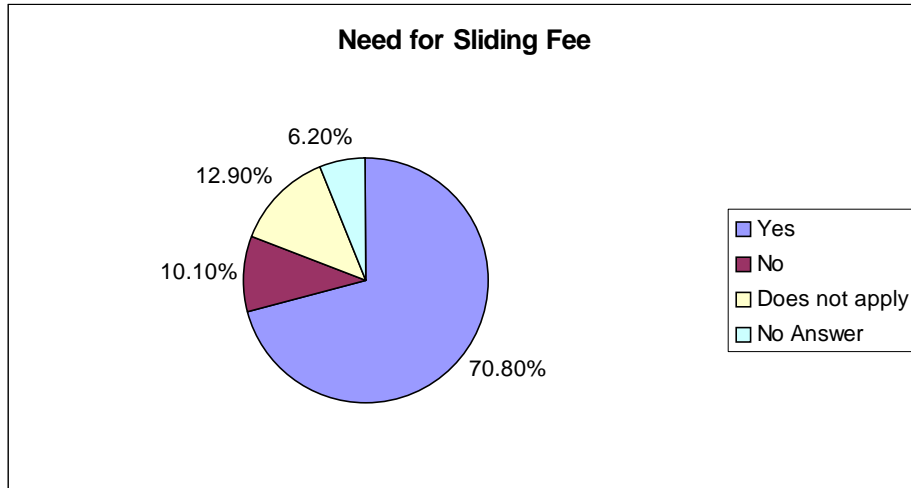
Seventeen percent of respondents use Tulsa’s federally funded Community Health Center (Morton), 3.7% access Indian Health Care Resource Center, 16.7% of respondents use private physician’s, 14.8% of the respondents utilize university-based medical services (OU & OSU) and 10% access “Other” providers for primary health care.



Do you need a doctor or clinic that charges according to your ability to pay (on a sliding fee basis)?

Yes	70.8%
No	10.1%
Does not apply	12.9%
No Answer	6.2%
Total	100.0%

Nearly 71% of the respondents reported needing a sliding fee scale, regardless of current provider, insurance, or income.



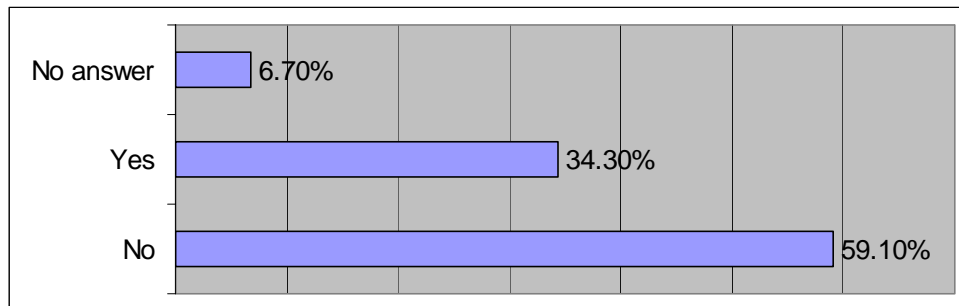
Note: The next four questions have to do with respondents not seeking, or not receiving health care. The four questions were spaced throughout the survey. This issue is of such importance that the assessors deemed it important to ask the question in different ways and compare the consistency of responses.

Have you ever had trouble getting a doctor's appointment because you couldn't pay?

No
59.1%

Yes
34.3%

No answer
6.7%



Reasons why respondents don't go to the doctor:

			Rank Order
Cost is too high	226	51.95%	1
No insurance	190	43.68%	2
Can't afford medicine	161	37.01%	3
Can't get a ride	95	21.84%	4
When I go to the doctor, I have to wait too long	92	21.15%	5
Couldn't get an appointment	74	17.01%	6
Didn't know where to go to get help	73	16.78%	7
Doctor or clinic too far away	70	16.09%	8
Health workers don't speak my language	63	14.48%	9
Not sure what help I can get	62	14.25%	10
Have to go to too many places to go to get the help I need	50	11.49%	
Insurance doesn't pay enough of the bill	47	10.80%	
Don't know enough about insurance	46	10.57%	
Need care after work or on weekend	43	9.89%	
Takes too long to get an appointment	40	9.20%	
Some doctors or clinics don't take my insurance	40	9.20%	
Don't like doctors	39	8.97%	
No day care / baby sitting available	31	7.13%	
Afraid of immigration	19	4.37%	
Other	13	2.99%	
Don't want people to know I'm at the clinic	10	2.30%	

TOTAL RESPONSES TO THIS QUESTION WERE 1484. THE 435 RESPONDENTS EXPERIENCED, ON AVERAGE, 3.4 BARRIERS TO ACCESSING HEALTH CARE.

Financial barriers: Cost is too high (51.95%), can't afford the medicine (37.01%), inadequate insurance coverage (10.8%), no insurance (43.68%) and providers do not accept their insurance (9.2%). Combined, these five factors represented the largest barriers to accessing health care: no insurance, underinsured, providers that did not accept their insurance and respondents that are unable to pay for medical services and/or medicine prevented individuals from receiving health care.

Transportation barriers: Nearly 22% of the respondents indicated that transportation is a barrier to accessing health care, 16.1% reported that medical providers were too far away to access medical care, and 11.5% of the respondents have to go to too many place to get care. During interviews with service agencies and providers, it was reported that bus routes have been dramatically reduced, thereby impacting the ability of the poor and working poor to access health care. This finding underscores the need for a wider-reaching mass transit system.

Problems with clinic/providers operations: Over 21% of respondents reported waiting past their appointment time to see their health provider, 17% reported that they could not get an appointment, 14.3% reported that lack of translation services at the clinic/provider presented a barrier to their receiving health care, and 9.2% of the respondents reported that it took too long to get an appointment.

Lack of consumer knowledge of available services: Nearly 17% of respondents don't know where to get help, 10.5% don't know enough about insurance, and 14.3% are not sure what help they can receive. This lack of consumer knowledge may reflect the lack of case management/care coordination, differences in medical systems for new immigrants and recently uninsured respondents.

Respondent comments listed in "Other" include:

- Every time I go I end up worse than before I went in.
- You have to have car insurance and gasoline to drive anywhere.
- Health workers scare me - I do not trust medical people any more.
- My bad teeth aren't important to them.
- I don't need to go.
- I have never been sick.

