



Healthy Communities  
of the Columbia-Willamette

**Communities in Charge:  
Overcoming Barriers to Access to the  
Oregon Health Plan and Other  
Public Health Insurance Programs**

**Part II,  
Implementing Improvement Recommendations**

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**MULTNOMAH COUNTY OREGON**

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## **Executive Summary**

In the fall of 2000, Healthy Communities produced a report for the Portland, Oregon, metro area Communities in Charge project, funded through the Robert Wood Johnson Foundation. The report, “Overcoming Barriers to Access to the Oregon Health Plan and Other Public Insurance Programs,” was based on multiple face-to-face interviews with people who conduct outreach and screening for the Oregon Health Plan and other public health insurance programs. (The full report is available on-line at [www.co.multnomah.or.us/health/cic](http://www.co.multnomah.or.us/health/cic).) The report included a list of recommendations for improvements to the Oregon Health Plan service delivery system.

As Phase II of its work on the Communities in Charge project, Healthy Communities has issued this report on possible strategies for implementing the improvement recommendations. As a neutral reporter, Healthy Communities has endeavored to provide this information in an impartial manner. This report is not intended to persuade – only to inform.

The report begins with a discussion of methodology and a section on general insights and perspectives gained during the research. In addition to individual issues and strategies, the report includes a section on general insights and perspectives gained during the research period. It then addresses each improvement recommendation individually, describing the issue, current work happening around the issue, possible future work, key people, and potential costs associated with change strategies. Finally, the report contains a list of key informant agencies, as well as a list of resource materials consulted by researchers.

As this report went to press, the 71st Legislative Assembly for the State of Oregon was still in session. On the docket were several bills which could substantially impact the structure and funding of the Oregon Health Plan. Any of these bills could potentially alter or nullify findings in this report. Policy issues would be most likely to see radical changes – the “human face” of the health care delivery system is less likely to change much in the face of need.

## **Methodology**

Healthy Communities reviewed each of the recommendations included in the original report, “Communities in Charge: Overcoming Barriers to Access to the Oregon Health Plan and Other Public Health Insurance Programs.” Several of the recommendations were broken out by the Communities in Charge project coordinator and developed into discrete research projects, which we will address in separate reports.

The remaining recommendations are addressed individually in the “Improvement Recommendations: How to Implement Changes” section of this report. Sources for information included personal interviews, telephone interviews, national literature and/or website information, and local program literature. The report attempts to protect the anonymity of individual’s providing primary source information at their request. Hence, the list of contacts (see appendix, p. 20) contains names of agencies, rather than names of individuals.

The information received from all sources was processed and categorized to build a report that addresses the question, “Who could/should take responsibility for implementing the recommendations for change found in the original report?” Healthy Communities, as a neutral convening and facilitating agency, has made every attempt in this report, as in the first, to report facts in an unbiased manner. We defer the task of advocating and promoting particular actions or strategies to the many individuals and agencies that have this directive as part of their mission.

## Realities of the Oregon Health Plan System: How They Affect Change

A basic, rarely-voiced reality operates in the background of all studies, plans, efforts, or discussions of the Oregon Health Plan (OHP): If every eligible person enrolls in OHP, the system will not be financially viable. In practice this reality turns into a “push-pull” battle for scarce resources and attention to details. There is a great deal of both talk and effort around achieving 100% OHP enrollment, with simultaneous knowledge that funds do not exist to support this vision. Outreach workers strive heroically to bring healthcare options to their clients, all the while knowing that workers are not fully supported by the system in their efforts. Mid-level program managers and bureaucrats attempt to achieve a balance between recruiting clients for OHP and avoiding over-enrollment. Propaganda continues, espousing the availability of OHP insurance coverage for every qualified individual.

Perhaps because of this “push-pull” reality, there is a strong sense of disconnectedness between many key offices and individuals involved in the OHP delivery system. Research revealed that agencies set policies without the input of those who will be required to implement them. One office answers questions differently than another office. Policy makers and bureaucrats state that front-line outreach workers don’t understand the limitations of what the State can offer and the reasons why. Outreach workers claim that the policy makers are out of touch with the realities of life for OHP clients. To quote one agency worker, “More is needed than just money to fix this system – the policy makers are disconnected from the front lines.” The feeling of working toward a mutual goal in a collaborative manner is largely missing.

