



Healthy Communities  
Oregon Health Systems in Collaboration

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

by  
Barbara Ballou  
Robert Gassner

Submitted to  
Communities in Charge Project  
Multnomah County Health Department

November 2000



**MULTNOMAH COUNTY OREGON**

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## Scope of the Report

Healthy Communities, a component of Oregon Health Systems in Collaboration (OHSIC), under contract with Multnomah County Health Department, researched information on efforts throughout Multnomah, Clackamas, and Washington counties to recruit and retain eligible individuals for the Oregon Health Plan (OHP), Children's Health Insurance Program (CHIP), and the Family Health Insurance Assistance Program (FHIAP). Through a series of interviews with agency providers, we gathered information on how access to OHP/ CHIP/ FHIAP is provided, efforts that are being made to keep enrolled individuals on these public assistance health insurance programs, and perceived obstacles that exist in the system.

## Methodology

We invited a diverse range of agencies to participate on an advisory group at the start up of our work. (See Appendix D for a list of advisory group members.) The advisory group was asked to describe the strengths and weaknesses they perceived in the system of access to OHP. Healthy Communities used these comments to build the questionnaire, which was administered to provider agencies.

It was necessary to develop strict definitions of terminology we would be using, to ensure that the answers we received from provider agencies were consistent. We asked several community workers for assistance with this process. The following definitions were agreed upon for use in this project: *Screening*, the process of assisting a potential OHP client with filling out the OHP application (and others) and processing that application for eligibility; *Prescreening*, asking basic income and eligibility questions of a potential OHP client to determine if he/she should be referred for an appointment with a screener; and *Information and Referral*, dispensing basic OHP information verbally or through written means, such as flyers, newsletters, and/or brochures.

The questionnaire was tested for clarity and comprehensiveness on a small group of agency providers, with a few minor changes being made. We were then ready to launch the interview process. We selected agencies to participate in the interview process through several paths: their inclusion on the official list of agencies in possession of an OHP date stamp; recommendations of other screening agencies; geographic location; type of clients served. Appointments with specific individuals were pre-arranged by telephone.

While some administrative information was occasionally obtained from the provider agency administrator, every effort was made to conduct the face-to-face questionnaire work with the agency person most directly involved with client screening or pre-screening. These interviews lasted on average one hour, depending on how engaged the interviewee became in the process. (Most of the interviewees had plenty to say and wanted to spend additional time making their points on a topic that was clearly of high importance to them.) In addition to the 19 face-to-face interviews with agency providers, some information was obtained via telephone. There were unsuccessful attempts to engage some provider agencies in this interview process. The information obtained was then compiled for this report.

Healthy Communities' contract with Multnomah County Health Department also included a "best practices" literature search. More than 40 books, journals, and websites were reviewed for information on how other cities, counties, and states are implementing Medicaid-based health insurance programs -- specifically efforts to provide easy access to the programs to all eligible persons and efforts to maintain clients on the programs. The results of the literature search are reported in a special section of the report; however, some recommendations from the search are also sprinkled throughout the report at the appropriate point of conversation.

Note that it was not possible to separate discussions about access to, enrollment in, and usage of the Oregon Health Plan (OHP) from similar information about the Children's Health Insurance Program (CHIP) and the Family Health Insurance Assistance Program (FHIAP). References to OHP throughout this report are meant to include CHIP and FHIAP unless specifically noted otherwise.

## General or Recurrent Themes

Several over-arching themes emerged from the interviews with provider agency staff members. Nearly every provider voiced these same concerns about the current access system for the Oregon Health Plan. Healthy Communities recommends that each of these issues be given thorough attention in any effort to improve health care access for low-income and special populations.

***The eligibility income cutoff for the Oregon Health Plan is too low.*** Every agency reported with frustration that they must inform the working poor of their ineligibility to qualify for OHP. These are people who work at low- to medium-wage jobs where either health insurance is not offered or it is too expensive to afford on their income. The children in these families sometimes qualify for OHP/CHIP, but the parents often do not. The parents either went without medical and dental care, or used a system of emergency or free services ranging from the safety net clinics to “secret” sympathetic provider care systems, or sought advice and/or assistance from family, friends, or neighbors. According to Nancy Vuckovic (39),

*While [the uninsured’s] self-reliant attempts to “do what you can do” in response to illness are laudable, we cannot ignore the health hazards that accompany lack of access to resources or appropriate information. Risks associated with drug interactions, side-effects, treating conditions in insufficient ways, and lack of monitoring of medication use can have a detrimental effect on personal health. These behaviors may also have wider-ranging effects on public health in the form of drug-resistance and masked but uncured contagious diseases. These risks are typically absent from discussions about the personal and health system costs resulting from lack of health insurance.*

***Non-profit agencies are devoting hours of employee time, administrative support time, printing costs, postage costs, and other resources to recruiting and retaining OHP clients, but they rarely receive any monetary reimbursement or support from the State (Office of Medical Assistance Programs) for this work.*** (Refer to the section on page 20 that discusses provider agency funding sources.) Nearly all of the interviewed agencies reported a need for more staff to work directly on OHP enrollment and retention. This is true of government agencies as well as non-profits. It was generally agreed that more staff would allow for more individual attention to clients, which (as discussed later in this section) was generally considered the key to getting the last percentage of eligible people enrolled in OHP. The non-profits we interviewed said they simply do not have the financial resources to provide sufficient staffing that would permit this intense level of service. Consequently, eligible clients fall through the cracks of the system. Some clients do not even understand the concept of health insurance, and many clients do not understand income restrictions, residency requirements, the need to choose a provider who accepts the OHP plan, monthly payment schedules, the reapplication process, and other program details. Without direct assistance, it is very easy for the client to lose health insurance coverage. As one caseworker said, “We don’t track whether people re-enroll in OHP, so we don’t know that they don’t have it anymore until there’s a medical emergency. It’s an after-the-fact situation.”

A sub-theme in this category is that the lack of “official status” with OMAP (the Office of Medical Assistance Programs) restricts some agencies’ access to resources. This is especially

true of non-profits that work with non-English-speaking clients. The agency may provide direct OHP enrollment services to a large number of clients, but it is not allowed to have a date stamp, does not receive regular visitation from a knowledgeable AFS worker, is not informed of changes to the health plan directly and does not learn about OHP trainings. Another issue is not being recognized as a medical provider if an agency does basic health screenings (such as the PSU Student Health Services site.) This requires a patient to start at the beginning with an accepted Primary Care Provider, including repeating tests and exams that are both costly and time consuming.

***Sites without OHP date stamps can lose clients.*** The official “date stamp” which launches an OHP application on its journey to eligibility processing is valued like gold by agencies that have one. As one agency worker said, “Having a date stamp is wonderful help! It eliminates the time delay in getting an application, and it minimizes the chance that the client won’t come back for help in filling it out.” Other agencies long to get hold of a stamp, recognizing that it would smooth the application process tremendously for their clients. Interviewees stated that the best recipe for successful enrollment of clients into OHP is to fill out the forms while the client is in the office with the staff person. Any delays or additional steps required by the system increases dramatically the likelihood that the client will not complete the process.

***Poor self-management skills frequently lead to clients not completing the OHP access/enrollment process.*** A constant underlying tension that emerges from interviews with provider agencies is the tough decision on how much to “babysit” people and how much to require them to take responsibility for their own lives. There is recognition that poor self-management skills are sometimes the reason why OHP-eligible clients do not complete the application process, use the services appropriately, or re-enroll at the appropriate time. Each agency seems to adopt its own unwritten policy about how to handle these situations. A few agency staff members straight out commented, “It’s not our job to babysit adults.” Others stated a belief that it is more important to get people enrolled in health insurance than to quibble over levels of personal responsibility.