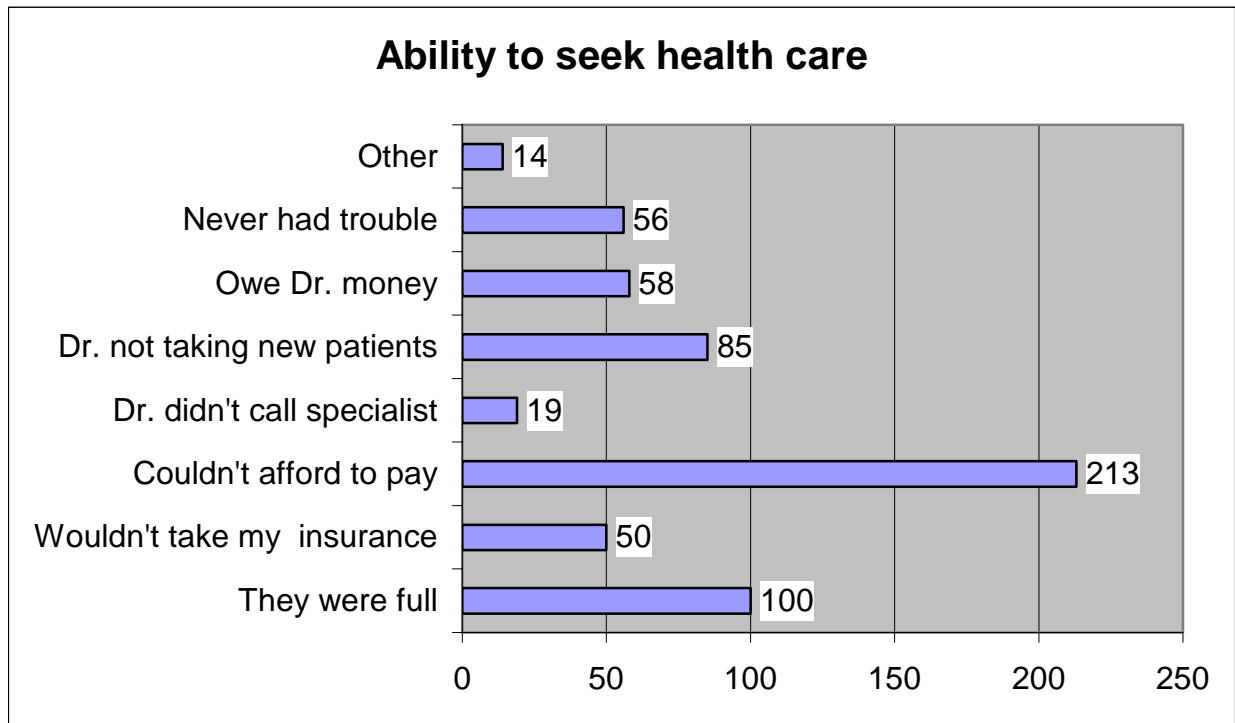
Of the 149 individuals that said they had trouble getting an appointment because they couldn't pay, the following were listed specifically:

Name of organization	Number of times mentioned
Morton	16
Private physician	10
St. John's	4
Unspecified hospital	3
OU	3
"Anywhere"	2
Hillcrest	2
St. Francis	2
Tulsa City-County Health Dept.	2
OSU	2
Planned Parenthood	2
Associated Center's for Therapy	1
Claremore Indian Hospital	1
Heart Institute	1

Reasons respondents were unable to visit the doctor or clinic:

Couldn't afford to pay	213	50.4%
They were full	100	23.6%
Dr. not taking new patients	85	20.1%
Owe Dr. money	58	13.7%
Never had trouble	56	13.2%
Wouldn't take my insurance	50	11.8%
Dr. didn't call specialist	19	4.5%
Other	14	3.3%
Total responses	581	1.4 instances per respondent

Over half of the respondents reported they were unable to visit a doctor/clinic because of their inability to pay. This data reinforces the complaint often heard during interviews and in case studies of the lack of affordable health care options in the Tulsa community, and helps to explain the increasing popularity of free clinics in the area.



Has a doctor's office or clinic refused to see you?

Respondents were asked to check all that apply. Total is greater than 100%.

My doctor has never refused to see me	127	30.0%
I could not afford to pay	108	25.5%
No health insurance	90	21.3%
I did not have an appointment	57	13.5%
I was late for the appointment	48	11.3%
I owed the doctor or clinic money	45	10.6%
I could not afford the co-pay	37	8.7%
Didn't take my insurance	31	7.3%
Doctor's office would not schedule an appointment	30	7.1%
The doctor doesn't treat my disease	23	5.4%
Total responses	596	

Comments listed under "Other" include:

- My primary care physician didn't refer me.
- Their contract ran out with my HMO.
- I don't speak English.
- They dropped my case.

After removing 127 responses (30% that had not been refused by their doctor), on average, the remaining 469 had 1.1 reasons they had been refused at the doctor's office. The most common reason was that they could not afford to pay. The second reason most often listed was no health insurance, and the third was no appointment. Reasons having to do with insurance were given by 28.6% of respondents. Reasons having to do with inability to pay were given by 66.1% of respondents. This high percentage compares closely to the two previous questions where 50.4% of respondents gave inability to pay as the reason for not visiting the doctor, and 51.95% indicated cost as they reason they don't go to the doctor.

In the above table, 30% indicated that their physician has never refused to see them, which compares with 59.1% of individuals indicating they have not had trouble making an appointment. When asked, 34.3% of respondents indicated that they had met with difficulty in getting a doctor's appointment because they couldn't pay. The inference can be made that for 2/3 of respondents, it is not possible to make an appointment, and for 34.2% upon arrival, the inability to make payment becomes a barrier.

How long do you have to wait to get an appointment?

