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Final Report
for the Communities in Charge Pilot Project
to Fund Community Based Organization
Outreach for the Oregon Health Plan

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Introduction

This report summarizes the method and results of a pilot project in public health policy change. The project's purpose was to verify whether or not providing direct funding to Community Based Organizations (CBO's) for community outreach about the Oregon Health Plan (OHP) would result in an increased recruitment and retention of people of minority status or with limited English proficiency on that public health insurance plan.

This project receives its funding from the Robert Wood Johnson Foundation. It is part of a multi-year Communities in Charge grant awarded to Multnomah County Health Department (MCHD). Healthy Communities of the Columbia-Willamette, Inc., a non-profit organization, contracted with MCHD to plan, implement, and evaluate the pilot project.

During the summer of 2001, Healthy Communities invited over 40 CBO's to two meetings to discuss their preferred method of payment for this project. We felt that the CBO's were in the best position to understand their own needs and what tools would best assist them with their work. Attendance at these meetings was low; however, the payment method described in this report was selected by the CBO's as their preference.

The remainder of the report will cover the following information: project design, implementation issues, data analysis, and recommendations.

Project Design

The purpose of the pilot project was to increase enrollment and retention in the Oregon Health Plan among people of minority status and/or with limited English proficiency. In earlier interviews with Community Based Organizations, we were told that CBO's could provide the most culturally-sensitive and community-specific outreach services. The CBO's contended that they could increase OHP enrollment among their community members if they had sufficient funds to engage in outreach.

The Project Coordinator for the Communities in Charge project offered to fund a pilot study to test this assumption. The pilot study offered each participating CBO a \$25 premium for each completed OHP application submitted through the Multnomah County Health Department Medicaid Unit. The Medicaid Unit would provide a full day of training to the staff members of the CBO's. Healthy Communities would select the participants, arrange the training day details, and issue monthly checks to the CBO's for the completed applications. Healthy Communities and the Medicaid Unit would evaluate the data at the end of the project, looking for changes in the rate of OHP enrollment among the participating populations.

Healthy Communities limited the number of participating CBO's to four, due to the relatively small pot of money available for the project. We attempted to make those four CBO's as diverse as possible, both in terms of the population served and the geographic location. Communities in Charge is a tri-county project serving Multnomah, Washington, and Clackamas counties in Oregon. We encountered limitations on our ability to recruit CBO's to participate in Washington and Clackamas counties, largely due to differences in their system structure for delivering OHP recruitment services and other social services to their residents. Clackamas County has a highly-centralized OHP recruitment system that is well-established and well-respected. Conversely, Washington County's OHP recruitment services are scattered throughout several clinics and social service programs ranging over the breadth of a large and growing county. Multnomah County's services are a mixture of these two extremes, reflecting the intense need to provide OHP outreach services to a densely populated area with a highly-diverse population.

The four CBO's selected to participate in the pilot project were all based in Multnomah County, though three of them provide services to clients from a broader geographic area. The primary client bases served by the CBO's included: African-American women in treatment for drug and/or alcohol addiction; Chinese-Americans; Hispanics; and refugees from Africa or former Soviet republics. Two CBO's specifically turned down the invitation to participate in the pilot project on the grounds that the per-application payment was insufficient. They stated that they had limited staff to provide a broad range of services to their clients. They would not be able to hire another staff member to conduct OHP outreach based on a per-application premium and current staff did not have time to begin including OHP application assistance in their duties. This turned out to be a concern for at least one of the participating CBO's as well.

A requirement for participation in the pilot project was that each CBO would send two staff members to a full-day training presented by the staff of the MCHD Medicaid Unit. The CBO's received a \$100/person stipend to help defray the costs of staff member attendance. The purpose of the training was to ensure that the CBO's had a base

of understanding regarding the correct methods for completing the applications, the type of health insurance programs covered, the necessary supporting documentation for the applications, and other important information. This knowledge could improve the likelihood of the OHP applications being approved quickly, without need for lengthy changes or requests for additional information. It should be noted that the OHP applications are not approved in the Medicaid office, but are forwarded to OHP's Central Office in Salem for approval.

Ten staff members from the four participating CBO's attended the training in mid-January. They received thick manuals of information, as well as OHP applications in languages appropriate for their clients. (OHP Central determines into which languages OHP materials are translated.) The training received high ratings from the participants, who uniformly reported that they learned new, useful information. They also met and interacted with the Medicaid staff members who would be their source for further information in the future. This person-to-person bond proved to be an essential part of the project's success. The Medicaid office received many calls from CBO staff members in the following weeks and the relationship will continue even after the project officially ends.

