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Insuring the Uninsured: Outreach Training for Community Health Workers

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2013

Insuring the Uninsured:

Outreach Training for Community Health Workers

Jeanese Hime

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Capstone Project

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University of Washington, Tacoma

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TSOCW 533: Advanced Integrative Practice II

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Introduction

Nearly one million individuals do not have health insurance in Washington State. The majority are low-income individuals and families. Many are currently eligible for public health care plans and a number of others will become eligible after reform through the Affordable Care Act. The problem is that nationally only 30% of those eligible for health insurance programs enroll in them (The Urban Institute, 2013). The public, particularly low-income individuals and families, need an increased awareness of health care reform policies and how it will impact them in order to reduce the uninsured rates and improve health outcomes.

As a social work student, I uphold the mission of the National Association of Social Work to "enhance human well-being and help meet the basic human needs of all people…" and I believe that health care is a basic human need and right. I also support and adhere to the fundamental principle of pursuing social change to reach a more just society. In the pursuit of social justice, I strive to ensure access to equitable and affordable health care services. From a systems perspective, we can see that our current health care system has many barriers to care, such as unaffordable health insurance, lack of reliable transportation, inadequate housing, and a general lack of information on health care programs and plans. In effect, those who end up the most disenfranchised are those living in poverty and minorities.

This intervention, an outreach training for community health workers, is an opportunity to address disparities in health care coverage. The three-hour course is designed to target communities with high uninsured populations and it will teach community leaders about health care reform and how to enroll their fellow community members in health insurance plans. By offering a training program on outreach to people within the targeted communities, we are able to offer the most effective training. This is true because those doing the outreach are individuals who are familiar with the culture and many times the language of the people in their community. These leaders will be able to seek out and help those that are not being caught by other outreach programs through clinics or other agencies, which may not have the same level of cultural-competence in their approach to reaching out to people.

Overall, the goal of this intervention is to increase the number of insured individuals and families in Washington State, particularly in regions that are low-income with high uninsured rates. This booklet will provide you with the background information of the need for this training and the curriculum that can be used for the training.

Project Proposal

Project Description

Sarah Kliff, reporter for the Washington Post recently noted that “a growing body of research suggests that most low-income Americans who will become eligible for subsidized insurance have no idea what’s coming.” Clearly, the public, particularly low-income individuals and families, not only need to be educated about new health care programs and insurance plans under the Affordable Care Act, but need assistance in signing up for them. King County alone has over 200,000 individuals living without health insurance. And, without it, many people forgo preventative care that could be potentially lifesaving. Outreach is an important tool to link people to health care resources. Many agencies, both non-profit and government-run, have developed outreach programs to address health disparities and teach communities about health care reform. The Healthy Communities Initiative of the Washington State Department of Health has already developed an in-person and online training program that strengthens the existing skills of community health workers who provide culturally competent health education, information, and outreach within their own communities. Also, the Washington Health Benefit Exchange is currently developing a navigator program to assist with enrolling people in health insurance plans. This program is still in the planning phase, so the details of their outreach are unknown.

Critical theory, from a social workers perspective, argues that changes need to be made to reduce health disparities. It insists that our country needs to value health care as a human right, not a privilege. Most health care providers are well aware of the existence of systemic barriers to accessing health care, such as lack of transportation, housing, or affordable health care, and many also know that people within one's culture and community can be the greatest advocates to overcoming these issues. Theoretically, it is apparent that outreach done by community health workers will be the most effective in changing our health care system and linking people to care.

Healthy Communities has supported leaders in various communities across Washington State to address existing health disparities and the Washington Health Benefit Exchange is doing its part to make it easier to find affordable insurance plans. However, I propose that a training template specifically to teach community health workers on ways to educate their communities about health care reform and to assist in enrolling individuals in insurance plans through door-to-door outreach is a necessary addition to the already existing work being done. This training will help reduce the number of uninsured individuals in the most vulnerable communities. This will, in turn, play a role in eliminating disparities related to accessing health care services. Furthermore, the training will encourage the community leaders to adapt the outreach to suit the unique cultural needs of their communities and by going door-to-door, they will be reaching out to those who are truly isolated from care. Small amounts of cost sharing is challenging for low-income people. As said by Solaner and Daniels (2011, p. 825), “we’re all one broken leg, one bad fall, or one case of pneumonia away from the house of cards completely falling down.” An outreach program that links people to affordable health insurance will be protecting individuals and families from financial deprivation and will be protecting our economy from excessive spending on health care costs.

Background

Across the world, countries have developed systems of health care for their people. Many industrial countries have implemented single-payer or universal health care. Throughout history, the U.S. has politically struggled with developing a program that is supported by the people and

politicians. In 1912, Theodore Roosevelt attempted to introduce sickness insurance, but the idea was defeated. In the 1930s, Franklin Delano Roosevelt sought to include health insurance in social security legislation, but it stood up to too much opposition, so he later abandoned it (Gorin, 2011).Medicare and Medicaid were implemented in the 1960s and in 1997, SCHIP, a program created to cover children whose family do not qualify for Medicaid, went into effect (Kirby & Kaneda, 2010). Over the years, these programs have come under political scrutiny on how they are issued and who qualifies for them. For this reason, we have seen many changes in the health care system and we will continue to see more.