More than 4 days - over 30 days	2.3%
More than 4 days - 30 days	7.8%
More than 4 days - 1-2 weeks	11.3%
More than 4 days	11.5%
4 days	11.5%
3 days	10.8%
2 days	12.9%
1 day	14.5%
No answer	17.5%

The overall wait time to get an appointment was 3 ½ days, with some individuals waiting long periods of time before they are able to see their physician. Case studies underscore the difficulty in receiving timely health care, especially for those receiving Medicaid and Medicare. Low reimbursement rates may be at the root of this problem, as area physicians must restrict the numbers of these patients they carry on their rolls to maintain the financial stability of their practice. Medicaid recipients, especially, report that the provider they have been assigned is often geographically far from their home. If transportation is not available, these individuals are unable to visit their physician, and may be forced to utilize hospital emergency departments as their only recourse.

How long after you arrive for an appointment, are you seen by the doctor?

15 - 30 mins	21.4%
30 mins - 1 hr	33.1%
1 - 2 hrs	21.1%
More than 2 hrs	6.4%
More than 2 hrs - 3 to 4 hrs	2.3%
More than 2 hrs - 6 hrs	1.4%
More than 2 hrs - all day	0.2%
No answer	14.0%

Individuals who rely on public transportation, transportation provided by their physician/clinic, or friends and family members to transport them to clinic/physician visits, report that the visit often requires the better part of a day. This is a significant problem for parents who have children in school. A need to see the doctor frequently results in well children being kept home from school because the parent is unsure of what time they will arrive back at home.

NOTE: From this point forward, total surveys used for analysis are 423, as 12 individuals did not complete the second page of the survey.

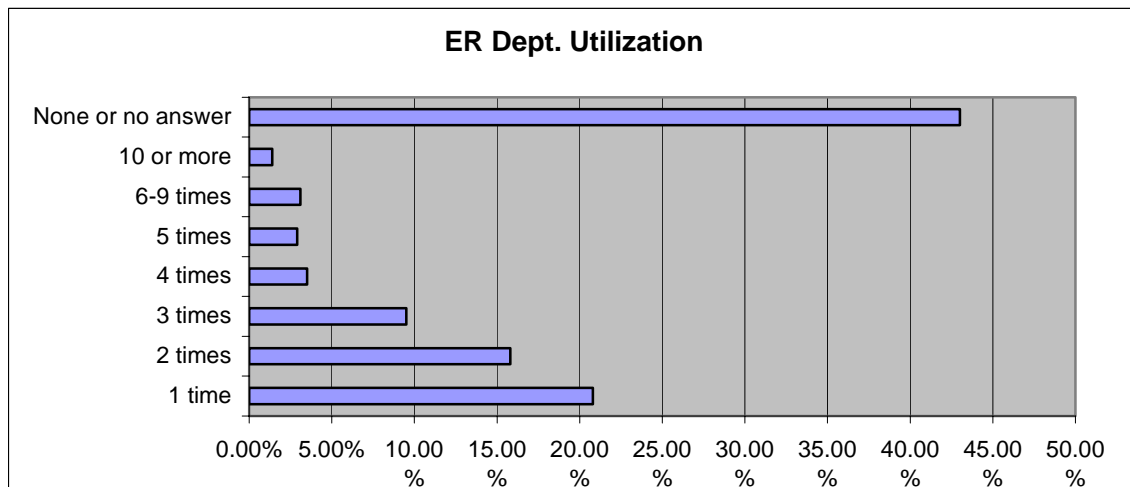
How long does it take you to see the doctor when you walk in without an appointment?

30 mins - 1 hr	17.7%
1 - 2 hrs	27.2%
More than 2 hrs	11.3%
More than 2 hrs - 3-4 hrs	4.9%
More than 2 hrs - 5-6 hrs	1.7%
More than 2 hrs - up to all day	1.4%
My doctor doesn't take walk-ins	19.9%
No answer	16.0%

How many times have you or members of your family visited the emergency room in the last year?

1 time	20.8%
2 times	15.8%
3 times	9.5%
4 times	3.5%
5 times	2.9%
6-9 times	3.1%
10 or more (highest number given was 50)	1.4%
None or no answer	43.0%

Hospital ER department studies indicate that it is often individuals with some form of insurance coverage (including Medicaid/ Medicare) who access these emergency services. This underscores the need to offer additional after-hours options for receiving health care.



How do you get to a doctor's appointment?

Respondents were asked to check all that apply. Total is greater than 100%.

I have a car	39.5%
Public bus	31.4%
Friend or family	23.9%
Walk	16.3%
My spouse takes me	10.4%
Taxi	5.2%
Doctor's office provides transportation	5.0%
Total responses	557

Fewer than 40% of respondents own their own transportation, once again pointing to a need to expand the options of public transportation to the Tulsa community. Only 5% of respondents received a ride from their physician or clinic.

What other health services do you need?

Respondents were asked to check all that apply. Total is greater than 100%.

			Rank Order
Dentist	232	54.8%	1
Eye doctor	182	43.0%	2
Family doctor	153	36.1%	3
Women's doctor	142	33.5%	4
Counseling	111	26.2%	5
Children's doctor	104	24.5%	6
Help in applying for benefits (DHS)	89	21.0%	7
Social services	70	16.5%	8
Psychiatrist	70	16.5%	8
Drop-in day care	70	16.5%	8
Diabetic care	64	15.1%	9
Case management	63	14.9%	10
Health classes	55	13.0%	
Physical therapy	47	11.1%	
Cancer treatment	46	10.9%	
Parenting classes	46	10.9%	
Alcohol/Drug counseling	42	9.9%	
Senior Citizen's day program	35	8.2%	
Total Responses:	1621		

A need for the following special doctors include:

- Asthma & allergy specialist
- Chiropractor
- Dermatologist
- Endocrinologist
- Oral surgeon
- Orthopedic surgeon
- Primary care physician

Respondents indicated that dental, eye, family medicine, women’s medicine, counseling services, children’s doctors, and help applying for benefits as the most needed other services. By combing the percentage of respondents who said counseling and psychiatric services are needed, a total percentage of 42.7% reiterates the need for additional affordable mental health services in the community.

What other things do you need to improve your quality of life? What would help you to get better health care?

These were an open-ended question; responses are grouped as follows. Respondents were asked to check all that apply. Total is greater than 100%.

