

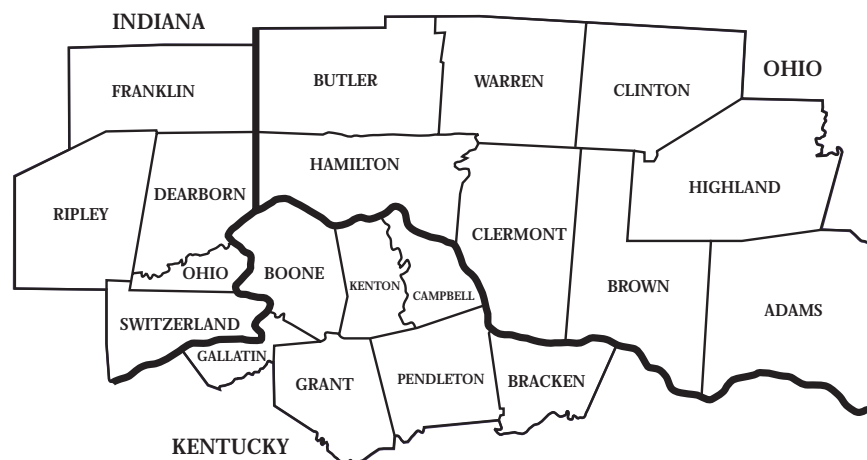
**Proceedings from
The Employment and
Health Insurance Roundtable
September 30, 1999**

Sponsored by:
The Health Foundation of Greater Cincinnati

Foreword

In 1997, The Health Foundation of Greater Cincinnati emerged from the sale of the ChoiceCare managed care company to Humana. Soon after, the Foundation began awarding grants to nonprofit organizations to improve health in a 20-county region encompassing parts of Indiana, Kentucky, and Ohio.

The Health Foundation of Greater Cincinnati's 20-county service region



While reviewing the grants we had awarded, the Foundation recognized a number of projects that were all separately addressing the important connections between health, health insurance, and employment. In the Fall of 1999, the Foundation called together these grantees to share information about their projects and open the discussion about the relationship between health and employment. The proceedings of this roundtable session are the basis of this report.

If you would like more information about any of the projects included in this report, feel free to contact the organizations themselves or the Foundation. If you would like additional copies of this report, contact:

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This report and others, as well as information about the Foundation's grantmaking programs, can be found on The Health Foundation of Greater Cincinnati's web site: <http://www.healthfoundation.org>.

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The Employment and Health Insurance Roundtable

A roundtable is a method of dissemination of information by bringing together a group of people working in a similar area of concern to share information. Each grantee has a piece of a bigger puzzle. By coming together and sharing what each knows, all leave knowing more than the learnings that came from their individual grant.

Often times grantees, who receive funding from local foundations, learn important and rich information when carrying out project objectives. Unfortunately there are few opportunities to share this information with others. The Health Foundation of Greater Cincinnati assists in the dissemination of information among grantees in its 20-county area by convening roundtables.

More than 30 persons attended *The Employment and Health Insurance Roundtable*, the first roundtable sponsored by the Health Foundation, on September 30, 1999. Health and employment are intricately and complexly connected. A person with poor health will have a difficult time maintaining employment. Moreover, only in the United States is employment the path to personal health insurance. Persons without employment, as well as many people with low-paying jobs, do not have health insurance. The Commonwealth Fund 1999 national Survey of Worker's Health Insurance found that, despite a booming

economy, one in five persons between 18 and 64 were uninsured and an estimated forty million people in the United States go without health care when sick because they cannot afford it.

To more closely examine this problem locally, ten projects working in the areas of employment, health, and insurance met and exchanged information. Margaret Hulbert, Government Relations Director for the United Way and the day's first speaker, explored "Employment, Health Care Access, and Advocacy." Chris Goddard, Deputy Director of Northern Kentucky Family Health; Dot Christenson, Executive Director of the Better Housing League; and Jimie Harris, Program Manager of the City of Cincinnati Division of Employment and Training moderated the three panels. Patricia O'Connor, Vice President-Program for the Health Foundation concluded the day discussing the future directions for employment and health insurance.

The roundtable was well received by participants. Ninety-five percent of the nineteen people who evaluated the program evaluated it as excellent or good. Ninety-five percent also strongly agreed or agreed that the information presented was useful and that the panels format was an excellent or good method of presentation. They also agree that networking with colleagues was an asset of the day. All participants received a

notebook with copies of the papers presented. Ninety percent of the participants found the notebook to be excellent or good.

Written comments such as “Excellent opportunity for networking and sharing information” and “Please have more forums like this one, it was excellent” has encouraged the Health Foundation to use the

Roundtable format in the future. Participants also commented that they wanted more discussion time built into the day. Finally the proceedings of the day are published and being shared with others who are interested in the area of employment and health insurance but did not participate in the Roundtable on September 30, 1999.

Employment, Health Care Access, and Advocacy

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When Ann McCracken invited me to talk to you today I told her I was not the right choice for a speaker. Until a year ago I didn't know HCFA from HIPAA, and I am still frequently lost in the alphabet soup of healthcare public policy. Although I am part of the coalition working to expand Medicaid coverage for the working poor, as I told her, I'm a generalist, not a specialist. I follow a variety of health and human service areas, but I am not a health care expert. I explained that, in fact, most of what I do know about healthcare I learned from the people who are presenting here today. I eventually decided to do this for the very selfish reason that it gives me the opportunity to once again learn from all of you, since I get to be here for your presentations.

As I prepared to talk with you today about health care, employment and advocacy, I decided that the choice of a generalist for this task actually made some sense. The challenge of healthcare policy is its complexity and continuous change. For someone outside the health care system, it is very hard to understand how we got where we are today. For new healthcare advocates

like myself, it's even more difficult to identify at what points change can occur. So that is where I started. How did we get here? What can we do to get where we need to go?

In looking for the answers, I utilized materials from a variety of sources. Especially helpful were the Center for Budget and Policy Priorities, The Access Project, UHCAN Ohio, and the Columbus Medical Association Foundation report on access. I particularly recommend *Health Care Policy: The Basics*, written by John E. McDonough, Dr.P.H., and published by The Access Project. It provided a framework for my understanding of health care, and I have excerpted liberally from it for my discussion. The Access Project generously gave me permission to use their graphs and charts for today's presentation. Dr. McDonough's full report, and other excellent material, is available on their web site at www.accessproject.org.

How did we get here? Hospitals began the first health insurance plans in the 1930's to encourage people to use their services. These first plans were "community rated" – everyone paid the same rate. Later employers

bought insurance for workers as an employment compensation that wouldn't violate the federal wage freeze in effect during World War II. This was the beginning of the employer-based system we have today.

There have been many failed attempts to establish a national health insurance. The first was during the World War I/Progressive era and a second during the Great Depression/New Deal era. President Franklin Roosevelt intended national health insurance to be part of Social Security, but failed to have it included. In 1948 President Harry Truman pushed for it again with no success. Each reform effort faced strong opposition from the American Medical Association and other interests. Meanwhile, other industrialized nations including Great Britain and Canada established their national systems.

The current U. S. system of care came from the success of 1960's health care reform efforts that created Medicaid for (some of) the poor and Medicare for senior citizens. Advocates believed at the time that this was the beginning of a system that would eventually cover everyone, but that expansion did not happen.

Beginning in 1970, traditional "fee-for-service" or cost based reimbursement structures, began to be replaced by Health Maintenance Organizations (HMO's) which united the insurers (who paid the bills) in one organization with the providers (who delivered care). Driven by increasing costs, Congress passed the 1973 HMO Act. It

required employers, who provided health insurance to include an HMO option for their employees, and provided financing and support for the development of HMO's. In 1974 President Nixon proposed a national "employer mandate" to require all employers cover workers, but he was opposed by advocates seeking a nationalized "Canada-style" health system (or perhaps he proposed the mandate to forestall the advocacy efforts).

During the recession of the early 1980's, employers utilized HMO's to hold down health care costs. In 1981 when President Reagan ended federal HMO subsidies, many converted from non-profit to for-profit. A variety of managed care models developed including Independent Practice Associations (IPA's) and Preferred Provider Associations (PPO's). HMO's grew from 20 million members in 1985 to 50 million in 1995, and began including the Medicaid and Medicare populations.

We all remember the most recent reform attempt - President Clinton's "Health Security Plan" in 1993, which proposed an employer mandate, mandatory enrollment, health insurance organized into regional community rating pools and strict government standards. Fierce opposition from the insurance industry, eventually combined with opposition from business, (utilizing an especially memorable media campaign) stopped proposed legislation.

Where are we now? Though there is growing dissatisfaction with health care,

particularly health care funding, there is still only very limited public awareness about the true strengths and weaknesses of the American health care delivery system. Most Americans believe we have the best system in the world. For them, an employer-based system is the norm, they will deride other country's "socialized medicine", and they support our "private, free-market" system. This series of perceptions is the framework through which most people view health care.

Reality is very different. Private spending on healthcare services is actually only slightly more than half of all health expenditures. Thus 43% of the 1996 expenditures (\$483.1 billion of \$1.035 trillion) are directly financed by federal, state and local governments. Of the private spending, \$337 billion comes from health insurance premiums paid by private employers, employees and self-insured individuals. But note that 31% of the expenditures, or half the amount spent on premiums, are consumer out-of-pocket expenses, including co-payments, deductibles and other consumer expenses. Of the public spending, Medicare is the largest expenditure, accounting for about one of every five dollars spent nationally on health care services. Medicaid accounts for about one-seventh of health system spending.

As to our belief that we have the best healthcare system in the world, the reality is more complex. It is fair to say that our health care system is more technologically advanced than most, but we lag far behind other

countries in important ways. While other countries are much better at emphasizing disease prevention, health promotion and primary care services, most of our resources are spent to cure illness and treat disease. Only a small amount of our medical expenditures are for prevention.

From my perspective the most important, and negative, difference between our system and that of other countries is access. The United States health care system falls behind all advanced, industrialized nations in providing access to healthcare for all its citizens. It is vital we understand this, not for any negative or blaming reason, but so we aren't frozen in the only model we know. Canada, Japan, Greece, Denmark, France, Germany and the United Kingdom each have less than 1% of their population uninsured. In 1997, 43.4 million Americans, or 16.1% of the U.S. population were uninsured. The United States leads the world in health care expenditures, but shows disturbing results on health status measures like life expectancy and infant mortality. This disconnect is very likely related to our lack of access.

The 1997 numbers of uninsured were before the full impact of welfare reform, which reduced the number of people on public assistance with the consequence of reducing those receiving Medicaid coverage. It was also before the implementation of the Children's Health Insurance Program (CHIP). You will hear more about the impact of both in today's presentations.

But what is most concerning is that the number of uninsured is growing, not declining. There were 25 million uninsured in the U. S. in 1980, and that number has grown by approximately one million per year. This increase has been constant in both good and bad economies.

Who are the uninsured? Men are slightly more likely than women to be uninsured. One-quarter of those 18-34 are uninsured compared to 8-12% for other age groups. Race has an impact, with whites least likely to be uninsured and Hispanics more than twice as likely as non-Hispanic whites to be uninsured. The impact of education is significant with 28% of those without a high school diploma uninsured, while only 9% of those with a college degree are uninsured. Increased income, like increased education increases the chance of being insured. There is growing awareness that many of the uninsured are, in fact, employed. Not unexpectedly, workers at small firms, part-time workers and non-union workers are each more likely to be uninsured.

Another important part of the employment/access equation is the shift in employer provided health care coverage from “defined benefit” plans to “defined contribution” plans. In the former, an employer paid for a set of benefits irrespective of cost. As the cost of health insurance premiums increased, employers moved to providing a fixed dollar amount of support for healthcare coverage, with the

employee absorbing the additional costs through co-pays, deductibles and premiums.

This transfer of cost directly to the employee has forced increasing numbers of workers to turn down employer offered coverage because they cannot afford it. Though the percentage of workers offered coverage did not change between 1987 and 1996, those who accepted insurance dropped from 88% to 80% in that same period. Again, low-income workers were least likely to accept offered insurance. Even when they have insurance, low-income families will delay treatment or not seek necessary care if co-pays and deductibles are too expensive.

Unfortunately, cost and availability are not the only barriers. Socioeconomic and cultural barriers are increasingly recognized as impeding access, including: language differences; cultural beliefs, provider perspectives and attitudes; and, as we will hear more about today, the need to “get information from a trusted place.”

There are also significant barriers resulting from the structure of the health-care delivery system itself. The system is complex and difficult to navigate. This is true for both the insured and uninsured. But for individuals with insurance, a primary care physician or staff member can direct them through the process, help them understand their medical bills and even intercede with insurers about payments. For most of the uninsured there is no primary care physician, no assistance with the bureaucratic maze, and no help understanding bills.

Because they lack the connection to the system that a primary care physician can provide, the uninsured frequently don't know where to get care. Even when poor families can access free care, they generally receive delayed care, less care, and few preventive services. Working poor are traditionally in positions with little flexibility in their work schedules. Since they are more likely to be a part-time employee, and have no sick leave or vacation, they may have to choose between wages and health care.

Capitation, as the primary method of reimbursement for care, can (though it doesn't have to) be a barrier to access. In a system where providers are paid a specific amount per patient per year, there is a disincentive to increase services.

Additional system barriers are shortages of health professionals in inner city and rural areas, inconvenient clinic hours, long waiting times for appointments, and lack of childcare or transportation. If care is secured, there are the same and additional barriers to filling prescriptions, taking medication as directed and getting follow-up care.

The Columbus Medical Association Foundation data suggests that the most significant barrier to care is the personal response to being uninsured. In a very real way, being uninsured is stigmatizing. The foundation describes the long-term uninsured as "internalizing" the very real barriers already described, leading to a "hopeless and helpless" response. Serious, chronic conditions are ignored; and more high-risk

behaviors like smoking, drinking, obesity and drug use are part of their lives.

So, where do we go from here? Actually, I'm hoping to hear some creative answers from all of you as to how we eliminate some or all of these very real barriers. But I do have three general suggestions for our work: information, allies and simplification.

For me, first and foremost, is information: better, simpler, more complete and shared. Only the awesome responsibility of speaking before this august group (fear of public humiliation) drove me to the reading and research required to understand even this bare bones history of healthcare. I know that most of you already know all this stuff. But our legislators do not or, if they do, people who do not will soon replace them. Our challenge is to develop a process of continual education and information for them and other community leaders.

Even the differences between Medicare and Medicaid and the populations they serve are confusing. But it is imperative that you to help those who are not insiders understand them. Confusion has real ramifications for healthcare and social welfare policy. For example: low-income parents and children are three-quarters of the enrollees in Medicaid, but only one-third of the program costs. Like our mythology about welfare, that is not widely understood.

As advocates we need to expand our vision and relationship with the entire health care system, not just the publicly funded portion. We need to enlist our corporations

and the business community as allies. They need to understand how decisions made by State Legislative Insurance Committees have community impacts beyond their corporations that they should be concerned about. In what ways can businesses and human resource departments become agents for CHIP and Medicaid enrollment for their low-income employees?

We need to make business and community leaders aware that delayed care, and care delivered in the emergency room to the underinsured and uninsured, impacts the cost of everyone's health care coverage and stresses the entire delivery system. Access does not have to be a finite commodity where if you get some, I get less or mine costs more. In fact, the lesson from other countries may be that increasing access lowers everyone's cost.

Since managed care and capitation are the delivery system paradigms for the foreseeable future, let's focus on how we increase their

strengths, minimize their liabilities, and apply them to our concerns in more effective ways than we have to date. Managed care and capitation have built into them some incentives to focus on preventative care. How do we eliminate the "prisoner's dilemma" of capitation and increase the incentives to focus on health and wellness?

And finally, we need a simpler system with one point of contact for health care information. A point of contact where low-income under- or uninsured people can have assistance thinking through the best place and way they can access appropriate care, get there, and get prescriptions and other needed treatments—a friendly place and a way they understand.

One final ending quote from Dr. George Kaplan, via the Access Project. He says, "We need to start thinking that economic policy is the most powerful form of health policy. As we increase people's economic well being, we increase the health of all."

Sources

- The Access Project
30 Winter Street, Suite 930
Boston, MA 02108
617-654-9911
www.accessproject.org
- Center on Budget and Policy Priorities
820 First Street, N.E., Suite 510
Washington, DC 20002
202-408-1080
www.cbpp.org
- "Access to Health Care: A Comprehensive Study Into A Community Problem"
Columbus Medical Association Foundation
431 E. Broad Street
Columbus, OH 43215
614-240-7420

Panel One: Who Are the Uninsured?

Moderator: Chris Goddard, Deputy Director of Northern Kentucky Family Health

Four community service organizations were asked to participate in a roundtable discussion concerning employment and health insurance. Each participant was asked to submit a paper that defined a problem that his or her respective organizations were addressing through its project. The problem was unique to their organization. The paper should include the approach used to address

the problem, the findings from the project, and the implications on the greater Cincinnati area.

The four presenters included the Jordan Center, Uninsured Cincinnati, the Franciscan Partnership, and the FreeStore/FoodBank. All four entities provided an introduction to their organizations before presenting their papers.

Jordan Center

Paper Presentation Overview

Problem: A growing number of working adults in Hamilton County have no health insurance. The Jordan Center recognized that the Welfare Reform Act of 1996 and the reconfiguration of health care delivery in the United States impact the working uninsured and underinsured.

Approach: The Jordan Center designed a WORKPLACE WELLNESS program to take its basic health assessments and services to small businesses with medically uninsured employees. The objective was to identify working uninsured adults, arrange with employers to conduct on-site health assessments, and monitor the health of employees to encourage the maintenance of basic wellness. The Jordan Center also initiated a WELLNESS EDUCATION & SUPPORT initiative. The objective was to

telephone survey clients about their preferences for holistic health education opportunities.

Findings: 1) Both Workplace Wellness and Wellness Education & Support programs are time-intensive for Jordan Center staff volunteers. 2) One limitation of Workplace Wellness program is that it relies on volunteer staffing. And volunteers are difficult to recruit. 3) Health coverage and prevention and wellness concepts are not always priorities for people struggling with daily economic survival. 4) A neighborhood-based development approach although time-intensive, may yield more long-term results than a solely needs-driven program development approach. 5) The Jordan Center's efforts are a stopgap measure.

Implications: The Jordan Center project is undergoing significant re-design, and so it

is premature to suggest implications for the Greater Cincinnati area.

Discussion Overview

Several barriers were raised that impacted the success of the project. Barriers included the existing lack of emphasis on health promotion and disease prevention by the US. The lack of emphasis resulting in nominal

reimbursement prohibits organizations from providing these needed services. Prevention and wellness concepts, as stated in the finding, are not a priority for this population and create a huge barrier. Many employers have little time and money to support activities that detract from their businesses, a third barrier.

Uninsured Cincinnatians

Paper Presentation Overview

Problem: To discover whether working people in Cincinnati have a lack of health insurance. Lack of insurance can result in limited access to medical care and difficulty in paying medical bills. It is also associated with poor health and disability, employment difficulties, problems paying for food and shelter, stress, and fear.

Approach: An exploratory study using both qualitative and quantitative research methods was developed to learn about the experiences, beliefs, attitudes, and preferences of uninsured workers in Cincinnati. Three Cincinnati neighborhoods were studied.

Findings: Findings were reported in several sections: health status, health care utilization, costs, health insurance, and health care preferences. Due to the limited space available, this report will not be able to share a comprehensive lists of findings. 1) In general, race, neighborhood, and income

were not related to the findings. 2) No participant reported in engaging in prevention activities. 3) Regarding health insurance, in two-thirds of participants' households, no one had health insurance. 4) A number of factors prevent workers from taking advantage of insurance even when offered by employers. 5) Little stigma was attached to Medicaid. 6) Regarding health insurance preferences, participants overwhelmingly (75%) endorsed health insurance as the preferred way to pay for health care.

Implications: 1) Providers who target the uninsured need to be aware that they may be perceived as “not as good” as places one can go when one has insurance. This perception may create a barrier. 2) The idea that insurance offers choices is increasingly challenged in a managed care environment. 3) Employers may have to offer benefits such as health insurance because the strong economy translates into greater competition for workers.

Discussion Overview

The project encountered difficulty in collecting data due to the transience of the population being studied. There is a tremendous need for empirical data to study and make policy decisions. A lack of access to behavioral health services is often overlooked. The number of Medicaid

recipients continues to decrease. Attention must be given to those who may be obligated to leave Medicaid prematurely. It is a misconception to believe that everyone who could be on Medicaid is. Uninsured are often younger with fewer health issues. It is not until later in life when chronic conditions become a more significant issue.

Mercy-Franciscan Health Partnership

Paper Presentation Overview

Problem: AFDC clients did not want to be on welfare but had to depend on it because of various circumstances.

Approach: Create a partnership model of volunteer practitioners, namely primary care physicians, to improve access for the poor. It considers itself a short-term program with the goal that families will be able to improve their employment situation within a period of two years, or those not yet eligible for Medicare or Medicaid will do so within that time.

Findings: 1) 62% of the Partnership members are female in comparison with 60% of the general population. 2) 75% of the members are single, separated, widowed, or divorced. 3) 50% of the members fall within the 18-49 year old age group. 4) Members

have significantly lower mental health status than the national population.

Implications: 1) Access to primary care can reduce utilization of the emergency department, especially for chronic conditions such as asthma and diabetes. 2) If individuals are members of a true care management program, members begin thinking about prevention, and about taking responsibility for their own health.

Discussion Overview

The current reimbursement system does not align the financial incentives of providers which prevents them working together to optimize the health status of the patient. Additionally, the same system discourages disease prevention and health promotion. The Partnership was amazed at how many eligible people have chosen not to participate.

FreeStore/FoodBank

Paper Presentation Review

Problem: Until more is known about the cause of barriers for those impacted by the

1996 Federal welfare reform it is difficult to design appropriate intervention or effective

health care models to recruit and serve the specific needs of this population.

Approach: The project identified a traditionally difficult population to study. An assessment methodology was developed and consisted of a psychosocial interview, several formal assessment questionnaires, a neuropsychological examination, and a neurological examination.