One Medicaid staff member made a point of extending an invitation to additional training to the participating CBO's. This training was provided by OHP Central staff. One of the CBO's was able to send a staff member to the training, which not only provided additional technical information but also allowed the individuals to get to know each other better.

Because of the personal and sensitive nature of the information contained in the Oregon Health Plan applications, each of the participating CBO staff members was required to sign a confidentiality statement. The CBO's also asked their clients to sign a waiver that allowed their applications to be forwarded to MCHD's Medicaid Unit for processing as part of this project. A monthly tally of applications submitted by CBO's was sent to Healthy Communities by the Medicaid Office. It was not coded to ensure confidentiality, although this had been discussed by project participants as a useful protective measure. Issues around confidentiality arose several times and caused some problems for the project. These will be discussed in more detail later in this report.

Healthy Communities received a monthly report from the Medicaid Unit which detailed how many applications each of the CBO's had submitted. It was an easy process to send out a check to each agency. There were no apparent difficulties or problems with this part of the process.

The CBO's were given information on whom to contact with questions during the course of the project. The Medicaid Unit received the most telephone calls, primarily related to specific technical questions about filling out the OHP applications. Healthy Communities received a few calls early on which were redirected to the Medicaid Unit for accurate and complete information. Questions about the structure of the project were directed to Healthy Communities. During the initial weeks of the project, communication needed to be frequent between the Medicaid Unit staff and the staff of Healthy Communities. This time element needs to be planned into the project design and funding.

Implementation Issues

Time and money were the overarching issues that limited the implementation of the pilot project. This is generally true of most projects and is no surprise. In the case of this project, which came to a premature closure due to outside circumstances, it was not possible to determine fully how much money would be needed to “do the project up right.” (It should be noted that after 3 months of implementation, a substantial amount of the original project funds (\$10,000) was still available for distribution.)

Limited funds for the pilot project meant that only a small number of CBO’s could participate. This limited the amount of representation that could be included in terms of diversity and geographic coverage. Also, as previously mentioned, the small premium amount per OHP application prohibited the smaller CBO’s from participating. Only the larger, well-established CBO’s with more staff were able to participate in the project. The smaller, newly-established CBO’s are often the ones serving the newest immigrant populations with the highest level of need for social services, including health care and insurance.

It became clear during the course of the project that one of the CBO’s already had a well-established relationship with a caseworker from the State Adult and Family Services Division. This caseworker was already able to assist with full completion of OHP applications and expediting their processing at the OHP Central Office. This CBO therefore expressed frustration with the extra time required to send their applications through the Medicaid Unit as part of this pilot project. They ultimately requested to continue receiving the premium while submitting their application through the AFS caseworker. This request would have been denied by Healthy Communities, as it would have undermined the established guidelines of the project, set an unfair precedent for the other participating CBO’s, and made it impossible to capture the data which informs the project evaluation. This situation also highlighted the need for a clear communication plan among project members, to ensure that a CBO did not receive different answers if they asked the same question of more than one agency.

There was a difference in perspective about the time committed to the training day. While the CBO staff members rated the training high, the Medicaid Unit staff (who provided the training) felt that one day was not sufficient to cover all the important information and to answer the detailed questions asked by the CBO staff members. The Medicaid Unit staff felt that a three-day training would be more appropriate. The OHP application is now five two-sided pages of cumbersome, confusing questions. The rules book for the Oregon Health Plan occupies six inches of shelf space in the Medicaid Unit. There are many exceptions to the rules. Clearly it is not a simple process to gain health insurance coverage under the Oregon Health Plan. One Medicaid staff member echoed a frequent complaint when she said, “The rules are set up to keep people off the Oregon Health Plan, not to get them on it.”

The smallest CBO participating in this project had problems dedicating staff time to OHP enrollment and outreach. The small premium amount did not cover the cost of hiring an additional staff member to do this time-consuming work. Current staff members wanted to offer OHP enrollment assistance to their clients but had very little

time to devote to it. It would be difficult to learn about the OHP rules and application procedures and stay current with them if one only did it occasionally. One Medicaid Unit worker referred to this as the “use it or lose it” rule. This CBO profited from frequent phone inquiries to Medicaid Unit staff about the details of filling out specific OHP applications. In this instance the CBO might find it easier to have a Medicaid Unit or AFS caseworker visit their agency on a regular basis to process applications. However, this runs up against the original issue of providing culturally-sensitive services to clients through CBO staff rather than through public staff. This conundrum is currently unsolved.