***Face-to-face, person-to-person contact works best in ensuring OHP enrollment and usage by clients.*** Every person interviewed for this study agreed that personal contact between provider agency staff and the client ensured the best results for enrollment, utilization, and retention in the Oregon Health Plan. Agency staff cited increased willingness on the part of clients to complete and return the enrollment form, increased likelihood of reporting changes of address and other important information, better understanding of how to use their insurance coverage, and increased likelihood of re-applying in a timely manner. The use of the OHP toll-free number was viewed as a necessary evil, with clients receiving only the most basic of information and services through that route. Access to that number was frequently difficult (the number was often busy), and many clients were not able or willing to make repeated calls to ask for information. Many of these people who constitute the last remaining percentage of eligible but unenrolled OHP clients have multiple pressing issues in their lives, such as violence, homelessness, mental illness, and others, which push health insurance enrollment lower on their list of priorities. Personal assistance from provider agency staff often helps these individuals and families to obtain and use medical insurance.

***Many agencies reported that the application was too complex and difficult for clients to understand.*** Despite repeated efforts to simplify the application forms for public insurance plans, many agencies report that their clients find them confusing and difficult to fill out. This is an issue that is being dealt with in nearly every jurisdiction across the country. Meyer and Silow-Carroll (23) in their overview of health care access, offer several suggestions for increasing Medicaid enrollment, including “Simplifying the application process.” The George Washington University Medical Center report on Medicaid enrollment and welfare stigma (12) identified six problems as significantly likely to affect decisions about enrolling, including “a long and complicated application form.” The Kaiser Commission on Medicaid and the Uninsured (30) cited “continuing key application and enrollment simplification efforts” as one of the best policy strategies for increasing Medicaid enrollment. Locally, one clinic administrator/provider put it succinctly when she said, “Patients don’t understand the application process or the system, and it’s *not* a language issue.”

***The requirement to provide 3 months of income proof is an obstacle for a high percentage of clients.*** For many OHP-eligible people, recordkeeping is not a learned skill or a priority. Also, many people work for cash and do not have ready access to proof of income. Employers who pay cash for services often are unwilling to provide such evidence, even when asked. It can also be a time-consuming, complicated task for an employee or former employee to seek such information, especially if they do not have ready access to a telephone or transportation to visit the former employer. One agency described in detail the problems with *which* three months of income the client must report. This particular client was denied OHP coverage because there were 3 pay periods in June and the holiday pay in July put her a few dollars above the eligibility cut-off. The client had to wait until later in the year to find a 3-month period of income that was more average.

***Information flow from OMAP and the AFS eligibility office to non-profit agencies engaged in pre-screening for OHP is insufficient.*** While government agencies and non-profits that have the date stamp report receiving good training and regular updates on changes to the public insurance programs, non-profits involved in pre-screening activities report a need for more training and more information. These are often the agencies that have first contact with eligible persons who come to them for other types of services (domestic violence relief, language-specific services, housing, etc.) If the workers at these agencies are unfamiliar with OHP eligibility requirements and the other types of medical insurance plans available to their clients, they are more likely to not make a referral to a screening agency -- or worse, to tell the client that they are not eligible. Once a client has heard that they are ineligible for OHP, they tend to hold that belief for a length of time and do not question their eligibility status. They may go for months without health insurance coverage, until they have another encounter with “the system” and perhaps receive accurate information which allows them to sign up for OHP.

***Access to a fully informed AFS worker or other eligibility specialist is highly useful to non-profit agencies that pre-screen clients.*** Since most pre-screening agencies do not have full information about OHP and other public health insurance programs, an alternative that works well is reported to be regular and quick access to a fully-trained eligibility worker. This can be in the form of a caseworker who spends regular hours each week at the pre-screening agency, a roving AFS worker who is on-site intermittently, or a designated OHP specialist

who is readily accessible by phone to the agency's staff and *who has developed a personal relationship with that staff*. This level of service smoothes the application and retention process for all OHP clients, not just those with special obstacles such as disabilities or a lack of English language ability.

***Insufficient applications, brochures, and posters are available to agencies.*** Agencies that pre-screen for OHP and other plans find it difficult to access printed materials. They readily distribute such information to their clients when it is available, which is sporadically. Many interviewees made comments such as, "We used to have a poster with tear-off tabs, but it didn't last long because everyone wanted the information. I wish we could get more of those." Official screening agencies (those on the AFS date-stamp list) reported good access to materials. However, as has been stated already, the pre-screening agencies are often the first access point for OHP-eligible clients. It is critical that plentiful information in a variety of understandable formats be available at these "entry point" agencies. The agencies should not have to ask for materials, but if they must, they should have a clear idea of whom to contact.

***AFS eligibility staff provides inconsistent and possibly arbitrary information.*** People who engage in screening for OHP and other health plans report receiving inconsistent and/or arbitrary answers to questions about specific situations. There is also a perception among many screeners that the AFS workers look far more closely for reasons to deny applications than for reasons to accept them. One screener said that "even people who haven't worked in years have to be sure to fill in zeros in the salary box or they will be denied for incomplete forms." Inconsistent answers are given on issues related to work-release inmates' qualifications, Federal payments to Native Americans and SSI-recipients, and some forms of college health insurance coverage as it affects OHP eligibility. The eligibility workers are seen as having too much room to interpret the rules. The agencies that did not identify this as a problem were those that had developed a personal working relationship with an individual in the AFS eligibility office.

***Community educational outreach is inadequate.*** While many public and private agencies offered educational programs to the public about the Oregon Health Plan during its early years, very few are doing so now. The general opinion is that everyone already knows about the existence of OHP and will ask for information about it if they think they might qualify. (Note that one local screener and several national studies have found that the "working poor" population is not used to asking for handouts and shies away from assistance. These people may be more willing to enroll in a health insurance program for which they qualify if the information is brought to them in a sensitive manner, rather than requiring that they seek it out (34, 37).) Conversely, there is a recognition that many people who do qualify for OHP do not ask for information because someone told them at some previous time that they did not qualify. Therein exists an important conflict.

Many of the screeners working for public agencies do provide training to their own agency staff and collateral agencies about OHP and other health plans. This is a significant source of OHP information for many of the small non-profits, who receive little information directly from OMAP.

## Population-Specific Issues

### Non-English Speaking:

Most public agencies indicated adequate resources for handling non-English speaking clients on site. Some use the AT&T language bank. Others have bi-lingual staff. However, non-profit agencies that specialize in working with non-English speaking clients indicate that their clients are unable to negotiate the medical and insurance systems without specialized assistance.

Most agencies reported more problems with clients accessing health care services than enrolling in an insurance program. An example of this is the Spanish-speaking couple with an infant in Washington County. The baby was running a fever on a weekend, so the couple called their Primary Care Provider. The answering service for the physician did not have bilingual staff, so the couple was unable to communicate their concerns. They decided to take the baby to the emergency room for medical attention. To their surprise, OHP would not cover the cost of the visit, because they were required to contact their PCP before going to the emergency room!

Another issue of concern with non-English-speaking clients is their level of choice about which health insurance plan and/or PCP will work best for them. Many of these clients are advised by agency staff to choose a plan and a provider at a large institution (Oregon Health Sciences University, for example). These larger health care provider agencies offer more translation services than a small medical office does. However, the original Communities in Charge focus group information (and other studies) indicate that patients report experiencing a greater level of satisfaction with their provider and their healthcare in general when they have a well-established relationship with a single provider in a setting close to home. This is clearly a built-in contradiction within the system.