Efforts to research the complex topics of Oregon Health Plan eligibility and enrollment were made more difficult by the obtuseness of the State system for planning and implementing the OHP. Many individuals interviewed for this report were confused by the myriad agencies, departments, and offices involved (such as Office of Medical Assistance Programs (OMAP), OHP Central, Adult and Family Services (AFS), Oregon Health Plan Policy and Research Office (OHPPR), etc) and the roles that they play. *It is difficult for an individual or an agency to know how to enter this complex system to seek answers to questions, make suggestions for change, ask for assistance, or otherwise interact. This seems like a critical stumbling block to achieving a collaborative process between government and community.*

A financial asset test is currently required for an adult to qualify for Oregon Health Plan coverage. It takes a great deal of effort by potential OHP clients to gather the documentation to meet the asset test. Outreach workers say it takes a great deal of time (and therefore money) for outreach workers and screeners to ensure that potential OHP clients bring proper documentation to them for inclusion with their OHP applications. The State invests considerable resources in verifying assets and investigating suspicious applications. The Kaiser Commission on Medicaid and the Uninsured released a report in April 2001 entitled “Eliminating the Medicaid Asset Test for Families: A Review of State Experiences.” (The report is available on-line at [www.kff.org](http://www.kff.org).) Healthy

Communities recommends that the State carefully review the costs and benefits of continuing to employ a financial asset test.

There is nothing static about the Oregon Health Plan system. During the course of this research, it became clear that everyone from the Governor to front-line outreach workers is talking about ways to fine-tune it. Advocacy groups and legislators alike are seeking change to the plan. Most changes require Federal approval. Meanwhile, communities continue to change and grow, and resource levels fluctuate with grant cycles, hot political topics, and elections. Up-to-date information about changes to the OHP system is highly elusive.

## **Improvement Recommendations: How to Implement Changes<sup>1</sup>**

### *1. Always include contact information for a local agency that can assist with applying for the Oregon Health Plan*

Healthy Communities convened a meeting of the Washington, Clackamas, and Multnomah County Health Department Medicaid outreach supervisors, the coordinator of the Oregon Covering Kids grant (a Robert Wood Johnson Foundation access project), and the executive director of the Oregon Health Action Campaign (OHAC). While this group totally agreed with the concept of including local contact agency information with each OHP application mailed out by the Office of Medical Assistance Programs (OMAP), it expressed several concerns about implementation of the idea.

- a. All of the county health department representatives reported having insufficient staff or funds to handle the anticipated increase in requests for assistance that a local contact number would likely generate.
- b. All expressed reservations about the politics of the proposal. They mentioned the “push-pull” reality (push for full OHP enrollment, pull of inadequate funding for full OHP enrollment). They anticipated “foot-dragging” or outright opposition on the part of OMAP and other State agencies.
- c. The group noted that the type of advertising associated with outreach efforts impacts the level of response. A controlled outreach effort might produce a more easily handled number of responses than a full-scale, community-wide advertising campaign.
- d. The group suggested several strategies, including 1) involving County Boards of Commissioners more closely in the effort to gain additional funding from the State for OHP outreach and 2) approaching private organizations (Oregon Association of Hospitals and Health Systems and CareOregon were mentioned) to provide funding for outreach.

OHAC has launched a pilot project in Marion and Polk counties. The project involves inserting a local contact number in all OHP applications mailed out by OMAP during the period from 6/1/01 through 8/31/01. The project should provide important information for the tri-county area on the feasibility and costs of inserting local contact numbers. The costs for the pilot project are being covered by funds from the Covering Kids grant. OHAC, with the assistance of OMAP staff, has trained volunteers to handle the anticipated increase in calls for assistance. They are providing telephone assistance a few hours each evening. At other times volunteers are available by appointment in person or they will assist small groups.