Racial Disparities abound in our current health care system. Blacks and Hispanics are three times less likely to be insured and more likely to rely on public health insurance programs (Kirby & Kaneda, 2010). High un-insurance rates are also found in the Korean and Vietnamese American populations. In California alone, one-third of Koreans and one-fifth of Vietnamese are uninsured (Kao, 2010). These disparities are often cause by cyclical disadvantages. This means that these populations' socioeconomic disadvantages lead to poor health and inadequate insurance, which spirals back into further socioeconomic disadvantages (Kirby & Kaneda, 2010). Paradoxically, the U.S. is one of the wealthiest nations, "yet it ranks poorly on health status by race, class, socioeconomic status, and infant mortality" (Francis, Berger, Giardini, Steinman, & Kim, 2009, p. 154).

In 2008, surveys found that 46 million people in the U.S. are uninsured and this number continues growing. Within this population, health disparities exist in abundance for minorities and low-income people. Without insurance many people forgo needed medical care, receive lower quality care, and incur exorbitant debt from health care costs (Butterfield, Butterfield, & Rocha, 2010). One in six King County residents between the age of 18-64 are uninsured. About 83,000 will be newly eligible for Medicaid and over 100,000 will be eligible for subsidized insurance through the Washington Benefit Exchange.

My first exposure to the issue of health insurance was as an intern and later case manager for the Pierce County AIDS Foundation in Tacoma. Most people living with HIV/AIDS must be on an antiretroviral therapy, which is usually 3 prescription drugs they must take every day to control the infection. Without insurance, my clients would struggle to afford this daily regimen. This would most often lead to a dramatic decrease in life expectancy and an overall negative impact on their quality of life. As an intern at the Swedish Cancer Institute in Seattle, I regularly meet people newly diagnosed with cancer who do not have insurance either because they do not know of programs they qualify for or it is too expensive. I've heard many individuals say, "I didn't get checked because of the cost of care and since I had no insurance, I just learned to live with the pain." Perhaps if these individuals had known about programs available to them, some of their illnesses could have been prevented. As can be seen in both my personal experience and the history of our country, the issue of who deserves health care and the policies implemented regarding this views have impacted the quality of life for countless people across our nation. In many cases, it has determined the life or death of an individual. Thankfully, many positive changes are occurring in our health care system. But, all the reform will be useless if people are not educated on what programs are available to them.

Risk/Opportunities

Benefit of project. Many programs and health care partnerships are already doing work to reduce the number of uninsured residents in King County; however, people continue to slip

through the cracks. Door-to-door outreach by a community health worker will be able to address this gap. These individuals have a deeper understanding of their community, can speak the local language, and understand cultural and spiritual practices, which creates an opportunity to connect and reach out to people that outside agencies and organizations cannot replicate. The community health workers will also come to understand where inequalities exist and will be able to contribute their voice and knowledge to advocating necessary changes in our health care system. Lastly, the program will have a positive impact on the financial aspect of our health care system by reducing uncompensated care and providing opportunities for preventative care.

Feasibility of project. Outreach to help people access health care services and sign people up for insurance plans is already being planned and implemented in communities across Washington State, which includes the Healthy Communities Initiative and the Washington Benefit Exchange Navigator Program. In fact, we are seeing an increased interest across the nation in doing outreach to enroll everyone in health care programs through nation-wide organizations such as Enroll America. This interest in outreach legitimizes this training and shows that many people and agencies would support it. Furthermore, the training targets leaders who are already passionate about making positive changes for their communities. For that reason, we will have highly motivated individuals interested in seeking out the training and making significant changes of the number of individuals insured in their communities.

Potential barriers. Some community organizations may not have the time, money, or resources to support our training program and recruit community health workers. Also, community health workers may already have significant needs of their own, which could impede on their ability to fulfill their role in signing individuals up for health insurance.

Liabilities. One of the main concerns will be the safety of the community health workers during door-to-door outreach, which will be addressed in the training. The community health workers will be asked to develop their own safety plan and do outreach in pairs. Another concern is the protection of personal and health information obtained while signing individuals up for health insurance plans. It will be important to educate the community health workers on ways of safeguarding confidential information.

Political climate and policy. Our country is in the midst of a dramatic change in how our health care system is run. Many individuals who are impacted by the changes may not have the knowledge of how it will affect their current health care. Outreach is necessary to inform the most vulnerable populations of the reform taking place within the next few years. Unfortunately, some opposition still exists regarding health care reform. However, Washington State has been fully supportive of the Affordable Care Act and will be implementing almost all suggested changes within the reform. In fact, there are many groups advocating for the adoption of a single-payer health system. This includes the Physicians for a National Health Program-Western Washington Chapter and United for Single Payer, both are working diligently to make the single-payer health system a reality. These policies as well as the many being implemented through the Affordable Care Act need to be shared with the communities that will be most severely impact.

Budget / Funding

Cost/method of payment. The Affordable Care Act offers a grant called "Community Transformation" that is awarded to state and local agencies and community-based organizations to implement preventative activities and services to address health disparities. The grant is $221

million to be allocated through the Centers for Disease Control. This training program may be eligible for funding through this grant.

Resources needed. The resources needed include a laptop, PowerPoint, and a projector for the training. Funding for printing off resource pamphlets and training handouts will also be necessary. The organizations and businesses within the target communities will be asked to provide the facility for the training. If that is not possible, grant money will go toward paying facility fees.

Logic model for grant proposal. See APPENDIX A.

Advertising

The program will seek out relationships with community-based organizations and most frequented places in targeted communities. This will include reaching out to churches, grocery stores, food pantries, restaurants, schools, and community centers. We will advertise the training program as free and recruit community health workers through word of mouth starting with community leaders and by fliers left at each location.