Findings: Currently there are no findings from the project. After three unsuccessful attempts to collect data, the project has secured permission for a fourth recruitment plan.

Implications: Once the data is collected, it is expected that the data will provide necessary information for developing further research opportunities and program initiatives to serve long term welfare recipients through identifying barriers to employment, skills, training and other social service and/or rehabilitation programming.

Discussion Overview

The frustration and obstacles in obtaining data, while disappointing, will not discourage the project.

Wellness for the Working Uninsured

The Jordan Center

Introduction

The Jordan Center provides preventive health services to the people of Greater Cincinnati who are medically underserved, with a particular interest in serving the working uninsured. At our two neighborhood centers in East Price Hill and in Madisonville, Jordan Center volunteers provide nursing assessments and consultation, dietary counseling, holistic health programs, psychological counseling, and massage and Healing Teach when available. Each year we participate in a number of health fairs, and collaborate with other agencies on special projects such as free osteoporosis screenings for low income women.

Volunteers are the cornerstone of our services. Our volunteers are professional nurses and dieticians, experienced holistic health practitioners, and clients who want to contribute to the mission of The Jordan Center.

The Health Foundation awarded The Jordan Center a grant in the spring of 1998 to expand our services to the working uninsured

of Cincinnati. This grant funded two large projects. The first project has helped us to establish a variety of holistic health classes and programs at our neighborhood centers. Our classes have included such diverse topics as *How to Parent a Child with Attention Deficit Disorder*, *Food and Mood*, and *Stress Management*.

The second large project funded by this grant is Workplace Wellness. This program is designed to take our health assessment and health education program to small businesses where employees do not have health insurance. In a thirty minute session, each employee will have a nursing assessment, receive consultation on health concerns, educational materials, and referrals for health care as needed.

The presenters for this Roundtable are Karen Grote, Executive Director of The Jordan Center, and Kate Fadick, the new coordinator of the Workplace Wellness program.

The Problem

A growing number of working adults in Hamilton County has no health insurance.

The welfare reform act of 1996 and the continuing reconfiguration of health care delivery in the US impact the working

uninsured and underinsured. As our country's social welfare system is dismantled, people who have depended on it for health care may

find that even though they are working, they are too rich for welfare and too poor to afford medical coverage. They are still living near, or even below, the poverty line. At the same time, our health and medical care system is experiencing rapid change. National public policy putting into place mechanisms creating access to health care for uninsured adults is not forthcoming, even though there is some evidence public opinion favors such policy. A recent survey by the Kellogg Foundation reports that a majority of its participants believe that health insurance should be provided to those who cannot afford it or whose employers do not provide health insurance.

We experience these national trends in Cincinnati and Hamilton County. In the census of 1990, there were over 242,705 people in Hamilton County in households with income less than 200% of poverty. Between 88,000-103,000 Hamilton County residents had no health insurance. Others are underinsured. (Taken from *OSU's 1997 Synthetic Estimation of Uninsured Rates* by

County in Ohio and The Ohio Department of Health, State Health Resources Plan, 1996.) In the Jordan Center's experience, many of these people are working adults. They are single women ages 25-45 with dependent children. They work in low-paying service sector jobs. Very often they have not received education or support for preventative care. Due to financial constraints, they may not even seek medical attention what symptoms first arise. When the condition worsens, far more expensive interventions are often required. And the gap widens. The health centers of the city of Cincinnati and independent non-profit clinics are facing financial struggles. Hospitals have undergone substantial restructuring; at least one has had to close services in low-income neighborhoods, due to a marked increase in uncompensated care. Many employers of low-wage workers still can't afford health benefits, the emergence of managed care notwithstanding.

The Jordan Center project seeks to address this gap in health services for low-income, working, uninsured people.

The Approach

Will providing Jordan Center's basic health assessments and services in the workplace and offering education and support for prevention and wellness significantly fill the health care gap for working, low-income, uninsured adults?

WORKPLACE WELLNESS is a program designed to take The Jordan Center's basic health assessments and services to small businesses with medically uninsured employees. The project objectives have been to identify working uninsured adults, arrange

with employers to conduct on-site health assessments, and monitor the health of employees to encourage the maintenance of basic wellness.

Identify working uninsured adults. The Jordan Center conducted research at the

library to identify small businesses. Information was gathered through a telephone client survey and by reviewing our client database information. We got additional information from six companies that offer business-to-business services and the Greater Cincinnati Chamber of Commerce.

Arrange on-site assessments. We began contacts with businesses with fewer than 25 employees, expanding later to include somewhat larger businesses. Prior to August 1, 1999, a total of 364 phone calls, many of them unsuccessful connections, were made to 79 companies or agencies. There were 40 complete refusals from employers to bring Workplace Wellness on-site, most from businesses offering medical benefits. Incomplete connection was made with 38 businesses, largely due to lack of response from employers. Two Workplace Wellness events were scheduled and occurred in July, 1999. Since August 1, a concentrated effort has been underway with the home health care industry, Community Action Agency (Head Start and home child care providers), temp agencies, and restaurants. On-site events are scheduled with a home health care corporation in October.

The Jordan Center's medical director and three registered nurse volunteers designed a basic format for on-site events. It includes basic health assessment, blood pressure and blood sugar checks, height and weight, a vision screening, education about health risks

and healthy habits, and referrals to health and human resources in the community. A health risk assessment, flu shots, and tetanus shots can also be arranged.

Encourage basic wellness. At our first event we encouraged basic wellness by completing the nurse assessment and consultation, offering educational materials and making referrals for medical care and community resources. We did not at this point complete the self-assessment tool or offer the comprehensive risk assessment.

WELLNESS EDUCATION AND SUPPORT was initiated through a telephone survey in the summer of 1998. Jordan Center clients were asked about their preferences for holistic health education opportunities. Since September 1998, 30 classes have been offered; 16 were canceled for lack of enrollment. The 14 classes completed required 31 sessions, with a total of 178 participants. Classes are advertised through monthly mailings. Presenters and facilitators are scheduled through collaboration with other health and service agencies. Child care is available. A September, 1999 day-long self-health workshop for up to 25 women had an enrollment of 21. Participants expressed a desire for a women's health support group. The Jordan Center has begun to work with those participants and two other neighborhood organizations to develop this support group.

Findings

Both Workplace Wellness and Wellness Education and Support programs are time-intensive for Jordan staff and volunteers.

One limitation of the Workplace Wellness program is that it relies on volunteer staffing. We are finding it difficult to recruit volunteers for this project.

Health coverage and prevention and wellness concepts are not always priorities for people struggling with daily economic survival.

A neighborhood-based development approach, also time-intensive, may yield more long-term results than a solely needs-driven program development approach. We are beginning to see this evidenced in our newer collaborative efforts.

The Jordan Center's efforts are a stopgap measure. Projects such as the HEALTHWEB are necessary for the development of an effective healthcare infrastructure for low-income, uninsured Hamilton County residents.

Implications

The Jordan Center project is undergoing significant re-design, and so it is premature to suggest implications for the Greater Cincinnati area.

Health Care Experiences of Uninsured Workers in Three Cincinnati Neighborhoods

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Introduction

Poor, uninsured working people residing in Price Hill, Northside, and Madisonville ($n=57$) were interviewed to determine their experiences with and attitudes about health care. Participants generally viewed their own health as good, yet almost 60% reported having an illness. One-fourth had no regular health care provider, and 20% of children did not have regular physician appointments. Participants were generally satisfied with the health care they received, although almost 25% had complaints ranging from long waits to poor treatment to racism. Costs for health care were reported to be manageable, but 42% had outstanding medical bills they could not pay or could pay on only erratically. Few had received free care or medications in the

past two years. Decisions about when to seek medical care were difficult, especially when children were sick. When they could not afford care, they used home remedies and did not keep follow-up appointments. They borrowed medications from others, cut pills in half to stretch prescriptions, and went without when they could not afford to purchase prescribed medications. Participants preferred health insurance over other ways to obtain health care, yet almost half could afford only \$50 a month or less to purchase insurance. Services targeted toward the uninsured need to consider this preference for health insurance and accompanying perceptions that insurance allows one choices and gets one better care and treatment.

The Problem

Lack of health insurance is a major social problem facing the United States. Forty million Americans (Donelan, et al., 1996) and an estimated 208,000 Cincinnatians (Thompson, 1996) are without health

insurance. Lack of insurance can result in limited access to medical care and difficulty paying medical bills and is associated with poor health and disability, employment difficulties, problems paying for food and

shelter, and stress, worry, and fear (Donelan, et al., 1996). Uninsured children often do not have regular physician appointments, go without care, and are not immunized (Families USA, 1997).

The Uninsured Workers study was undertaken to discover whether uninsured

working people in Cincinnati have experiences similar to those reported above. Specifically, this study was designed to explore and describe the health status, experiences with health care providers and health insurance, and preferences for health care services among the working uninsured in three Cincinnati neighborhoods.

The Approach

An exploratory study using both qualitative and quantitative research methods was developed to learn about the experiences, beliefs, attitudes, and preferences of uninsured workers in Cincinnati. This information was collected through face-to-face interviews with participants using an interview schedule, which was developed by the research team with input from the Health Foundation of Greater Cincinnati staff. The interview schedule contained both open- and closed-ended questions designed to elicit participants' unique ideas and experiences about health care, as well as specific information of interest to the research team.

Information collected included

- demographic characteristics of participants and their household members;
- current employment information and work history for the past two years;
- the places participants went for health care services and their evaluations of the care they received;

- the costs incurred for health care and the ways cost affected decision-making about seeking health care services;
- experience with employer-sponsored health insurance and Medicaid in the past two years;
- preferences for ways of obtaining and paying for health care.

In addition, participants reported on their health status using the Medical Outcomes Study Short Form (MOS SF-20) (Ware, Sherbourne, & Davies, 1992) and were asked about self-care activities and their own and family members' illnesses.

Three Cincinnati neighborhoods, Price Hill, Northside, and Madisonville, were selected as research sites for this study. These neighborhoods have significant populations of the working poor and offered the opportunity to select a racially diverse sample. All three have city health clinics, as well as a number of other health care providers. Neighborhood residents were hired

as community consultants. These consultants provided information about neighborhood characteristics (e.g. what health care services were available) and located potential participants. Twenty participants from each neighborhood were sought. Graduate students in Social Work and Psychology were hired and trained in interviewing. They conducted the interviews with study participants. The community consultants were present at interviews to provide clarification and support as needed.

A convenience sampling method was used. Participants were recruited in several ways. The community consultants recruited the majority of participants from among their family, friends, and acquaintances, who in turn referred other uninsured people. Flyers were posted in Northside and Madisonville businesses and social service agencies advertising the study. Other participants were recruited by the staff and volunteers of the CAIN food pantry in Northside, the Madisonville Emergency Assistance Center, and the Braxton F. Cann Clinic in Madisonville. One community consultant was able to recruit a number of participants from a local factory where she had contacts. Interviews were conducted between August and December 1998 and were held in a number of locations, including consultants' homes, participants' homes, the factory mentioned above, and neighborhood agencies.

Signed consents were obtained from all participants. All interviews were audio taped,

and interviewers made notes on the interview schedules throughout the interviews. Interviews ranged from 30 minutes to 2 hours; most were in the 30- to 40-minute range. Participants were paid \$10 immediately upon completion of the interviews and were given a resource sheet listing medical and dental services in these neighborhoods.

Audio taped interviews were professionally transcribed, and the research team coded the transcripts. The coded data were then categorized using TextSmart1.1, a qualitative data analysis program. The data were then used in two ways. Categorized data that could be quantified were loaded into SPSS and analyzed statistically. These data included demographic information, responses to the MOS SF-20, and answers to closed-ended questions (e.g. "How much did you and your family spend for health care in the past year?"). Other data were not quantifiable, but consisted of stories and explanations given by participants. Exemplars are used in this report to illustrate participants' experiences.

Sample Characteristics

The sample was composed of 57 uninsured workers. Selected demographic characteristics of the sample are summarized in the table below. Of note is the relative poverty of the sample: 82% of participants lived in households with annual incomes of less than \$25,000.

Table 1. Sample Characteristics by Neighborhood

	Price Hill	Northside	Madisonville	Total
Sex				
male	8	4	5	17 (29.8%)
female	11	16	13	40 (70.2%)
Age				
< 21 years	2	1		3 (5.3%)
21 - 30	11	5	3	19 (33.3%)
31 - 40	4	7	5	16 (28.1%)
41 - 50	1	3	5	9 (15.8%)
51 - 60	1	1	4	6 (10.5%)
61 - 70	1	2	1	4 (7.0%)
Race				
African American		8	18	26 (45.6%)
White	19	12		31 (54.4%)
Relationship Status				
single	7	4	6	17 (29.8%)
married	5	5	4	14 (24.6%)
widowed	2	2		4 (7.0%)
divorced/separated	4	7	6	17 (29.8%)
cohabiting	3	2		5 (8.8%)
Education				
< high school graduate	10	5	2	17 (30.4%)
high school graduate	6	8	8	22 (39.3%)
some college	3	5	5	13 (23.2%)
college graduate	1	2		3 (5.4%)
graduate degree	1			1 (1.8%)
Employment				
service	12	10	8	30 (52.6%)
trades	2	1	6	9 (15.8%)
factory	2	2	2	6 (10.5%)
clerical	2	1	1	4 (7.0%)
professional	1	2	1	4 (7.0%)
(missing)				(4) (7.0%)
Household Income				
< \$15,000	7	10	9	26 (45.6%)
\$15,000–24,999	7	8	6	21 (36.8%)
\$25,000–34,999	5	1	3	9 (15.8%)
> \$45,000	1			1 (1.8%)

Slightly more than half of the households (56%) had minor children in the home. 30 participants had children and

2 participants had grandchildren at home. Mean household size was almost 3 (range

1 to 9), and 3.75 for non-single-member households.

Because employment and health insurance are linked, detailed information about work histories for the past two years was collected. 12.3% of participants were currently self-employed, and 31.6% worked part-time. Over half of the participants had worked at their current jobs for a year or less,

although almost 30% had been continuously employed at the same job for at least the past two years. Almost one-quarter of those who had been at their present jobs for less than two years reported no prior job in that period, suggesting significant periods of unemployment. Of those changing jobs in the past two years, only 3 reported leaving a job for a better one.

Findings

Findings are reported in several sections: health status, health care utilization, costs, health insurance, and health care preferences. In general, race, neighborhood, and income were not related to the findings, except in a few cases as noted below.

Health Status

Table 2 shows participants' health status as 3 variables based on responses to the MOS SF-20:

- *Total health status*, a mean comprised of scores on 5 general questions

about health (5-point scale, 5 = best health);

- *Functional limitations*, a mean comprised of scores on 6 questions about physical functioning (3-point scale, 3 = least limited);
- *Mental health status*, a mean comprised of scores on 9 questions about emotional functioning (6-point scale, 6 = most positive mental health).

Table 2. Descriptive Statistics for Means of Total Health Status, Functional Limitations, and Mental Health Status (MOS SF-20)

	N	Mean	Median	Std. Deviation	Variance	Range	Minimum	Maximum
Total Health Status	57	3.4561	3.7500	0.9744	0.9495	3.50	1.50	5.00
Functional Limitations	57	2.6491	2.8333	0.5239	0.2745	1.83	1.17	3.00
Mental Health Status	57	4.3298	4.4000	0.9961	0.9921	4.20	1.80	6.00

Participants' self-reports of health were generally positive. As expected, total health status was correlated with mental health status and even more strongly with functional limitations. The relation between mental

health status and functional limitations, while not significant, was in the expected direction. None of these 3 variables was correlated with demographic characteristics, expect age

was negatively correlated with functional limitations.

While participants made positive assessments of their health, almost 60% reported having an illness. Allmost 75% reported one or more illnesses in the their families, with 50% reporting one illness and

23% reported two or more. Only 27% reported that no one in their family had an illness. Illnesses were categorized by type, and their distribution among participants' families is shown in the table below (percentages total more than 100 as some participants reported more than one illness).

Table 3. Types of Illness in Participants' Families¹

Type of illness	Count	Percentage
circulation & heart problems	12	17.4
asthma	6	8.7
diabetes	5	7.2
major illness	10	14.5
injury & joint problems	10	14.5
dental & vision problems	5	7.2
birth defects	3	4.3
mental health problems	5	7.2
none	13	25.5

Having an illness was correlated with functional limitations but not with mental health status or total health status as measured by the MOS SF-20.

Participants' self-care or wellness activities involved life-style choices. To keep themselves healthy, participants reported eating right (35), exercising (27), and following doctors' orders and taking prescribed medication (8). Participants also mentioned these activities, along with quitting smoking, as things they could or

should do to promote health. Lack of time, money, and motivation prevented participants from doing these things.

Only 8 participants reported that someone in their families had care giving responsibilities, and none reported receiving formal services.

Health Care Utilization

One-quarter of the participants had no regular health care provider, and the others used a variety of providers, as shown in the table on the next page.

Table 4. Regular Provider

Type of provider	Count	Percentage
none	13	22.8
city clinic	17	29.8
hospital clinic	9	15.8
VA	3	5.3
private MD	8	14.0
free clinic	2	3.5
(missing)	(5)	(8.8)
Total	57	100.0
none	13	25.5

Whether a participant had an illness or not was not related to having a regular provider or the type of provider one had. African Americans were more likely to have a regular provider and more likely to use a city clinic for regular health care, and there was a trend toward Madisonville residents, more than residents of the other two neighborhoods reporting the same.

Participants reported high levels of satisfaction with health care services they received. 72% were satisfied with the care they received from regular providers, and there was a trend toward African Americans and Madisonville residents being more satisfied. Complaints of those who reported being dissatisfied included the belief that care provided was not good, being treated poorly or disrespectfully by staff, long waits for appointments or in the waiting room, the physician being rushed, and racism. While some participants stated they would not

return to providers if dissatisfied, others felt forced to use these providers as they had no other choices. A few participants who were satisfied with care they received also related experiences that tended to contradict this evaluation. For example, one man reported that he was diagnosed with diabetes at the same point in time when his right leg had to be amputated due to complications from that illness.

Eleven people did not know of health care services in their neighborhoods. This lack of knowledge was not related to having a regular provider or being satisfied with health care services received.

Costs

While participants’ reports of costs incurred for health care were generally low, cost appeared to have an effect on decisions to seek health care. Tables 5 and 6 on the next page show costs incurred for health care in the past month and past year respectively.

Table 5. Health Care Costs in Past Month

Cost	Count	Percentage
nothing	22	38.6
\$50 or less	19	33.3
\$51-100	3	5.3
more than \$100	8	15.4
(Range: \$140-600)		

Recent expenditures for health care appeared manageable, but many participants had accumulated bills that were burdensome. 10.5% reported being able to pay bills on a regular basis and 33% had no outstanding bills, but 42% said they could not pay outstanding bills or make payments on them only erratically. This woman’s comment illustrates the dilemma faced by the working poor:

I've paid some on them, but it's like, a lot of times things come up, like with the kids going back to school, or if I don't make as much money as I thought I was going to make at work and it's a choice between, you know, are you going to get groceries or, you know, how much can you pay on this bill?

Participants almost always incurred costs when seeking health care. Only one participant received free care from a regular health care provider. More than 17% were charged the full fee by regular providers, while 57.9% were charged on a sliding scale or reduced fee basis. Over 68% had received no free health care services in the past two years.

Cost often prevented participants from seeking medical care. 57% reported going

Table 6. Health Care Costs in Past Year

Cost	Count	Percentage
nothing	4	7
less than \$100	13	22.8
\$100-499	17	29.8
\$500-999	9	15.8
\$1000 or more	8	15.7
(Range: \$1000-12,000)		

without care in the last two years when they felt they needed it. Medical problems that were untreated included minor ailments (e.g. cold or flu), injuries and acute conditions causing pain, and chronic conditions (e.g. high blood pressure). In addition, some people did not receive follow-up care when recommended (e.g. for fractures). 34% reported going without prescribed medications in the past two years; these included antibiotics, pain medications, and medications prescribed for chronic conditions such as hypertension.

In deciding when to seek help, participants weighed the seriousness of the condition and the possibility of treating it at home against incurring a large expense. They understood that complications could result from untreated conditions, but cost was a more immediate concern. Decisions were most complicated when the sick family member was a child, as this mother’s comments illustrate:

... if they're running a fever and I get scared and I think, you know, should I take them or not, you know, if the fever gets too high the, you know, and I try putting them in a cool bath or something like that to bring the fever

down. It's that kind of stuff, you know. I mean, you try not to go, if you can avoid it at all, you know.

When they were unable to afford care, they used home remedies. When they were unable to afford medications, they borrowed pills and inhalers from friends and money from family members to buy medications, cut pills in half to stretch prescriptions, or did without. Only a few participants mentioned getting help from agencies to purchase medications.

More than 21% of households with children reported that the children did not have regular appointments with health care providers. In part, this was a function of age, with older children being seen as having outgrown the need for regular check-ups. Only one participant reported that her children were not immunized and that was by her choice. Only 7% paid the full fee for immunizations, while 10.6% paid for these on a sliding scale or reduced fee basis.

Participants incurred other costs related to their health. Almost 20% lost jobs because of illness, and a few missed days of work and were forced to reduce their hours. A striking example of the way illness can affect employment is seen in the experience of this young woman with systemic lupus. She was on an unpaid medical leave for over two years from a company where she had previously worked for nine years. She encountered problems returning to work.

They just didn't have a job for me when the doctor did release me. So, you

know, they said, "Well, we'll find you a job but there's no guarantee that you'll get what you had" and what they had for me...was like \$6 an hour when I had been making \$12...The doctor had allowed me to come back part time...and they wouldn't let me come back until I was full time. And then even after that he said, "Well, no more than 6 hours a day," and they didn't want to agree with that. So I just said, "Screw it."

She provided child care in her home while working getting a bachelor's degree which she believed would allow her to obtain a good job where she could work six hours a day.

Health Insurance

In two-thirds of participants' households, no one had health insurance. Children were the household members insured in more than three-fourths of households in which someone had insurance. Among households with children or grandchildren ($n=32$), half had children who were insured, primarily through Medicaid programs. In two households, only some of the children were insured.