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<sup>1</sup> The order of these comments follows the order of recommendations in the original report (“Communities in Charge: Overcoming Barriers to Access to the Oregon Health Plan and Other Public Health Insurance Programs,” prepared by Healthy Communities in November 2000. See pp. 15 and 16.

Conversations with OMAP staff revealed a variety of opinions and attitudes about the feasibility of inserting local contact numbers. The remarks ranged from “OHAC’s pilot project will be just that -- it will go away after three months,” to “This is very simply accommodated – it just involves inserting one more piece of paper into a packet that is already coded for a specific county.”

Department of Corrections staff rate the absolute cost of adding a local contact number to the application packet as minimal. Oregon State Correctional Institute inmates process the actual stuffing of envelopes in response to requests for OHP applications. OSCI’s inmate labor program charges OMAP clustered rates for inserts, with 5-7 inserts being at one rate and the rate increasing as the number of inserts jumps to the next higher cluster. The increases are very nominal – possibly as low as one cent per page. Increases in costs to OMAP for this process would likely be offset by a decrease in calls to the OHP Central information line or in other State-level requests for information as clients instead call on their local contact agency.

## 2. Encourage client “self-empowerment.”

OMAP staff pointed out that it is ultimately the client who owns his/her OHP application, regardless of how much assistance he/she receives in completing it. The client must sign the form and accept responsibility for the information contained in it. Therefore, it is in the client’s best interests to fill out the form him/her self whenever possible.

Other methods for encouraging client self-empowerment in the OHP process could include simplifying the application so less assistance is needed, making applications available at many locations throughout the community, and making the application available on-line. No one method may suit everyone. As mentioned in Healthy Communities’ original report, there is considerable difference of opinion about how face-to-face assistance impacts client self-esteem (or the “stigma” attached to receiving public assistance). The Kaiser Institute on Medicaid has also suggested that eliminating the asset test would make OHP seem less like welfare, therefore increasing clients’ willingness to apply.

Multnomah County has taken a step toward electronic outreach and eligibility screening for OHP and other services for low-income people through its “Eligibility Estimator” program. Available at computer stations throughout the county, this program allows an individual to put personal information about income, family size, and expenses into a simple, user-friendly program which then reports back on *potential* eligibility for assistance programs, including OHP. A task force on hunger relief is striving to make this program available on-line and statewide by the end of 2001. The task force is comprised of representatives from Multnomah County’s Budget and Quality Office, Oregon Food Bank, state agencies, Community Action Directors of Oregon, and others.

The Internet is already used as a tool for accessing health insurance in some states, including California. Health-e-App is one of the efforts California uses to streamline

eligibility into the state's Medi-Cal (Medicaid) and Healthy Families (Children's Health Insurance Program) programs. More information on this effort is available from the Reuters Health at [www.reutershealth.com](http://www.reutershealth.com).

HIV/AIDS outreach workers have accomplished health improvement goals through efforts that include client self-empowerment and intra-community support. Information about this illness is readily available to the entire community through print materials, web sites, informational meetings, and many other avenues. People in need of support or assistance can access a compassionate network of other people who have experienced HIV/AIDS in some way and are prepared to help. This type of approach is currently being advocated and practiced by the Oregon Health Action Campaign.

### 3. *Specific client populations*

a. Non-English-speaking (Limited English Proficiency): Healthy Communities is currently convening agencies that work with LEP and minority populations to discuss issues specific to these community based organizations. How best to fund their outreach work (from the community based organizations' points of view) is the expected outcome of these meetings. A separate report will address these issues.

b. Native Americans: Included in (a.) above.

c. Pregnant Women: Dr. Tina Castaneres, medical director of La Clinica del Cariño Family Health Care Center, is quoted as follows in Oregon Health Forum (*Volume 11, No. 4, April 2001*), "One sick baby costs a lot of money. Prevention costs pennies. It is cost-effective to provide prenatal care to their mothers to keep these children out of neonatal intensive care." OHP policy makers will decide whether to continue funding special outreach and services to pregnant women. Also see item #7 below (community outreach workers), which relates to specific methods for recruiting pregnant women into the Oregon Health Plan and methods for funding that work.