			Rank Order
Job / Better job opportunities / Money	82	19.4%	1
Comprehensive, affordable health care, including dentistry and eye care / To be seen even if I can't afford to pay right then	73	17.3%	2
Affordable health insurance / Better health insurance / Benefits	62	14.7%	3
More health clinics / More doctors that speak my language	54	12.8%	4
Better health care / A clinic where I am respected / Better service from providers and clinic staff (see me on time)	42	9.9%	5
A clinic close to my home	27	6.4%	
More knowledge about health care and nutrition	27	6.4%	
Help with medications / Affordable medications	19	4.5%	
My own vehicle / Reliable and convenient transportation	18	4.3%	
Assistance in accessing services / Advocacy	18	4.3%	
Affordable specialty care, testing, and medical equipment / Affordable hospital care	16	3.8%	
Counseling / Support groups/Outreach	12	2.8%	
A home / Housing	11	2.6%	
A clinic with flexible hours / Open nights and weekends	9	2.1%	
Job training / School	7	1.7%	
Free health services	6	1.4%	
Total responses	483		

Some of the comments made by respondents include:

- A clinic that cares & doesn't take all day.
- A clinic that is close that should see me regardless of ability to pay.
- A clinic that will reach an agreement so I can possibly pay.
- A clinic within walking distance that will see me after work even if I can't pay at that time.
- A place where you can be welcome and feel safe.
- A support group so I won't feel so alone.
- Better care/quality of care. Doctors who care about their patients as people not the illness or money that they have to pay.
- Clinics with workers who care about the health of the people & know how to treat the people with respect and civility.
- Doctors that speak my language.
- I am a dialysis patient - I will eventually need an electric scooter or wheelchair - now I need a cane.
- I go to the doctor once a month for a shot because I have to have it. I cannot afford to go for anything else - the doctor will not let me pay it out.
- I have cancer and I need a surgeon.
- I have gallstones and have been waiting to have them taken out for 6 years. Every time I go to the hospital they won't do anything for me because I can't afford to pay.
- I need a legislator for me. (To be represented.)
- I need medicine that doesn't cause side effects that are worse than the original symptoms.
- I would like to have a clinic that is clean and where people know what they are doing and they are not students.
- I would like to work part-time but to do so would jeopardize my qualifying for mental health medications.
- I'd like to start seeing a counselor as well as having my medical needs met.
- If I trusted a good MD or PA or counselor - I have lost my faith in trusting people.
- It's hard to ride public transportation when you're in pain.
- More clinics that are able to attend to us without insurance.
- More clinics that help people who can't afford it.
- More help with medications. A majority of people do without 1/2 their medications because they have no money and no help.
- Our income is too high to get a reduced rate on lab work, X-rays, office visits & medicines, but not high enough to pay for charges out-of-pocket. My private physician charges less for an office visit than Morton Clinic does. My spouse has Medicare - I do not.
- Some help with expenses in regard to hospital costs.
- Someone whom I can trust to unload memories that I cannot seem to get over for last 14 years - they are military trauma - mental.

- Stop turning people away because they have no insurance - its all about money, not helping people.
- Sunday busses so I could go to church (I don't want to ride the church bus - it is just children).
- There ought to be a clinic in my language and in my area.
- To be able to visit in a clinic without fear.
- To be free from depression - I was diagnosed with bipolar.
- To have good health care in a clinic where I have confidence in those that help me.
- Understanding doctors.
- We need a clinic that is close and will not speak down to us.
- We need help.

QUALITATIVE DATA COLLECTION

Three levels of qualitative information were collected for this needs assessment: 1) focus groups with consumers and providers of various services, 2) case studies from consumers and providers, and 3) agency interviews.

FOCUS GROUPS: Fifty-four providers and/or consumers participated in 7 focus groups for this component of the needs assessment. The focus group data collection represented a structured qualitative data collection method. Specific questions were asked and participants were asked to rank order the information. The focus group information follows.

How do you and your consumers pay for doctor visits? (Rank Ordered)

1. Medicare
2. Cash
3. Free services
4. Other insurance
5. Medicaid
6. SSDI
7. Sliding fee scale

Do you and your consumers have trouble getting in to see a doctor?

All 54 participants reported YES.

Do you feel discriminated against due to ethnicity?

29 (53.7%) participants reported YES.

How would you rate the health status of Tulsans?

All 54 participants reported POOR.

BARRIERS TO ACCESSING HEALTH CARE REPORTED BY FOCUS GROUPS

BARRIERS	Incidents
Didn't have Co-pay / co-pay too high / owed money	7
No case management / care coordination	7
Medication Assistance not received	7
Denied access due to lack of documentation	7
Transportation	6
Can't access community health center	5
Rude staff	5
No Insurance / wouldn't take insurance	4
A long time delay getting an appointment with the provider	4
Long waiting list / limited provider services	4
Long wait time after appointment	4
Need after hours health care	3
Insurance would not pay for some medications	3
Translator not available	3
Rescheduled appointments	3
Can't get appointment desk to answer and / or schedule	2
No referrals to other social services	1
Missed last appointment, clinic wouldn't schedule another appointment	1
Test, lab, physical therapy, etc	1
Writing letters to insurance to obtain needed medical care	1
Could not get referral to sub-specialty doctor	1
Providers changing	1
Physician Assistant versus Doctor	1

Comments: The focus groups reported the following as the top four issues:

- 1) Patients were denied access to health care due to not having all or part of a co-pay. The focus groups gave numerous examples, from consumers that had been turned away from the health care setting because they lacked as little as 25¢ of their total co-pay fee, to consumers being charged a \$90.00 co-pay fee which they could not afford.
- 2) No case management / care coordination prevented accessing needed health care. The focus groups voiced the lack of referrals, locating primary care physicians, sub-specialty medical services, mental health services (etc.), making appointments, assisting with medications and other client advocacy and linkage activities created barriers that prevented accessing health care.
- 3) Assistance with obtaining medications (i.e. compassionate care, insurance, etc) is not offered in most health care settings. Patients were often not able to comply

with medical treatment because they cannot afford prescribed medications and the health provider did not provide assistance to obtain these medications.

- 4) Patients were denied access due to lack of the proper identification and/or documentation. In many cases the patients were not aware they needed this documentation to access health care.