Hispanic: The system as a whole has developed considerable resources for recruiting, enrolling, and retaining Spanish-speaking clients in OHP. Most telephone welcoming messages are bilingual, which provides up-front understandable information and directions. Considerable outreach is continuing to provide information to Hispanic clients about OHP and eligibility requirements. Nearly every public agency that screens for OHP has Spanish/English bilingual staff, and many of the non-profits do as well. No one reported difficulties accessing OHP information by Spanish-speakers. Accessing services was more difficult.

Chinese: Very few services exist to help Chinese-speaking people access medical care in the tri-county area. The Chinese Service Center helps approximately 20 people per week with OHP issues, including enrollment, retention, and access to medical services. Often this involves clarifying misinformation that a client received from another Chinese-speaking source (such as religious leader, relative, business associate) about eligibility standards. Beyond the language barrier, there are many cultural differences that make understanding the American medical and insurance systems difficult for Chinese immigrants. Some Chinese with major medical problems choose to return to China for treatment, because the cost of

airfare is less than the cost of medical care here. Although the Chinese Service Center provides services to the nearly 30,000 thousand Chinese residents of the Portland area, they do not have a contract with OMAP, nor do they receive any financial or other resources for the OHP-related work they engage in. Because the Chinese-Americans are immigrants rather than refugees, no special services exist for them within the Medicaid system.

Russian: Efforts to interview service providers for Russian-speaking refugees were unsuccessful. Language differences clearly present difficulties for these clients, and some bilingual resources are developing within the community.

Vietnamese: Like the Spanish-speaking clients, the Vietnamese speakers have considerable resources within the OHP enrollment system. Several public agencies have bilingual staff to assist with enrollment and retention in OHP. The Asian Family Center provides assistance to clients who need additional help with the OHP system. Resources for Vietnamese-speaking clients are more limited in Washington and Clackamas counties, where there are few, if any, screeners or pre-screeners who speak Vietnamese.

### **Native Americans:**

While Native Americans in the tri-county area do not face the language barrier that confronts other minority populations, there are cultural differences that exist and may impact on OHP eligibility. Specifically noted was the Native American concept of family support. When a family member is in need, others help out as much as possible, including sharing food, housing, and money. The resources are pooled and not held separate. This complicates the answer to the OHP application question about "household income." There is perceived pressure by Native Americans to deny their needy relatives full family support -- if they do help, the needy family might never qualify for public assistance. (See the NARA brochure in Appendix H.) There is also reported confusion and misinformation among OHP eligibility staff about tribal income and how it impacts on eligibility for OHP. This lack of clarity leads to delays and denials for OHP benefits.

### **Pregnant Women:**

All agency staff interviewed agreed that the current special policies for pregnant women were useful, well-received, and making progress in ensuring that qualified women receive adequate pre-natal and post-natal care. There were no significant concerns raised about improvements to the system for this group of people, other than the overall concern about the income level cutoff being too low.

### **Developmentally disabled:**

The current system leaves it unclear who is responsible for meeting the OHP enrollment and maintenance needs of adult developmentally disabled individuals: government agencies or non-profit DD advocates. The question has been raised as to whether this is this an Americans with Disabilities Act issue. While the Disability Services Offices are mandated to provide services to the developmentally disabled, many DD advocates believe that these

services are in fact not being provided at appropriate levels. One caseworker estimated that one out of five DD adults does not receive appropriate OHP assistance through DSO.

Advocates at non-profit agencies assume the responsibility for much of the intense case-management that this population of OHP clients requires. Resources are limited and need is very high. Another issue facing this specific clientele is that of HMO enrollment. HMOs limit the list of potential providers, yet DD people already have a short list of providers who will accommodate their special needs. HMOs compound this problem. There is also a lack of clarity as to which Federal program assistance dollars disqualify a client for OHP. Answers forthcoming from OMAP vary.

In 1997, the Child Development and Rehabilitation Center and the Office of Medical Assistance Programs jointly sponsored a Parent Satisfaction Survey for families with a special health care needs child. The report states that parents/guardians “were satisfied with their child’s health care coverage, their managed health organization, and the Oregon Health Plan,” and that “with few exceptions, parents reported ease of access and availability to both primary care providers and specialists”(18). The report did find that parents of children with exceptionally high needs experienced significantly more difficulty with access and were significantly less satisfied with the care and service they receive. The report did not address the same OHP enrollment and retention questions as this Communities in Charge survey (instead focusing on medical *services* access); however, the information is sufficiently related to the topic to be useful.

#### **Ages 60-64 (not yet Medicare eligible):**

Because this population *is* eligible for services through Aging Services Division, they have many services available to them: a well-developed, caring service system, specialized resource and referral base, caseworkers, and even some additional insurance options. (See the enclosed booklet, “Health Insurance Options for Midlife Adults” as an example of clear, concise information targeting this population, Appendix H.) Excellent caseworker training exists on OHP and other health insurance plans. The access system seems to work better than average for people in this category.

#### **Youth:**

No consistent message emerged about access limitations for adolescents. This may be a worrisome sign, as this population “continues to lack insurance at a higher rate than most other age groups in the United States, [and] large numbers of adolescents are eligible for, but not enrolled in, Medicaid and CHIP” (American Academy of Pediatrics report (29)).

No educational or recruitment materials specific to adolescents were in use at interview sites. One counselor/screener stated that printed materials alone don’t work with this population anyway -- word of mouth is the system for spreading information amongst teens. Local community colleges provide little information to students about health insurance options. School nurses, especially in Washington and Clackamas counties, have little access to information about OHP/CHIP and have even less time to provide attention to families needing

insurance. Usually a referral is made to a screening agency, but no follow-up is provided. Even this level of service is most likely to occur with younger children and their families.

In many instances our society considers adolescents capable of caring for themselves but fails to provide them with the rights or information to do so adequately. Building trusting relationships with care providers who provide services and information is a necessary foundation for keeping adolescents involved with regular healthcare.

### **Work-release program participants:**

Unclear guidelines currently exist regarding eligibility for this group of people. They are not “in custody,” but also are not considered eligible for OHP because of their custody status. Both Washington and Multnomah County Corrections Department staff state that the OHP eligibility office automatically returns any application with a work-release program address on it. Many of these clients have mental health diagnoses for which they need medication, but no financial resources or health insurance to pay for it. They also are on the threshold of release back into the community, where they will need to reestablish their productive and personal lives. Because of the “captive audience” quality of this situation, this is a perfect place to inform these clients about OHP and to begin the enrollment process. It is currently a lost opportunity.

### **College Students:**

Confusion exists regarding the fit between OHP and student basic health insurance coverage. Inconsistent answers are received from OMAP by college health services staff and students. Also, when students work during summer break (most frequently at positions with no health insurance options), they then are not income-eligible for OHP coverage until winter term. Information from OMAP to college campuses and the flow of information about OHP to students is very limited.

This population is often ignored because they are presumed to be young and healthy, but accidental injuries and life-impacting illnesses do occur to people in this age range. (See an example of the brochure which Portland State University Student Health Services uses to inform students regarding the need for health insurance coverage - “Don’t Risk It!”, in Appendix H.)