d. Developmentally disabled: Responsibility for ensuring that the OHP system appropriately serves developmentally disabled clients lies with government agencies (OMAP, Aging and Disability Services offices). Community based organizations serving developmentally disabled individuals are currently acting as both OHP outreach workers and advocates for their clients. Reorganization of the State Department of Human Resources (DHR) and the development of Lifespan Respite Programs (see information at [www.cpt.hr.state.or.us/respite](http://www.cpt.hr.state.or.us/respite)) in all three of the Portland-area counties should improve OHP information availability and advocacy for the developmentally disabled population.

e. Ages 60-64: This age cohort continues to have OHP information and assistance services available through Aging and Disability Services offices. As the State Legislature strives to achieve a balanced budget for the next biennium, cuts are being

proposed for many programs. Services to seniors may be substantially decreased. If that happens, funding for this category of people to receive services could disappear or be severely limited. They could easily begin to “fall through the cracks” if their access to services through ADS disappears. To maintain current levels of service, outreach to this group would need to be picked up by other non-governmental agencies. This would require additional resources for those organizations.

f. Youth (from birth to pre-teen): (See # 5 below for teens/adolescents)

The Robert Wood Johnson Foundation Covering Kids grant, a source of funds specifically for outreach to children and their families, is scheduled for extension through 2004. The Oregon Health Division currently holds Oregon’s Covering Kids grant. As of this report’s date, OHD does not intend to reapply for the grant. Other organizations may decide to submit an application and take over the Children’s Health Insurance Program (CHIP) outreach work projects currently funded through this grant. In the Portland metro area, that involves outreach to homeless youth through Outside In. The availability of Covering Kids dollars and how those dollars are strategically targeted could have a substantial impact on OHP/CHIP outreach services in the Portland metropolitan area.

The impact of the “push-pull” reality affects coordination of the Covering Kids grant. While no one would deny that all children should have access to health care, there is substantial political maneuvering around the State’s use of CHIP funds and the ability of the State to cover all qualified children with medical insurance. Distrust of State-level policy makers exists among many agencies because of historical use of CHIP funds.

A pilot project is currently underway between Multnomah County Health Department and Multnomah Education Service District. This project’s goal is to train school health nurses in a basic understanding of OHP/CHIP and to provide them with a simple referral system for helping children to become enrolled. This project, which has a strong evaluation component, should reveal interesting and applicable information on the effectiveness of providing OHP/CHIP outreach through schools.

Healthy Communities will be researching the applicability of this pilot project to the other two metropolitan-area counties – Clackamas and Washington. The Education Service Districts in these counties do not provide school nursing services, so changes to the methodology would almost certainly be necessary. A separate report will be submitted to the Communities in Charge Coordinator on this research.

g. Work Release/Incarcerated Population: The issue of access to health insurance and healthcare for individuals being released from prison/jail is one of serious concern, with broad-reaching ramifications. Currently these individuals must wait until they are released from custody to be able to apply for OHP coverage. Applications received at OHP Central prior to release from custody are categorically denied. The obvious result of this policy is a lag between the time the individual receives health care through the jail system and the time OHP coverage begins. While this is of concern for all individuals, the greatest concern is for inmates who have mental health diagnoses, alcohol and drug

diagnoses, or a combination (dual-diagnosed). Without continuous access to prescription medication, these individuals are at high risk for medical relapse and new legal offenses.

The percentage of incarcerated individuals who have mental health/A&D/dual diagnoses is increasing to the point where one OSCI supervisor referred to jails as “the mental hospitals of the new century.” Police officers are called upon to intervene in situations with mentally ill individuals which once would have been handled by trained mental health professionals. The results often end up as newspaper headlines.

Two projects are currently underway at the Columbia River Correctional Institute (CRCI) in the Portland metro area to address this “revolving door” problem. The first is a collaborative effort between OMAP/OHP and CRCI. In a one-year project which began 1/1/01, over 250 inmates in one section of CRCI are being offered an enhanced OHP application process as they approach their date for re-entry into the community. They are receiving OHP applications prior to their release date. Applications are being accompanied by a letter from CRCI staff, stating that this person is part of the pilot project. OHP Central is then processing the application, rather than categorically denying it. The aim is to get the OHP card into the person’s hands as soon as possible after release (inmates currently receive a 14-day supply of prescription medication upon release from custody). The card is mailed either to the inmate’s home address or, if none exists, to the parole office.