Evaluation Criteria

Data to prove the effectiveness of the program will be collected in multiple ways. First of all, the Training Coordinator will keep record of how many community health workers attend each training and if it is meeting the goal amount. The Training Coordinator will also administer the pre and post survey to determine how much is learned at the training. By comparing responses from the pre and post survey, we will be able to evaluate how much has been learned and how helpful the training has been. The community health workers will have a tracking tool that will be used to mark down who they meet and who they help sign up for insurance. This data will be compiled and compared to data collected by the Washington Benefit Exchange Navigator Program to determine the percentage of individuals the community health workers sign up for health insurance over the amount the other program enrolls. Each community health worker will be asked to see the individuals they enroll three separate times in order to ensure they get accepted into the health insurance program and they re-new during the eligibility review period.

Data Collection Worksheet See APPENDIX B.

Next steps.

First step will be to develop a relationship or affiliation to the Healthy Communities Initiative of the Department of Health and the Washington Benefit Exchange Navigator Program. Both these programs are doing similar work and an affiliation with this proposed training will improve its effectiveness. As for the training, it will be offered as an in-person 4 hour training each month to communities across Washington state. The training will target communities that have high uninsured populations. It will take place in the most frequented community organization or businesses. The training will include a PowerPoint presentation and case study analysis. At the beginning, participants will receive a handout with a general overview of the training information. Then, they will fill out the pre-survey. Next, the instructor will present a PowerPoint, which will cover the following topics: the Affordable Care Act, health insurance plans in Washington State after health care reform, how to do door-to-door outreach, opportunities for advocacy for health care reform, safety planning for outreach, and a case study analysis. The case study analysis will require breaking the participants into groups of three to discuss how they would help the presented individual or family in the case study enroll in a

health insurance plan. After the training, the participants will receive a handout of resources related to accessing health care to be given out to the communities they serve. Finally, participants will receive a certificate of completion. These community health workers will not only be reducing health disparities in their communities, but they will be contributing to the final goal of all citizens and many documented immigrants having health insurance in our state. Also to note, the trainings will be updated regularly to address changes that continuously occur in our health care system, particularly regarding insurance programs. Community health workers who have attending previous trainings will be able to return to the new trainings for any updated information.

Intervention

Course title: Insuring the uninsured: door-to-door outreach training to enroll community members in health insurance plans

Course Duration: Three hours

Target audience: Community health workers in highly uninsured areas of Washington State.

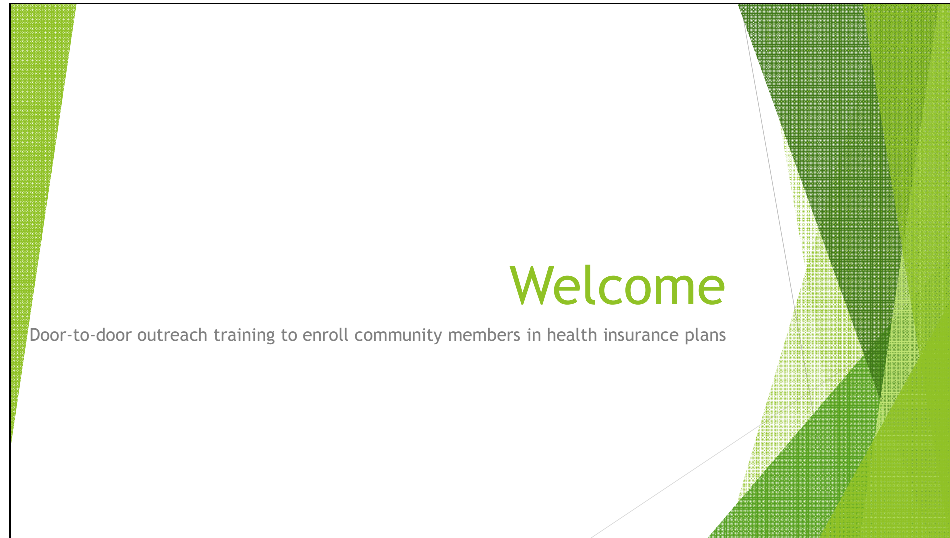
Course material and resources: Laptop, projector, surveys, and other handouts (the tracking tool and reference sheet)

Learning objectives: By the end of the training program, learners will:

1. Understand the basics of the Affordable Care Act.
2. Develop skills to enroll individuals in health insurance plans in WA State.
3. Gain knowledge to perform outreach.
4. Understand how to use cultural knowledge to reach the most vulnerable people.
5. Learn how to make an effective safety plan.
6. Develop the tools to advocate for necessary changes.

Section	Duration*	Objectives Covered
Washington State: The Future of Health Insurance Plans	30 minutes	1,2
Discussion Question	20 minutes	1,2,6
Important Agencies	7 minutes	1,2
Outreach	18 minutes	3,4
Role Playing	25 minutes	2,3,4
Safety Planning	18 minutes	4,5
Advocacy	4 minutes	4,6

*Additional minutes not included above: introductions, pre and post surveys, agenda, and breaks