Most participants worked for employers who did not offer health insurance, although 40% worked for employers who did. Participants gave these reasons for not having this insurance: hadn't worked there long enough (6), couldn't afford premiums (5), not full-time employee (4), and not eligible for other reasons (e.g. insurance not offered for their position) (4).

Participants expressed few negative feelings about Medicaid. The majority said they would apply for Medicaid if eligible; only 4 said they would not, and 5 would do so only for their children. Nine participants reported that someone in their households, generally children, was covered by Medicaid, and almost 20% reported that someone in their family lost Medicaid coverage in the past two years, including 11 (or almost one-quarter) with incomes of less than \$25,000. In only two cases was this because they obtained health insurance through a job. More than 80% of participants themselves (i.e. excluding family members) had never had Medicaid coverage in the past two years, including 42% of those with household incomes less than \$15,000. The majority of participants with children had heard of Healthy Start and CHIP, but less than a third of these had applied or were applying.

Health Care Preferences

Study participants overwhelmingly endorsed health insurance as the preferred way to pay for health care. 75% preferred insurance, while 7% preferred free clinics, 5% preferred a “pay as you go” arrangement, and 5% had more than one preference. Participants preferred insurance for the following reasons: have a choice of provider (10), cheaper as it covers bills (10), get better care or treatment (9),

have access to care, safety net (8), and know in advance what you’ll have to pay (4). The value of health insurance is illustrated by the comments of this woman who was diagnosed with ovarian cancer four years ago:

I was complaining of the symptoms for a year before it was found and it was only found because I pushed for them to do surgery. Actually a tumor had popped up to where you could actually see it and the doctor said, “We can give you medicine, or we can let it go and see what happens or we can do surgery,” and she made it sound as if surgery was a last option and I said, “No, do surgery,” and she did and that’s when she found out I was in Stage IV cancer... And I think that if I had health insurance that surgery was the first thing thought of to find out what that was and why it was there and then probably could have prevented the disease from spreading as bad as it did.

While participants wanted health insurance, cost would be a barrier. Almost half said they could afford only \$50 a month or less for insurance. A third reported that they would not buy insurance if it meant they could not afford something else; they had no extra money and bought only necessities. Those who would be willing to give up something else to buy health insurance mentioned the following: entertainment or social activities (5), cigarettes (5), cable TV (3), fast food or treats (3), clothes (2), telephone (2), long distance calls (1), and car (1).

Implications

The methodology of this exploratory study of uninsured workers, as well as the small, non-random sample, limits the generalizability of the findings presented here. However, the findings suggest a number of implications for the delivery of health care services in the Cincinnati area. These implications center around the preference for health care insurance, perceptions of Medicaid, the effect of cost on decisions to seek health care, and prevention activities.

Health insurance was strongly preferred by participants, who felt it provided them with more choices and better care and treatment, although participants were generally satisfied with all the types of providers mentioned here. However, services targeted toward the uninsured, such as free clinics and the city health department clinics, need to be aware of this potential barrier to utilization: they may be perceived as “not as good” as places one can go when one has insurance. In addition, the idea that insurance offers choices is increasingly challenged in a managed care environment; insurance may not prove as valuable in this area as the uninsured believe.

While the majority of participants worked for employers who did not offer insurance, a significant percentage of participants’ employers did. However, a number of factors prevent workers from taking advantage of this: employers may limit employees’ hours to make them ineligible for

insurance; workers may not stay in a job long enough to become eligible for insurance; and workers may not be able to afford expensive premiums. If a good economy translates into competition for workers and higher wages, employers may need to offer benefits such as insurance and workers may remain in jobs long enough to become eligible. However, many of the participants in this study who left jobs did so because of health problems, interpersonal difficulties with coworkers or bosses, and dislike of the job, suggesting that non-economic factors play an important role in employment decisions. Even if workers do remain in jobs long enough to become eligible for insurance, premiums are often prohibitive, especially for family coverage.

Participants attached little stigma to Medicaid, with the majority stating that they would apply if eligible, although several expressed frustration with the process. Given the relative poverty of this study’s sample, it is surprising that there are so few current or recent Medicaid recipients. The reasons for this are unclear. It may be that people will say one thing but do another; that the hassles involved in applying are greater than one’s motivation to do so; or that people are uncertain about eligibility standards, especially in an era of welfare reform with its goal of caseload reduction. Further study is needed to determine if Medicaid is a viable option for the uninsured. State-sponsored medical programs for children may be more valuable to uninsured workers, as seen in the

fact that several participants with children had actually applied for Healthy Start or CHIP at a time when CHIP was a relatively new program. Aggressive efforts to enroll the children of uninsured workers in these programs seems warranted, especially as parents concerns about when to seek care often center around their children..

Although participants gave positive reports about their health, many reported having illnesses. In addition, many participants told stories about going without health care when they needed it because of cost. This combination of illness and neglect is potentially harmful to the uninsured. Ensuring access to care while minimizing costs should be a priority in providing services to the uninsured. However, this is complicated by the expressed preference for health insurance, which may limit the attractiveness of services offered for free or at reduced rates.

Prevention efforts need further exploration. No participant reported engaging in prevention activities such as annual physicals, mammography, or screenings for

high blood pressure or colon-rectal cancer, although young children generally received prevention services. It is unclear if participants did none of these or if they did not consider them activities related to promoting health and so did not report them. Additional study of uninsured workers' prevention activities is warranted, and educational efforts to promote these practices may need to be expanded and targeted toward them.

People lacking health insurance adapt to certain expectations about their health and options for health care which may prompt satisfactory reports about health and services. They use common sense and their own cost-benefit analyses in deciding how to deal with illness and when to seek help. In many cases, these efforts are successful. Yet they also recognize that they are missing out on something that would be of benefit, and this translates into a preference for health insurance which would provide access and eliminate difficult decision-making about what to do when someone is sick.

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Primary Health Care for the Medically Indigent

Mercy-Franciscan Health Partnership Program

Presented by: Holly Mechley

Edited by: Kathleen Hunt

Introduction

Organization

The Mercy-Franciscan Health Partnership is a program which is provided by Mercy Health Partners (MHP) through the Mercy Franciscan Hospital Mt. Airy. MHP is a member of Catholic Health Partners, a national organization of catholic health care providers. The Mission of Catholic Healthcare Partners is to “extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and under-served.” The core values underlying CHP’s mission are: compassion, excellence, human dignity, justice, sacredness of life, and service. As an indication of commitment to this mission, the combined Mercy-Franciscan health systems last year provided a total of \$25 million in social services, community outreach and education, and unreimbursed medical care.

Project Summary

The Mercy-Franciscan Health Partnership Program (“The Partnership”) began as a pilot project in 1996. The goal was to create a model of health care for the “working poor,” and replace the emergency room as their

source of primary care. The Partnership is a coalition of volunteer health care providers (comprised of hospitals, physicians, specialists, and the U.C. Family Practice Residency Program) which offer accessible, affordable, quality health care to the medically indigent in the Greater Cincinnati area. This care consists of treatment, education, prevention and case management, and includes a prescription drug program. The Partnership targets working poor families whose income is at or below 150% of the Federal poverty limit. Upon acceptance and enrollment, The case manager teams each family with a volunteer, primary care physician. Participants receive a medical insurance card, which requires them to make a \$3 copay for medical care, and a \$5 copay for prescriptions.

Presenter

Holly Mechley is the Case Manager for The Partnership. She is also an active advocate for the needs of Partnership families and other medically indigent people in the Greater Cincinnati area. In her role as advocate, Holly also epitomizes the core values of the MHP Mission: compassion,

excellence, human dignity, justice, sacredness of life, and service.

Holly is active at the local and state level and has been one of a core group who have been working on improving health care for the uninsured and underinsured. She is a member of: the Ohio Advisory Committee on the Children's Health Insurance Program (CHIP), which advises on outreach activities within the State of Ohio; the Health WEB Committee, a coalition of healthcare providers in Greater Cincinnati who are studying the need for, and access to, health care for uninsured and underinsured; a participant in the Southwest Ohio Children's Coalition; and a member of the working team

for the Robert Wood Johnson Grant to the State of Ohio for the CHIP outreach, which is being administered by the Ohio Commission on Minority Health. Holly is one of twenty people nationwide who has recently been invited to participate in the Access Project on Expanding and Sustaining Volunteer Health Care Programs, which is being held in Oakland, California in October.

Prior to working with The Partnership, Holly spent six years as an elementary educator, four years in the criminal justice system, and thirteen years as a licensed social worker. Holly has a B.S. in Elementary Education, and a Masters in Science.

The Problem

"In speaking with AFDC [TANF] clients, usually single mothers, I heard the statement again and again that the woman didn't want to be on welfare, but had to depend on it because of various circumstances of health problems, lack of education, paternal desertion and (most often cited) the need for dependable medical coverage."

--"The View From the Kitchen Table," by Richard Riegel (taken from the article "Welfare Reform Three Years Later," Cincinnati Enquirer, August 5, 1999).

I am sure that it is not news to any of us that the ranks of the "working poor" are swelling beyond anyone's ability to support. The need for primary health care for the medically indigent continues to escalate as increasing numbers of persons are cycled off of Welfare and into low paying jobs. Nowhere is this more true than here in Hamilton County where active welfare cases have decreased more than 50% since welfare reform began. The majority of those affected (and the majority of The Partnership's participants) are

single women with children. These women need to continue to work, and we must help them stay at work — first, by stabilizing, then improving their health.

As of September 1st, The Partnership is providing primary care to 210 families (280 individuals), utilizing the services of 125 primary care physicians and approximately 20 specialists and ancillary providers. A recent profile of The Partnership's participants revealed that

62.2% were female, 75% are single, and 50% are between the ages of 18–49.

The primary occupations of the women include waitressing, day care, cleaning/janitorial, and health care aides. These jobs either do not offer health care, or it is not affordable for the employee.

Any unexpected expense throws them into crisis, and money for private health insurance is out of the question. Furthermore, lower-income Americans are generally in poorer health than people with private coverage, and they do not seek treatment until their condition becomes critical. Untreated, conditions such as hypertension, depression, and even simple infections can become a life-threatening crisis that requires hospitalization. Mortality rates for the working uninsured are fully 25% higher than for those who are insured.

Even when the medically indigent revert to emergency rooms for primary care, more than likely they will leave there with a prescription for medications which they cannot afford. Since 1993, there has been a \$40 billion, or 18.4%, increase in health care spending; the largest portion of that is attributable to the rising cost of pharmaceuticals. Partnership families make daily choices of how to spend their limited income, and when faced with a choice, medicine is often last. Partnership participants have reported such alternatives as sharing their child's medicine (because the child is covered by Medicaid), filling prescriptions piecemeal, or, as in most cases, not at all. Needless to say, their illness then worsens and they go to the emergency department for care.

The Approach

In 1995, some forty health care professionals and leaders came together to brainstorm on possible ways to improve access to health care for the poor in our community. Various models of care were studied, and The Partnership model of volunteer physicians was chosen.

The Partnership was designed as a stop-gap program in the hope that permanent policy changes would eventually be made to address health care. The Partnership considers itself to be a short-term program with the goal that families will be able to improve their employment situation within a period of two years, or that those not yet

eligible for Medicare or Medicaid will do so within that time. Since the inception of the program, approximately one-third of Partnership participants have “disenrolled,” in general because they no longer need the program.

Partnership members are enrolled by completing an application with the case manager and providing proof of income. An admissions committee reviews their application. Once approved, the enrollee receives a membership card, is assigned a primary care physician, and is enrolled in the Kroger Pharmaceutical Program. Membership is renewed at yearly intervals.

One of the innovative aspects of The Partnership is the fact that health care is provided to each participant, not at a clinic, but in their physician's office. The participating volunteer physicians provide the same quality service to Partnership participants as it does to their other patients, and does so alongside other patients. Partnership participants are not required to fill out special forms or anything else that would otherwise set them apart. The Partnership treats its members with respect and expects them to be responsible patients. By continuing to increase the number of volunteer physicians, we are also increasing the number of sites where people can access care.

One factor which contributed to the success of The Partnership was the already established relationship between U.C. Family Practice Center and the Franciscan Hospital in which it was based. By partnering with U.C.'s Residency Training Program, we have the opportunity to teach young doctors the value of voluntarism and the importance of understanding the individual needs and circumstances of their patients. This training is not a part of traditional medical education.

The Residents are also being exposed to an holistic approach to medicine, since this is integral to the mission and philosophy of CHP. Hopefully, residents will take this philosophy with them as they develop their own practice, and will pass it along to other physicians. Patients are also benefitting from this philosophy, and are able to access

complementary health modalities which would otherwise not be affordable to them, eg, massage therapy, stress management, acupuncture, etc.

Another contributing factor to the success of The Partnership was the inspirational leadership of Dr. Jeff Heck, the Director of U.C.'s Family Practice Residency Program, who became the Medical Director of The Partnership. The Partnership also received strong support from the hospital's congregational sponsors. The tie that bound all of these components was the common mission to provide primary care to the underserved.

The Medical Director of The Partnership worked with the Director of Mission Services to get the pilot operational. In 1997, Holly Mechley was hired as the case manager, and also serves as the liaison with the hospital, the Family Practice, the physicians and specialists, community organizations, and the prescription drug program. A part-time support person was added in 1998 to help with correspondence, data base management, administration of the Kroger Prescription Plan, assistance with outcomes measurement data, and clerical support. Interns from The Urban Health Project (second year medical students from U.C. Medical School) have been used during the summer months to conduct in-home surveys, and produce a newsletter.

The Partnership realized early on that it would not be successful unless it could incorporate a prescription drug program to

support its participants. In 1997, the Kroger Company, Diversified Pharmaceuticals and United Medical Resources agreed to provide this critical component. The Medical Director worked with The Kroger Company Managed Care Coordinator to adopt a

formulary for The Partnership. United Medical Resources agreed to keep data on Partnership members. This program was then funded in part by a grant from The Kroger Company.

Findings

Baseline information for demographics was calculated by comparing 153 Partnership adult members with the entire patient population of the U.C. Family Practice (28,799 persons). The health baseline data was taken from the “Health Status Profile SF-36,” which all participants must complete.

As noted from Figure 2, below, 62.2% of The Partnership members are female, in comparison with 59.5% of the general practice population. Figure 4, below, indicates that 75% of The Partnership members are single, separated, widowed, or divorced. This is 25% higher than the comparison group.

Figure 2. Percent Gender Breakdowns for FHPP Patients and Franciscan Hospital-UC Family Medicine Patients.

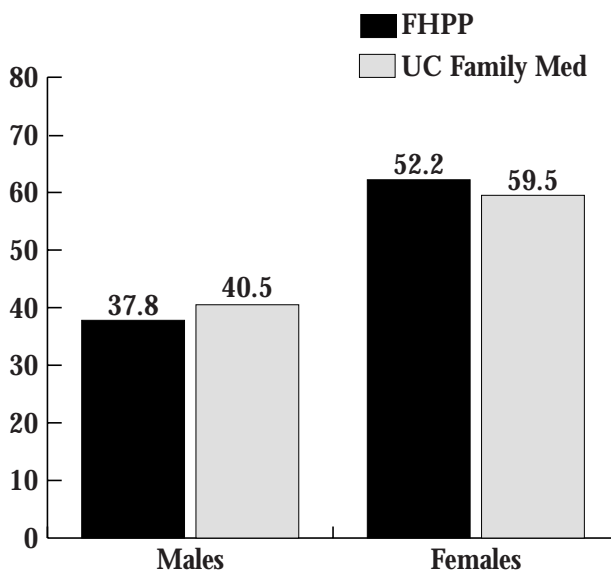
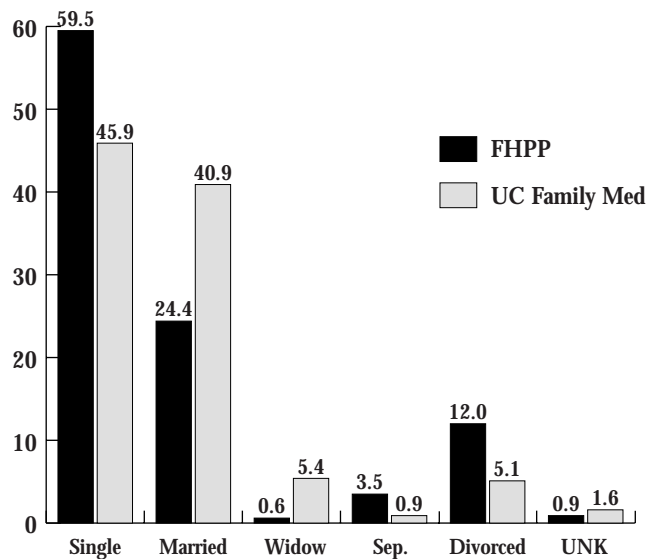


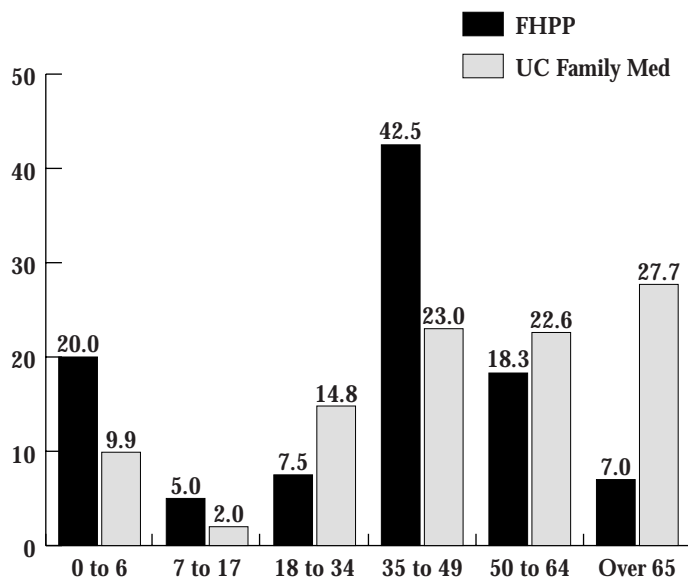
Figure 4. Percent Marital Breakdowns for FHPP Patients and Franciscan Hospital-UC Family Medicine Patients.



The majority of The Partnership members fall within the 18-49 year old age group (50%), as compared to 38% of the control group (Figure 5).

In summary, the typical Partnership client is an unmarried (75%) woman (52%), between the ages of 18-49 (50%).

Figure 5. Percent Age Breakdowns for FHPP Patients and UC Family Medicine Patients



Of the women in the 18-34 age range, 40 of them (80%) are single mothers (all are full-time parents to their children). We also inquired about their jobs and the amount of time they worked outside of their home. Table 1 shows that of the 50 women, 32 worked part time, and 18 worked full time. The primary occupation within this age group was waitressing. Reportedly, none of the

restaurants that employ these women offered health care benefits. Other common occupations within this group were child/day care and health care. After reviewing the occupational data, it is clear that most jobs at which these women work do not offer health insurance or the employee share of the company insurance plan is not affordable for them.

Table 1. Occupational Breakdown for Women ages 18 to 34 Enrolled in FHPP.

Occupation	N	%
Waitress	12	24%
Daycare Worker	6	12%
Health Care Aide	6	12%
Cleaning/Janitorial	4	8%
Temp Agency	3	6%
Haircare	3	6%
Retail	3	6%
Miscellaneous	13	26%

The mental health summary of the SF-36 indicates that The Partnership participants have significantly lower mental health status than the national population, and that four times as many Partnership members view their mental health status as

poor compared to the general population. (See Table 2). These outcomes are not surprising, as the most prevalent diagnosis for the Partnership participants is depression. (See Figure 6).

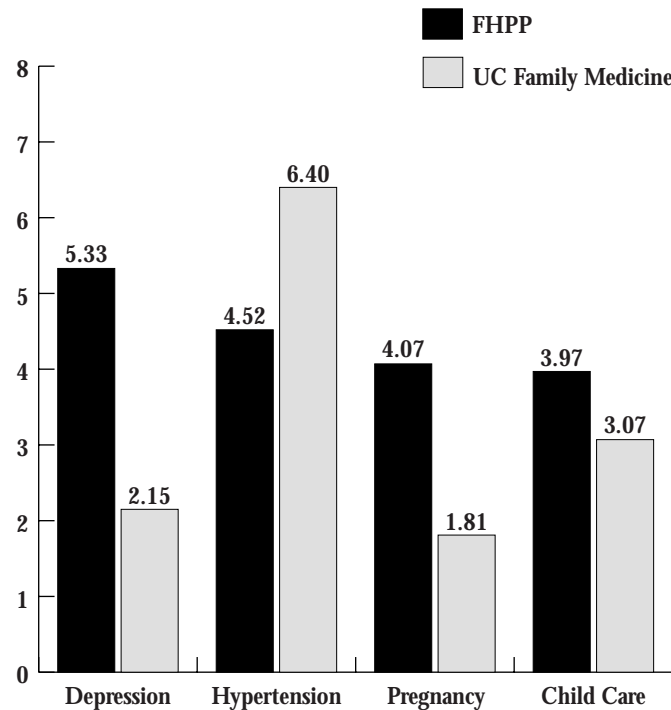
Table 2. Results of Quality of Life/Health Survey

Instrument	Mean	% 2 St. Dev. below mean	Risk ratio
Mental Health Status			
National	50	5%	
FHPP	31.1	19.7%	4.7***
Physical Health Status			
National	50	5%	
FHPP	32.9	15.5%	3.3**

*** Significant at the .005 level.

** Significant at the .025 level.

Figure 6. Diagnosis Comparisons for FHPP Patients and UC Family Medicine Patients



Findings from our enrollment, and a Patient Satisfaction Survey indicated:

- 507 persons who did not previously have primary health care, have received it; the average length of time without health care was 5.9 years (ranging from 2 months to 32 years!)
- 36% of those surveyed stated that, prior to entering The Partnership, the emergency room was their primary source of health care.
- 67% of those surveyed said their decision-making process regarding when to see a doctor had changed.
- 97% indicated that case management had helped resolve problems encountered with their health care.
- 90% rated the prescription plan as good/excellent.

The physical health summary shows that, compared to the general population, three times as many Partnership participants view their physical functioning as poor.