According to CRCI staff, barriers to the initiation and smooth progress of this project have included: bureaucratic red tape, confidentiality issues, and glitches within the parole system (the main point of contact for the released prisoner).

CRCI staff is tracking rates of recidivism within the pilot project population. OMAP and OHP staff is tracking costs related to medical service usage. The potential cost savings to law enforcement, courts, and other parts of the system are not being tracked. No special funding is being used to support this project. A report on the project will be available after 12/30/01, when the final data are compiled.

Also at Columbia River Correctional Institute is a project to provide “re-entry” information to selected inmates (those with a mental health diagnosis) in the general prisoner population. This consists of six weekly lectures on topics of high usefulness to someone being released from incarceration, including a presentation on the Oregon Health Plan and how to enroll. Medicaid outreach specialists from Multnomah County Health Department are currently making these presentations.

This project began in May 2001. No special funding is being used for it. No special permission was required to start the program – it grew out of discussions between front-line CRCI and Adult Community Justice staff members. The program will be evaluated through tracking of recidivism rates and number of contacts between the inmate and the assigned parole officer after release.

Both of these projects begin to address the issues of inmate release and require little special or additional funding. They are examples of front-line worker ideas implemented with little need for policy change. In light of repeated comments that Healthy Communities heard from many individuals about the disconnect between policy makers and front-line workers, these projects represent a fresh model for OHP system development.

g. College students: When the Oregon Health Plan was established, college students were not eligible to apply for coverage. The assumption was that college students were eligible for health insurance coverage through their parents' policies. One person involved in the original decision to exclude college students said, "College students' eligibility for OHP was more of a budget process, less of a people process." A Medicaid Policy Analyst could not say if any assessment had ever been conducted regarding college students' insurance needs.

On 1/1/98 college students became eligible for OHP with the following limitations:

- They must meet the income requirements for a PELL grant (though they don't need to be receiving one)
- They must have no other health insurance coverage
- They must not have been covered under other health insurance for the past six months (This is similar to the language for the CHIP program)
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These requirements are still in place for college students. Some colleges require students to buy school-offered health insurance.

According to a Medicaid Policy Analyst, only a few college students apply for OHP coverage. When they do, their applications are screened according to eligibility requirements, and also examined closely to determine the type of school insurance coverage and healthcare access the student already has (e.g., through a school clinic). As of spring, 2001, 1700 students meet the PELL guidelines and are on OHP.

At Portland State University, students who take 4-8 credit hours per term have the option of purchasing the school's basic health insurance plan. All students who take 9 or more credit hours per term ("full time students") must enroll in the basic insurance plan. If PSU students mark on the OHP enrollment form that they have insurance, they are automatically denied OHP. The PSU basic plan does not offer major medical coverage, but OHP does. This certainly seems to set up a double standard of health care coverage for students as compared to non-students. This issue needs to be examined fully by OMAP, preferably in conjunction with college and student representatives.

PSU's Director of Clinic Services believes it would be helpful to have a contact person in the OHP office, so OHP could know what the PSU plan offers and vice versa. Until the issues related to student OHP qualification equity can be addressed, OMAP could designate an individual to be the knowledgeable contact with college campuses. It

appears that OMAP is satisfied with the level of communication with colleges, while the colleges find communication inadequate.

Healthy Communities has made repeated attempts to compare PELL grant income guidelines with OHP income guidelines to determine their equality. The PELL grant income guidelines are based on a complex formula of at least five factors. Financial aid specialists report that it is like trying to compare apples and oranges; however, their informed undocumented opinion is that students who are in need of health insurance are being denied OHP because they do not meet the PELL grant income guidelines. They call the PELL guidelines “complex and imperfect” and do not think they should be used as the basis for public health policy.