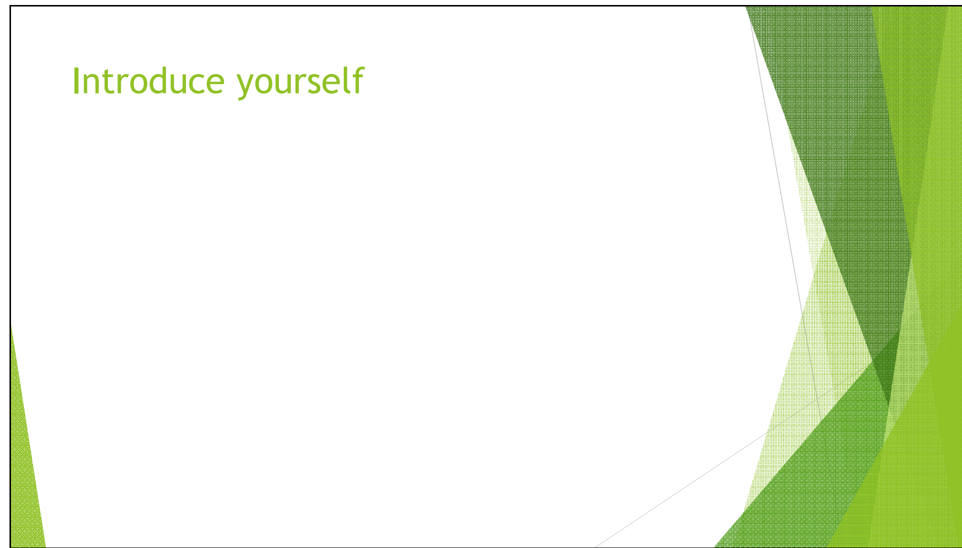


Duration: 13 minutes
Talking points:

Thank you all for coming and welcome to the outreach training to learn about health care reform and how to enroll our families and friends in health insurance plans. At any point during the training, please feel free to make comments and ask for clarification on any topics that we cover. Let's get started. The first thing we are going to ask you to do is fill out a survey to help us better understand what you already know about health care reform policies and insurance plans and suggestions on how we can improve this course. Please take the next 10 minutes to complete it. When done, bring it up to me.

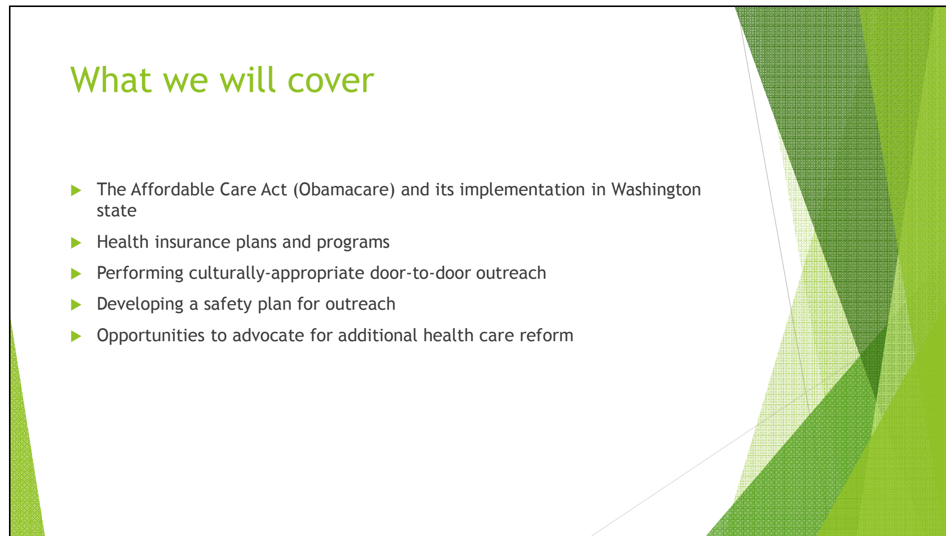
Additional information:

It is not necessary to include your name on the survey. The additional comments section could be anything you think would help us improve the training. For example, how we can better recruit others for this course. Be specific.



Duration: 10 minutes
Talking points:

Now, I would like us to go around the room, share our names and what brought us here today. (Allow each person 30 seconds-two minutes depending on attendance)

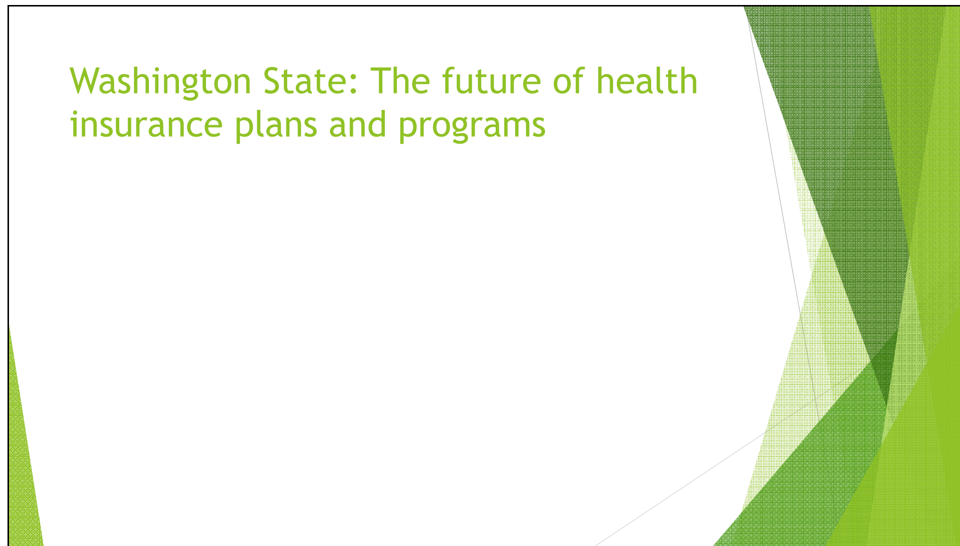


Duration: 3 minutes
Talking points:

Before we begin the course, we will go over the agenda. The first part of this training will provide a brief overview of health insurance programs that people within your community will be eligible for and how the Affordable Care Act, or what is better known as Obamacare, will impact these programs. After that, we will talk about how to perform outreach that is specific to your community's culture and you will have an opportunity to role play scenarios to give you a chance to practice doing outreach. Next, we will talk about making a safety plan to protect yourself while out in the community, and lastly we will discuss how you can do your part to make necessary changes in our health care system that address health disparities in our communities. Just as a note, we will have two breaks during this three hour course, but people are free to step out of the room as needed. Any questions?