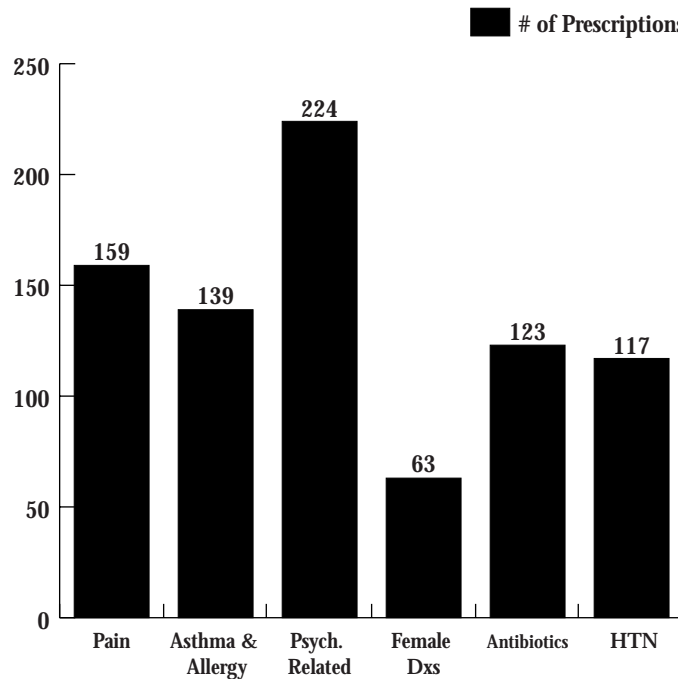
Even with the support of The Kroger Company, and a \$500/year benefit limit per member, the cost of the pharmaceuticals remains a problem. Projected cost for pharmaceuticals for 1999 is \$37,000. More than one-half of this cost is currently unfunded. Some families do exhaust their annual cap. When a member has reached their maximum benefit, The Partnership works with them to get free medications through a pharmaceutical company, or other local sources.

As noted, depression is the most prevalent diagnosis of Partnership participants, and this is reflected in the drugs being prescribed. (See Figure 7.)

Perhaps the most surprising finding, is that hundreds of persons who are given

information about The Partnership, fail to follow up.

Figure 7. Number of Prescribed Drugs by Type of Drug Classification.



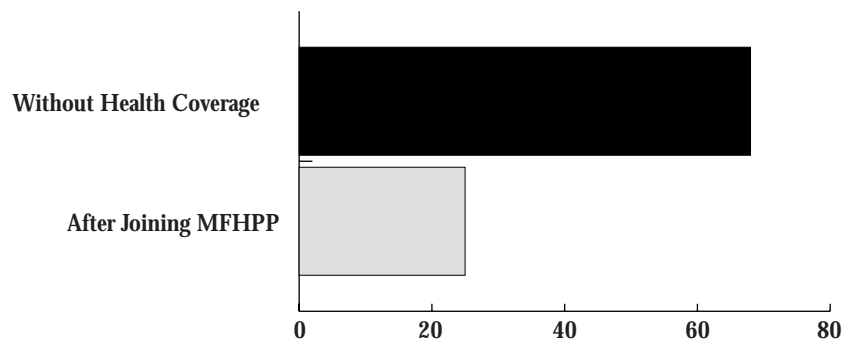
Implications

The Partnership has demonstrated that access to primary health care reduces utilization of the emergency department, especially for chronic conditions such as asthma and diabetes. (See “Comparison of Visits to the ER.”) For the first time in their lives, these individuals are beginning to think about prevention, and about taking responsibility for their own health. Individuals are learning about “disease

management” and are receiving the support they need to begin practicing it. One participant wrote:

“Because my health is now much better, I can only say that if other people benefit as I have, their outlook on life will be much better. I appreciate what [The Partnership] program has done for me and for all the assistance you given me. I am sure there are many individuals who will have need for programs such as this.”

Comparison of Visits to the ER



The vision of The Partnership was to muster a volunteer force of physicians, medical students, nurses, and other staff to create a coalition of health care providers who would offer accessible, affordable, quality care to the medically indigent in our community. The Partnership has demonstrated that the spirit of voluntarism is alive and well in the current health care environment. However, the competitive managed care market has caused some larger health delivery systems to prohibit physician involvement. The Family Practice Residents who participate in The Partnership are educated about the value of social responsibility, and the fact that, in many ways, health care is a social service to which all members of our community should have access. Health care systems and managers need to be made aware of the importance of care for the uninsured.

The following is an excerpt from a paper written by Angela Rackley (the 1999 summer intern) about her experience and learnings:

“Through my internship, I learned that medicine is more than just societal influences and knowledge. It is about

people, those you serve and those you work beside every day. It bothered me to hear people talk about care they needed, yet was out of their reach. [I realized] that I should give back to the community where I can, especially once in practice.”

We have also learned that behavior is not easily changed, no matter how beneficial the alternatives may be. We have been amazed at how many eligible people have chosen not to participate in The Partnership. We have realized that we cannot affect the entire medically indigent population, but must focus our efforts on those who are desirous of changing their behavior and are willing to accept responsibility for their own health. What this means is that not all people referred to us will be enrolled, and that some will be disenrolled for noncompliance. We will do whatever we can to refer others to programs which may provide for other needs.

The implication here is that we must continue to work together to close the gaps. Again, quoting Angela:

“I learned by working with Holly the value of communication between community agencies, social workers, and members of the health care community.

I was never aware of all the community resources available to individuals in need!...It seemed impossible to keep up with the ever-changing world of public assistance and private aid. During a conversation with Holly one afternoon,

I realized that I don't have to know everything. I should be aware of as much as possible, but should also look to others for help. This is where I believe communication comes in, communication between fellow physicians and the community.”

Hamilton County Welfare Employment Study

FreeStore/FoodBank

Introduction

The FreeStore/FoodBank distributes food and other product to over 550 non-profit member agencies in 20 counties through the Product Distribution Services Division. The scope of our member agencies include non-profit school, daycare, and retirement centers, residential and non-residential facilities serving persons with mental illness, mental retardation, chemical dependencies, victims of abuse and homelessness.

The Client Services Division provides food, furniture, and other products directly to the community. Services include housing counseling and rental assistance, referral services for health care, employment, and other needs, assistance with budgeting and planning, and intensive budget management for persons with mental illness and/or mental retardation.

The impact of welfare reform has potentially devastating affects on the FreeStore/FoodBank and many of its member agencies. As persons, never before dependent on working to sustain their families, are timed off cash assistance dependence on food banks, soup kitchens, and homeless shelters are anticipated to far exceed these agencies' ability to meet the demand. Therefore, the FreeStore/FoodBank is interested in identifying the needs of the

long term welfare recipient, develop services to meet the needs of this population toward work habilitation and influence legislature on the potential impact of time limits. However, there is a lack of information available in regard to long term welfare recipients and their potential disabling conditions, which preclude working successfully given the current supports available in the community.

The Hamilton County FreeStore/FoodBank Employment Problems Study is the result of collaboration between the FreeStore/FoodBank, University of Cincinnati, Riverhills Health Care, David Ruhmkorff & Company, Health Resource Center, and Hamilton County Department of Human Services. The study is intended to discover potential disabling conditions and/or other reasons certain individuals have relied on the welfare system rather than seek out steady employment. The study will recruit 100 long term welfare recipients to participate in several assessments to determine possible mental health disorders, neurological disorders, addictive disorders, learning disabilities, or other problems which may impact successful long term employment.

The presenter today is Kimberly Secker. Ms. Secker has been involved with the

project team six months prior to its funding. She has been employed by the FreeStore/FoodBank for two years and has twelve years experience developing, implementing and supervising vocational programs serving persons with disabilities and/or

disadvantages. Ms. Secker serves as the Project Manager. The Co-Project Officers are Dr. F. Robert Wilson, Ph.D., a professor of counseling with the University Of Cincinnati and Dr. Robert Reed, MD, a neurologist with Riverhills Health Care.

The Problem

In 1996, Federal welfare reform ended cash aid to families through Assistance to Families of Dependent Children (AFDC) as an entitlement. It created a new program, Temporary Assistance to Needy Families (TANF), that required an increasing percentage of recipients to work while receiving welfare and imposed time limits of five years for receiving cash assistance. Twenty percent of the caseload may be granted extensions beyond the time limit for hardship reasons. In Ohio, the TANF program is called Ohio Works First (OWF). OWF benefits are limited to thirty six months. After being off assistance completely for two consecutive years, families who can demonstrate hardship may reapply and receive benefits for up to two more years.

Inherent in the above mandates is the assumption that those receiving assistance are able to work regularly and become self sufficient within a few years at most. However, this assumption, open to challenge even when the law was passed, is becoming increasingly untenable as those who are readily employable leave the rolls. Welfare caseloads have already dropped by forty eight

percent since September 1992 as people find other means of support or fail to comply with requirements for cash receipt. A growing proportion of the caseload has serious family and personal barriers to becoming self sufficient. Experts believe some parents may never be altogether self supporting or able to work at all, while many others will become self supporting only with considerable assistance. These families are referred to as the hard to serve because existing strategies (e.g. sanction, incentives, and support services) are ineffective in getting the parents into the workforce or able to maintain steady employment.

Research based on national studies provides rough estimates and descriptions of the various barriers to work that parents face, based on AFDC caseloads several years ago. For example, between fifty four and eighty nine percent of families on AFDC in 1991 were estimated to have significant barriers. About a quarter were estimated to have some mental health difficulty, thirty seven percent to have problematic alcohol and drug use; sixty five percent, low basic skills; and seventeen percent medical problems in the household head. At least twenty eight percent had limited

work force involvement. (Statistics cited by LaDonna Pavette et al., in *Welfare-to-Work Options for Families Facing personal and Family Changes: Rationale and Program Strategies*, Urban Institute, August 1997.)

Little information, particularly empirical information, exists about the causes of many of these barriers, patterns of barriers, or the prevalence of problems in the current TANF population, which is assumed to be much higher. In Ohio and Hamilton County statistics available are primarily demographic and based on data collected for administrative purposes. For example, it is known that seventy two percent have received cash assistance for more than thirty months, about fifty five percent have less than a high school education and seventy five percent of family heads are African American, while in the past about half were. There is no information currently available which would indicate if families who have depended on public financial assistance for more than thirty months are impacted by mental health disorders, neurological disorders, addictive disorders, cognitive deficits or any combination of the above.

It is also difficult for Hamilton County Department of Human Services (HCDHS) and social service agency staff to identify serious personal and family problems, such as

those listed in the above paragraph, and the potential impact on employment. Welfare participants themselves may not be aware of some barriers (e.g. mental health problems or brain injuries) or the implications of these problems for going to work. There is also no local, state, or federal statistical information which offers the occurrence of these disorders in the current welfare caseload.

Until more is known about the cause of the barriers, which may be serious psychological, neurological, psychiatric, or cognitive deficits, it is difficult to design appropriate intervention or effective health care models to recruit and serve the specific needs of this population. While national but probably obsolete statistics and research, as well as some local administrative data and experience (anecdotal data) all suggest widespread work barriers, such data offer inadequate guidance for planning. As a result, local OWF participants continue to be referred to and fail at programming which does not meet their needs. Moreover, there is no way to identify who on the current caseload may be unable to work (at least enough for self support) or may be disabled enough to be eligible for other income streams such as Supplemental Security Income (SSI) or for existing vocational rehabilitation service.

The Approach

The population for this study consist of the traditionally hard to Serve population of unemployed women with limited education,

who are heads of single parent families and have received Ohio Works First (OWF) cash assistance for at least twelve months.

Specifically, the population will be defined by these characteristics:

- has 2 or more children
- been on OWF cash assistance for at least 12 months (Since October of 1996)
- have completed not more than 12 years of schooling
- if working, working less than 90 hours per month
- between the ages of 18 and 45

The assessment methodology for this study consists of a Psychosocial interview, several formal assessment questionnaires (both clinical questionnaires and formal assessment instruments) which because of the variability in reading ability found in this population, will be administered orally, a neuropsychological examination, and a neurological examination. Data will be collected in seven content areas: (a) home and family history; (b) employment status and history; (c) educational status and history; (d) employment attitudes, job skills, and employment problems; (e) health status including physical, medical, neurological, mental, and emotional problems; and, (f) legal status. To obtain information about these content areas, a variety of assessment methodologies will be employed. These include:

- **Intoxication Assessment.** On each day of data collection, each participant will be screened for intoxication (alcohol, crack cocaine,

marijuana, or other street or prescription drugs) according to a standard protocol.

- **Employment Structured Interview Schedule (ESIS).** Personal status and history data will be collected through the use of a structured interview developed by qualified members of the project team.
- **Neurological Problems Questionnaire (NPQ).** The NPQ was adapted from the Mayo Clinic Data Collection Sheet, a standard data collection device used in neurological assessment.
- **Symptom Checklist-90-Revised (SCL-90-R)** (Derogatis, 1977, 1983) is a 90-item self report symptom inventory developed to be used with an extensive range of respondents including medical patients and various types of psychiatric outpatients and inpatients. Dimensions measured include (a) somatization, (b) obsessiveness, (c) interpersonal sensitivity, (d) depression, (e) anxiety, (f) hostility, (g) phobic anxiety, (h) paranoid ideation, and (i) psychoticism. In addition, three global indices and an index of caseness provide critical screening data useful in judging mental and emotional impairment.
- **Neurological Assessment.** Neurological assessment, supported

by data collected in the ESIS interview with the NPQ, will be carried out by appropriately trained medical professional (Dr. Robert Reed). The neurological examination may consist of (a) an evaluation of mental function, (b) walking and balance assessment, (c) evaluation of vision, (d) evaluation of strength and reflexes, and (e) a brief medical examination.

Neuropsychological assessment, also, supported by data collected during the ESIS interview and the NPQ, a neuropsychological examination will be carried out by appropriately trained neuropsychological professional (Dr. Michael Hartings). This examination will involve screening for subtle neurocognitive deficits which can constitute barriers to employment. These include disorders of learning, attention, concentration, speed and accuracy of mental processing, learning, and memory.

During this assessment, several standardized instruments will be used. These instruments have been selected from a standard battery of neuropsychological instruments in use by the profession at the present time, including; (a) Cognistat Neurobehavioral Mental Status

Examination, (b) TrailMaking A & B, (c) The Kaufmann Functional Academic Skills Test (KFAST), (d) Wechsler Memory Scale III, and (f) Wechsler Adult Intelligence Test - Revised.

- **Occupational Work Ethic Inventory (OWEI)** (Petty, 1993; Hill, 1995) The OWEI is a 50 item self report instrument designed to assess an individual's work ethic attributes.
- **Public Assistance and Employment Status.** Information about participant use of public assistance and employment status will be gathered on a quarterly basis for one year following completion of interview and examination gathering. Each quarterly data file will contain monthly data for the three month period. Data elements will include current employment and education status, hours worked, amount of earnings, hourly wage, case opening and closing data, sanction status, food stamp status, medical assistance status, subsidized housing status, number and demographics of individuals in the household, and other related data. This data will be supplied by the Analysis, Research, and monitoring Unit of the Department of Human Services.

Findings

At this moment, there are no findings from this project. However, it is expected that data collection will begin by the 1st of October. Though this project was funded over a year ago, significant problems have been encountered in its implementation. The study was initially designed to utilize a random sample of those meeting the population criteria currently listed in the rolls of the Department of Human Services, however, when our initial mailing got essentially no response from those to whom the invitation was sent, the strategy was discontinued. After a series of planning meetings, a second plan was formulated to recruit participants through face to face contact at the Cash Club, an employment program for the hard to serve. Before the plan could be submitted for approval, the Cash Club was discontinued. Again, after a period of planning, a third plan was developed wherein face-to-face recruitment would be conducted at another Department of Human Services program, the Life and Work Planning Sessions. Permission to change the research protocol was sought and obtained and interviewers contracted. Unfortunately, just prior to the planned starting date for data collection, the Life and Work Planning Session program was discontinued.

We have recently secured permission for a fourth recruitment plan. The Department of Human Services. Women fitting the population criteria for this study are routinely

offered the opportunity to participate in the Department of Human Services, Solutions Program, a program designed to encourage those served by the Ohio Works First assistance program to remove barriers to employment. All agreeing to enter the Solutions Program receive \$50.00 per month on the condition that they engage in barrier removal activities like arranging for child care, arranging for transportation, obtaining a telephone, and/or getting necessary work related clothing. Participation in the Employment Problems study will be included as another optional activity qualifying as a barrier removal activity. We believe that recruiting with referral from the Department of Human Services will have at least two important advantages: (a) a large number of individuals, up to 75 per week, who meet our population criteria are seen by DHS Employment Counselors so it is likely we can obtain our sample expeditiously; and (b) data necessary for verifying that the recruit meets our population criteria is available to the DHS Employment Counselors so determination of eligibility will be facilitated. To insure that potential recruits are protected from inappropriate coercion several steps will be taken: (a) participation in this research will be offered as one option among several in which a DHS client can participate to satisfy their obligations to DHS, (b) DHS Employment Coaches will be given a script to use in presenting the research study option

to their clients, and (c) the study will be explained by a project staff member who is not associated with DHS prior to the candidate being offered the consent form to sign. Four interviewers - two professional mental health workers and two graduate students in counseling - have agreed to conduct the psychosocial interviews and to administer the psychological tests which are part of the protocol.

When data is collected, it is anticipated that we will be able to provide a broad spectrum description of the (a) home and

family history; (b) employment status and history; (c) educational status and history; (d) employment attitudes, job skills, and employment problems; (e) health status including physical, medical, neurological, mental, and emotional problems; and, (f) legal status of this hard to serve population. We are particularly interested in determining the proportion of individuals who provide evidence of serious problems with physical, medical, neurological, mental, and emotional health.

Implications

The Hamilton County - FreeStore/FoodBank Employment Problems Study will provide descriptive data about the traditionally hard to serve population of unemployed women with limited education, who are heads of single parent families and have received OWF cash assistance for at least twelve months. We expect that this data will provide necessary information for developing further research opportunities and program initiatives to serve long term welfare recipients through identifying barriers to employment, skills training, and other social service and/or rehabilitation programming. Additionally, this project may provide initial data for further research necessary for health

care planning to serve long term welfare recipients.

We intend to identify the needs of a population which has not traditionally been screened for mental health, cognitive, or addictive disorders. Through identification of the needs of this population and publicizing the results of the project, the health needs of a long term welfare recipient will have a greater potential for being served or met. Through the study, service providers, social service agencies, and practitioners of low income health care will have an increased awareness. Additionally, this information may be used to support public policies which are responsive to the needs of the community.

Panel Two: Employment Supportive Services: Building Capacity

Moderator : Dot Christenson, Executive Director, Better Housing League

Today's job market and job seekers are very different than as little as five years ago. The job market offers many choices, there are an abundance of job openings, particularly at the lower wage, semi-skilled level. National and local demographics project that for the next decade there will be far more entry level jobs than 16-22 year olds to fill them. At the same time, these jobs are often for low pay, many are part time with few, if any, benefits. Another "new" factor in the job market is the major corporation and small business use of Temporary Employment Services, sometimes for extended periods, as a means to screen future full time employees before permanent employment and benefits.

Today's entry level employees are also different from recent generations of young, inexperienced job seekers. The two research papers presented in the Employment Supportive Services: Building Capacity section of this Roundtable confirm this. Queen City/Mitchell Mental Health Career Services work with individuals who are not eligible for County-supported programs because they do not meet dual diagnosis criteria or may not be "508" certified. The program participants have a history of substance abuse or problems with anxiety, but their problems are not severe enough to

qualify for traditional County services. Individuals with less severe drug and mental health problems are targeted by this program.

The Queen City paper presented by Pamela Owners, Program Director and Julie Eason, Career Counselor, outlines how mental health and substance abuse problems can be addressed simultaneously with job preparation services. In addition to individual counseling, significant group work is undertaken by the participants. After finding employment, a participant graduates from this program but remains in touch with the Career Services center for follow-up support. This follow-up support appears to be crucial to the participants' success on the job. But before completion of the program is possible, the participants must be identified and encouraged to enroll in the program.

The majority of successful participants are referred to the service by friends. It is interesting that once in the program, the level of involvement of the referral source (whether friend, probation officer, case manager) did not make any difference in the participants' successful program completion. Among this group of job seekers, individuals know what kinds of jobs they want and many want to work. They often have the required skills for a above-entry job, however they

lack confidence and are afraid they will not succeed. Long term job success appears closely correlated with the presence of the on-going support group work and length of time since the last episode of substance abuse. This is a vulnerable population which will cycle in and out of the work force as they cope with recurring incidents of mental instability or “fall off the wagon” by reverting to temporary substance abuse. A significant amount of the substance abuse is alcohol.

The second paper included in this section was “Journey Toward Self-Sufficiency: A Qualitative Study” of Cincinnati Works. As in the Queen City group, a majority of the participants want to work but simply do not have the work-readiness skills and/or personal confidence to achieve and maintain employment. Cincinnati Works found three categories of participants in their work preparation/job placement program. About one third want to work, need some help upgrading or learning new skills, and once placed they do well. In fact, this group returns to Cincinnati Works to continuing improving skills because they understand the potential for job promotion and increased income.

Another category of workers are those who cycle in and out of employment, similar to the experience of those who have cyclical problems with mental health or substance abuse. They complete job training and placement, work for up to several months and then some occurrence in their lives

interrupts work and they quit or lose their job. These “job interruptions” may be perceived discrimination at work, adverse reaction to a job evaluation or criticism for performed tasks, or some problem outside the workplace such as loss of child care, illness in the family, or having to move to alternative housing. Or, in some cases, they work until they have enough money to live on for a short period of time and they cycle themselves out of the work force.

The final category are the very tough, hard-to-place. These are individuals with very low self esteem, an inability to get or be organized enough to get up, get dressed and get to work. These individuals are ineffective or resistant to seeking full time employment.

A significant finding from the Cincinnati Works population was that over half the interviewed group stated they had no health problems when specifically asked. However, these same participants indicated a variety of problems such as alcohol, arthritis, asthma, bronchitis, depression and hypertension, and others as reasons for not being able to work. One half of the Cincinnati Works group was also mildly to morbidly overweight. Those with health benefits obtained them through their job or another family member’s employment. One third rely on Medicaid.