The proposed two-tiered OHP system that the legislature is currently considering (House Bill 2519) would apparently change the PELL income guidelines relative to regular OHP income eligibility guidelines. The impact of this proposed program change should be examined for its impact on student eligibility.

A key OMAP staff member mentioned the idea of using an annualized income formula for college students (and also for seasonal workers). This could prevent some of the sporadic OHP eligibility situations in which seasonal workers find themselves. No other OMAP staff or college personnel were familiar with discussions around this idea, when asked. It was pointed out that the Federal Health Care Financing Administration (HCFA) would need to approve any such change to eligibility requirements, as would the State legislature. As of this report date, no such change has been proposed.

#### *4. Maintain special policies for pregnant women and domestic violence victims.*

Policies regarding coverage for pregnant women are discussed in Item 3c (above). No information was available from key legislators’ offices or domestic violence policy staff regarding potential changes to services during this legislative session.

#### *5. Health care access to adolescents*

A highly successful model for health care outreach to adolescents is the School Based Health Clinics (SBHC). A report issued in 2001 (“Oregon School Based Health Centers 2001 Report – available in the Appendix section) shows a high level of success with teens through these clinics (95% of teens reported a high rate of satisfaction). Since adolescents are reported to use traditional medical services at lower rates than any other age group, this is a remarkable statistic. SBHC’s allow a trusting relationship to be built between patient and health care provider, which has been shown to be essential to drawing adolescents into the health care delivery system. Significantly, mental health services are also provided through SBHC’s. These services are often identified as critical to healthy teen development and frequently not readily accessible in the general community.

Since 33% of SBHC clients reported having no insurance, this is an excellent venue for providing both medical services and outreach about OHP/CHIP.

The limitations of SBHC's include their confinement to specific geographic areas. Teens do not readily visit another school campus for services. Homeless youth or others not attending schools also do not have regular access to services at a SBHC. Reports show that dental and vision care are rarely available through SBHC's.

According to the Oregon SBHC 2001 Report,

*a total of twenty Oregon SBHC's received some form of state support. Thirteen SBHC's received state general funds from the Oregon Health Division. Four others received final payments from the Oregon Making the Grade Partnership for School-Based Health Centers grant distributed through the Oregon Department of Human Resources from the Robert Wood Johnson Foundation.*<sup>2</sup>

The State Legislature has been supportive of funding for SBHC's, as the RWJ Foundation money has expired. The State Legislature will decide whether to continue that financial support into the future.

Another venue for OHP outreach and healthcare services to adolescents is the network of agencies serving homeless youth in downtown Portland. Outside In, one of the partnering agencies is an outreach site for the Covering Kids project. While the Oregon Health Division is currently the Oregon Covering Kids grant recipient, it may not reapply for that role in the upcoming grant cycle. Outside In's funding from this source could be in jeopardy, depending on the outcome of a change in grant administration.

Planned Parenthood is also a frequent point of contact for adolescents. They seek reproductive health information and services from this agency, which has a reputation for providing a high level of confidentiality for its clients.

*6. Improve communication between local Adult and Family Services and County Health Department offices.*

Clients using Adult and Family Services offices often rank customer service as very low quality. This rating cuts across cultural and language boundaries. Staff from community based organizations and other agencies also regularly report rude or uncaring treatment from some AFS workers and have gone so far as to suggest mandatory "sensitivity training" for AFS staff. The restructuring of the State Department of Human Services may make a positive difference in customer service quality, including its relationships with County Health Departments.

Adult and Family Services also has implemented a new plan of special districts for Oregon Health Plan administration. (See map in Appendix section.) Key people will specialize in geographic regions of the state, with the goal of ensuring more local sensitivity and increased continuity of service to county health departments and

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<sup>2</sup> There are 13 School Based Health Centers in Multnomah County, one each in Clackamas and Washington counties.

community based organizations. This new system directly responds to negative feedback from statewide organizations and agencies about AFS ability to understand local needs.

Information gathered for this report indicates that AFS offices regularly refer their clients to county health departments for assistance in filling out OHP applications. This creates additional work for the health department staff. OMAP has a policy which requires any site with an OHP date stamp to offer application assistance to its clients. Enforcement of this policy is not uniform.