HEALTH CARE SERVICES NEEDED ACCORDING TO THE FOCUS GROUPS

Rank	Item	Frequency
1	Case management for all consumers and bilingual/bicultural case management for Hispanic consumers	7
2	Assistance in obtaining prescribed medications	6
2	Mental Health – inpatient and outpatient	6
3	After hours health care	5
3	Transportation (taxi vouchers)	5
4	Longer hospital stays, psychiatric care, etc.	4
4	Culturally appropriate reproductive services for male / female, esp. adolescents	4
4	Affordable dental care, especially restorative	4
	Community education regarding accessing health care	3
	Translation at reasonable cost	3
	Substance abuse treatment- inpatient and outpatient	3
	Primary health care in public housing units	2
	An array of services for undocumented individuals	2
	Bilingual/bicultural staff (24 hours)	2
	Domestic violence services for Hispanic women	2
	Services for older individuals	2
	Primary health care for children	1
	Written materials in Spanish	1
	Lab, x-ray, specialty medical services	1
	Services for men	1
	More HIV counseling and testing	1
	Better insurance coverage for mental health disorders for both in-patient and outpatient services	1

Comments: Focus group participants indicated that case management and care coordination were the most needed service. The second most needed services were assistance with obtaining medications (which can be a function of case management/care coordination) and increased services for mental health (both inpatient and outpatient services). The need for additional affordable mental health services is confirmed in the survey portion of the assessment. The focus groups listed after hours community health care and transportation needs as the third most common need. The fourth most commonly listed items were longer hospital stays and/or care, culturally appropriate reproductive services, and dental services.

CASE STUDIES: The process of collecting the case study data was to offer individual consumers an opportunity to discuss difficulties and barriers in accessing health care. Information given by each individual was recorded through data processing and reviewed by needs assessors. Themes and categories were determined, and the frequency of occurrence was documented.

Overall results: Sixty-four cases were collected with 75 incidences (individual patients) recorded. There were 160 attempts to access health care with 36 incidents of ER and/or hospitalizations reported for this section of the needs assessment. In addition, information was separated into two distinct clinical settings, hospital and outpatient.

Many of the individuals that participated in the case study section of this needs assessment had numerous incidents of barriers to accessing care. They reported a cycle of hospital encounters with only emergent needs being met, poor hospital discharge care coordination, numerous failed attempts to access primary health care, extreme difficulty accessing sub-specialty medical services, and health issues not being managed in out-patient settings to the point that they became emergent and had to access hospitals to receive medical treatment.

Hospital: Represented in the case studies incidents were all of Tulsa's major hospitals, with 30 incidents of ER visit and/or hospitalizations.

Ranked by frequency, individuals reported the following barriers:

- 1) Needed **Care Coordination** for medications, additional testing (scans, ultrasound, etc), medical services, medical supplies and follow-up treatment. Upon discharge from hospitals, patients struggle to access follow-up health care. Delayed follow-up appointments with doctors were frequent, with some specialty medical providers not accessible. Receiving treatment for non-emergent medical needs is most difficult.
- 2) **Case Management** services were the second most frequent barrier at the hospital level, for transportation and referrals to other medical care and/or social services and/or benefits.
- 3) Patients reported "**No insurance**" prevented them from receiving medical treatment that was non-emergent.
- 4) Lack of **Cultural sensitivity/language**. Patients reported that culture and/or language was problematic in receiving treatment. Some individuals reported discrimination due to ethnicity and/or language. For example when a translator was not available at the hospital, family members have been asked to translate for the medical team, which resulted in misinformed consent to treatment. In addition, discharge instructions were not linguistically clear.

- 5) **Insurance not paying for medication.** Patients reported being discharged with new prescriptions for medications that their insurance company would not pay for.

Outpatient clinics: Tulsa has one federally qualified community health center, a health center providing services to Native Americans, two educational institutions (medical schools), and an array of medical services provided by faith based organizations, in addition to the city county health department, and specialty service clinics (i.e. Planned Parenthood). A complete provider listing for Tulsa and the surrounding area is available from HealthNet; requests for the listing can be communicated through the CAP office at the Tulsa City-County Health Department. The following list groups the available services by type:

Federally- and/or state-funded outpatient clinics whose mission is to serve underinsured and uninsured patients. Payment sources include federal funds, sliding fee, Medicaid, Medicare, other insurances and some services free with limited programs.

Educational/teaching institutes whose mission to educate and train physicians. These institutions accept patients on a sliding fee schedule, Medicaid, Medicare and other insurances. Services are full-range from hospital (in-patient) care to outpatient specialty services.

Faith-based outpatient services care for patients with zero pay source (no insurance). These clinics/services provide episodic care, operate on a volunteer and donation basis, and operate partial medical and/or dental clinic days.

Definition of terms: For the purpose of this needs assessment the following terms have been defined:

Care Coordination- securing related health care services needed for the patients. This includes such activities as discharge planning, referral and acceptance to primary health care providers, medical testing (i.e. laboratory, x-rays), referral to specialty medical services (i.e. cardiologist, etc.), and obtaining durable medical supplies (i.e. oxygen, etc).

Case management- securing needed resources to ensure medical recommendations can be followed. This includes application to benefits programs (SSDI, Medicaid, Medicare, Advantage, DHS, etc), medication resources (i.e. prescription assistance, etc.), and referrals to other medical and social systems (adult protective services, housing assistance, mental health, food pantry, DHS, etc).

OUPATIENT BARRIERS TO ACCESSING HEALTH CARE

BARRIERS	Incidents
DENIED PATIENT AN APPOINTMENT	
Patient owed a balance	16
Would not schedule patient (reason unknown to patient)	15
Patient's appointment was rescheduled	11
Provider refused patient due to condition and/or other medical reason	10
Patient did not have part or all of the co-pay	10
No Insurance / did not take insurance	7
No provider available	6
Patient did not have required documentation	6
Appointment made for a weekend when provider was not open	1
CASE MANAGEMENT	
Medication assistance not received	5
Assistance and/or referral to SSDI/Medicaid for application	5
Referrals to other social services	4
Transportation	4
Hospice	1
Adult-protective Services	1
CARE COORDINATION	
Test, lab, physical therapy, etc	11
Writing letters to insurance company to obtain needed medical care	2
Could not get referral to sub-specialty doctor	2
PROVIDER ISSUES	
Misdiagnosis	11
Providers changing	5
Provider would not perform lab work	5
Patients were told a Physician Assistant was a Doctor	3
Changed patient medications	1
Physician would not continue current drug treatment due to cost	2

Hispanic Case Studies:

In addition to the barriers to accessing health care for the overall group, Hispanic individuals are experiencing specific barriers:

- 1) Long wait past appointment time, reported by 7 individuals
- 2) Discrimination due to language/ethnicity, reported by 9 individuals

3) In appropriate billing, reported by 11 individuals -- bills for services not received and/or bills received for services, which were paid for at time service. This prevented them from being able to schedule an appointment.