The decision to make a life change and work toward self-sufficiency was stated as family and material needs, and their individual need to be self-supporting. Without recognition of these needs participants fall into the third group of those

unable or unwilling to obtain and maintain regular, permanent employment. Some came to the program for education and to gain new job skills. Major barriers to successfully maintaining employment were identified as transportation, child care, legal problems, poor work history and unstable housing. The most common additional services requested by the program participants who wanted to become self-sufficient were computer skills training and stress management.

The roundtable discussion centered on the barriers of transportation, child care and housing for individuals in circumstances similar to those in the Cincinnati Works program. Queen City participants have an additional burden, and perhaps need even more on-going support due to the difficulty of dealing with a former substance abuse habit or mental instability. It was clear that low income, first time job seekers, particularly those with a “generational curse” (no role models, their family never before self-sufficient) should not be expected to

complete a jobs program and then be left to cope on their own. Very low income individuals, and particularly single parents, have highly stressful lives with little time or resources to manage the many demands made on them.

Safe, affordable housing remains a major problem, and it effects the entire family. The mobility of poverty results in poor job attendance and performance and children changing schools several times within a year. Unstable housing perpetuates the poverty cycle. Obtaining a job is not enough to become self-sufficient. At low wage levels, housing, medical care, child care and transportation are required to provide the opportunity to be stable enough to move up on the job. There will be many who continue to cycle in and out of employment, sometimes (perhaps often) for reasons beyond their control. On-going case management and peer support is essential to maintain even minimal employment.

Career Services

Queen City/Mitchell Mental Health Services

Introduction

Description of Organization

Career Services is operated by Queen City/Mitchell Mental Health Services (QC/M). QC/M is known in the community as a lead mental health agency for adults with mental illness. Career Services opened its doors for business in October of 1998.

Career Services is a comprehensive treatment program for adults with co-occurring disorders of substance abuse and mental health. Participants in the program can expect to achieve goals related to mental health, sobriety, and employment. Different from programs designed to solely address chemical dependency or mental disorders, Career Services is based on a philosophy of treating both the mental health and substance abuse issues concurrently.

Individuals who attend the program are known as “participants”. Each participant is matched with a Career Counselor. The counselor first completes an assessment of strengths, interests, and goals, as well as substance abuse and mental health issues, employment history, family and social supports, and medical history. Based on this assessment the Career Counselor works with the participant to develop time specific goals, and develops a service package for the individual that meets assessed needs and goals. This can include skill-based groups, individual counseling, in-depth career

exploration (one-on-one), job coaching, and other needs as determined. All services are focused on assisting the participant to obtain and maintain employment while remaining sober and stable. The program offers 20 groups per week on the topics of employment (i.e. career exploration, anger management at work), substance abuse (i.e. relapse prevention, recovery lifestyles), and mental health (i.e. overcoming anxiety, self-esteem, coping skills).

Program components offered by Career Services include: diagnostic assessment, group counseling, individual counseling, coping skills, health/wellness, substance abuse treatment, recovery maintenance, career exploration, resume development, job placement/advancement, job club, and follow-up/aftercare services.

Presenters

Pamela Owens, M.A., LPC, is the Program Director of Career Services. She is currently a doctoral student at the University of Cincinnati in the Counseling Program. Pam specializes in group counseling and has presented on group interventions at several national conferences this year including the American Counseling Association and the American Psychological Association.

Julie Eason, B.S., is a Career Counselor providing groups and individual services to

participants in the Career Services program. In addition, she serves as the marketing coordinator, presenting program services to over 140 agencies in the past year. Julie has extensive experience providing case

management services to adults with severe mental illness and will present at the National Association of Case Managers conference in October.

The Problem

A community-based assessment completed prior to the grant application indicated a substantial need for services for individuals who may not meet the county eligibility requirements for dual diagnosis programs which are based on severity. These individuals may not be “508 certified”, a county certification that allows the individual to qualify for many programs and services. For example, an individual might have a history of substance abuse and problems with anxiety, but would not qualify for services because anxiety disorders are not considered “severe” under eligibility requirements for the Ohio Department of Mental Health. A needs study completed by Shumavon Consulting Services in 1995 identified “treatment for adults with both substance abuse and mental problems” was a major gap in mental health services in Hamilton County. The study showed that 18.5% of the Hamilton County’s 867,728 residents have a diagnosable mental illness or mental disorder. Based upon the 1995 research of Marc Alan Schuckit, M.D., 30% of the national adult population with severe problems of substance addiction also have pre-existing psychiatric disorders. These statistics suggest that in Hamilton County alone there is a population of over

8,700 adults who could benefit from the interventions offered at the Career Services program.

According to the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, the total costs of alcohol, drug abuse and mental health disorders in 1990 were estimated at \$314 billion. The greatest portion of these costs comes from the loss of productivity due to injury or illness (34%). On a local level in Hamilton County, the dual diagnosed population served by this project has a major economic impact on the people of Hamilton County and surrounding areas. Based on a breakdown from the Mental Health Board’s 1994 needs assessment, morbidity (productivity loss) amounts to \$75 million dollars annually and treatment \$88 million.

The target population for this grant consists of individuals with both substance abuse and mental health issues. However, the program does not target individuals with severe mental illness, but rather, focuses on less severe mental health problems. The dually diagnosed population in general is greatly underserved in the Hamilton County and Northern Kentucky areas. Many programs have substantial waiting lists and

may not treat the issues of substance abuse and mental illness. In addition to a lack of services for people with dual diagnosis, and a greater lack of programs for those with non-severe mental health problems, very few, if any, programs focus on both issues concurrently while assisting the individual

meet employment goals. Further compounding this problem is the fact that many employment focused programs screen out people struggling with sobriety, and some chemical dependency or employment programs screen out people with a mental disorder.

The Approach

The approach used by the Career Services program is guided by a philosophy of treating both the mental health issues and substance abuse simultaneously and in a unified manner. The flow of services is as follows:

Initial contact/Referral: One of the goals of the program is to provide ease of entry by encouraging individuals to self-refer, as well as accepting referrals from case managers, therapists, and other providers. Typically, when an individual calls, an orientation meeting is scheduled within 24 hours for the initial visit. General questions about the program are answered and information is provided about admissions criteria. As soon as the meeting is scheduled, a welcome letter and directions are sent to the individual. At the initial meeting, the intake coordinator discusses the program and solicits information from the potential participant to determine if the program is a good fit based on individual needs. A tour of the facilities is conducted and potential participants are introduced to all of the Career Services staff. If the individual wants to join the program, a match is made between the person and a Career Counselor.

Intake: Following the initial orientation, the intake is scheduled as soon as possible (usually within a day or two). The assigned Career Counselor meets with the individual, completes all intake paperwork including the Addiction Severity Index, informed consent, and so on. The Career Counselor uses motivational interviewing techniques to develop a treatment service plan based on the individual's needs, after building initial rapport with the participant. This plan may include certain groups and individual services. If a person needs additional services or resources, the Career Counselor will work to obtain what might be needed. For example, a person might not have a case manager, and may need assistance in obtaining Medicaid. The Career Counselor can assist in filling out forms, and in helping the person negotiate the process of obtaining benefits and services such as child care.

The First Phase of Treatment: Participants in the program are encouraged to attend groups a minimum of three days a week that focus on areas of mental health and substance abuse, as well as employment. Examples of the groups in this phase include:

self-esteem, weekly goal setting, emotional wellness, men's/women's group, relapse prevention, personal empowerment, and many others. A strong emphasis of the program is the development of a healthy support system. During the early stages of treatment, individuals are encouraged to attend a weekly job club/luncheon to meet other participants in a less structured environment. Participation in the program is encouraged via an incentive plan that is based on the number of groups attended per week. Some individuals who start the program may already be employed and may need specific assistance around job retention. The Career Counselor works with the individual to reduce the risk of termination or may work with employed individuals who are interested in upgrading or changing their employment status. Those who enter the program interested in immediate employment may choose to participate in a rapid employment group while also attending mental health and substance abuse groups. Drug testing is available throughout the course of treatment if the referral agent, or participant wish to use random drug screening services.

The Second Phase of Treatment:

Participants who have completed at least two weeks of program participation can move to the second phase of treatment. The length of time an individual stays in each phase varies according to individual need. The second phase of treatment focuses primarily on employment; however, mental health and

substance abuse issues are also addressed throughout. Groups participants attend during this phase include: career exploration, anger management at work, communication skills, coping skills, recovery lifestyles, and several others. Six weeks after the start of the program, each treatment plan is reviewed to determine progress, and new goals are established when needed. The Addiction Severity Index is also completed to compare with the assessment completed at intake. Participants who obtain employment during this or the first phase are encouraged to use their career counselor as a resource for maintaining employment. If job-coaching services are needed, they will be provided. Upon securing employment, information is collected about the type of job each individual obtains, benefits, pay, and a weekly tracking form is completed to determine if the job is maintained for 90 days or longer. Those who are working can attend an evening support group specifically for working participants.

Graduation: When an individual meets their employment goal(s), they are graduated from the program and move into the follow-up phase. A certificate is provided to each person who graduates, and referral agents (if applicable) are notified of successful completion of the program.

Follow-Up Services: Participants are eligible to remain in follow-up for up to one year from their start date in the program. Follow-up services vary according to each individual's needs, employment situations,

mental health, and recovery status. For example, “John” moved through phase one and two of the program in four months. He then obtained a full-time day job and can no longer attend program groups. John calls his Career Counselor on the phone when needed for support. Once a month, the counselor meets John near his work site for lunch and

to discuss any problems John is facing. Once or twice, the Career Counselor worked with John’s supervisor to address John’s attendance problems at work. Every Thursday night, John attends a group at Career Services where he networks with and gains support from other working participants.

Findings

As the program nears its first anniversary of opening the doors for business, initial findings and patterns are beginning to emerge. Some of these findings are considered below:

1. Several of the clients referred (by others or self) do not meet the mental health criteria of the program but struggle significantly with sobriety. Meaning, on a functional level, these individuals might be better served by more intensive programming. While we have not excluded any individual based on a diagnostic code, each individual’s functional level is considered during the initial program orientation. To date, individuals who have a high functioning level but also a 508 certified major mental illness have been able to engage in the program and have more success in our program than in other programs that have been tried. Several of these clients have mentioned that they just “didn’t fit in” to other programs and
2. Criminal justice providers, such as probation and parole officers, seem more than willing to refer clients to our program. We receive many calls from the probation officer while they have the client in their office and an intake appointment is scheduled. However, the probation/parole officers are frequently hesitant to make program attendance a requirement, therefore, there is no leverage in getting the client to actually attend their scheduled appointment.
3. Many of the clients who most need our services are not currently working because of motivational problems in combination with substance abuse or mental health issues. Helping the client or potential client move from

pre-contemplation to actually engaging in the change process can be difficult when motivational levels are low.

4. Individuals who have a recent work history are more likely to become employed in 12-16 weeks. This period of time is substantially shorter than individuals who have been out of work for significant periods of time prior to entering the program.
5. Individuals who are not diagnosed with a psychotic disorder are more likely to engage in program services than those with a psychotic disorder.
6. The length of sobriety affects the individuals level of engagement in the program, but does NOT effect the individual's ability to find/sustain employment. Meaning, those with longer periods of sobriety are generally active participants, but those who relapse are frequently able to maintain employment with support and relapse plans.
7. Approximately 32% of referrals resulted in intakes. Analysis of referrals vs. intakes indicates several reasons for the low number of intakes: the person does not meet the mental health criteria (too severe or no mental health issues), lack of follow-through (i.e. one or more orientation meetings are scheduled but the person does not show), the person obtains a job and does not want to engage, relapse, a fear of losing benefits if gainful employment is achieved, legal problems, lack of support from significant others.
8. Of those referred by a "friend", 60% completed the intake process.
9. Participation level is not affected by the involvement of the referral source. The engagement rate is the same regardless of the involvement or lack of involvement of the referral source. This is somewhat surprising as it makes logical sense that the additional support of a case manager, therapist, probation officer, or other provider would have a positive impact on engagement. However, our findings indicate that this is not true. Those without these supports are just as likely to engage in the program.
10. The top ten referral sources include: current/former participants, the Department of Human Services, a friend, Hamilton County Probation, Mental Health Services East, Ohio Adult Parole Authority, QC/M Case Management, Starting Over, University Hospital, self-referrals.
11. In terms of marketing, referrals tend to increase just following a presentation. Presentations resulted in more referrals than brochure drops or mailings. Presentations that were given directly to potential participants (in residential treatment, day treatment, and so on) led to more

- calls and orientations than presentations to care providers or supervisors of care providers (i.e. case management supervisors, clinical directors).
12. A profile of characteristics that may indicate a higher level of potential success in the Career Services program include: self-referred or referred by a friend; a minimum of one year of sobriety; not diagnosed with a psychotic disorder; have received mental health services at some point in the past; have sustained employment for a minimum of one year in the past; have a high school diploma or GED; are between the ages of 30-50 and; are partially to fully financially supported by outside sources (i.e. SSI, SSDI, family, unemployment).
 13. Of those completing the intake process and engaging in the program, 75% obtained employment and 83% maintained employment for 10 weeks or more. Typical jobs are labor (metalworking, construction, forklift operator), sales/customer service (hotel, restaurant, retail), transportation, professional (managerial, social services), and clerical.
 14. Of participants, 58% are male, 41% female; 76% Caucasian, 21% African American, 3% Native American; the average age is 37.
 15. The clients who have attended the program to date seem to be highly independent in their ability to determine what jobs they want, and to follow-up on the application process. Many participants have said that they know what they want, they just need the support and skills to get there. We have offered on many occasions to go with individuals to interviews, to assist in the process. But in most cases, rather than wanting staff to be directly involved, individuals want someone with whom to practice interviewing skills, and someone to help them deal with the anxiety of the interview. And we spend a great deal of time with those individuals who did not get the “dream job” as we help them re-energize to try again, while maintaining mental health and sobriety.
 16. We have found that the participants seem to really value the group-based services. During focus groups, on monthly group evaluations, and in informal conversations, again and again clients mention how helpful and supportive they find the groups to be. Participants seem to value learning new skills and trying out new behaviors in a safe environment where peer support is high.

Implications

Career Services has been open for operation for one year in October. The project is funded for two additional years. Our first year has been one of development and implementation. It has been a year of learning, growing, and change. Over the remaining funded time, we expect the implications of the project to become clearer. However, it is clear that assisting individuals with the maintenance of mental stability and sobriety is much less expensive to the community than hospital care or a life-long pattern of unemployment and dependence on government subsidies. Employed program graduates will become taxpayers, and may require less public assistance in the form of programs and services than those who are unemployed. The Greater Cincinnati area will thus benefit from the increase in employed citizens and the decrease in those needed life-long support. At this initial juncture, we predict that the implications of the project will indicate the following:

- There will continue to be a substantial need for services in the Greater Cincinnati area for people who have been diagnosed with both substance abuse and mental health issues. More specifically, the need exists for programs addressing these issues simultaneously while encouraging employment as a means of gaining stability.
- Individuals who most need these services are the most difficult to engage due to low motivation problems caused by substance abuse and mental illness.
- Individuals who have support services in place and who engage in programs such as Career Services will have high levels of success in gaining and maintaining employment.
- There is not one single solution for addressing the needs of this population. Rather, services must be tailored to the individual and their needs, culture, values, skills, and their substance abuse/mental health status.
- Individuals who engage in follow-up services are more likely to maintain employment and sobriety on a long-term basis.

As the program continues to evolve over the next two years, we expect to be able to more clearly address the implications of such a project on the Greater Cincinnati area. We look forward to collecting data and tailoring our services to have the widest impact possible for individuals with substance abuse and mental health issues. Clearly, assisting these individuals with employment issues will have a long-term impact for both the individual and the community.

Journey Toward Self-Sufficiency: A Qualitative Study

A Research Project For Cincinnati Works

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Introduction

Cincinnati Works is a privately funded jobs initiative which was founded in 1996 to assist people who are living in poverty to find and keep full time employment with health benefits. The vision of the organization is to eliminate poverty in the Greater Cincinnati area. A major emphasis of our work is to support our members in the retention of employment as they move toward self-sufficiency. “Journey Toward Self-Sufficiency: A Qualitative Study” was

conducted by Linda LaCharity, R.N., Ph.D , an Assistant Professor and researcher at the College of Nursing and Health, University of Cincinnati. This study is designed to more clearly identify the issues that support as well as interrupt the process of achieving self-sufficiency. The qualitative format of research was selected, in order to hear the experiences and factors directly from the people who are in the process, in their own words and from their own perception.

The Problem

Cincinnati Works recognizes that in order for a person to successfully achieve self-sufficiency, retention of employment is a critical. Although Cincinnati Works’ membership is a life-time membership and retention services and employment support are ongoing, there are still members who do not successfully retain employment. Since our inception in the spring of 1996, Cincinnati Works’ staff has made several observations regarding the more typical paths to self-sufficiency. Generally, we have identified three categories of Cincinnati Works’ members as they relate to the pattern

of job search and/or employment retention. They are as follows:

1. Those who obtain employment and are able to retain their original job for at least one year.
2. Those who cycle in and out of full time employment, make frequent job changes, but continuously seek and obtain employment.
3. Those who are ineffective or resistant to seeking employment.

The Cincinnati Works’ staff has observed that family and individual physical and

mental health related issues frequently contribute to employment absenteeism and ultimately job loss. As we designed the research, we asked the questions, “ How much do health care related issues actually effect the successful pursuit of self-

sufficiency?” and “What other factors promote or inhibit the successful pursuit of self-sufficiency?”

The intent of the research was to discover what these factors were, from a job seeker’s “eye view,” and adapt our program to meet the identified needs.

Methodology

The method of inquiry guiding this study was qualitative and involved in-depth interviews with study participants. The broad focus of qualitative research is on human experiences from the perspective of research participants, using their own language. The goal of in-depth interviewing was to learn what was important in the minds of participants, their meanings, perspectives and definitions of how they view, categorize and experience the world. The purpose of this descriptive study was to gain insight into the experiences of participants as they attempted the transition to self-sufficiency. An additional aim was to begin identification of factors that influenced success or lack of success in this transition.

Based on prior research, an interview guide was developed to assure consistency of focus areas in all participants’ interviews. The interview guide was reviewed by staff members at Cincinnati Works and revised to reflect suggested changes. The interview guide began with a broad range question, followed by more specific open and closed ended questions. Interviews conducted in this manner tend to facilitate establishment of rapport between participants and the

researcher. Participants were asked to describe their experiences with the transition to self-sufficiency and respond to related questions based on the interview guide. Interviews were audiotape recorded.

Forty-five individuals were recruited by Cincinnati Works staff to participate in the study. Participants were recruited from clients who had attended the Cincinnati Works program. There were three groups of 15 participants: those who were successful in obtaining and keeping employment, those who cycled in and out of full time employment and those who were ineffective or resistant to seeking full time employment. Inclusion criteria were individuals who had participated in the Cincinnati Works program, and were able to speak English and complete the taped interview. Exclusion criteria were any form of physical or cognitive impairment that limited ability to recall recent or past experiences or limited expression of those experiences.

Interviews were conducted in quiet, private settings in the Cincinnati Works offices. Prior to beginning each interview, the purpose of the study was described for each

participant and informed consent was obtained. Demographic information was collected and interviews were completed. Interviews generally required between 1 and 2 hours. All interviews were transcribed verbatim. After each interview, this researcher immediately wrote field notes containing investigator insights, perceptions and ideas.

Data analysis began concurrent with continuing data collection. Analysis involved listening to the recorded interviews as well as reading and re-reading the interview transcriptions. Repeated reviewing of transcripts facilitated attainment of a sense of the whole interview as well as identification of emerging themes and patterns. Emerging themes, interpretations

and ideas were recording in the process of uncovering the experiences of participants with the transition to self-sufficiency.

Interview transcriptions and field notes were organized and managed by computer using the program QSR NUD.IST™. This program facilitated coding and analysis of the interviews, demographic data and field notes. Additionally, this program assisted in handling a large quantity of qualitative data through processes including indexing or coding, searching and theorizing. Relationships between coded data can be observed through a flexible tree-like structure, constructed as part of the indexing system, using themes and sub-themes. A major advantage of this program was the preservation of context for coded data segments.

Participants

Participants received \$100.00 for their input into the study. All 45 participants arrived for their interviews at the time and date agreed upon when they were recruited for the study.

Forty-five Cincinnati Works clients agreed to participate in the study. Thirty participants were women and fifteen were men. The majority (42) were African American and three were Caucasian. Participants' ages ranged from 19 to 47 (mean 32.5 years). Most participants were single parents, living with their children. The number of children that participants acknowledged ranged from none to seven. Not all of the children lived with their parents. The age of children living with

participants ranged from 7 months to 20 years. Participants' involvement with the Cincinnati Works program ranged from 4 months to almost 3 years.

Fifteen participants stated at the time of their interview that they were working full time, while 3 stated they were working part time. Five participants were attending school full time. Length of time employed at present job ranged from 2 months to 3 years. Participants who were not currently employed stated that their unemployment ranged from 1 or 2 months to 5 years. Ten unemployed participants stated that they occasionally worked for a temporary agency.

While over half of this group (25) stated that they perceived no health problems, participants described a wide variety of health difficulties. Health problems included alcoholism, arthritis, asthma, bronchitis, depression, gestational diabetes, hypothyroidism, hypertension, irritable bowel syndrome, lupus (SLE), multiple sclerosis, sickle cell trait, tuberculosis, surgeries to the

knee and wrist, and back injuries. Additionally, 25 of this group were mildly to morbidly overweight. Many participants stated that they lacked health insurance or would lose coverage when they lost their assistance benefits. Fifteen participants stated that their health benefits were through their job or a family member's job. Thirteen stated that their health benefits were through public assistance.

Findings

The major themes that emerged on analysis of the interview data included positive factors affecting the decision to make a change, barriers to seeking employment, role models for work and employment, life changes affected by employment, factors which make a job attractive, personal strengths, personal areas in need of improvement, definitions of success and advice for people who decide to make a change and seek self-sufficiency. Two additional areas of focus included helpful services provided by Cincinnati Works and suggestions for additional services. The attached table provides a summary of the major themes and sub-themes.