Because AFS offices and county health departments often see the same clients, more conversations and cross-trainings between the two agencies could be useful. The financial impact would be little. Generally speaking, when staff members of different organizations know each other personally, business interactions improve. Creating these “opportunities” may need to be mandated at the administrative level rather than assuming that managers will make them happen.

#### *7. Create community outreach (health) worker model.*

The community-based health outreach worker model is gaining in popularity and is becoming more broadly accepted as a successful means of conducting health outreach to specific communities. (See bibliographic reference sheet in Appendix section.) The Multnomah County Health Department has developed a strong program using community health workers and is a good source of information for other counties or agencies interested in this model. Another local example of this type of project can be found at El Programa Hispano (part of Catholic Charities), where nearly 50 Hispanic community members have begun a multi-phase process for becoming health outreach workers and educators.

One indication of the acceptance being accorded to community outreach health workers is a current proposal to regulate and standardize their work. Senate Bill 791 (which as of this report date is still pending) would establish a community health worker board within the Health Licensing Office to adopt standards for subgroups (e.g., diabetes educators, asthma educators). Such regulation could lend credibility to community health workers’ efforts; however, it could also discourage the participation of the very community-based citizens who currently lend strength to the movement.

The Americorp program offers community based organizations one avenue for obtaining and funding community health workers. Each Americorp member is assigned to a community placement (often with one agency, though his/her time could be split between two or more agencies with similar missions). The agency must provide \$5000 annually to support the Americorp member, with the remainder of the cost being picked up by the Federal government. The \$5000 match money could be shared between organizations, thus minimizing the cost to any one CBO. The funds could come from many sources, including grants. One person suggested that OMAP could fund some of these match dollars. CBOs could recruit in their own communities for culturally-competent applicants to fill the Americorp position.

*8. Maintain retroactive emergency coverage.*

This relates to the concept of date-stamping each application, as there can be no “retroactive” date without an origination date on the application. The concept of date-stamping applications is a source of conflict for those working with the OHP system. Generally speaking, most bureaucrats within the State system see a need for maintaining the date-stamp system to maintain control over the applications, while most client advocates wish to open up the application system and eliminate the date stamp altogether. Some advocates suggest that OHP applications should be as readily available as voter registration forms.

Any change to the current system of application distribution and date-stamping would need to be approved by the State Legislature. If the applications become freely available, it is possible that more qualified people would apply. This could impact on the financial resources available to support the Oregon Health Plan

*9. Make OHP materials more readily available, especially to non-profits – and --*

*10. Ensure that non-profits are aware of OHP trainings and updates.*

Oregon Health Plan trainings and materials both fall under the purview of OMAP. Currently OMAP ships outreach materials only to agencies with date stamps on an automatic basis. Agencies without date stamps can request up to 300 OHP brochures at one time from OMAP. Some agencies do this on at least a weekly basis to ensure that they have sufficient information available to share with their clients.

OMAP does not maintain a list of agencies without date stamps that wish to receive printed materials on a regular schedule. It should be fairly easy and relatively inexpensive to set up a shipping list to provide scheduled distribution across the state for new materials, special materials (posters), and language-specific materials. The costs would include a little staff time to maintain the list and ship the materials, actual packaging and shipping costs, and printing costs. OMAP staff argued strongly against their ability to provide this service. Again, this issue touches on the tension between widely advertising the availability of OHP and dealing with the applications that are received through that advertising, both in terms of processing and funding.

*11. Materials and trainings should encourage people to apply for OHP more than once.*

OMAP’s printed OHP outreach brochures (see sample in Appendix) and its current website on “Do you qualify for the Oregon Health Plan?” ([www.ohppr.state.or.us](http://www.ohppr.state.or.us)) do not have statements encouraging people to reapply – or even to submit an application the first time. Instead they give much information encouraging people to assess their own qualifying status. In comparison, OMAP’s training curriculum actively discourages outreach workers/screeners from making an eligibility “guess” on their own. They are instead encouraged to send in the completed application to OHP Central so specialists can make that determination. This seems like a conflict in policy, with individuals being

encouraged to assess their own eligibility but trained outreach workers being discouraged from doing so.