4) Language barrier and/or no bilingual staff/language was reported by 7 individuals.

5) Cancelled appointment without notifying the patient was reported by 5 individuals.

Comments:

In the case studies collected, individuals reported numerous attempts to access care, however barriers described above prevented individuals from accessing outpatient health care services. Frequently, individual's conditions were chronic, and/or urgent; when they could not access outpatient treatment, the conditions became emergent, forcing the individual to rely on hospital emergency departments for medical care. When discharged from the emergency room or hospital, individuals reported that few discharge/care coordination/case management activities occurred. Barriers to accessing outpatient health care continued to prevent the individual from obtaining needed outpatient services and again the individual was forced to resort to accessing care from a hospital emergency room. This cycle of inappropriate utilization of hospital emergency services was reported time and again. In addition, the Hispanic individuals included in these case studies reported numerous additional barriers related to either language or ethnicity in accessing medical treatment in the outpatient and/or hospital settings.

AGENCY INTERVIEWS: This survey consisted of eleven questions, which were asked of agency directors or their designees. The questions were designed to mesh with consumer surveys and provider focus groups to provide an overall picture of the ability of Tulsans to access health services, as well as to highlight areas of need. Twenty-one agency heads or their designee were interviewed using this structured format. The agencies interviewed represent a broad range of safety net health and social service providers serving persons in Tulsa. Many agencies interviewed serve or advocate for persons that are disenfranchised as a result of linguistic, cultural, educational, financial, age, health, disability, or other barriers to service. The goal of the survey was to gather information from these agencies that further describes the ways persons they serve access services and the barriers they encounter.

What is your opinion of the health status of Tulsans?

One hundred percent of respondents had less than positive comments regarding the health status of Tulsans. Individuals with insurance are generally considered to be healthy, as noted by 30% of respondents, although high rates of infant mortality, teen pregnancy, and smoking were considered indicators of a need for more preventative and educational health services. Regarding access to health care for persons with Medicaid or who are uninsured, comments included: "below average to poor", "very poor," "frightening", "slow and difficult", "forced to use ER", "difficult to find quality

providers” of health care, “long waiting lists for primary care for Medicaid beneficiaries”, and “long wait to see a doctor often results in our clients going to the ER.” An interesting point is that concern about access to services for clients with Medicaid eligibility was as great or greater than concern for access to health services for persons who are uninsured. No agency representative indicated that the health status of Tulsans that were uninsured or who received Medicaid benefits was adequate or better than adequate.

Do your clients have access to care on evenings and weekends? (For medical clinics, what type of after hours/call coverage do you provide?)

Half of respondents reported that their agency does not have access to care after hours or on the weekends. Forty percent of respondents provided limited access to most services. Ten percent of respondents mentioned crisis lines, shelters, and some case management programs having access to services round the clock. A few isolated service providers have extended hours one or two nights a week. The most common response was that their clients access the ER after hours or weekends for medical treatment.

Are all your clinics or service centers accessible through public transportation?

Nearly 70% responded with an affirmative, but all qualified that response. Attempts have been made over the last few years to reduce the number of public transportation routes and the frequency of those routes. When these plans would significantly affect access to health and social services, the transit authority has been responsive to citizens’ input and thus far has maintained existing routes. The bus system does not operate in the evenings, and there is very limited service on Saturdays, with no service on Sundays. Thirty percent of respondents provide limited access to transportation in some form or another. Problems exist for the many citizens that live in surrounding communities and suburbs, rural areas and some parts of East Tulsa where the bus lines don’t operate. For persons needing health care or related services that don’t have transportation and are not near a bus line, transportation remains a major barrier to care.

Do you involve the family and or client’s support network in delivering services?

Eighty percent of responding agencies indicated that they involved the family and/or the client’s support system. Twenty percent reported that they attempt to involve the family and have experienced limited success, or were unsuccessful. The most common explanation for failure to engage other family members in providing support to a client was the issue of other family members being required to work (the working poor), and being unable to take time off to attend to the health concerns of other family members. Other agencies, particularly those serving homeless clients, pointed out that the relationships with the support system and/or family had often been severed, resulting in reliance on social service providers.

Do you coordinate your agency services with other agencies or with schools?

A majority of the agencies have informal relationships with other agencies that offer related services to their client populations. It appears that most arrangements are

functional and have occurred as a result of specific needs emerging and coordination being required to meet the needs of a client or a group of clients. The Community Service Council was mentioned as a coordinating body for community services.

Do you have referral mechanisms for services needed beyond the scope of your agency?

All answered yes.

What are the most common referrals?

The answers to this question varied more than any other category, depending on the mission of the agency interviewed. Many agencies were mentioned frequently. The clinics at the University of Oklahoma and to a lesser extent Oklahoma State University were identified as primary care providers for most clients that were Medicaid beneficiaries. Family and Children's Services was mentioned as providing crisis intervention and mental health counseling services. The Tulsa County Pharmacy and Neighbor for Neighbor were identified as resources for medication. Tulsa Housing Authority was mentioned as the primary resource for housing support. Youth Services of Tulsa was the resource identified for shelter and support to youth, and Domestic Violence Intervention Services was the agency referred to for domestic violence issues. The Tulsa City-County Health Department, Oklahoma Department of Human Services, Morton Comprehensive Health Services, Community Action Project, Catholic Charities, Planned Parenthood, Ability Resources, Salvation Army, John 3:16, the Day Center for the Homeless and "all of the other agencies in the Blue-Book" were identified as needed referral resources.

Are your clients able to access those services in evenings or on the weekend?

All agencies responded negatively. Some explained that the problem was that services were not available. Others pointed out that public transportation was not available, even if a clinic were open on an evening or weekend. A few administrators pointed out that clients accessed hospital emergency rooms as a last resort after hours and on weekends.

How is the referral made?

Many agencies provided written information about resources that enabled the client to make an appointment. Other agencies made appointments for the clients, and some actually transported the clients.