Positive Factors

Participants cited responsibilities, family needs, educational needs and material needs as the most common positive factors associated with the decision to make a life change and work toward becoming self-sufficient. Examples included bills needing to be paid, material needs of children such as

clothes and school supplies, desire to provide a stable home environment, and the desire for self-betterment through attainment of additional educational credentials such as the GED. Twenty-five participants stressed the value of additional education, in the pursuit of self-sufficiency. The desire for independence was a positive factor for 15 participants, while emotional needs were a focus for 12 others. Participants generally felt that their decision to make a life change was supported by family and friends, however there were some notable exceptions such as ex-spouses and parents who feared loss of influence or control with their grown children.

Barriers

Common barriers to seeking employment and making a life change toward self-sufficiency included transportation, child care, legal problems, poor work history, unstable housing arrangements, and lack of education or job credentials. These findings tend to support barriers found in the literature. A common, but unexpected barrier was the perception of a

learning disability among 24 participants. The most common disability was with reading, while mathematical skills were a close second. Most participants had not been evaluated or diagnosed with a learning disability, however they perceived a problem. Another common barrier cited by 22 study participants was the fear of failure or rejection. Descriptions of these fears included submitting resumes and attending interviews, then not receiving any feedback from potential employers. Participants stated that at times, these fears immobilized their efforts toward the transition to self-sufficiency.

Additional barriers included poor self esteem, lack of support, abuse (both as a child and an adult), and negative cycles. One participant named a potent barrier the “generational curse.” The generational curse, as defined by this participant, stems from how one is brought up, role models, values, ethics and responsibilities. Nineteen participants supported this concern.

Less commonly mentioned barriers included problems with children at school, race, gender and age. While 38 participants admitted the use of substances, only 16 spoke of a history of substance abuse. The most commonly abused substance was alcohol. The majority of participants who admitted to substance use occasionally drank alcohol or smoked marijuana.

Role Models

Parents were the most commonly cited role models for work, with grandparents second

most common. Mothers and grandmothers were most frequently praised as role models. Other role models mentioned included aunts, uncles, and siblings. A pastor, teacher, school nurse and counselor were role models for one participant. Four participants cited television, movie and sports figures as role models.

Life Changes

The most common life change discussed by participants was their feelings about themselves when they were working or looking for work as opposed to when they were not working. Participants generally felt much better about themselves in relation to their decision to make a life change and try to become self-sufficient. Roles and relationships were perceived as improved as a result of this decision. Thirty-eight responses indicated that participants felt they were treated differently by family and friends when they were working versus when they were not employed. Predictably, many participants spoke about material gains that could result from being self-sufficient.

In response to a question that asked participants how they managed when not working, 27 cited public assistance, 18 mentioned odd jobs and temporary agencies, 13 spoke of help from family and friends, 8 spoke of living off others and 8 admitted to illegal activities.

Attractive Job

Factors that made a job attractive to participants most commonly included

benefits, pay and the type of work. Additional important factors included training, enjoying the job, liking the people at work, and working a shift that did not interfere excessively with family life. Participants found potential for advancement and a career, mental challenge and the possibility of helping others to be attractive features for employment.

Personal Strengths and Areas in Need of Improvement

The two most commonly cited personal strengths were spirituality (32) and a strong work ethic (20). Eighteen participants believed that their ability to learn quickly was important, while 15 stated that their strength was a strong work history. Being a “people person,” having good job skills, a positive attitude and common sense were also cited frequently as personal strengths. Personal qualities cited as strengths included humor, persistence, patience, maturity, adaptability, openness, dependability, caring, organization and intelligence.

Personal areas in need of improvement covered a wide span according to responses by participants. However, the most commonly cited areas included laziness (13), motivation (11), temper control (11), work performance (11), and coping with stress (10). Eight participants stated the need to change their negative attitude toward work, while seven cited the need for increased assertiveness and improved skills. Six participants stated the need to follow through and finish what they started.

Factors Associated with Success

Meeting goals (19), having a good job (18) and earning enough money to have savings (19) were the three most commonly cited definitions of success among study participants. Other commonly mentioned factor included increased self esteem, educational credentials, career stability and advancement, happiness and independence. Material signs of success included one’s own home. Eleven participants stated that their family was the most important factor related to feeling successful. While participants readily recognized their criteria for success, several stated that they did not personally feel successful. Six participants perceived success as contingent upon the praise of others such as supervisors, family and friends.

Advice for Others

All participants stated that they would recommend the Cincinnati Works program to others, however 39 made this statement without prompting. The second most common advice from participants was to perform a self assessment (31) to determine interests, skills, strengths and areas that need improvement. Nineteen participants stressed the necessity of making the decision to make a change, while 14 stressed the need for additional education and 13 supported the importance of setting appropriate personal goals. Additional frequently cited advice included avoidance of “job hopping,” working toward the change every day, staying off the streets and participating in volunteer work. Participants stressed spiritual faith, believing in one’s self,

and staying focused as strategies for managing this life change. Practical advice included presenting a neat appearance and being honest with potential employers.

Cincinnati Works: Helpful Services and Suggestions for Change

Cincinnati Works was discovered by most participants through advertisements, recommendations from family and friends, and through case workers. Participants highly praised the services provided by the Cincinnati Works program. Interview skills, resume creation and job leads were the most commonly cited positive services. Clients felt that the staff at Cincinnati Works was supportive both short-term and long-term. Life skills and legal assistance were often cited as unexpected benefits of involvement with this program. Descriptors of how participants felt they were treated during the program

included respect as adults, tough love, and providing hope. Twenty-three participants stated that the program helped them increase their self-confidence and twenty-two cited improved self-esteem. When compared with other job help programs, participants consistently stated that Cincinnati Works was the better, more positive program.

Twenty-one participants stated that no additional services were needed for the Cincinnati Works program. Their perception was that the program does an excellent job preparing clients to seek employment, and as one participant stated, “covered all the bases.” The two most commonly recommended additional services were computer classes (7) and stress management (6). Four participants recommended more career focus, more one on one interview practice and more advertising to make the community aware of the of this program.

Implications

Review of the literature revealed no study that examined the experience of transitioning from poverty to self-sufficiency from the perspective of clients. This study provided insight into this transition from the point of view of people participating in the process. Much of the interview data supports the broad range of personal and family issues that have been found to impact this process in previous studies. However, the study also provides new insight into this transition from the perspective of people attempting to make this change.

A major focus, for agencies that assist clients during attempts at transitioning to self-sufficiency, is support in coping with the barriers people encounter and must overcome to be successful with this process. Participant data supported the necessity of continued focus on adequate transportation and quality, affordable, trustworthy child care as barriers to seeking and keeping employment. Providing legal assistance, in many cases expunging clients records, is another area that was important to participants. Access to resources for stable housing, as well as

programs that provide training and educational credentials were also viewed as important strategies to overcome barriers to self-sufficiency. A related issue that will require additional attention by agencies providing support for this transition is the problem of perceived learning disabilities noted by study participants. Not only will these difficulties affect the ability to complete GED programs, but they will also affect clients' ability to participate in and complete other training programs, which can lead to employment credentials.

Incorporation of self assessment questions about learning difficulties, as well as administration of an assessment tool for basic skills such as reading, writing and mathematics can help to determine the need for additional work on these basic skills. Improvement of such basics may greatly enhance an individual's self esteem and employment prospects.

Participants' descriptions of their fears of failure and rejection may also be related to self esteem and learning difficulties.

Although this issue seems logical and predictable, it has not been discussed in previous studies as a barrier to employment. Because these fears immobilized the change oriented efforts of clients, they must be acknowledged and strategies developed to assist clients to both recognize and cope with their fears. Two study participants described one of the helpful services provided by Cincinnati Works, as a discussion of the risks and benefits of making life changes.

Specifically focusing on their risks or fears allowed these participants to expect and recognize the phenomena, resist the blocking effects, and continue with their efforts to become self-sufficient.

The problem of a poor work history or a work history punctuated by temporary service positions was viewed as a conundrum by participants. Some felt that they needed to work, but the pattern of taking temporary positions made their resumes less attractive to potential full time employers. Participants recognized the value of temporary services in providing needed work experiences, but expressed caution about becoming too reliant on this type of service. A strategy suggested by one participant was to stay with the same temporary agency for a long period of time, then to focus on their longevity with the same agency in both resumes and contacts with potential full time employers. In response to a question that asked what factors were most likely to cause a person to leave a position, participants most commonly cited boredom, anger or loss of temper with peers and supervisors, and a negative attitude toward the type of work and work place. However, participants from the successful group were more likely to line up a new job before quitting, while participants in the other two groups were more likely to leave the job one day and not return the next.

Assessing and reinforcing personal strengths as well as noting areas that need improvement can be beneficial. Nine participants stated that a useful service

provided by Cincinnati Works was helping them to perform a self-assessment. Additional emphasis on self-assessment, focusing of both personal strengths and areas needing improvement, as well as learning deficits could be beneficial to clients' employment prospects. Self-assessment should be taught as a continual process, including acknowledgement and praise for strengths and realistic, personally valued goals for improvement.

Health problems were a factor for 20 study participants. They described a wide variety of ailments, many of which limited the types of work participants could perform. Health care benefits were among the top three most popular attractions to a job, yet not even all of those who worked full time were covered with health benefits. While participants expressed concern for their own health care, they were even more worried about health care benefits for their children. The lack of health care benefits for the working poor is a nationwide problem. Participants spoke of using downtown free clinics as well as programs for their children such as the CHIP program. Staff members at Cincinnati Works research low-cost health care benefits, collect the information and put clients in touch with resource people who can assist them with attaining health care benefits. But even with these efforts, many participants stated that either they or their families were without health care benefits.

Cincinnati Works is perceived as providing not only useful services for these

clients, but also as a source of professional and personal support. Even research participants, who did not feel supported by family and friends, felt supported by the Cincinnati Works staff. The list of positive services provided by this organization is almost as long as the list of barriers participants felt they needed to overcome. Key elements repeatedly discussed by participants were the long-term nature of the help offered and the perception of the non-judgmental nature of the Cincinnati Works staff. As one participant so aptly stated, "they must be doing something right." The complexity of the human dilemma precludes a silver bullet answer to the problems people encounter when they attempt the transition to self-sufficiency. Needs vary across age and gender groups. When participants stated that the Cincinnati Works staff was the most helpful service provided by the organization, they often spoke of the intense individual attention they felt they received.

By extension on the need for individual attention, thirty-three of the forty-five participants ended their interviews by thanking the researcher for the opportunity to share their stories. The interview process was perceived as a therapeutic and useful experience that helped them to gain focus and perspective on their individual situations and needs for help, as well as their inner strengths and areas where they would benefit from improvement.

Journey Toward Self-Sufficiency: A Qualitative Study
Coding Sheet

+ Factors	Barriers	Role Models	Life Changes	Attractive Job	Helpful SVC	Add SVC	Strengths	Need to Improve	Success	Advice
Material needs	22 Transportation	32 Parents	20 Roles	23 Pay	25	24 Resume	7 Computer Class	4 Appearance	2 Happiness	9 Cincinnati Works
Emotional needs	12 Lack of Education	25 Grandparents	11 Feel about self	45 Benefits	32 Interview Skills	36 Counseling	3 Spirituality	32 Attendance	7 Independence	9 Assess Self
Family	28 Legal problems	6 Aunts / Uncles	6 Material	15 People	22 Clothes	12 > 1 on 1 interview	4 Work Ethic	20 Longevity	4 Meeting Goals	19 Make Changes
Spirituality	2 Child care	32 Siblings	2 -home	11 Location	8 Follow-up	14 > Legal Help	1 People Person	13 Training/Skills	7 Good Job	18 Education
Support	35 Child School	9 Pastor	1 -things	12 Shift	19 Self esteem	22 > Advertising	4 Common Sense	10 Negative attitude	8 Family	11 Find spirituality
-Parents	12 Health	9 School Nurse	1 -car	4 Challenge	16 Self confidence	23 More resume	2 Fast Learner	18 Managing money	1 Productive	2 Play the Game
-Children	11 -sexual	0 Teacher	1 Treatment	45 Atmosphere	9 Adult respect	9 > Drug Help	1 Positive attitude	11 Lack Assertiveness	7 Helping others	5 Develop Skills
-Sig. Others	9 -substance use	38 Counselor	1 -same	7 + Future/stable	7 Round Table	8 > participation	2 Persistence	8 Lack of trust	4 Praise	6 Believe in Self
-Friends	12 Substance Abuse	16 Others	4 -different	38 Flexibility	6 Job Leads	20 Homework	1 Patience	3 Putting self last	1 Money / Savings	19 Try every day
Independence	15 Housing/Clothes	23	Relationships	26 Help others	17 Long term help	19 Career Focus	4 Maturity	7 Separate home/work	2 Material Goods	6 Volunteer
Responsibilities	40 Hours/Days Safe	10	Independence	3 Career	12 Good Staff	29 Stress Mgmt	6 Adaptability	6 Low Self Esteem	5 Own Home	11 Stay off streets
Education	25 Job Skills/credentials	19	Future Planning	3 Environment	8 Handouts	6	Openness	3 Taking Advice	1 Self Esteem	15 Be responsible
Avoid trouble	1 Hardest	27	Managed before	45 Productive	2 Support	25	Family	4 Temper/Anger	11 > Education	10 Stay Focused
	Race	7	-Assistance	27 Type of Work	29 Tough Love	7	Dependability	8 Motivation	11 Stability/Career	10 Set Goals
	Gender	3	-family help	8 Professionalism	6 Hope	5	Caring	7 Work performance	11 Power	2 Avoid Job Hopping
	Age	5	-friends help	5 Enjoy Job	20 Cover Letters	3	Self Presentation	7 Judgment	4 Create + change	3 Long Term Planning
	Fear of Rejection	22	-live off others	8 Advancement	12 Self Assessment	9	Good References	2 Laziness	13 Advancement	7 Don't Lie
	Poor self esteem	16	-odd jobs	10 Training	20 Life Skills	19	Team Player	2 Alcoholism	2	Appear Neat
	Lack of support	18	-temp services	8 Employer Cares	6 Applications	8	Professionalism	3 Managing Change	4	
	Fear of Failure	22	-illegal activity	8 Full Time	3 Transportation	7	Work History	15 Procrastination	2	
	Work History/Temp	28			Resources	8	Organization	3 Vocabulary	4	
	Learning Disability	24			Risks/Benefits	2	Job Skills	10 Coping with Stress	10	
	Generation Curse	20			Legal help	14	Intelligence	5 Finishing things	6	
	Abuse	12						Parenting	5	
	Negative Cycles	8			How Found CW	45				
					-family/friend	16				
					-advertisement	19				
					-case workers	10				
	Others' Barriers	36	None	10	Other programs	23	None	21		

Panel Three: Through Insurance to Health

Moderator: Jimie Holmes Harris, Program Manager of the City of Cincinnati
Division of Employment and Training

Affordable health care is a vital element in a thriving economy. Persons of all income levels and social status have the same need for both accessible and affordable health care. The statistics confirm that over half of uninsured workers are employed full time and that many have been steadily employed for more than 1 year. 90% of all the uninsured children are members of working families. The information exchanged during the roundtable examined programs and efforts current in place to address these and other startling fact about the status of health care in Ohio.

The roundtable session was divided into two areas for exploring the topic of “Through Insurance to Health.” The first area dealt specifically with the need for health care as it relates to children. The second area dealt with the health care needs of adults.

Eileen Cooper Reed from the Children’s Defense Fund (CDF) shared with the group a key initiatives her agency has been working on since July 1998 to make health care a reality for children in Greater Cincinnati. CDF has been assisting the Hamilton County Department of Human Services with the dissemination of information and registration of families for the Children’s Health Insurance Program (CHIP).

Following Ms. Reed’s presentation, much dialog ensued around the number of individuals who were eligible for the services, but had failed to participate. It was not completely clear all the reasons families had for not feeling comfortable to avail themselves of these free services for their children, however, issues around privacy seem to be the primary response given by prospective participants when asked to register their children. Many just did not want to be involved with the “welfare system”. To address this concern CDF is now exploring ways to encourage employers to support CHIP through on site work site registration. So far employers have not received this effort as well as CDF would have hoped. Currently there are approximately 9,000 families participating in CHIP in Hamilton County.

In Butler County an attempt to address and resolve some the problems associated with CHIP registration was discussed in four educational forums. Jeffrey Diver, Executive Director of Supports to Encourage Low-income Families (SELF) presented information on the scope and outcomes from these forums. The goal was to attract and educate 300 business representatives on the link between accessible health care for families and a stable, reliable workforce. 350 business representatives attended the

forums. All seemed very receptive to the information and concepts, however, Butler County is made up of approximately 98% small businesses and there was not much enthusiasm for supporting a health care plan that did not include health care coverage for their employees. There are approximately 1,300 families currently participating in CHIP in Butler County.

Randy Moore and Kara Ringer of The Regional Head Start Children's Health Collaborative Project shared their latest initiative to bridge the gap between uninsured children and health care. Although the project is in the beginning stage, the plan has sound assessment and implementation procedures. This collaboration between four agencies will unfold in two phases. The final phase is expected to help build healthier communities by developing up-to-date, accurate needs assessment of the primary care providers in the service area as well as a directory of providers for Head Start families. This assessment data will provide information to education the medical community and parents.

The project hopes to serve 3447 throughout the Head Start service

region. These families will reside in Butler, Clermont, Hamilton and Warren Counties.

Col Owens from Legal Aid Society of Greater Cincinnati (LASGC) and Dr. Steven Howe from the University of Cincinnati presented information during the adult segment of the roundtable. Their topic was "Health care for Low-income Working Parents: An Estimate of the Number of Uninsured Parents in Ohio Eligible for an Expanded Medicaid Program". Dr. Howe shared information gathered during work on a funded research on the aforementioned topic that supported the need for Medicaid expansion.

Their report greatly magnified for the roundtable participants the under utilization of dollars and programs by uninsured adults due to the narrow eligibility standards. The source of the data used to come to this conclusion was extrapolated from the Current Population Survey, a joint research program of the U. S. Census Bureau and the Bureau of Labor Statistics. The project was completed and a report published in March 1999. The study became a focal point of a successful advocacy effort in the budget session of the Ohio General Assembly to expand Medicaid to this population.

Greater Cincinnati Project

Children's Defense Fund

The Children's Defense Fund (CDF) Greater Cincinnati Project was launched in 1993 to advocate for the children of Greater Cincinnati so that no child is left behind. By building effective coalitions with a wide number of socially active organizations, CDF has successfully created a community synergy that has served to improve the quality of life for children in Southwest Ohio.

Among other key initiatives for children, CDF has been working since July of 1998 on assisting the Hamilton County Department of Human Services with CHIP outreach. It has done this through evaluation of HCDHS outreach efforts and those of its outreach subcontractor Hunter Health. This work is being carried out under a grant from the Health Foundation of Greater Cincinnati. In addition, CDF has recently been awarded a three-year grant from the Robert Wood Johnson Foundation. The Ohio Commission on Minority Health is the lead agency in Ohio for the RWJ grant. CDF is the lead agency for Hamilton County and the two remaining sites are Cuyahoga and Hocking counties.

Hunter Health via contract with the Hamilton County Department of Human Services has conducted the majority of outreach for CHIP in the Greater Cincinnati area since its implementation in 1998. CDF

has positioned itself as a value-added component to their outreach. As will be discussed in greater detail, Hunter Health already has made progress with employer-based CHIP outreach. The task at hand for CDF is finding new and creative ways to enhance the efforts of Hunter Health's employment outreach.

Presenting for us will be Eileen Cooper Reed, Executive Director of CDF. Her work experience includes social work, community development, college administration and regional planning. After obtaining her law degree, she served at the Court of Appeals for the Sixth Circuit and the Hamilton County Prosecutor's Office before becoming a Juvenile Court Referee. Since May of 1993, she has served as the Executive Director for CDF, Greater Cincinnati Project. Eileen's community involvement has also centered around children, having served as a board member for Walnut Hills Child Development Center, Committee of Management for the Melrose YMCA, Capital Campaign Committee for the Marva Collins Preparatory School and President of the North Avondale PTA. She is a steering committee member of the Cincinnati Youth Collaborative and Cincinnati's Black Community Crusade for Children and board member for Hospice of Cincinnati.

The Problem: Employment and Health

One of the many problems facing working low-income families today is access to healthcare coverage. Due to high premiums and co-payments, health insurance plans offered to employees, in many cases, are not affordable. For other employees, the opportunity to acquire health insurance may not be available at all. The high cost of health insurance coverage is problematic for both employee and employer. Employee absenteeism, due to caring for their sick uninsured children results in loss wages and will often jeopardize their employment status. On the other hand, employers experience productivity issues when employees are forced to stay home to take care of children, who often suffer from preventable illnesses.

In addition, one of the unintended consequences of welfare reform was a massive loss of healthcare for children. Since the arrival of welfare reform in 1996, over 800,000 children have lost Medicaid coverage according to a recent report published by Families USA. As parents

transition from welfare to work, they lose healthcare coverage for their children because transitional Medicaid runs out or, as in some cases, transitional Medicaid was never made available to them.

Because 11 million children in the United States are presently lacking health insurance and an increasing number of parents are transitioning from welfare to work, there is an urgency for new affordable healthcare options, such as CHIP. Therefore, CDF is now exploring ways to encourage employers and employees to take advantage of what CHIP offers children.

Although CHIP is a cost-free healthcare program, employer and employee problems still exist with efforts to sign families up. Previous outreach efforts have revealed several areas of concern: some employers, due to time and energy, are reluctant to incorporate CHIP enrollment into normal human resource activity and employees are often resistant to the idea of receiving public assistance, regardless of how it is packaged.

Approach: Outreach Methods to Engage Employers

Hunter Health, to date, has initiated three major mailings to employers concerning CHIP. Approximately 5,000 employers were targeted. The mailing included a letter describing the advantages of offering CHIP to employees and a CHIP brochure. The employers, who responded to the mailings,

were given brochures to distribute to workers and CHIP posters to hang in the workplace.