Issues of confidentiality became a sticking point for the project. Because of limited funds, only two or three CBO staff members were invited to attend the training. These individuals were required to sign a confidentiality form that had been developed by Multnomah County. The form was intended to protect the individual’s confidentiality and to protect the County from legal harm. One of the CBO’s uses six staff members to assist clients with OHP applications. When the untrained individuals submitted applications to the Medicaid Unit, the Medicaid Unit would not accept them because the staff person had not signed a confidentiality agreement. The CBO was then forced to restructure their internal processes, funneling all the OHP applications through one staff person. They claimed that this was a difficulty for them and cited it as the reason for their low application numbers. The CBO’s director expressed frustration with the misunderstanding about the need for training all staff members. The Medicaid Unit tried to accommodate by offering additional, brief trainings to the others staff members. The situation was not fully resolved by the time the project ended; however, it clearly represents not only a specific problem but a cultural difference between the world of non-profit CBO’s and large government agencies.

Data analysis

The four participating Community Based Organizations were all located in Multnomah County. Three were situated in Inner Southeast Portland and one was located in North Portland. The primary populations served by each CBO's were: Asian; former Soviet bloc and African refugees; African-American; and Hispanic.

A total of 51 individual people applied for Oregon Health Plan insurance through 20 applications. Only 26 of those individuals reside in Multnomah County. The following is a breakdown of pertinent data from those individuals:

County of Residence

Multnomah	26
Washington	25
Clackamas	0

Race

Asian	23
Hispanic	10
White	13
Black	5

Age

Under 36 months	9
3 - 17 years	12
18 - 59 years	20
60+ years	10

No data was provided to Healthy Communities about the primary language of applicants. Also, no data was provided about the gender of applicants.

This pilot project was ended prematurely due to outside changes beyond our control and not directly related to the design of the project. It is very difficult to extrapolate meaningful trends from such limited information. However, we draw attention to the following facts of note:

- Half of the OHP applications came from Washington County residents, in spite the recruiting agencies all being sited in Multnomah County.
- Nearly half of the applicants were Asian, which is a much higher percentage than the incidence of Asian population in this metropolitan region.
- Nearly half of the applicants were children under age 18.
- 20% of the applicants were seniors.

Recommendations

Even though many CBO's believe that they can offer the best services to their clients because of their cultural awareness and language abilities, CBO's participating in a project such as this one should be required to inform their clients that services are also available directly through public offices. In small cultural enclaves, privacy may be an issue for an individual applying for the Oregon Health Plan. A neighbor or distant family member may be the person who assists with the OHP application. While this may be a welcoming, comfortable fact for some clients, other clients may find that it deters them from seeking the assistance they need to fill out the application. The choice should be clearly offered to each CBO client, and conversely to each public client who could seek assistance from an appropriate Community Based Organization.

Keep training at one day. CBO's don't have time to devote to 3 days of training. This is a luxury enjoyed only by large organizations, such as government agencies. Use the phone assistance system, which works quite well if personal relationships have been established.

One participating CBO has suggested the creation of a website with easily accessible information on the health plans and dental plans that clients must choose. The site could be regularly updated for each OHP plan and include information on which counties are open for enrollment, where providers are located, and who is accepting new patients. This site "could also give information on bilingual or bicultural doctors or which providers have special abilities to provide quality service to people with limited English proficiency."

Although many of the CBO's -- both those contacted to participate and those actually participating in the pilot project -- recommended that it would be better to fund %FTE rather than per-application premiums, Healthy Communities recommends trying the premium approach again. The foreshortened period of time in which this pilot project was able to operate made it difficult to assess its effectiveness. It seemed clear that each CBO needed at least a month or two to get their internal systems set up for full participation in the project. Unfortunately, it was just at this point that this pilot project was forced to close down. The premium method still holds promise, it was selected by the CBO's themselves during community meetings, and it does provide financial assistance to CBO's doing OHP outreach and enrollment work in the community. It should not be abandoned as a model until further research on its effectiveness has been conducted.

Project Partners

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Lutheran Community Services Northwest

Chinese Service Center

Insights Teen Parent Program, Programa Puentes

Legacy Emanuel Project Network

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