How do you follow up?

Answers to this question varied, and were split approximately 50/50 in response. Agencies that were more involved in case management often followed up with the client to make sure that the service had been provided and that the needs had been addressed. Other agencies either did not have this capacity, or simply did not follow up.

Are there other types of referrals needed by your clients that you are unable to make?

This question often generated an emotional response. All agencies respond that there were referrals needed by their clients that they were unable to make. Respondents identified serious gaps. It was repeatedly pointed out that Spanish speaking and other non-English speaking clients were not able to access many services without having their own interpreter. This was a serious issue with primary care, emergency medical services, shelter services for youth and abused women, and mental health as well as most other services in Tulsa. Issues for Hispanic clients are further complicated by the extremely limited availability of access to primary health services for patients without insurance. This was stated repeatedly as a problem with OU, OSU and Morton. Requirements by providers of picture identification or “proof of homelessness” also limited access to primary care services.

Waiting lists for persons with Medicaid at OU and OSU are reported to be long. Some agencies claimed the wait is as long as 3 to 4 months, up to 5 months, before being seen for primary care. Seventy percent of respondents reported that dental services are generally considered “not available” for the uninsured or persons with Medicaid, particularly those with physical disabilities. Many agency directors described their clients as getting care only when a tooth rots and has to be extracted, and then this after a lengthy wait. Sixty percent of agencies responded that mental health services have declined to the point that they are generally considered unavailable until a client reaches such an acute mental status that hospitalization is required. Hospitalization can be for a few hours or a few days. After hospitalization for a mental health crisis, the client often ends up at a homeless shelter and begins the cycle of decompensation again.

Twenty-five percent of respondents mentioned specifically that medications are often financially out of reach for many clients, particularly for the unemployed and working poor without insurance. The limit of three prescriptions per month placed by Medicaid results in many individuals going without needed medication. Twenty percent of agencies responding specifically voiced housing concerns. The wait for housing for single individuals through Tulsa Housing Authority is reported as being between several months up to 2 years. Families can generally access housing more quickly, although it was stated that locally housing is near or at capacity. This essentially creates extended homelessness for hundreds of individuals in Tulsa. Thirty percent of respondents mentioned that substance abuse services beyond detox are often unavailable and a waiting list is not realistic. Relapse for these clients is considered nearly automatic. Half of agencies responding pointed out that a wide range of “specialty” care services from neurology, psychiatry, podiatry, pediatrics, ear/nose/throat specialists, and others were considered inaccessible to Medicaid and uninsured patients.

Do you believe there is adequate capacity for other agencies to accept your referrals?

If the clients have insurance, there was generally considered to be adequate capacity. For all other clients the answer was generally “no”. Essentially 100% of respondents

mentioned inadequacies in access to substance abuse services, mental health services, and the other services identified above. The most common response was related to the “waiting lists”. Again, a common statement following “no” was, “They go to the ER”.

Do you believe your clients experience barriers to receiving referred services (insurance, cost, transportation, language, hours open, immigration laws, day care, wait time too long)?

If an agency director paused after this question was asked, a list was read. Many then said “yes, all of the above.” Ninety percent specifically identified cost as a major barrier for their clients. Eighty percent of agencies that worked with Hispanic clients stated that there is a lack of bilingual staff, including within their own agencies. Similarly, for undocumented immigrants and their children, many social services are not attainable. Limitations to public transportation, both in the geographic areas served and the times that buses run were expressed by sixty percent of respondents as barriers to receiving services. Lack of dignity in treatment was pointedly mentioned by several agencies.

What agency do you consider responsible for coordination of services for clients that are served by your agency?

No agency was identified as coordinating services for clients in Tulsa. Some agencies provide case management and care coordination services for some of their clients. The consensus was in support of an agency that had a Community Health Information Network and the case management capacity to become involved in coordinating services for the underinsured and uninsured residents of Tulsa.

How do you accommodate special needs, i.e. cognitive, cultural, language, and disabilities?

Are there physical barriers eliminated?

All agencies stated that physical barriers within their agencies were eliminated, although it was noted that many offices were obstructed in ways that were not accessible to persons in wheelchairs. Restrooms located at the agencies were not always handicapped accessible. Most agencies, however, appeared to be ADA compliant.

Do you have materials in multiple languages?

This was an issue for 80% of agencies responding. A common response was that the agency was “planning” or “in the process of” making materials available in multiple languages. Two agencies provided support to other agencies to translate written materials in various languages and to provide interpreters. Most agencies had some basic materials available in Spanish.

Do you have employees who speak languages spoken by your clients?

Very few agencies have this capacity, including many agencies that serve a large number of clients that do not speak English. Most stated that they would like to have bilingual staff and that they have tried to hire staff that are bilingual, but they have not attracted qualified applicants. This barrier to services was considered by many to be the most significant, given the recent influx of Spanish speaking residents, and the lack of bilingual and bicultural resources to address their health and social services needs.

Do you charge for your services? If so, how do clients pay for your services? What is your policy for people that are unable to pay for services (co-pays, sliding fee, full charge)

Eighty percent of responding agencies do not charge for their services. Twenty percent charged according to sliding scale fee. Each stated that they provided services regardless of ability to pay.

Do you perceive your consumers/patients being without insurance, underinsured, or with limited coverage?

The client populations that receive services from the agencies interviewed were largely uninsured or Medicaid beneficiaries.

If this needs assessment identifies gaps in service, how willing and able is your organization to change to meet those needs?

Agencies were in consensus that they did not have additional capacity to provide more uncompensated services, but that they would participate in a consortium effort to improve access to and coordination of services and would welcome a Community Health Information Network. If gaps in services were identified and new ways of delivering services were developed to address the gaps, they would participate in a collaborative effort to join other service providers to meet those needs.

If a computerized community referral database system were developed, would you use the system for referrals?

All agencies stated that they believed they would use the system. A common caveat was that the benefits must outweigh the additional effort of entering the information into the database. One agency administrator that does everything “by paper” questioned the efficiency of the effort compared to her past experiences with “the computer.”

How would your agency benefit from using the community referral database system?

Eighty percent of responding agencies stated that they believed that the system would make referrals easier and quicker for themselves and their clients. The benefits of follow-up information being available and outcome data being accessible across disciplines were mentioned by a few agencies.