Additional information:

Other aspects of health care reform not related to insurance programs or plans will not be discussed. If individuals want to learn more about those changes, you can contact the training coordinator after the meeting and she will mail or email additional information to you.



Duration: 1 minute
Talking points:

Let's get into the first section of this course. We will discuss the various health insurance plans, both public and private, that people within your communities are currently eligible for or will be eligible for in 2014 when Obamacare policies go into action. Please to do not hesitate to interrupt me at any point if you have questions or would like any clarification on the information we are covering.

Medicaid

- What it is.
  - Medicaid expansion
    - Individuals below 138% Federal Poverty Level (FPL), not incarcerated, meet citizenship requirements, and are not eligible for Medicare
    - 10 Essential Health Benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Duration: 5 minutes

Talking points:

Many of you already know about this program, so please feel free to provide any input you think would be helpful while I review it.

First, what is it? Medicaid is a state-run, and both state and federally-funded, public program that provides health coverage to low-income individuals with disabilities who are legal permanent residents. As of now, being low-income does not automatically qualify you for the program. However, as part of the Affordable Care Act, individuals with incomes below 138% the federal poverty level will now be eligible for the program as long as the meet the other eligibility requirements, which are citizenship or documentation of legal permanent residency of the United State for at least five years, and not being incarcerated.

Incarcerated individuals must have their health care covered by the facility that they are in. If they have health coverage through Medicaid prior to their incarceration, they will lose it once they have been charged with a crime. If you have additional questions about their coverage, I encourage you to look into the National Association of Counties who have written about this topic in relation to county jails on their website, naco.org. We will talk later about undocumented immigrants and their opportunities for coverage later on.

Health benefits through Medicaid will be treated equally to those available through the Qualified Health Plans, which we will talk about later, and must include the 10 essential health benefits listed here on this slide (read them). Increased transparency for the plans is also a requirement of the Affordable Care Act. And, applying for the programs will be streamlined through one portal that will automatically determine eligibility through either information already stored in their database or self-reported information from the applicant. We will discuss this more later on when we talk about the Health Benefit Exchange.

Additional information:

138% the federal poverty level is $15,415 annual income for an individual and $26,344 annual income for a family of three.

Medicaid: managed care payors and plans

- What are they?
- Who are they?
  - Community Health Plan, Coordinated Care, Amerigroup, and Molina
- Important details
  - As of now, certain "incentives" exist that make certain plans appealing
    - For example, wigs and bras for individuals with breast cancer are covered by some managed care plan, but not classic Medicaid
    - Hopelink and the COPES program are only available through classic Medicaid
  - Individuals can request to change plans

Duration: 7 minutes
Talking points:

Managed care payors and plans—what are they? These are organizations that are under government contract to provide and manage health insurance plans for individuals who qualify for Medicaid.

Community Health Plan (CHP) is a non-profit organization created by a group of community health clinics. Taken from the website, "our goal is to provide you and your family access to affordable, high-quality medical care services. We serve all ages, from seniors to babies, with providers who have deep community roots and include some of the best doctors, nurses, and specialists in the state. This means our members have access to first-class medical care—and it's just down the street."

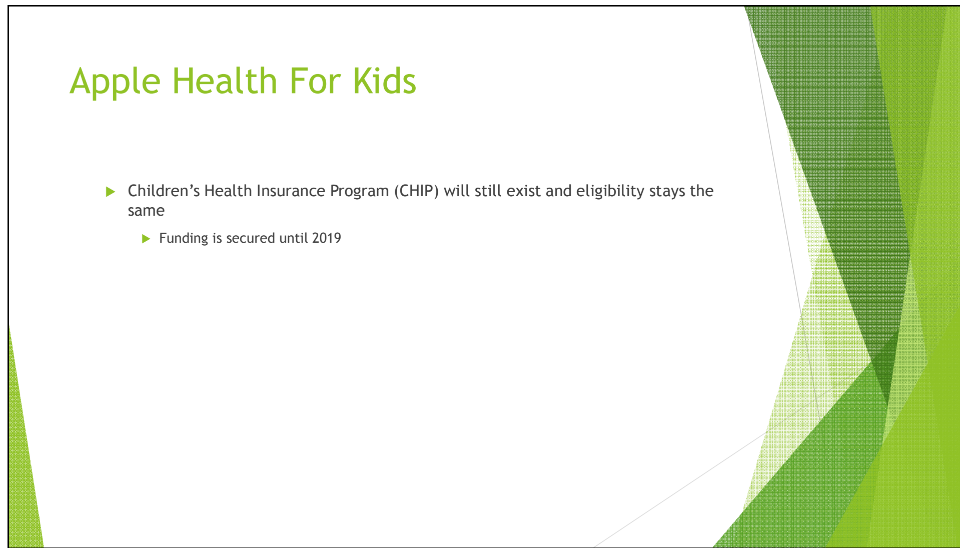
Molina is considered one of the main competitors of CHP because of the coverage offered. They are for-profit and operate in 15 states across the US. Here is the "about us" information taken from their site: "Molina Healthcare, a FORTUNE 500 company, has grown into one of the leaders in providing quality healthcare for financially vulnerable individuals and families. Currently, Molina Healthcare arranges for the delivery of healthcare services or offers health information management solutions for nearly 4.3 million individuals and families who receive their care through Medicaid, Medicare, and other government funded programs."