## Improvement Recommendations

### **Primary recommendations for improvement to the current access system**

***The OHP central office should always include a local contact name and phone number with any application or notice of eligibility/denial mailed out.*** This will improve the likelihood that a client will establish a personal relationship with a local knowledgeable screener, which in turn improves the likelihood of the application being completed correctly, the client utilizing health care services fully, and the client maintaining coverage as long as he/she is eligible. Although some studies (12) have promoted the idea of minimizing client contact with welfare offices and maximizing privacy as part of the Medicaid enrollment improvement process, this was not borne out as a preferable method during this study. The overwhelming majority of screeners and pre-screeners stated that one-to-one, in-person contact with the client was the key to a successful OHP experience. (See Interview Data Chart, page 26, for ratings of how well the current system meets the needs of clients and tracks/completes enrollment.)

***Agencies should encourage client “self-empowerment” as much as possible -- don’t do for clients, do with clients.*** At the same time, utilize every possible method for tracking client applications. In other words, set the clients up to succeed with their own efforts to access OHP. As an example, one non-profit agency encourages the client to write the answers to the OHP application herself (if able), so the form and the information will be familiar when the application for continued enrollment arrives in the mail.

***Resolve issues with specific client populations, as listed on previous pages.*** Policy changes to impact some of these issues are already underway, specifically the question of eligibility for work-release inmates.

***Maintain special policies for pregnant women and domestic violence victims.*** Continue to give priority to applications from these clients. Maintain the Oregon Mothers Care caseworker at the OHP eligibility office.

***Examine more closely the system for providing health care access to adolescents.*** Work with adolescent groups and health care providers to develop adolescent-specific outreach materials and an educational program that reaches into sites frequented by adolescents (schools, school-based health centers, family planning and STD clinics, Job Corps sites, community colleges, child care centers used by teen parents, summer job recruitment sites, etc.) Examine OHP/CHIP payment methods for changes that would facilitate adolescents’ ability to utilize health care services in settings that are familiar and comfortable to them.

***Improve communication between local AFS and County Health Department offices.*** These agencies need to become more aware of each other’s practices and to coordinate their services more closely. There is a great deal of misinformation and lack of information about services offered by these agencies, even within the same county or the same community. This creates confusion for clients and duplication of effort for agencies, and sometimes even fosters a competitive atmosphere between agencies, which is not in anyone’s best interest.

**Consider creating a community outreach worker model to improve OHP access.** Provide outreach at grocery stores, churches, and other “regular” places that people go on a daily basis. Train neighborhood residents to do this outreach, possibly offering an extra month on OHP as an incentive. The role of community health workers is gaining recognition throughout the country (9), and has recently been introduced into the Multnomah County Health Department.

### **Secondary suggestions for improvement to current access system**

**Maintain retroactive emergency coverage.** This is viewed as a very important part of the OHP program. It appears to be used more regularly in Clackamas and Washington Counties. Caseworkers in Multnomah County refer to it as a thing of the past. They recognize that clients occasionally use this emergency coverage as an excuse for not maintaining regular coverage via OHP. One provider/pre-screener attempts to avoid this problem by enforcing “disincentives” (a per visit fee) to patients who qualify for OHP but are not enrolled.

**Make OHP materials more readily available, especially to non-profits.** This may require the development of a system for ensuring regular distribution of materials to a broader list of agencies than those with date stamps. At a minimum, a phone number for requesting more materials should be included with printed materials that are distributed about OHP. (See Interview Data Chart, page 26, which shows satisfaction ratings comparisons between government and non-profit agencies.)

**Ensure that non-profits are aware of OHP trainings and updates.** Offer trainings at times and places convenient for non-profit staff members. Perhaps tailor trainings to particular populations, such as domestic violence staff, non-English speaking services staff, day care staff, etc. Pay special attention to Clackamas and Washington counties, where current training was rated substantially lower than in Multnomah County (see Interview Data Chart, page 26).

**Materials and trainings should encourage people to apply for OHP more than once.** Misinformation and/or changes in eligibility status often prevent eligible people from enrolling when they become eligible.

**Improve telephone access to the toll-free OHP information number.** Many people commented that the toll-free number was difficult to reach and that staff was unfriendly, unhelpful, and/or arbitrary. Providing a local contact resource to clients with their enrollment information may decrease the number of calls to this number also.

**Use Consumer Credit Counseling as a referral resource** to help people understand money management, set priorities including healthcare for themselves and their families, and create a plan for life’s ups and downs. The Kaiser Survey of Family Health Experiences found that “it is their families’ experiences that define most Americans’ view of the health care system. And most Americans base their decisions about insurance coverage with the health needs of all family members in mind” (37). Efforts to educate consumers about the importance of healthcare for their family members and the best methods for planning for continuous coverage could lower the rate of medically uninsured.

## Best Practices - Nationally and Locally

Research in national literature indicates that states and localities across the country are grappling with the same health care access issues that confront us locally. The link between health insurance access, housing, economic poverty, environmental health, nutrition, and other social determinants are being explored through many studies and research projects. For an excellent overview of the healthcare access issue, see “Increasing Access: Building Working Solutions,” a publication of Community Voices (23).

No single program, community, or even philosophy emerges as the “best practice” for improving the healthcare access of citizens. However, there are recommendations and examples that stand out as worthy of notice and consideration. These are broken out here into sub-categories for discussion: general principles for improving ease of enrollment in Medicaid programs, cultural competency issues, and location/program specific examples of exceptional work.

### *General principles for improving ease of enrollment in Medicaid programs*

The Kaiser Commission on Medicaid and the Uninsured lists four steps that most states have taken to simplify enrollment for at least their child health coverage programs:

- \* using joint applications for Medicaid and CHIP programs;
- \* eliminating the asset test for eligibility;
- \* eliminating the face-to-face interview; and
- \* requiring only an annual redetermination.

The same study recommends the following steps to simplify enrollment, which few states have implemented at this time:

- \* presumptive eligibility (enables children who appear income-eligible to enroll temporarily in Medicaid and receive services, giving families time to complete the formal application process);
- \* self-declaration of income (elimination of documentation); and
- \* 12-month continuous eligibility (guarantees continuous eligibility for children in both Medicaid and CHIP programs regardless of changes in income or other family circumstances that may occur in the interim)

Developing a closer relationship between screening agencies and philanthropic organizations is recommended by one local caseworker, who has accomplished just that with a local family charitable trust. She has access to a “slush fund” to meet the emergency needs of clients who

contact her agency for medical assistance. This could mean paying for tires for a family car so they can drive their child from Florence to the hospital for cancer treatments. Providing front-line workers with some discretion in meeting the needs of their clients could be useful to both client and workers, as the workers express a great deal of dismay at being unable to “bend the system” in even the slightest way for those cases of great need.

Allowing people to access health services in settings that are most comfortable and convenient for them is one avenue for increasing access. According to a report in *Adolescent Medicine* (29), efforts are underway in a number of states to develop appropriate models for inclusion of school-based health centers and other adolescent-oriented providers in managed care arrangements. An article in the *American Journal of Public Health* (21) hypothesizes improved access to health care by “recruiting more physicians from less advantaged backgrounds . . . because a disproportionate percentage of such physicians would establish practices in their home communities.” They are presumed to be more knowledgeable of and sympathetic to issues pertaining to people of their own socioeconomic background.

The business concept of marketing is entering into the literature pertaining to healthcare access. Utilizing well-established marketing techniques from the private sector to “sell” the desirability of the Oregon Health Plan or other public insurance programs is a trend to notice. This will perhaps include close attention to the various subsets of potential customers. An article in *Pediatrics* (27) cites the socioeconomic and health status characteristics of SCHIP-enrolled children compared with Medicaid-enrolled children. The findings indicate marked differences in these two groups, reflecting a need for different educational/marketing approaches to gaining enrollment in the two programs.