To make this a win-win situation, how might your agency contribute in a reciprocal fashion (personnel, space, funds, discounted services, contractual services at cost)?

Forty percent of the agencies interviewed indicated that they had space available and many agreed to make personnel available to the effort. The expertise of each agency was generally considered a resource that would be made available to others through training opportunities, specifically mentioned by 85% of respondents. There was a general willingness to collaborate with others in contractual relationships, making each agency’s resources available to a consortium effort.

Comparison of Consumers and Focus Groups

Focus group listed needs:

- Medication assistance
- Mental health services
- After hours community health care
- Transportation
- Hospital care

Consumer listed needs:

- Dental services
- Eye care
- Family medicine
- Women's medicine
- Counseling Services

47.5% of respondents rate their health as fair, poor or very poor

100% of individuals participating in focus groups reported poor health

100% of agencies reported negative health status

Agency listed needs:

- Dental services
- Mental health services
- Assistance with medications
- Housing
- Longer term substance treatment
- Specialty medical services

BARRIERS:

Agency	Consumers	Focus groups
Cost	Financial/Cost	Financial /Cost
Bilingual staff	No insurance	Case management
Documentation	Transportation	Medication assistance
Waiting lists	No money for Meds	Documentation
Disrespectful staff	Transportation	Transportation
	Wait too long	Rude Staff
	Can't get an appointment	Can't access Community Health Center

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MAJOR FINDINGS AND RECOMMENDATIONS

The purpose of this project was to assess the health status and barriers to health care for individuals residing in the Tulsa area. This project was funded by the U.S. Health Resources and Services Administration (HRSA) through the Bureau of Primary Health Care (BPHC), sponsored by Tulsa Community HealthNet, and administered by the Tulsa City-County Health Department. Four sources of data were evaluated during this project. The results and recommendations of this project are based on these four sources of data:

- 1) Consumer surveys (**N=435**),
- 2) Focus groups (**7**) with providers and consumers (**N=54**),
- 3) Case studies with consumers (**N=64**), and
- 4) Health and social service provider agency interviews (**N=21**).

Survey sites were chosen based on an analysis of U.S. Census 2000 Data. Interviews and survey collection were conducted at various locations, concentrating on geographic areas with a high concentration of individuals at or below the federal poverty level, and thereby at risk for being under and uninsured. In addition, the needs assessors attempted to geographically represent all sections of the city of Tulsa by collecting data from various zip codes within the Tulsa MSA.

The following represents the major findings of this study:

- The needs assessment represents data from all geographic quadrants within the City of Tulsa.
- 78% of the male respondents were from 20 to 49 years old, 76% of the female respondents were from 20-49 years old.
- The respondents ethnicity/race was 36% Hispanic, 32% Caucasian, 19.5% African American, 8% Native American, and 2.5% Asian.
- 34% of respondents spoke a language other than English as their primary language.
- 47.5% of respondents rate their health as fair, poor or very poor.
- 50.8% of respondents only go to the doctor when they are sick and or hurt.
- Over one third of the respondents do not have a medical home for primary health care.
- 70% of respondents reported that they need access to a doctor or clinic that charges according to a sliding fee scale. This concept is identified with affordability of services.

- Financial barriers, i.e. uninsured, underinsured, costs of medical care, were the greatest barrier to accessing health care. Qualitative data confirmed financial issues as the greatest barrier.
- 34.3% of the respondents report having trouble getting a doctor's appointment because they couldn't pay.
- 34.2% reported they had been turned away from the doctor's office due to inability to pay.
- 52% report not going to the doctor because they can't afford it.
- 20% of respondents report that they, or another member of their family, visited a hospital emergency department at least once within the last year.
- Within the qualitative data, lack of case management/care coordination was the second greatest barrier to accessing care. This is reflected in the survey data as client knowledge. Lack of proper documentation of financial status and/or immigration status, and transportation issues were also given as major barriers.
- Respondents reported transportation as the second greatest barrier to accessing health care. Agencies reported lack of public transportation affecting their clients' ability to access care. Case studies and provider interviews confirm that lack of transportation is a barrier to receiving health care.
- 60% of respondents must rely on others for transportation to a doctor's appointment. Only 5% receive a ride from their doctor/clinic.
- 55% of respondents have a need for affordable dental care. Restorative care was specifically mentioned, rather than relying primarily on extraction.
- Problems with clinic/providers operations were the third greatest barrier accessing health care. A perceived lack of respect was a common theme among interviews and focus groups.
- Client knowledge and ability to access available services was the fourth greatest barrier to accessing health care.
- Case studies indicated that frequently individual's conditions were chronic, and/or urgent. When they could not access outpatient treatment, the conditions became emergent, forcing the individual to rely on hospital emergency departments for medical needs. When discharged from the ER or hospital, individuals reported that few discharge/care coordination/case management activities occurred. Continued barriers to accessing outpatient health care prevented the individual from obtaining needed outpatient services and again the individual would be forced to access a hospital emergency department to receive care.

- Cases studies indicated that consumers felt discrimination occurred due to ethnicity, language and/or ability to pay.

RECOMMENDATIONS:

- Results of qualitative as well as quantitative data indicate that Tulsans have difficulty accessing primary health care; therefore, safety net providers, especially, should investigate ways in which their services might be more easily accessed.
- Further study regarding the policies and services provided by Tulsa safety net providers, in particular, perceptions and experiences of the public in not being able to access services.
- An educational initiative to inform the public of the services, policies, and restrictions of safety net providers.
- Due to consistent themes found in the qualitative data indicating discrimination, further assessment regarding discrimination due to language and/or ethnicity is needed.
- Refinement of the needs assessment tool to capture additional information on discrimination, and the overuse of the free clinic system when other options exist.
- Investigation into lack of post-ER / post-hospital follow-up care.
- Collection of additional surveys.
- Survey patients utilizing free clinics to ascertain why they rely on the free clinic system for primary health care rather than accessing a sliding fee safety net provider.
- Further involvement of area medical professionals in volunteering at free clinics and safety net providers.
- More extensive collaboration among safety net providers to reduce duplication and increase sharing of services, most especially case management / care coordination, i.e. referrals to medical care providers and assistance in accessing resources for pharmacy assistance.