In addition to the dissemination of CHIP materials, on-site presentations and enrollment sessions were scheduled at numerous work sites. The presentations consisted of face to face meetings with employers to educate them on CHIP and to

discuss the best strategies to help them sign up their employees. CDF, as well, participated in a number of these presentations. The enrollment sessions provided employees the opportunity to fill out the application with assistance from Hunter Health staff. Several weeks before the on-site enrollments, flyers were distributed listing the verification information they would need to bring. On-site presentations and enrollments were conducted at Crown Temporary Services, The Maids, Veteran's Security Patrol, Kinko's and LaRosa's restaurants, as well as others.

Over the next several months, the Children's Defense Fund expects to take a leading role with employment-related CHIP outreach in Hamilton County. Mass mailings to area businesses will continue to be a part of our strategy. Still to be explored are other strategies and tactics to engage employers in the process. They include:

- Encouraging employers to incorporate CHIP enrollment as a

part of their initial hiring process. Including CHIP at this stage reduces the stigma of public benefits and makes it more comparable to private insurance.

- Interfacing with job readiness programs, which assist parents moving from welfare to work. Participants in these programs often lose health insurance for their children due to confusion and misinformation about transitional Medicaid.
- Contacting the various Chambers of Commerce, the Small Business Administration, labor unions and other large umbrella employer's resource associations. The goal is to have large business-related organizations set the tone regarding the importance of CHIP enrollment and have employers follow their lead.

Findings & Expectations

Because strategies for employer-based CHIP outreach has only begun in this last quarter, we can only speculate on future findings at this time. Of the 5,000 mailings targeted to low-wage employers in the Greater Cincinnati area, only 29 employers responded. The 29 on-site enrollments resulted in 50 CHIP applications. While the results from this campaign could have been

better, it did provide us with some useful insight to certain attitudes and behavior surrounding CHIP enrollment.

One of the several theories as to why this campaign didn't produce higher enrollment numbers revolves around privacy issues. Applying for free insurance/public benefits in full view of co-workers may have made potential applicants uncomfortable and, as a

result, unwilling to take advantage of the opportunity. Such reasoning is more evidence that CHIP enrollment via employers could be more effective if it were integrated into general human resource activity.

We expect this may be more appealing to applicants than on-site enrollments conducted by unfamiliar people in open spaces.

The other theory presents a problem that isn't employer-specific. Rather, it's a problem that shows up across all the various avenues of outreach. Even though CHIP is marketed and packaged as a health insurance option for working families, it is still perceived by many as a welfare-related program. Because CHIP is administered through the Hamilton County Department of Human Services, many eligible families still resist due to the stigma of the agency alone. Therefore, the challenge becomes overcoming the culture of previously formed attitudes and opinions regarding county assistance programs. Again, presenting CHIP as an employment-related benefit via human resources activity, as opposed to a welfare-related program may encourage more families to take advantage.

Convincing employers, however, to institutionalize CHIP through human

resources activity may prove to be difficult. While the employer has no direct out-of-pocket expenses, there are considerations of time and energy spent by human resources staff. Since Hunter Health encountered hundreds of rejections to do informational presentations, it is reasonable to expect a high number of employers will be also opposed to this approach. Unless the Ohio Department of Human Services streamlines the application and loosens the verification requirements, employers may be reluctant to incorporate the CHIP application into regular hiring procedures.

However, it is our contention that engaging larger umbrella employer resource organizations such as area chambers of commerce, small business associations, labor unions and others, we will find worthwhile success.

Welfare reform has led to an increase in job readiness programs. Expectations are high that these programs will be less resistant to engage in CHIP enrollment activity. Programs of this nature are inherently more responsive to the issues and problems that confront families going through the welfare to work transition. Consequently, we expect to find these programs willing to integrate CHIP into their assistance efforts.

Implications

The expected implications of employers becoming active in CHIP enrollment include a variety of changes that are significant for both employer and employee. Employers

should experience a decrease in their turnover rate due to the stability and affordability of health benefits provided via CHIP. One of the major reasons low-income

employees are transient is due to their search for adequate and affordable benefits. This has certainly been an issue with thousands of workers in Hamilton County, who rely on temporary services for employment. Hence, as a result of CHIP, we expect job retention to be positively affected.

CHIP provides preventive care so employees may be less likely to miss work due to a sick child at home. Studies show the uninsured or underinsured are hospitalized 50% more often than the insured for what would be considered avoidable hospital conditions. As a result, employees are happy because they don't miss work, which means they don't lose wages due to sick children. Having CHIP available will result in a win-win situation for both employer and employee. Employees will establish a primary provider relationship enabling them to become more dependable workers. Employers will see a decrease in loss work time and have a more satisfied and productive workforce.

Looking at the possible impact of CHIP enrollment through employers in a broader sense, there is another implication to consider beyond on the job satisfaction shared by both employer and employee. If CHIP employer enrollment can become institutionalized, perhaps it will begin to change some of the stigmas and negative opinions associated with receiving public benefits. With the time limits of welfare reform set to start affecting Ohio Works First recipients in 2000, now is the time to not only transform the system "as we know it", but also transform the way people view public assistance. Historically, recipients receiving Medicaid have often experienced what seemed to be impersonal and demeaning interactions with county caseworkers. Now the point of contact will be employers, who have a vested interest in providing for the overall needs of the employee and their family.

Regional Head Start Children's Health Collaborative Project

**Hamilton County Educational Service Center Head Start;
Warren County Community Services, Inc., Head Start;
Child Focus, Inc. of Clermont County Head Start;
and the Butler County Educational Service Center Head Start**

Introduction

Head Start in Ohio is both a federal and state funded comprehensive early childhood program serving at risk and/or special needs children from birth to five years of age and their families. Head Start has been in existence since 1965 and initially was developed to help break the cycle of poverty. Today, Head Start supports parents as the primary educators, nurtures and advocate of their children.

Head Start is designed around three core areas:

(1) Child Development and Health

addresses education, nutrition, disabilities and mental health, and physical and dental health.

(2) Family and Community

Partnerships includes parent involvement, social services and collaborative partners in the community.

(3) Program Design and

Management includes human resource management, systems and procedures, facilities, materials and equipment and program governance.

Head Start is mandated to assure that children receive basic health services and is the payer of last resort if the child needs medical services. This has taken a financial toll on the program and Head Start staff spends an inordinate amount of time helping families access medical care. Consequently, the Hamilton County Educational Service Center Head Start program in partnership with Warren County Community Services, Inc. Head Start; Child Focus, Inc. of Clermont County Head Start; and the Butler County Educational Service Center Head Start program are working collectively to produce an efficient health delivery system for Head Start children and their families. The Regional Head Start Children's Health Collaborative is a result of this partnership and staffs a project director, two coordinators, and a support assistant.

The Regional Head Start Children's Health Collaborative Project plans to develop strategies that will decrease barriers to primary health care for the Head Start population by (1) better defining and narrowing the problem through the development of a needs assessment and

(2) using the needs assessment to help increase access to primary care providers by increasing the number of providers to serve this population. The Collaborative is committed to assuring that all children in the Head Start program are optimally healthy, go to school ready to learn and enter into the elementary school environment in top physical condition.

Presenters

Jenny Cox, RN, BSN has worked in community health for 10 years beginning as a pediatric nurse. She soon entered into nursing administration and expanded her talents to program administration. Jenny is currently working in collaboration with Head Start and

Lincoln Heights Health Care Connections, Inc. and authored the grant that made this project possible.

Randy Moore, RRA has been retained as Project Director. His background has been in health education, health information management and hospital administration. He has extensive experience in program development to address community need based health programs.

Kara M. Ringer, MS is the coordinator of Hamilton/Clermont for the Collaborative Project. Her background is in health education and health planning/administration. She has worked in the Cincinnati Public School system and Medicaid managed care.

The Problem

While all four counties of Head Start have health service needs that are unique to them, all share some common barriers to care. Barriers such as lack of transportation and inaccessible hours of service exists but, one common and critical barrier is the lack of “medical homes” (primary care providers) available to the children. Many children receiving assistance even through CHIP (Children’s Health Insurance Program) cannot find primary care providers to receive basic medical services. Consequently, the Initial Task Force looked further into this problem and found that it was much more complex than just lack of providers. These complexities include:

- The number of CHIP funded children are increasing in each county, but the number of providers that will accept CHIP has not increased proportionately.
- Some providers accept new CHIP patients one month, but do not accept them the next month.
- Providers may impose rules on patients that have CHIP, but not impose the same rules on other patients.
- Families do not always understand the concept of a “primary care physician” and may “doctor hop” which frustrates the physician offices and diminishes

the care received. Providers who “cap” the number of CHIP patients may fill quotas quickly while the family is in fact not a patient of that particular physician.

- Providers do not always have the knowledge to deal with different cultures and socioeconomic groups and may not accept a certain group because of their past experiences.
- Families where both parents work or single parent families cannot get their children to the doctor during “traditional” hours (9am to 5pm) may forgo preventive measures and take their children to the emergency room when ill.

This situation not only has left families with children unable to get needed services but it has a financial impact on each Head Start agency and the hospital emergency system as well.

- Head Start staff spends many hours finding providers for children to perform physical exams, follow up on existing health problems, and assuring those children receive continuous care. Head Start staff spent 30% of their time addressing these types of health issues. Therefore, when that time is converted to a dollar amount based on the support staff's salary it costs Butler County \$170,216; Clermont County \$56,842; Hamilton County \$173,250 and; Warren County \$27,588 annually.
- The hospital systems takes a toll because children are seen in the emergency room for visits that could easily been taken care of in a primary care physician's office. This is very costly- \$300 and upwards in the ER at Children's Hospital versus \$50 or more at a doctor's office.

The Approach

This project is divided into two phases. The first phase will gather information and develop a needs assessment to establish baseline data. Interviews and/or surveys will be a method for collecting the data.

Information obtained, but not limited to this area will include: (1) why and how many primary care providers don't accept CHIP and uninsured populations, (2) how many CHIP patients are “capped” by the provider,

and (3) what is the provider's quota for “capped” CHIP patients.

By helping Head Start families understand the concept of primary care providers and the importance of developing relationships with their provider we can help them receive continuous, comprehensive, quality medical and dental care. This will be managed through (1) administering pre and post-tests to gage the families understanding of preventive health

care issues, to determine their current health practices and definition of health in addition to evaluating their behavior change as a result of our education; and (2) providing interactive hands on programs and year-round learning opportunities, we will educate families about preventive health care and the need for consistent care from providers. Some of the activities/developments used to address each counties unique situation are “Redifests”, media attention, and a school-based health center. “Redifests” offer immunizations, physicals, and dental screenings while providing resources that give families the opportunity to meet area providers and begin to develop relationships as well as connect with other community resources.

The second phase of the project will use the needs assessment to target where in the collaborative regions are primary care providers and services deficient as well as where barriers to accessing a medical home are greatest. This phase will also help to educate providers, the Head Start staff and families. We can begin to accommodate

children seeking a medical home by encouraging providers to increase their caseload. This will be achieved partly by addressing providers individually and in groups to (1) educate them about the problem facing uninsured and underinsured children; (2) increase their cultural sensitivity regarding this population; and (3) focus on issues that may have stopped them from seeing this population in the past. Also by acquiring assistance from other health professions such as nursing and residency programs we plan to increase service in those areas lacking primary care providers. This will be accomplished by developing relationships and networks with these programs to encourage the establishments of training sites in needed areas.

Our final approach to increase awareness of the problem is by mass distribution of the needs assessment regionally to providers, agencies servicing children, and hospital systems. This will be done to encourage them to join our efforts to help children find medical homes.

Expected Findings

Through the needs assessment portion of this process, the Collaborative expects to determine the number of medical and dental providers who accept CHIP and uninsured populations while concomitantly determining the reasons why providers do not accept these populations. Secondly, Head Start

families will be surveyed to determine barriers to obtaining medical and dental care from their perspective. It is also expected that results of this survey will help determine health education and service needs of Head Start families. The completed needs assessment is expected to provide a total

picture of available services and gaps in services in each county.

Using the needs assessments results, areas of greatest need will be targeted for improvement. As a whole these areas may be addressed through provider, family and staff education. It is expected that new innovative

ways to provide medical and dental services will need to be developed, possibly to include utilization of physician/dentist extenders (e.g., nurse practitioners, physician assistants, health training program personnel and/or hygienists).

Implications

The needs assessment when finished will give a better picture of the available services and gaps in services in each area. The needs assessment may prove to be a valuable tool for hospital systems to use when they are developing satellite offices. The tool will also be helpful to providers such as community health centers and public health providers when they seek funding to provide services for the uninsured and underinsured. In addition legislators can use this tool to fight for increased services and better health care legislation to serve this group. The needs assessment will also point out gaps in services and be used to increase funding and resources for these areas.

The long-term implications of this project will help to build healthier communities by (1) developing an up-to-date, accurate needs

assessment of the primary care provider situation and a directory of providers for Head Start families (2) developing creative ways of educating providers about the needs of these children and enticing them to serve this population as well as educating parents about preventive health and dental care providers and (3) beginning to develop other approaches to barriers to care as perceived by Head Start families. The impact on the health care community in general will hopefully provide more than awareness and education, but persuade providers to establish working relationships with community resource groups/agencies that assist underserved children and their families to improve access to care. Eventually we hope that this project will become a model that others can follow.

CHIP Awareness Forums

Supports to Encourage Low-income Families (SELF) Butler County, Ohio

Introduction

Supports to Encourage Low-income Families (SELF) is a nonprofit social service organization and Butler County's state-designated community action agency.

Founded by the late County Commissioner Janet Clemmons, SELF was incorporated in late 1995 and began serving the community in 1996. SELF's mission is "to enhance the quality of life for county residents by impacting the causes of poverty and empowering individuals to achieve and sustain self-sufficiency." As a community action agency, SELF is charged with providing services that have a measurable and potentially major impact on the causes and conditions of poverty in the county.

SELF's core programs include jobs, education, mentoring and emergency services. In 1998, SELF served more than 8,700 individuals through its offices in Hamilton, Middletown and Oxford and helped hundreds of families increase their household income.

SELF also serves as an advocate for low-income families, spearheading the Butler County Self-sufficiency Coalition, the Butler County Child Care Coalition and the Welfare Reform Monitoring Project. The organization is also a certified site for Butler County JobLink, Butler County's one-stop system. SELF is a member of the Hamilton Health

Care Leadership Group, which is working to build a new consolidated primary health clinic. That group's efforts have accelerated in light of the closure of two of Hamilton's health clinics.

In May 1998, SELF and the Lincoln Heights HealthCare Connection (LHHC) became the outreach contractors for the Children's Health Insurance Program (CHIP) for Butler County. SELF handled the media, public relations and marketing while LHHC organized door-to-door canvassing of neighborhoods and other efforts to sign up eligible families. More than 1,300 children were added to the program.

In late 1998, SELF and LHHCC contacted The Health Foundation of Greater Cincinnati and proposed to conduct four educational forums on the link between accessible health care for families and a stable, reliable workforce. The goal was to attract 300 business representatives. A part of these forums focused on the importance of Ohio's Children's Health Insurance Program (CHIP) and how participants could support the outreach activity in Butler County. Speakers included the chamber representatives, elected leaders, small business employers, and hospital representatives.

The educational forums titled, “A Healthy Workforce = Stable Communities,” had four objectives:

1. Establish the direct link between accessible health care and a workforce with fewer absences and more stability and tenure;
2. Gain buy-in for the need for health care for uninsured populations, especially those transitioning from welfare to work;
3. Educate various constituencies of Butler County (employers, chambers of commerce, policymakers, government agencies, schools, nonprofits) as to the opportunities for health insurance for working families, including the importance of maintaining the momentum of sign ups for new Medicaid programs; and
4. Garner support and mobilize the community to work for more health insurance options for the children of working families.

The presenter is Jeffrey Diver, executive director of SELF. Mr. Diver was the principal organizer of this project. He joined SELF in April 1996 as its first executive director. Previously, he was field director for the National SAFE KIDS Campaign in Washington, D.C. Chaired by former U.S. Surgeon General C. Everett Koop, M.D., National SAFE KIDS is a program of Children’s National Medical Center in Washington. The Campaign affiliates with lead organizations, primarily health departments and hospitals, to build grassroots coalitions across the country to address unintentional childhood injuries. Mr. Diver has been published in several national publications and made more than 50 presentations on public/private partnerships, grassroots organizing, and public awareness campaigns. He is a native of Warren County, Ohio.

The Problem

Health insurance is an economic necessity for families of all income levels to ensure they have access to preventive and acute health care. In addition to personal suffering, lack of insurance leads to greater absences from work and school and higher impact on the family budget. In fact, anecdotes demonstrate that the lack of insurance can wipe out a family financially if a medical emergency occurs. Conversely, adequate health

insurance is critical for a family to achieve and sustain economic self-sufficiency. With more businesses offering low-paying jobs, limited employee benefits and outsourcing more work, fewer people are able to obtain needed insurance. In Butler County, there were as many as 8,335 children under age 18 without health insurance. (1995 Estimate by Ohio State University). Of the 3,932 low-income clients served by Supports to

Encourage Low-income Families (excluding its Emergency Home Energy Assistance Program) since 1996, some 36 percent (1,408) reported that they have no insurance. (SELF report dated October 21, 1998)

Other startling facts on health insurance:

- Over half of uninsured workers are employed full time. (The Henry J. Kaiser Family Foundation, 1997)
- 90 percent of uninsured children are in working families. (The Health Foundation of Greater Cincinnati)

- One in four uninsured children uses the hospital emergency room as a regular source of health care or has no regular source of care. (The Children’s Defense Fund)
- The uninsured are hospitalized at least 50 percent more often for “avoidable hospital conditions” like pneumonia and uncontrolled diabetes, than the insured. (The Kaiser Commission on Medicaid and the Uninsured, June 1998)

The Approach

The primary approach was to raise the awareness of the public — specifically the private sector — as to the ultimate costs to businesses for uninsured workers and their families. Secondly, the public was then mobilized for action on the issue and to ensure that eligible families take advantage of CHIP. The costs to businesses focus on lower productivity due to employees’ and/or their children’s illnesses and longer absences when preventive health care (i.e. mammograms) has not been accessed. This is in addition to additional family stress of the unreimbursed or subsidized costs, which may be more than if preventive health care had been received.

The process used for the forums was:

- A committee of seven representatives of Greater Cincinnati organizations planned and implemented the workshops and produced the related materials. Representation on the

committee came from: United Way of Greater Cincinnati, SELF, Lincoln Heights HealthCare Connection, Greater Hamilton Chamber of Commerce, Legal Aid of Cincinnati, business recruiter Bernie Crum, and the Butler County Department of Human Services.

- Extensive efforts were made to recruit businesses to participants. Included were:
 - ♦ First securing the commitment and participation of the Butler County Chamber Caucus, an association of all five chambers of commerce in the county and chaired at the time by the president of the Hamilton Chamber of Commerce.
 - ♦ Some 4,215 flyers were produced and distributed

- through all five Chambers of Commerce newsletters in Butler County.
- ♦ More than 150 flyers were distributed at miscellaneous meetings and on counters.
- ♦ Additional advertising was secured in one chamber newsletter and the newsletter *Fax News*.
- ♦ Targeted mailings were made to: 22 retailers and discount stores, 15 businesses on SELF's mailing list, 85 directly to human resource managers and 13 to major employers.
- ♦ 50 businesses were faxed reminders as follow-up to mailings. Additionally, 15 faxes to temporary agencies.
- A brochure was produced summarizing the most current national data on health insurance availability and the impact on businesses and current resources. More than 4,000 copies were individually mailed to businesses in Butler County or hand delivered at meetings.

Findings

- Despite extensive recruitment efforts, two forums were cancelled due to poor registration. However, the partners devised a new strategy: bring the message to businesses through existing venues, such as their associations. Therefore, additional sessions were planned through Rotary clubs and the Butler County Chapter of the Society for Human Resource Management. **A grand total of 350 business representatives attended the forums.**
- A post-test was administered to the business representatives at three of the sessions; 51 responded. The highlights are:
 - ♦ 71 percent of the participants found the information to be helpful; an additional 20 percent found it “somewhat” helpful.
 - ♦ Businesses consistently reported they would use the knowledge to share with co-workers, employees, and employers and that they would refer individuals to the program.
 - ♦ Out of five awareness assessment questions, a vast majority of participants answered correctly on four questions. The fifth question asking what percentage of the country's employers have access to family health coverage proved confusing to most.
- Most businesses in Butler County (as many as 98 percent by some accounts) are small businesses with less than 25 employees.

- Small businesses report that current health insurance plans are not affordable, some plans don't offer family coverage, and family coverage if offered is financially out of reach for most employees.
- The chamber of commerce plan touted as an option at the educational forums is "individually rated" therefore lower priced group pricing is not offered, necessitating the development of such a group pool.
- Businesses were unaware of CHIP despite extensive media coverage in Butler and surrounding counties. Once informed, there was considerable interest in using CHIP as an alternative to less affordable programs.
- Business representatives overwhelming understood the messages delivered at the forums as evidenced by the evaluations.
- We were able to get the attention of businesses and were well received because we talked about "what's in it for them" and the fact that our presentation was professionally prepared and targeted to the specific audience.
- However, once it was realized that CHIP is expanded Medicaid and that the "welfare department" is involved, there was some negativism expressed. In fact, an anti-government sentiment skepticism was felt.
- One stumbling block is the complexity in explaining the eligibility for CHIP business people (i.e. poverty level, household income, etc.).
- There is still a big gap between getting the message and information to businesses and insuring that the information gets to the employees so they would have an opportunity to sign up.
- It was critical that we gained the support of the Butler County Chamber Caucus, which has representation from all five chambers in the county. If we had not had that support, advertising, obtaining mailing lists and support from *individual* chambers would not have been possible.
- The support from the Society for Human Resource Management (SHRM) chapter in Butler County was needed for success. SHRM helped promote the forums to their members and other business leaders.

Implications

- It is possible to gain business support for workshops on health insurance and its connection to a stable workforce. However, until more options are available for insuring employees not just their children, the message is received but gaining action is more difficult.