### ***Assuring Cultural Competency***

Cultural competency is defined here as more than language or cross-cultural issues. It includes issues of understandability for the consumer and perceived stigma attached to poverty. It is clearly not just non-English-speakers who struggle with cultural access to “the system.”

A study conducted for the Henry J. Kaiser Family Foundation on “Perceptions of How Race & Ethnic Background Affect Medical Care” recommended the following strategies for improving racial and ethnic sensitivity within the healthcare system, thus improving clients’ desire or willingness to enroll in Medicaid HMO programs:

- \* diversifying the health workforce;
- \* improving physician awareness about diseases that disproportionately affect specific minority populations; and
- \* increasing the acceptance of alternative health care practices such as herbal therapy and spiritual healing.

Several studies indicate a large gap in the perception of the level of cultural competency in the current medical system. While minorities continue to decry biased treatment, most providers maintain that they treat all their patients the same and only identify language issues as a problem.

The Kaiser Foundation report cites studies in Los Angeles and Washington, DC, regarding the success of cultural competency training for medical providers. The HHS Office of Minority Health and Resources for Cross Cultural Health Care published in 1999 a list of 14 recommended standards for culturally and linguistically appropriate health care (15). Although these standards are well developed and undoubtedly useful, it is unclear how they could be applied to health care providers working in private offices or other small business settings.

Other examples of efforts to deal with the language barrier issue include Multnomah County Health Department's report, "Response to Bureau of Primary Health Care Initiative to Assess Linguistic Services" (24), and Diversity Rx's summary of culturally competent health services (9).

### ***Outstanding Examples of Best Practices***

No one location exemplifies best practices in all areas. Several sites are worthy of special mention, however:

- ▶ AHEC/Community Partners coordinates two statewide initiatives in Massachusetts, which promote community-based outreach to expand health care access. Not only do the programs target enrollment, but they also seek to assist clients with healthcare utilization. Moving Beyond Enrollment has several sites throughout Massachusetts. For more information on AHEC/Community Partners, go to their website at [www.ahecpartners.org](http://www.ahecpartners.org).
- ▶ The Maryland Access to Care Program (MAC) had considerable success in increasing Medicaid enrollment in its first two years. Improvements were noted in enrollment, use of primary care providers, and fewer emergency room visits. The cost to the program increased due to high rates of usage, but weighing these additional costs against the improved health of the clients will be examined in future studies.
- ▶ The Buncombe County Medical Society Project Access (Asheville, North Carolina) is an outstanding example of physicians participating in a collaborative effort to provide all residents access to proper medical care. The physicians believed it was to everyone's benefit to avoid patient delays in seeking needed health care due to financial concerns, which in turn caused inefficient and costly health care utilization and the physicians' frustration with recurring health care problems receiving "band-aid" care. This project served as a model for the similar effort, "Project Access," in Sedgwick County, Kansas.
- ▶ Navajo Communities in Action for Wellness demonstrates a high-level of community involvement in health and wellness education. This project has several components, including drug and alcohol abuse prevention, breastfeeding promotion, nutrition, exercise,

and appropriate use of healthcare resources. Adolescents and elders are regularly used in planning and carrying out educational programs to promote healthy behaviors. Messages tie into the traditional Navajo belief system. One important component of this program is the belief that “knowledge is power.” The first people to receive results from any health study conducted on the Navajo Nation are the citizens who participated in the study. Funders, government agencies, and others receive the information later.

- ▶ The Children’s Defense Fund recently published on the Internet the “CHIP Checkup: A mid-term report on the State Children’s Health Insurance Program.” States are rated in several categories on how well they have implemented the CHIP program. One category is “family friendliness,” which included questions related to program eligibility, simplicity of application, and necessity for proving family assets. Oregon received the highest possible rating in this category.
- ▶ The Oregon Health Plan received high marks from Children First for Oregon, which attributed the low percentage of low-birth-weight babies (5th among states) and low infant mortality rates to OHP’s “commitment to providing health coverage to the most needy families and the working poor” (7).
- ▶ An interview with the East Multnomah Branch of Aging Services Division (ASD) highlighted the many excellent practices employed by that agency for enrolling and maintaining clients on the Oregon Health Plan. The agency’s commitment to never limiting their client base, its well-designed computer program which allows tracking of clients’ OHP status, the smooth dovetailing of OHP recruitment with screening for other services, and the level of OHP training available to caseworkers through ASD’s OHP liaison worker all add up to a system that delivers both high-quality service and excellent client satisfaction.

## Funding Sources for Agencies (Financial Support for OHP-Related Activities)

The public agencies used as a source of information for this report nearly all reported that they receive tax dollars as part of their budget to support the screening and/or pre-screening activities carried out for the Oregon Health Plan. This work is viewed as part of their public service mandate. An exception was Washington County Corrections Work Release Program, which reported using general funds for OHP-related work.

Head Start programs include health-related services in their standards of performance. Federal funding for Head Start programs could then be construed as supporting OHP-related work.

Educational institutions, from local school districts to education service districts to colleges, receive funding from multiple sources. No one interviewed for this project indicated receiving any special funding from the Office of Medical Assistance Programs (OMAP) or any other source specifically to conduct OHP-related activities.

The private, non-profit agencies used as a source of information for this report generally relied upon a variety of funding paths for their activities, including screening and/or pre-screening for the Oregon Health Plan. Some funding came from government sources via contracts (though not specifically for OHP-related work). Other sources included grant funding, private donations, and earned income.

Most of the non-profit agencies indicated that they receive no funds from OMAP or any other state government agency for conducting OHP-related work. The exceptions to this were Native American Rehabilitation Association, which receives a small amount of OHP funding to cover transportation costs and other support services for clients of its drug and alcohol program, and Outside In, which currently receives funding from Multnomah County for 8 hours of health-related outreach to youth and adults.

## Question By Question Summary of Responses

### 1. How do people get to you for screening/pre-screening?

By far the majority of clients being screened or pre-screened for OHP have contacted the agency for other services (Head Start, domestic violence, food stamps, housing assistance, etc). Those agencies then ask questions about the client's health insurance status. If appropriate, an application is filled out for OHP or other public insurance programs, or a referral is made to an agency that does the screening. Some clients do contact an agency specifically to apply for OHP. These clients tend to get less follow-up with their application process. They are referred to Salem AFS to request an application or the agency will send them an application directly.

Without a case manager at the agency or some other on-going contact purpose, the client's status is not tracked and there is presumably a greater risk that the client's success with "the system" will be low. Some clients are more or less mandated into situations that get them screened for OHP eligibility, such as inmates, families participating in the Head Start program, domestic violence victims. These touch points are excellent opportunities for getting eligible people enrolled in OHP.

### 2. What type of outreach and/or education to the community does your agency do regarding OHP, CHIP, FHIAP?

In the early days of the OHP, some agencies had special programs about OHP which they offered to the community. Very few agencies do this any longer (migrant workers is the notable exception). On the one hand, there is a general feeling that "everyone knows that OHP exists and will ask for it if they need it." On the other hand, there is a realization that much erroneous information about eligibility requirements is in the community and that eligible people are not applying because they were turned down once or because someone gave them false information. Case management and intense community outreach to certain types of clients provide specific information about OHP to some people. Most agencies would willingly distribute OHP brochures; however, some of the non-profit agencies expressed difficulty in obtaining materials.