Coordinated care, is an out of state agency that is, as quoted by their website, "backed by Centene—a Fortune 500 company with over 27 years of experience in the Medicaid industry and a robust portfolio of specialty health solutions…designed to deliver high quality, locally-based healthcare services to its members with our providers benefitting from enhanced collaboration and strategic care coordination programs."

Amerigroup is another out-of-state contracted company. Their website states, "Currently serving approximately 2.7 million members in 13 states nationwide, Amerigroup is dedicated to offering real solutions that improve health care access and quality for our members, while proactively working to reduce the overall cost of care to taxpayers. Together with WellPoint's affiliated health plans, we serve more than 4.5 million beneficiaries of state sponsored health

plans in 20 states, making us the nation's leading provider of health care solutions for public programs."

The important details to note are each plan has "incentives" or additional benefits and services they provide, which I have given an example of on the slide. That is why you and the individuals you work with should pay attention to the plan you are going to be placed in and to ask questions about coverage and available incentives. Even more important, individuals need to remember that they have the ability to request a different plan regardless of how you sign up for them. So, if another plan provides services or benefits that better fit their needs, they can switch.



Duration: 2 minutes
Talking points:

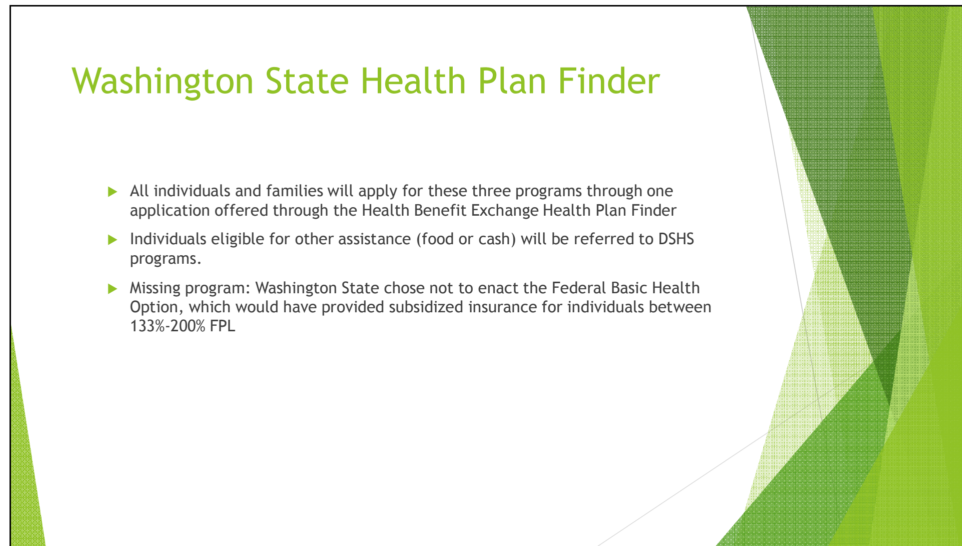
Apple Health for Kids is the Washington States' Children's Health Insurance Program, otherwise known as CHIP. The current program eligibility is all children under the age of 19 whose household income is under 300% the federal poverty level. The income that is used to determine eligibility subtracts any work-related child care costs and child support. There are no resource limits, which means applicants family can own a home or a car and it won't count against them. For premium coverage, a child cannot be covered by Medicaid or any other insurance plans. This program, run through DSHS, provides coverage for medical, dental, and vision. Funding will stay the same for this program until 2019. It will be important to keep updated about the possible changes to this program as it insures over 30,000 children in Washington State.

Additional Information:

A chart of income requirements based on household size can be found at dshs.wa.gov.

Duration: 3 minutes
Talking points:

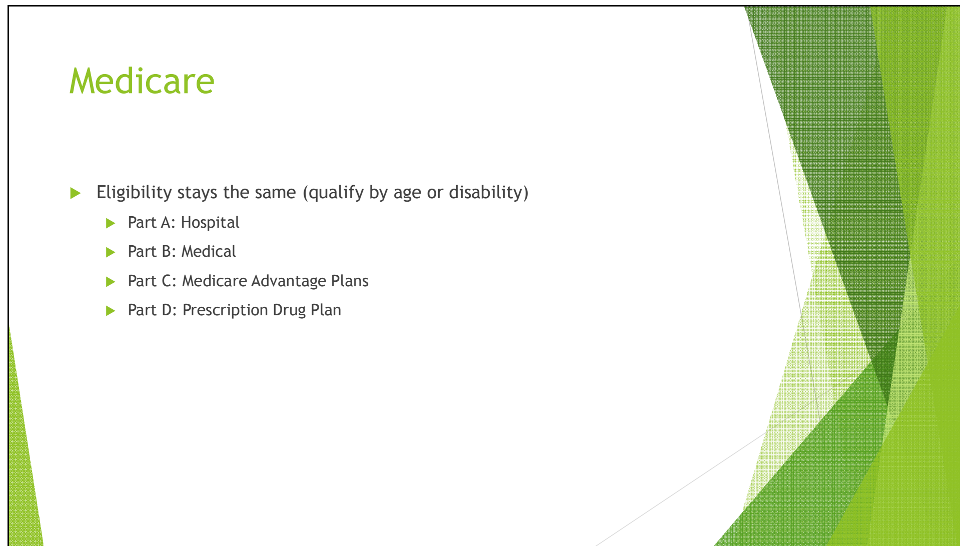
The Washington State Health Benefit Exchange will be the gateway to all insurance plans offered in Washington State. Through either hard-copy, telephone, or web portal, an individual will fill out one application and be sorted into the program or plan they are eligible for. Individuals with incomes below 400% the federal poverty level will receive a tax credit to help pay for the cost of their insurance plan. Those who do not qualify for publicly funded programs will be able to purchase commercial insurance called Qualified Health Plans through the exchange. We will talk more about this on the next slide. The private insurance plans will be available for purchase as an individual or small business. Businesses with under 50 employees will qualify for a tax credit if they purchase insurance through the exchange for their employees. Penalties will be put in place for both individuals who continue to be uninsured and for businesses who do not offer affordable insurance to their employees. As of now, the exact amount of these penalties is unknown. However, some individuals will be exempt if they are able to argue that health insurance continues to be too expensive for them.