*12. Improve telephone access to the toll-free OHP information number.*

OMAP tracks calls to its various OHP phone lines closely. Reports show that the application line had no more than a 30-60 second response time on the majority of calls received recently. Only 3-4% of people hung up before their call was answered. This line is answered by Oregon Correctional Institute inmates, who are trained to take requests for applications accurately and also to answer a few basic questions about applying for OHP. Supervisory staff for the inmates states that there is adequate staff coverage for the application line.

Other OHP telephone lines (including the number people call to find out the status of their submitted application and the number people call for assistance in filling out the application) are more likely to experience backups and delays. Staffing limitations are considered to be the main issue in providing prompt telephone service. Any future project which would encourage clients to call a local number for application assistance is likely to decrease the demand for telephone assistance through the OHP Central office. This decrease could result in a financial savings that could be transferred to local assistance programs to support their outreach work. Data from the Oregon Health Action Campaign's pilot project in Marion and Polk counties may shed light on the realignment of services and their relative funding needs.

*13. Use Consumer Credit Counseling Services as a referral source.*

Consumer Credit Counseling is a non-profit agency that assists individuals with serious financial debt problems. Medical bills are listed as the second most common reason for financial crisis (after credit card debt). Staff members at CCC were unable to say if the category of credit card debt included medical bills as well.

Most customers of this agency do not know about hospital charity care policies. In fact, CCC staff members are largely unaware of these policies. Healthy Communities has linked Consumer Credit Counseling to Multnomah County Health Department's Medicaid Office Supervisor to learn more about the recent changes to hospital outreach around charity care policies.

Consumer Credit Counseling does not keep specific data related to its clients' medical bills and debt (e.g. medical institution, type of medical bills, family status of patient, etc.). Communities in Charge may want to develop a joint project with CCC to track these kinds of data on their clients and medical bills. Oregon Health Action Campaign has information about the impact of medical bills on individuals' and families' financial stability.

A local model exists for linking financial literacy training with public support dollars. The City of Portland and the Northeast Workforce Center are using Consumer Credit

Counseling to provide financial literacy training to people receiving relocation funds because of the new I-5 MAX line construction. CCC charges \$50 per client for this training. The goal is to ensure that public funds invested in the community are used for sustainable change. Funding for this project comes from the City of Portland's Bureau of Housing and Community Development.

Most of Consumer Credit Counseling's clients are above poverty level (their annual income is approximately \$25,000 to \$30,000, but reliable statistics are unavailable). This category of "working poor" likely includes the same group of people who do not qualify for most public assistance programs or for the Oregon Health Plan. One CCC staff member stated that "folks at poverty level must do an even better job of managing their assets than folks with more resources." He believes that offering financial literacy training to low-income individuals is not a case of "blaming the victim," but rather assisting him/her to make the best financial choices possible.

## Sources

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Consumer Credit Counseling  
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Human Solutions, Inc.  
Multnomah County Department of Community and Family Services  
Multnomah County Health Department  
Multnomah County Health Department, Communities in Charge Project Coordinator  
Northeast Workforce Center  
Oregon Health Action Campaign (OHAC)  
OHAC Equal Access Campaign  
Oregon Health Division, Covering Kids Project  
Oregon Health Division, School Based Health Clinics Program  
Oregon State Department of Corrections, Columbia River Correctional Institute  
Portland State University, Financial Aid Office  
Portland State University, Student Health Services Office  
State of Oregon, Adult and Family Services Central Office  
State of Oregon, Office of Medical Assistance Programs  
Washington County Department of Health and Human Services

## Appendices

Adult and Family Services OHP District/County breakout map

Evaluation of Community Health Worker Programs: A Brief Bibliography

Oregon Health Plan outreach brochure (revised 7/98)

Oregon Health Plan outreach brochure (revised 4/01)

Oregon Health Plan Policy and Research Office web page printout

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Oregon Department of Human Services, Oregon Health Division's *Oregon School Based Health Centers 2001 Report*