Some population-specific brochures about the importance of health insurance coverage exist. (See Appendix H, examples of materials.) Some agencies will convey limited information about OHP changes to their clients through newsletters. Government agencies with specialized staff still frequently offer formal or informal training on OHP and other public insurance plan policies to their own agency staff, as well as to other community agencies. This is generally offered in the context of an explanation of their full range of services (a general overview of agency services, including screening for OHP). Most agencies will answer telephone inquiries regarding OHP to anyone who calls; however, many agencies limit their assistance with the application process to their own clients.

3. What challenges/barriers do you encounter with people you screen/prescreen?

Income limitations are being set so low that working poor are unable to qualify. There is a necessity for clients to provide documentation for three months of income. Many clients simply do not maintain records, or their life situation has them working in jobs that are sporadic, cash paid, and no documentation exists. Self-employed individuals also have problems providing proof of income. Developmentally disabled people have special needs and require high levels of individual attention to successfully negotiate the access system. Mentally ill people are frequently unable or unwilling to follow through with the necessary tasks to gain access to OHP. Many people who are eligible for OHP have mobile lives, which do not lend themselves to recordkeeping, maintaining current address records, or making health insurance coverage a priority. Many people have poor self-management skills – they simply do not accept responsibility for following through on assigned tasks.

4. What seems to work well with the current screening system?

Having a date stamp on site at an agency speeds up the application process and goes a long way to ensuring that people don't "get lost" in the process (picking up an application, taking it home to fill out, and never bringing it back). Agency's longevity and visibility in the community – folks know they can go there for OHP assistance. A knowledgeable, seasoned worker can work wonders – know what specific info to seek to really advocate for client's special issues. Doing some phone screening before seeing client, so client knows what documentation to bring to the screening interview. Special policies for pregnant women and domestic violence victims smooth and hasten the process tremendously. Face to face contact with clients works better than anything else to ensure completion of the application process and utilization of the services. Having an AFS or County health department worker visit a pre-screening agency on a regular schedule to assist clients with applications, answer agency staff questions. Agency staff developing a personal relationship with a particular person(s) at Salem AFS office creates a happier work environment, lends itself to people on both ends going the extra mile for a client. This sometimes is a worker assigned to specific types of cases, such as Oregon Mother Care or senior applications. OMAP training sessions are good quality, if not frequent enough. Retroactive application for emergency hospital visits. (This seems to happen more regularly in Clackamas and Washington counties; people in Multnomah county talk about it as a thing of the past.) AT & T Language bank has worked well for some agencies.

5. How well does the current screening system meet the needs of your clients?

*See Interview Data Chart (page 26).*

6. If some members of family are eligible for OHP and some are not, what do you do?

Well-trained staff (such as AFS workers or County health department staff) will look at all the factors in a family's case and make application to as many other public health insurance plans as might possibly apply. The worker may also know about

changes a family can make to become eligible for a certain plan. Most employees of non-profit agencies are not familiar enough with those alternative plans to make recommendations. They generally steer non-OHP-eligible family members to safety net clinics or their own network of local providers who will provide free or reduced price services. They become quite adept at ferreting out such providers.

7. How do you follow-up with people who receive information or an application?

There is a wide range of systems used for tracking application status, from no system at all to every application being followed every step of the way. Generally the government agencies do the most with tracking the applications, often by computer. (Aging Services Division has the best example encountered during these interviews) Small non-profit agencies generally have fewer resources to allow for tracking applications, although some manage to do a thorough job in spite of limitations. There is also a range of viewpoints among agencies and the individuals who work there as to how much “babysitting” is appropriate, i.e., should adult applicants with no disabling conditions be held responsible for their own follow-through with the application process. Agencies that provide case management of clients for multiple services usually incorporate OHP follow-up in that process. People who simply pick up an application for OHP but do not request other services frequently are not tracked. Different “tricks” are used by each agency to ensure that applicants return their applications, such as providing stamped envelopes, asking client to return application to agency office rather than to OMAP directly, sending follow-up letters, or even providing incentives for youths. Head Start requires a physical/dental exam for children before they can start the program, which forces enrollment in some kind of insurance plan.

8. How well does the current system track and complete the process of getting people enrolled in OHP, CHIP, FHIAP?

*See Interview Data Chart (page 26).*

9. What do you or your agency do to help people stay on insurance (not drop off temporarily or permanently)?

Again, viewpoints vary from agency to agency on whether the re-enrollment process is primarily the client’s responsibility or the agency’s. Some agencies maintain tickler files or other systems for tracking each client on OHP, and also track people into the field when their OHP is near to expiring. Agencies that provide case management usually include timelines for reapplication in their case files (sometimes linking OHP reapplication date to food stamp or other services reapplication dates). Other agencies do no tracking whatsoever. Agencies do offer to help clients fill out the re-enrollment form. One suggestion for simplifying the process is for the agency to keep a photocopy of the original application, so not all the information needs to be reported again by the client. Several agencies recommend that the client be required to actually do the writing on the application, so the process and information is familiar to them when it is time to reapply. May help get waivers for unpaid premiums, so coverage

will not lapse. Alert clients during initial enrollment to watch for the reapplication packet. Provide change of address forms to client at enrollment (either OMAP's or their own), so client will know how/where to file. One agency offers a monthly class on how to reapply for the OHP (Virginia Garcia). Assist clients with signing up for appropriate HMO, so it will be convenient and comfortable for them to use it. Some agencies (mostly non-profits serving non-English-speaking clients) do a great deal of intense work in this area. Having a local contact agency/person to talk to about reapplication, change of address, etc., seems to smooth the process, make it more accessible to clients than simply calling the 800 number or mailing notice to Salem. Clinics/ agencies sometimes allow clients to use their mailing address if they are homeless or move frequently – this avoids having monthly statements returned to Salem. Use the term “medical home” to explain concept of PCP.

10. How well does the current system encourage and facilitate people staying on OHP, CHIP, FHIAP?

*See Interview Data Chart (page 26).*

11. What do you or your agency do to help people make full use of their insurance?

Help them to choose an appropriate health plan (convenient, comfortable, accepted by current provider). This is especially important for clients in rural areas. (Sandy and Oregon City are the main sites for all of rural Clackamas County.) Advocate for client with doctor's offices, pharmacies, “system”, finding specialists. Encourage clients to make appointments early, so health care needs will be taken care of within 6months of coverage. Many clients have backed up health care needs when they first go on OHP (esp. true of DV victims and their children). Mental health services available through OHP are often discussed with clients – depression often an issue. While most clients understand the basic concept of health insurance, many don't understand HMO's/ PCP's. Educate clients not to use emergency room as a clinic. (Note: If regular provider does not provide interpretation services, including after hours, client may end up at emergency room to obtain services.)

For non-English-Speakers, especially those who speak a language other than Spanish, Russian, or Vietnamese, agencies provide lots of assistance with scheduling doctor's appointments, obtaining interpreters, explaining system. Actions that help with this issue include: Having client make next appointment while they are at the clinic with an interpreter; using large system providers (like HMO's) that have a good record of having interpreters available; having staff available by phone to answer client's questions regarding using the OHP, letting clients know that staff will be available and providing a card with the correct phone number. The 800 number is difficult to use for agencies and clients alike – hard to get through, inconsistent answers to questions, unable to ask detailed questions on specific cases. Works much better to have a local knowledgeable person. Encourage parents to see to children's dental, vision, and immunization needs. Case managers sometimes incorporate wellness goals into case plan for a client. OHAP managed care booklet often given to client by larger agencies. Refer to other resources also, such as WIC program.