Duration: 3 minutes
Talking points:

As we said in the previous slide, everyone will apply for health care plans and programs through the Washington State Health Benefit Exchange's Health Plan Finder. If you are eligible for any other assistance, either food or cash, you will be automatically referred to DSHS. This is being done in attempts to further streamline benefits and services provided by the state. One important aspect of the application is you will not have to provide additional documents. They will either already have your information stored in a data-base resembling the one used by the IRS or they will accept self-reported statements from the applicant.

Before we move on to the next slide, I want to briefly mention one program that Washington state has chosen not to implement, which is the Federal Basic Health Option. Modeled after our current Basic Health plan, this program would provide subsidized insurance for individuals between 133% and 200% the federal poverty level. The Urban Institute has run a micro-simulation of this program for Washington State and found that it would be effective in providing insurance for over 160,000 Washingtonians at a rate that was affordable. As many of you already know, many low-income people forgo purchasing health insurance because they are more greatly impacted by other costs, such as gas, rent, and groceries, so it is financially impossible to afford it. The reason why our state decided to stall on its implementation was the worry that it would further convolute an already confusing health care system and we would see greater churning, which is when people move from different insurance plans based on fluctuating income and other eligibility criteria.



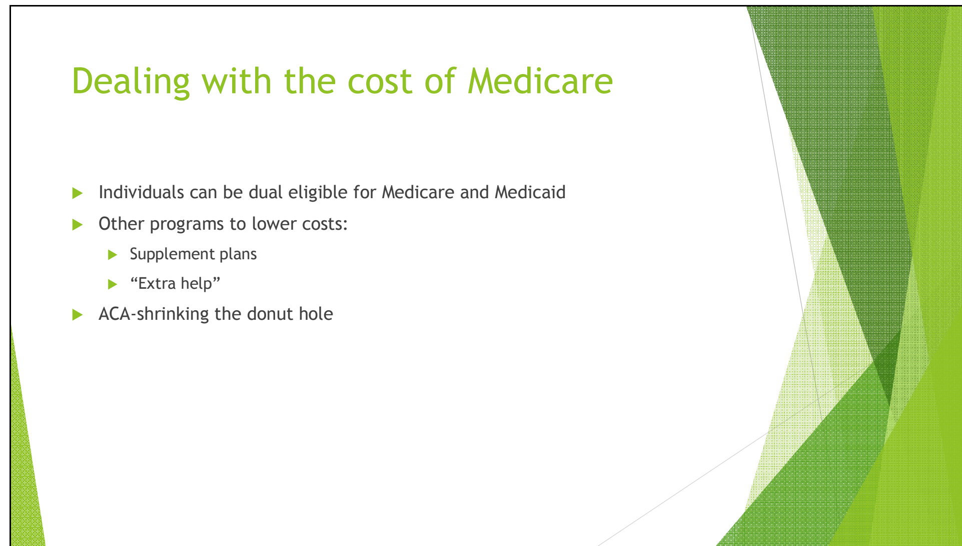
Duration: 3 minutes

Talking points:

Medicare is a federal health insurance plan that is available to individuals over 65, with End-Stage Renal Disease (ESRD), or have been receiving social security benefits for two years. Part A covers 100% hospital costs. Part B covers 80% medical costs, like routine doctor visits. People can opt out of part B and some people because they do not want to pay or cannot afford the 20% cost-share. However, this is not usually advised because it will leave a huge gap in your coverage and can keep you from seeking out routine preventative care. Part C are Medicare Advantage Plans, which are offered through a private insurer. Many people choose to enroll in these because they cover services that are not included in either Part A or Part B. They often include a Part D plan as well. Medicare Part D plans by themselves are the prescription drug plans. This is usually where patients encounter the most trouble with paying for medications, especially when they reach the donut hole, which we will talk more about later. In general, these plans are also offered through private insurers and may include premiums, deductibles, and copays. Medicare can help you enroll in any of these, but the challenge people often encounter is there are too many options. This is where you can be helpful. You want to make sure they get an affordable plan that also covers all their health care needs and prescriptions.