- Possibly due to the perceived lack of options, business representatives were not as likely to come to “stand-alone” workshops to address health insurance. However, targeted messages to existing gatherings of businesses proved more successful.
- There is a need for simplification of the CHIP program (compare it to the programs in Florida and Georgia) and the development of a program to insure lower-wage earners.
- Development of more health coverage pools for small employers is needed.
- An approach should be developed for convincing employers to share the knowledge of CHIP with their employees. While it cannot be documented that employers did not share their knowledge, the number of businesses completing follow-up forms requesting materials was disappointing.
- Businesses need to be involved in an ongoing discussion on the health care issue to essentially address their contradictory messages— affordable health insurance is needed (which is expensive) and yet most businesses want no new taxes. Society of course is bearing the cost of the uninsured.

Health Care for Low-Income Working Parents

An Estimate of the Number of Uninsured Parents in Ohio Eligible for an Expanded Medicaid Program

Presented by: Legal Aid Society

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Introduction

This research project was funded by a grant from the Health Foundation of Greater Cincinnati to the Legal Aid Society of Greater Cincinnati (LASGC). LASGC provides legal representation, information, advice and referral to low-income citizens in Hamilton, Butler, Brown, Clermont and Warren Counties who meet federal poverty guidelines and other eligibility requirements. Services are free to eligible clients. Each year LASGC helps approximately 4,000 families.

LASGC also addresses larger issues which affect the low-income community. Included among these are problems faced by public assistance recipients moving into employment. LASGC has addressed a number of issues over the last decade including child care, health care, transportation, child support enforcement, education and training, job placement, and job development.

This project was undertaken to help inform and support advocacy to expand health care options for low-income working parents. Medicaid eligibility for parents has historically been linked to eligibility for welfare. Under recent federal legislation, states can offer Medicaid coverage to parents whose earnings make them ineligible for cash assistance. Offering Medicaid to such persons insures that they can take jobs without health care benefits.

More specifically, the study was designed to develop estimates for the number of uninsured parents and guardians in Ohio under 150% of the federal poverty level who might be eligible for an expanded Medicaid program. Estimates were based on Current Population Survey data made from the U.S. Census Bureau and U.S. Bureau of Labor Statistics. Cost estimates were developed from those estimates of potential eligibles.

The project was completed and a report published in March 1999. The study became a focal point of a successful advocacy effort in the budget session of the General Assembly to expand Medicaid to this population. The work resulting in the initial published study, and subsequent revisions and expansions developed in response to questions from legislators and analysts, is described in this paper and presentation.

The presentation will be provided by Dr. Steven R. Howe, Associate Professor, Department of Psychology, University of Cincinnati; and Col Owens, Senior Attorney, Legal Aid Society of Greater Cincinnati, and Adjunct Professor of Law, University of Cincinnati College of Law.

Dr. Howe earned a PhD in social psychology from the University of Cincinnati

in 1980. He worked for 13 years at the U.C. Institute For Policy Research, where he served as director of the Southwest Ohio Regional Data Center. In 1993 he assumed a faculty position in the U.C. Department of Psychology, where he teaches courses in statistics and methodology and conducts externally-funded evaluation and policy studies.

Col Owens has been a senior attorney at LASGC since 1986. He manages the Welfare Team and the Transition Project, a multi-team project focused on policy reform to support clients moving from welfare to work and other low-income working people. Mr. Owens has taught at the U.C. College of Law since 1990, and currently teaches a course entitled “Poverty and the Law.”

The Problem

Medicaid eligibility for adults who are not disabled has historically been linked to eligibility for cash assistance through welfare programs. However, recent federal legislation (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) permits states to offer Medicaid coverage to families in which the adults earn enough income to make the family ineligible for cash assistance.

There are three major reasons why an expansion of the Medicaid program to low-income working parents might be beneficial.

- It would contribute to a healthier workforce and improve the ability of

low-income wage earners to maintain employment. Welfare recipients who had been covered by Medicaid can lose health insurance when they find employment and the job does not provide health insurance coverage immediately.

- An expanded Medicaid program for adults might indirectly improve the health of children. The Children's Health Insurance Program (CHIP) has been under-utilized, possibly because parents do not benefit personally.
- The Medicaid program can be expanded by leveraging state dollars

to secure federal dollars that can be spent on health care services for the working poor.

In planning for the fiscal impact that an expanded Medicaid program might have, it is important for policy makers to have as accurate an estimate as possible of the number of people who might be newly qualified for Medicaid coverage. Therefore, the primary objective of this study was to develop a current estimate of the number of

uninsured Ohio adults in households with children. Adults in such households are not always the parents of the children.

Grandparents, adult children, other relatives, foster parents, unmarried partners of single parents and other non-relatives may all live in an eligible household. Therefore, a secondary objective was to refine the estimate by producing separate estimates of the number of adults broken down by the relationship to the child.

Methodology

Source of Data

The source of the data used to estimate the number of uninsured parents in Ohio was the March 1998 demographic file of the Current Population Survey (CPS), a joint research program of the U.S. Census Bureau and the Bureau of Labor Statistics. The CPS is conducted continuously. Randomly selected households stay in the sample for several months before being replaced by newly sampled households.

The CPS has three purposes.

- It is used to monitor the labor market. For example, it is the source of the widely reported monthly estimates of the unemployment rate.
- It is used to study special issues on a non-recurring basis.
- The March survey of the CPS is always devoted to producing updated demographic profiles of the nation,

and the product of the March survey is referred to as the Annual Demographic File.

The March 1998 file was based on interviews with one respondent from each of 50,353 households across the country. As with the more familiar U.S. Census of Population and Housing, the respondent in the CPS is asked to produce information about all of the individuals who live in the household, and not just him or herself. Much of the data collected in the survey concerns the previous calendar year, in this case 1997. Thus, the estimates presented in this report are for 1997.

Measuring the Absence of Health Insurance

There is no single variable in the CPS that can be used to determine if an

individual was covered by health insurance during the preceding year. Rather, it is necessary to identify the uninsured by determining who had none of the following: (1) Medicare, (2) Medicaid, (3) CHAMPUS, (4) private insurance through an employer, (5) private insurance through a policy of someone else in the household, or (6) private insurance through someone outside the household.

Initial Record Selection

In order to target the population of interest, Ohio adults in households with children, the following selection criteria were applied successively.

- Records had to be for the State of Ohio (decreased file from 131,617 records to 4,707 records).
- Records had to be for households with more than one person (decreased file from 4,707 records to 4,177 records).
- Records had to be for households with at least one member under the age of 18 (decreased file from 4,177 records to 2,695 records).
- Other married couple households that contain only one family (122 households, or 4.5%).
- Single parent households with own children under the age of 18 and no other members (359 person records, or 13.3%)
- Other single parent households that contain only one family (66 person records, or 2.4%).
- Multi-family households that contain one or more related subfamilies only (125 person records, or 4.6%).
- Multi-family households that contain one or more unrelated subfamilies only (149 person records, or 5.5%).
- Other multi-family households, which might have involved such things as adult guardians of unrelated children, the presence of both related and unrelated subfamilies, and so on (54 person records, or 2.0%).

Classification of Households

Every record remaining was classified according to the following household typology:

- Married couple households with own children under the age of 18 and no other members (1,820 person records, or 67.5%)

It was not possible to determine if married partners of householders were the biological parents of the children. For example, a female householder with two children who divorced her husband and remarried cannot be distinguished from a female householder with two children who was still married to the father of the children. It is not known to what extent some of these different family configurations might result in different Medicaid eligibility determinations.

Classification of Adults

Children under the age of 18 were eliminated from the file, reducing the size from 2,695 records to 1,405 records. Adults were categorized as follows:

- Parents of children under the age of 18 (1,148 records, or 81.7%)
- Non-parental guardians of children under the age of 18 (46 records, or 3.3%).
- Adult children, or anyone age 18 or older whose parent was in the home (120 records, or 8.5%).
- Other adults, such as non-guardian grandparents or unmarried partners of the householder (91 records, or 6.5%).

Family Income and Poverty Thresholds

Each record included total family income and the low-income poverty threshold, or the dollar amount that would mark the minimum amount that family income could be without the family being considered below the poverty line. The poverty threshold is largely determined by family size, but it also varies as a function of the ages of members, so several different families could be exactly the same size but yet have different poverty thresholds. Using family income and the poverty threshold, a ratio of family income to the poverty threshold was calculated for each adult in the sample. For example, suppose an adult lived in a family with a 1997 family income of \$30,000 and for which the poverty

threshold was \$19,250. This ratio would be $\$30,000/\$19,250 \times 100$, or 156. This means that family income is 156% of the poverty threshold.

It is important to understand one minor problem with the analyses performed. By and large, the family structures are congruent with how assistance groups would be defined for public assistance benefits. For example, suppose a single parent has two children under the age of 18, and that there is nobody else in the home. She and her children would correspond to the assistance group. About 80% of the adults in the sample came from households in which there is congruence between the assistance group and the household.

An example of a household that does not correspond to the assistance group would be a 23-year-old son who lives in a household with his single mother and 16-year-old sister. Any income he contributes to the household would count as family income. Further, his presence would increase the poverty threshold. He would not, however, be eligible to be a member of the assistance group for welfare benefits. If his income is low, he might force the family's ratio to the poverty level down, but if his income is high, he might force the ratio up. Thus, sometimes this situation would result in a family meeting an eligibility threshold when an assistance group would not and sometimes it would disqualify a family when an assistance group would qualify.

Results

The data indicate that 13.3% of adult members of Ohio households with children did not have health insurance during 1997.

Eligibility for an expanded Medicaid program would not extend to uninsured persons whose family income fell above a certain threshold defined as a multiple of the

poverty level. Analyses were performed under the assumption that nobody with a family income more than 150% of the poverty threshold would be eligible.

Accordingly,

Table 1 presents the number of uninsured persons who fall below and above this threshold value.

Table 1: Income Levels for Uninsured Adult Members of Ohio Households with Children

	Below 150% of Federal Poverty Level	Above 150% of Federal Poverty Level
Parents	129,424	165,467
Other Guardians	10,866	2,792
Adult Children	41,987	42,380
Other Adults	31,211	25,034
Total	213,488	235,673

All further analyses were focused on the estimated 140,289 persons in Table 1 who are uninsured, parents or guardians, and live in families with incomes below 150% of the federal poverty level. The rationale for an expanded program was to help to stabilize households with children by providing health insurance to the people who have the greatest responsibility for the economic well being of their families. Other adults (e.g., unrelated persons or grandparents who are not the guardians) and adult children do not ordinarily bear this burden of responsibility. Other guardians, such as grandparents, might have this responsibility, and so are included in subsequent analyses. Note, however, that little is known about the circumstance of their guardianship. For example, it may not be

formal, but merely temporary, while a parent is away.

Some of these 140,289 parents or guardians do not need an expanded Medicaid program because they are eligible for the existing Medicaid program. Within the range of family incomes between 0% of the federal poverty level and 150% of the federal poverty level, eligibility for the existing Medicaid program is as follows.

- Families with incomes below 33% of the federal poverty level are always eligible for the existing program.
- Families with incomes above 33% of the federal poverty level but below some upper threshold for the existing program may or may not be eligible for the existing program and,

consequently, might be eligible for the new program.

- Families with incomes above this upper threshold for the existing program would be eligible for an expanded program as long as their incomes did not exceed the upper threshold for the new program.

Table 2 shows the maximum number of persons who would be eligible under an expanded program. The present study was based on the 1998 CPS only. The Center on Budget and Policy Priorities (CBPP), a Washington, DC policy institute with bipartisan credibility, had independently

prepared an estimate of the same maximum caseload for an expanded program in Ohio, but for the years 1995, 1996 and 1997.

Table 2 shows that the best current estimate for the maximum number of parents and guardians with incomes less than 150% of the federal poverty level eligible for an expanded Medicaid program in Ohio is 115,315. Estimates were also developed for incomes less than 125% and 133% of the federal poverty level. The table shows that the estimates vary from year to year as a function of sampling error, changes in the availability of health insurance plans, and economic conditions affecting the size of the workforce.

Table 2: Estimated Maximum Number of Uninsured Ohio Parents and Guardians Who Might be Eligible for an Expanded Medicaid Program

Income as a Ratio of the Federal Poverty Level	CBPP 1995	CBPP 1996	CBPP 1997	Present Study 1997
Between 33 and 125%	76,520	100,125	91,795	90,754
Between 33 and 133%	82,640	104,692	97,845	96,804
Between 33 and 150%	88,232	127,248	116,513	115,315

Table 2 overstates the number of persons eligible for an expanded program because 33% is merely the limit below which people are eligible for the existing program. Some people with incomes above 33% of the federal poverty level might be eligible for the existing program because of the Earned Income Disregard, which allows people to retain Medicaid benefits for up to 18 months after they begin working. The purpose of the Earned Income Disregard is to prevent people who start to earn income from being

penalized through the immediate cessation of public assistance benefits such as Medicaid.

Consider the example of a two-person family that includes a working mother and a dependent child. The mother earns \$800 a month. Under the Earned Income Disregard, the first \$250 is set aside and half of the remaining income is set aside. If the balance (\$275 in the example) is below the Medicaid Payment Standard shown in Table 3, the mother would qualify for coverage under the existing program.

Thus, by taking the appropriate Medicaid payment standard for the size of the family, doubling it, and adding \$250, it is possible to calculate the monthly income beyond which a person would lose eligibility for the existing program and therefore benefit from an expanded program. For a family of size two,

that monthly income would be \$842, which translates into an annual income of \$10,104, or 93.1% of the federal poverty level. The eligibility thresholds for families larger than two persons are shown in Table 3. Using these thresholds to estimate the minimum number of Ohio adults eligible for an expanded program resulted in Table 4.

Table 3: Upper Limits of Eligibility for Existing Program

Family Size	Federal Poverty Level (Annual)	Medicaid Payment Standard (Monthly)	Eligibility Threshold
2	\$10,850	\$296	93.1%
3	\$13,650	\$362	85.6%
4	\$16,450	\$447	83.5%
5	\$19,250	\$523	80.8%
6	\$22,050	\$582	77.0%

Table 4: Final Estimated Minimum Number of Uninsured Ohio Parents and Guardians Who Might be Eligible for an Expanded Medicaid Program

Income between upper threshold for existing Medicaid and	Persons
125% of federal poverty level	37,518
133% of federal poverty level	43,568
150% of federal poverty level	62,080

Implications

Initial Costs Implications

As noted above, persons with family incomes below 33% of the federal poverty level are eligible for the existing Medicaid program. Persons with incomes between 33% of the federal poverty level and some upper threshold that varies with family size may or may not be eligible for the existing program. Persons with incomes above this threshold are not eligible.

Given these considerations, the number of parents and guardians who would be eligible for an expanded Medicaid program is estimated to be 62,080 persons (from Table 4) to 115,315 persons (from Table 2). This assumes that eligibility for the expanded program would be cut off for families whose incomes exceed 150% of the federal poverty level.

Medicaid coverage costs approximately \$125/month for non-disabled adults, or \$1,500 a year. However, not every person eligible for an expanded Medicaid program would take advantage of the program. Cost estimates were prepared based upon the assumption that 50% of the persons eligible for the expanded program would apply. It was believed that this enrollment rate was conservative from a budgetary perspective, meaning that there was reason to believe that not even this many adults would enroll. For example, it was noted that the enrollment rate for the Children's Health Insurance Program (CHIP) was in the range of 25–30% at best.

Under this assumption, it was initially estimated that 31,040 to 57,658 people would apply for an expanded Medicaid program, and that the total cost of their coverage would be \$46.6 million to \$86.5 million. However, since the state share of Medicaid expenses is 42%, the cost of an expanded program to the State of Ohio would be somewhere between \$19.6 million and \$36.3 million.

Legislative Developments and Follow-up Research

The genesis of this project was the passage of federal welfare reform legislation in 1996 that de-linked Medicaid and welfare, allowing states for the first time to extend Medicaid coverage to working people ineligible for welfare. Have-A-Heart Ohio (HAHO), a statewide human services advocacy coalition,

determined in 1998 to undertake an effort to expand Medicaid coverage to working parents in the 1999 budget session of the Ohio General Assembly. Many organizations involved with HAHO became committed to and involved in this effort. Among the most important were the United Way of Cincinnati, the Health Foundation of Greater Cincinnati, and the Ohio United Way. Of particular significance was the Ohio United Way's adoption of this expansion effort as its number one priority for the 1999 session of the General Assembly.

At the outset of this endeavor, the Ohio Department of Human Services (ODHS) did not adopt Medicaid expansion to parents as a priority. ODHS was primarily concerned about other issues, including particularly the expansion of the Child Health Insurance Program (CHIP) up to 200% of the poverty level, which had been adopted as a priority by the Governor. It is also concerned about the cost of expanding parent eligibility to 150% of the federal poverty level.

Once the above-summarized report was made available to ODHS and to the Legislative Budget Office (LBO), questions arose about the failure to include in the original estimates those parents under 150% of the poverty level who already had insurance. After discussion with ODHS and LBO it was determined that the original estimates should be revised to include that population, and Dr. Howe immediately undertook that additional work. Counting this group raised the number of parents

under 150% of poverty potentially to be covered from 115,000 to 305,000.

However, a second issue closely related to this one undercut somewhat that dramatic difference. ODHS and LBO questioned the presumed take-up rate of 50% in the initial study. By adding insureds to the potential eligible population, the take-up rate became a two-dimensional rather than one-dimensional task. One rate had to be developed for the insureds, and another rate for the uninsured. As guidance, it was noted that the blended take-up rate for the insured and uninsured sections of the CHIP program in 1998 was 20%, which included a much higher rate for uninsured and a much lower rate for insureds. Assuming a higher take-up rate for a fully implemented program, ODHS finally settled on a blended take-up rate of 25% for this initiative and all parties agreed. Dr. Howe's work from that point forward incorporated that assumed take-up rate.

The numbers developed as the budget worked its way through the House budget process resulted in final cost estimates of \$120-150 million for a fully implemented program in the out-years, or \$50-63 million state share. Those cost estimates helped defeat this measure in the House, as they were considered too high to be acceptable.

As the budget went to the Senate, advocates determined that an analysis should be developed at a much lower percent of the poverty level. After analysis and discussion, it was determined that estimates should be developed for 100% of the poverty level.

Dr. Howe immediately undertook this additional work as well. The result was a total potential eligible population of 130,000 people, and a final cost estimate of about \$50 million for a fully implemented program (\$20 million state share). This was premised on the agreed-upon 25% blended take-up rate. Upon review of these numbers, the Director of ODHS determined that this was an acceptable and important measure to pursue, and undertook personal advocacy with the Governor and legislative leaders. The result was to bring this effort back up on their radar screens as a viable objective.

The next critical development was the decision of Sen. Merle Kearns, Senate Majority Whip, to sponsor this program as an amendment to the budget in the Senate Finance Committee. With active effort on her part, as well as the ODHS Director's and coalition's parts, the Senate Finance Committee adopted the amendment. It was included as well in the budget as passed by the entire Senate.

Once the House and Senate versions of the budget were considered by the Budget Conference Committee, it became clear that House members had stronger objections to the measure than had come out in the House debate. For the most part, comments during the House debate had been directed toward cost implications and not to other policy issues. However, a strong confrontation between House and Senate members ensued in the Conference Committee with the Senate ultimately prevailing in terms of the program

being included in the final budget. However, as a concession to House concerns, a two-year time limit was added to the expanded eligibility.

The undertaking of this research project by the Legal Aid Society, with the support of the Health Foundation, was critical to the success of the overall venture. Not only the original study, which helped legitimate the issue during the House budget process, but also the ongoing work of Dr. Howe at each

juncture when questions arose that could have defeated the proposal, were critical to the ultimate success. Seldom will a \$5,000 investment be leveraged into \$50 million of benefit in such a short period of time in such a compact process. The participants in the advocacy effort are extremely grateful to the Health Foundation for its early support of this project, which made possible its eventual success.

Concluding Thoughts

Patricia O'Connor, Ph.D.
Vice President-Program
The Health Foundation of Greater Cincinnati

I would like to summarize some of the themes we have heard today. There have been a wide variety of programs presented, but many commonalities in the projects that have been presented.

First, everyone is struggling with apathy. We see it in providers, clients, employees and policy makers. Policy makers don't support changes these days unless they are shown the proof by provider data. Providers are so busy reacting to change that it is hard to mount and sustain special efforts to make a difference. Health and social services workers are faced with clients who don't engage.

Second, the hard-to-serve poor are often very hard to find and to engage. Over the two year course of the projects presented here, there has been time for the Foundation to learn not to fund projects by underpaying poor people who participate in the projects. Their time is valuable to them, and their contributions to informing our projects is worth more than minimum wage – especially when the result of abstemious payments is no participation by informants and failed projects. The nominal payments of yesteryear - \$5 for an hour of time – just don't fit today's circumstances. We find that we frequently suggest that projects pay more for the effort volunteered to them by participants.

Third, from the projects we heard about today, depression, substance abuse, learning disabilities, and physical abuse suggestive of neurological problems seem to be strongly associated with poverty, chronic unemployment and lack of insurance coverage for health care. The burden of disability among the poor and the uninsured seems very high.

Fourth, and sadly, poor people internalize many negative things about themselves. They have had a share of losses, and seem to believe they can do little to change their circumstances, so it is no wonder that they are apathetic. In our projects, we saw a pattern of poor people lowering their expectations and giving up hopes. Perhaps expecting less – in the way of good health and other life areas – is a way to keep from being disappointed. People with obvious impaired abilities said their health was fine. What they seemed to be saying is that their health is fine – for someone like them. And honestly, good health is sometimes just not an important priority for them; survival issues are more important.

Finally, we see that there are programs out there that are making a difference. Your programs help us to see reality from the bottom up, rather than through the lenses of complacency. There is a large amount of positive energy in the programs and findings that we heard about today. People who cared

put them together and found ways to make them happen.

Hope is the antidote to apathy. We admire all of you who are working to create hope. Your work is not as well rewarded in our society as other kinds of work, and we are all poorer for that. For the poor who have been

lost or forgotten, who don't know the way out of their problems, and who can't afford to believe in a better future, you provide hope, and a roadmap for the way out. The Foundation wants you to know how much we appreciate and admire what you are doing.