12. How does your organization train/support screeners/outreach workers?

The larger agencies rely primarily on OHAP training, which they rate quite highly. Some large agencies have a dedicated OHP worker either on site or readily available to them. Most agencies believe the OHAP trainings should be offered more frequently – new staff members often have to wait several months before they can attend. Trained staff share their knowledge with new workers, as well as with other community agencies and the public. Nearly every agency interviewed remarked that a knowledgeable worker could move mountains and really make a difference for getting clients onto OHP. Smaller non-profit agencies received far less training about OHP and frequently stated that they need more training. They often must rely on AFS or Health Department staff to answer questions about OHP, and they have almost no knowledge of other public insurance plans (CHIP, FHIAP, other). There is a risk that clients will receive inaccurate information from agency staff that want to be helpful but do not know full information. Some non-profits have a “health advisory committee.” Non-profits who provide a great deal of OHP pre-screening might want to consider having a health professional on their Board of Directors who could keep staff up-to-date on OHP regulations. School secretaries are often the pre-screeners for families with children; they need more training/information about OHP. Overall, the area of training was rated higher than most other areas related to OHP.

13. How well does current training meet your needs as a screener/pre-screener for OHP, CHIP, FHIAP?

*See Interview Data Chart (page 26).*

14. Do you have suggestions for change/improving the screening/prescreening process?

*See primary and secondary suggestions for improvement to system (page 14).*

15. Do you have suggestions for improving outreach or education to increase enrollment of eligible people?

*See primary and secondary suggestions for improvement to system (page 14).*

16. What challenges/barriers do you encounter within your organization?

Clinics that are not considered “providers” by OHP must refer clients to a PCP, where s/he must start all over with testing and services. (A “non-barrier” is cross-training staff to handle all OHP functions, including emergency applications.) Staff want to help, but are not trained to give full accurate info. Some agencies have policy to give *no* information rather than wrong information. High caseloads do not allow enough time to talk much about health issues and problem solving with client. High caseloads put limits on workers’ willingness to take on OHP clients when no money is coming to agency for doing such work. Domestic violence victim clients are frequently afraid of being tracked through OHP system by abuser.

17. Are there any other comments or information you would like to share?

*General comments incorporated throughout report.*

## Interview Data

### *Responses to Satisfaction Questions*

#	County	Type of org.	Question 5 (Screening)	Question 8 (Enrollment)	Question 10 (Retention)	Question 13 (Training)
1	M	Public Univ.	3	4	3	4
2	M	Government	4	4	4	5
3	C	Government	4	4	4	5
4	M	Government	4	3	4	4
5	W	Government	2	2	1	2
6	M	Nonprofit	3	3	3	1
7	C	Nonprofit	4	3	2	4
8	W	Nonprofit	4	4	3	3
9	W	Nonprofit	4	4	4	4
10	M	Nonprofit	1	3	2	4
11	M	Nonprofit	4	3	3	4
12	M	Nonprofit	3	4	2	4
13	C	School District	3	NA	3	1
14	C	Government	3	3	NA	3
15	W	Nonprofit	5	4	5	3
16	M	Government	5	4	4	5
17	M	Nonprofit	2	1	1	4
18	C	Government	3	4	2	3
	5C, 9M, 4W	7 government, 9 nonprofit, 2 other				
Number			18	17	17	18
Mean			3.4	3.4	2.9	3.5
Mode			4	4	3	4
Range			1-5	1-4	1-5	1-5
Std. Dev.			1.04	0.86	1.14	1.20

Notes:

C = Clackamas County, M = Multnomah County, W = Washington County.

Scale: Either 1 = “not at all” to 5 “meets all the needs” or 1 = “very poorly” to 5 = “very successfully”

Question 5: How well does the current screening system meet the needs of your clients?

Question 8: How well does the current system track and complete the process of getting people enrolled in OHP/CHIP/FHIAP?

Question 10: How well does the current system encourage and facilitate people staying on OHP/CHIP/FHIAP?

Question 13: How well does current training meet your needs as a screener/pre-screener for OHP/CHIP/FHIAP?

### *Summary of All Responses*

Question	Mean (average)	Mode (most common)	Range (highest-lowest)	Standard deviation
5	3.4	4	1-5	1.04
8	3.4	4	1-4	0.86
10	2.9	3	1-5	1.14
13	3.5	4	1-5	1.20

### *Average of Responses*

Question	Overall	By county			By type of organization	
		Mult.	Clack.	Wash.	Govt.	Nonprofit
5	3.4	3.2	3.4	3.8	3.4	3.3
8	3.4	3.2	3.5	3.5	3.5	3.2
10	2.9	2.9	2.8	3.3	3.1	2.8
13	3.5	3.9	3.2	3.0	3.6	3.4

### *Most Common Responses*

Question	Overall	By county			By type of organization	
		Mult.	Clack.	Wash.	Govt	Nonprofit
5	4	3	3	4	3	4
8	4	4	4	4	4	3
10	3	3	2	-	5	3
13	4	4	3	3	5	4

### *Observations*

Four interview questions asked people to use a 1-5 scale to rate the current system for providing OHP, CHIP, and FHIAP on how well it (1) meets the needs of their clients, (2) tracks and completes the enrollment process, (3) encourages and facilitates people to stay enrolled, and (4) meets their training needs as screeners or pre-screeners. (See the previous page and also Appendix E for the full text of the four questions.)

The interview results show:

- A wide range of opinions exists in the responses to all four questions.

- Overall, interviewees feel the current system meets some but not all of the needs of their clients, does a less than successful job of tracking and completing enrollment, does not encourage and facilitate people to stay enrolled, and meets some of the training needs of screeners and pre-screeners.
- Interviewees in Clackamas and Washington counties rated the system higher than interviewees in Multnomah County in terms of how well it (1) meets the needs of clients and (2) tracks and completes enrollment.
- Interviewees in Clackamas and Washington counties rated current training much lower than interviewees in Multnomah County in terms of how well it meets their needs.
- Interviewees with nonprofit organizations rated the current system lower than government organizations on all four questions, especially in terms of how well the system tracks and completes enrollment and encourages and facilitates people to stay enrolled.

## PROJECT CONTACTS LIST

### Personal Interviews

Adult & Family Services, Mid-Multnomah County Branch, Stephanie McCray,  
Operations Manager  
Adult & Family Services, Oregon City Branch, Nancy Alioth, Case Manager  
ARC of Multnomah County, Bill West, Adult Case Coordinator  
Chinese Service Center, Holden Leung, Executive Director  
Clackamas County Health Dept., Linda Herman, OHP Human Services Assistant  
Clackamas Women's Services, Laurel Mohan, Outreach Coordinator  
Head Start, Oregon City, Michael Buonocore, Health & Nutrition Coordinator  
Head Start, Washington County, Pam Otten, Health Coordinator  
Multnomah County Aging Services, East Branch, Brian Scazzafavo, Case Manager  
Multnomah County Health Dept., Medicaid Unit, G. Jean Thomas  
Native American Rehabilitation Association, Sheila Kirk, OHP Specialist  
North Portland Nurse Practitioner Community Health Clinic, Mariah Taylor,  
Administrator, and other staff  
Oregon City School District, Paula Apa-Hall, School Nurse  
Outside In, Anna Vail, Health Programs Coordinator  
Portland State University, Student Health Services, Sandy Franz, Clinic Director, and  
Alice McCarthy, Clinic Nurse  
Virginia Garcia Clinic, Alejandra Mitchel, OHP Eligibility Specialist  
Washington County Community Action: Opening Doors Program, Catherine Fleischman,  
Program Coordinator  
Washington County Corrections, Karleigh Mollahan, Community Corrections Center  
Supervisor

### Telephone Interviews

Mt. Hood Community College, Krissie Bloom, Campus Nurse  
Multnomah County Restitution Center, Sharon Comstock  
Multnomah Education Service District, Student Health Services, Jayme Thomson, Supervisor  
Russian Oregon Social Services, Case Manager  
Washington County AFS Office, Hillsboro, Special Services Manager

### Attempted Interviews

Lutheran Refugee Program, Russian Caseworker  
Mt. Hood Medical Center  
Willamette Falls Hospital  
Aging Services Division, Clackamas County

## Advisory Group Members

Rafael Arellano-Barberra, Educate Ya, Inc.

Crystal Busch, National Association for the Advancement of Colored People

Robert Delf, Medical Society of Metropolitan Portland

Kathy Hammock, Wallace Medical Concern

Gloria Krahn, Oregon Health Sciences University

Holden Leung, Chinese Service Center

Jackie Mercer, Native American Rehabilitation Association

Vicky Nakashima, Oregon Health Division

Barbara Neely, Multnomah Education Service District

Rich Reiner, Consumer Credit Counseling Services

Robert Rivers, Eastwind Community & Family Center

Mark Story, Raphael House

Marcia Suttenger, Service Employees International Union, Local 49

Thao Xiong, Asian Family Center

Gretchen Yost, The ARC of Multnomah County

# Communities in Charge Education and Outreach Questionnaire

A Healthy Communities Project  
Fall, 2000

Agency Name: \_\_\_\_\_ County: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## **SECTION 1**

Name and title of person from whom information received: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

What actions related to OHP, CHIP, FHIAP does this agency engage in?

\_\_\_\_\_ Eligibility Screening \_\_\_\_\_ Eligibility pre-screening \_\_\_\_\_ I & R

\_\_\_\_\_ Outreach \_\_\_\_\_ Education programs

Is this agency:

\_\_\_\_\_ Non-profit \_\_\_\_\_ For-profit \_\_\_\_\_ Government

What are your funding sources for the screening/prescreening, outreach and education related to OHP, CHIP, FHIAP?

What are the populations you serve? How many people?

What is the geographic area you serve?

May we interview one of your screeners/outreach workers?

**SECTION 2.**

**Questions for Screener/Pre-Screener**

Person Interviewed \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

1. How do people get to you for screening/pre-screening?
  
2. What type of outreach and/or education to the community does your agency do regarding OHP, CHIP, FHIAP?
  
3. What challenges/barriers do you encounter with people you screen/pre-screen?
  
4. What seems to work well with the current screening system?
  
5. How well does the current screening system meet the needs of your clients?  
(Circle one)    Not at all        1.....2.....3.....4.....5    Meets all the needs
  
6. If some members of family are eligible for OHP and some are not, what do you do?
  
7. How do you follow-up with people who receive information or an application?
  
8. How well does the current system track and complete the process of getting people enrolled in OHP, CHIP, FHIAP?  
(Circle one) Very poorly    1.....2.....3.....4.....5    Very successfully
  
9. What do you or your agency do to help people stay on insurance (not drop off temporarily or permanently)?

10. How well does current system encourage and facilitate people staying on OHP, CHIP, FHIAP?

(Circle one) Very poorly 1.....2.....3.....4.....5 Very successfully

11. What do you or your agency do to help people make full use of their insurance?

12. How does your organization train/support screeners/outreach workers? What kind of training do they get? How much? Who provides it?

13. How well does current training meet your needs as a screener/pre-screener for OHP, CHIP, FHIAP?

(Circle one) Not at all 1.....2.....3.....4.....5 Meets all the needs

14. Do you have suggestions for change/improving the screening/pre-screening process?

15. Do you have suggestions for improving outreach or education to increase enrollment of eligible people?

16. What challenges/barriers do you encounter within your organization?

17. Are there any other comments or information you would like to share?

## List of Area Agencies That Have an OHP Application Date Stamp

Adventist Medical Center, 10123 SE Market, Portland  
Clackamas County Public Health, 1425 Beaver Creek Road, Oregon City  
CODA, Inc-Alpha Treatment Center, 1427 SE 182nd Ave., Portland  
CODA, Inc-Tigard Recovery Center, 10362 SW McDonald, Tigard  
CODA, Inc, 1027 E. Burnside, Portland  
Confederated Tribes of Siletz Indians, 3715 SE 39th Ave., Portland  
DePaul Youth Services, 4411 NE Emerson, Portland  
Eastmoreland Hospital, 2900 SE Steele, Portland  
Legacy Emanuel Hospital, 2801 N Gantenbein, Portland  
Legacy Good Samaritan Hospital, 1015 NW 22nd Ave., Portland  
Legacy Meridian Park Hospital, 19300 SW 65th Ave., Tualatin  
Legacy Mt. Hood Medical Center, 24800 SE Stark, Gresham  
Multnomah County Health Department, 426 SW Stark, Portland  
Native American Rehabilitation Association, 2901 E. Burnside, Portland  
OHSU Hospital, 3181 SW Sam Jackson Park Rd, Portland  
Old Town Clinic, 219 W. Burnside, Portland  
Oregon Primary Care Association, 812 SW 10th Ave., Portland  
Outside In, 1236 SW Salmon, Portland  
Providence Milwaukie Hospital, 10150 SE 32nd Ave., Milwaukie  
Providence Portland Medical Center, 4805 NE Glisan, Portland  
Providence Rose Haven Outreach, 116 NW 3rd Ave, Portland  
Providence St. Vincent Medical Center, 9205 SW Barnes Rd, Portland  
Tuality Health Care, 335 SE 8th, Hillsboro  
Virginia Garcia Memorial Health Center, 85 N. 12th St., Hillsboro  
Washington County Health Department, 19945 SW Boones Ferry Rd., Tualatin  
Washington County Health Department, 155 N. 1st Street, Hillsboro  
Washington County Health Department, 12550 SW 2nd Street, Beaverton  
Woodland Park Hospital, 10300 NE Hancock, Portland

Additionally, all State of Oregon Adult and Family Services branch offices

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## Sample Outreach and Education Materials Distributed by Agencies

- American Association of Retired Persons, "Health Insurance Options for Midlife Adults."  
AARP Headquarters, 601 E Street, NW, Washington, DC 20049. [www.aarp.org](http://www.aarp.org).
- Clackamas County Health Department, "The Oregon Health Plan" flyer with local contact information.  
Clackamas County Health Department, 1425 Beaver Creek Road  
Oregon City, OR 97045, (503) 655-8471.
- Community Action Organization, Opening Doors Program, three flyers.  
Opening Doors Program, 19945 SW Boones Ferry Road  
Tualatin, OR 97062, (503) 692-8552.
- Native American Rehabilitation Association of the Northwest, Inc., general services flyer.  
NARA, 2901 E. Burnside, Portland, OR 97214 (503) 230-9875
- North Portland Nurse Practitioner Community Health Clinic, general informational flyer.  
NPNPCHC, 5311 N. Vancouver, Portland, OR 97217 (503) 284-5239
- Oregon Department of Human Services, "Information About the Oregon Health Plan" booklet and OHP enrollment forms.  
ODHS Oregon Health Plan Hotline: 1-800-359-9517.
- Portland State University, American College Health Association flyer "Don't Risk It!"  
ACHA, P.O. Box 28937, Baltimore, MD 21240. [www.acha.org](http://www.acha.org).
- Also, printed home page for the Office of Oregon Health Plan Policy and Research -- the site that Oregonians encounter when they enter the World Wide Web seeking information on the Oregon Health Plan. [www.ohppr.state.or.us](http://www.ohppr.state.or.us).