Additional information:

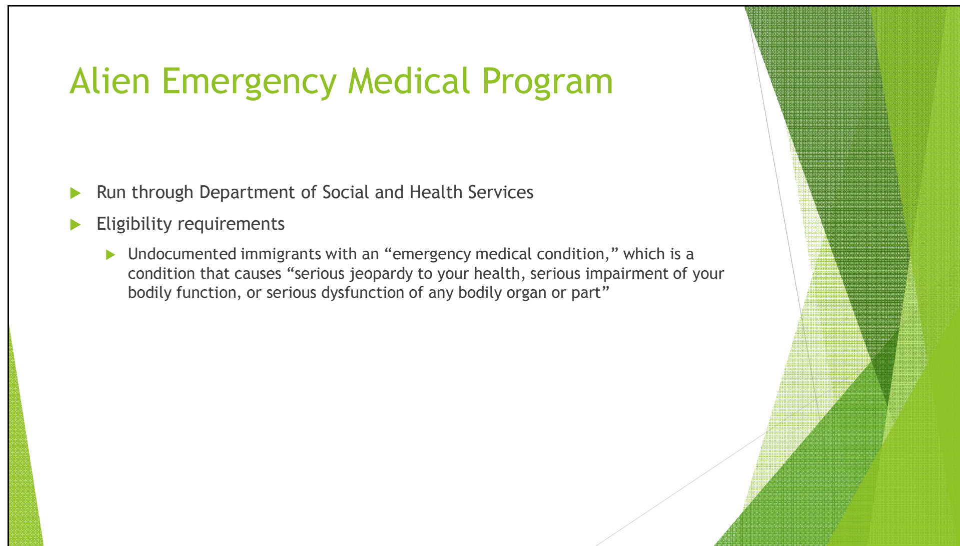
If you want more information on Medicare, it is highly suggested that you visit medicare.gov.



Duration: 3 minutes

Talking points:

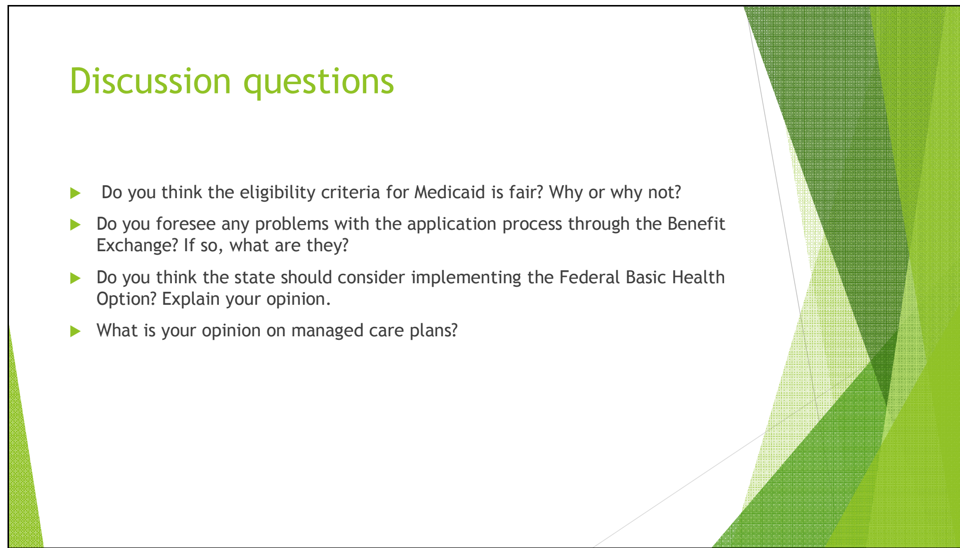
As mentioned earlier, individuals with Medicare must pay 20% of their part B. These costs can bankrupt or cause severe financial hardship for families with limited incomes. In that case, you have the opportunity to point out other options to cover the cost. The first being that some individuals may be dual eligible for Medicare and Medicaid. If the individual qualifies for Medicaid, it will cover the 20% cost-share. If their income is too high, these individuals can apply for supplement plans, such as ones offered by AARP, or even "extra help" low-income subsidies through Social Security. For assistance on this, it would be beneficial to call 1-800-Medicare directly or get help from the Statewide Health Insurance Benefit Advisors. We will talk more about them later. Lastly, it is important to mention that the Affordable Care Act has plans to close the donut hole, so that individuals will not be negatively impacted by the large costs incurred when an individual gets caught in it. The donut hole is when you have reached the part D plan's limit and you must cover 100% cost of prescriptions. This can be thousands and thousands of dollars that people don't have, so they will often stop taking the medication. The gap is shrinking because of requirements in ACA that have led to a reduction in the cost of brand-name drugs by 50% and generic-named drugs by 14%. It is estimated that individuals with this coverage will save more than $3000.00 by 2020 because of the Affordable Care Act.



Duration: 3 minutes
Talking points:

The Alien Emergency Medical Program may see some changes once the Affordable Care Act takes full effect, but as of now it is staying as it has been. First point to note is that it is run through the Department of Social and Health Services or DSHS and the eligibility requirements are very strict. To qualify for the program, an undocumented individual will need to have an "emergency medical condition," which is a condition that causes "serious jeopardy to their health, serious impairment of their bodily function, or serious dysfunction of any bodily organ or part. Overall, preventive care, like routine check-ups, will not be covered. With this particular population who will want to know about free clinics in the community and be able to assist people in finding them. You can even offer to be their interpreter or find interpreter services for them. The important part of interpreting will be to make sure you do not impart your own biases on the individual and make sure they are making their own health care decisions. To find free clinics, you can contact the Washington Free Clinic Association who know of 30 clinics across Washington State. There number is (360)705-0892 or you can visit them online at www.wafreeclinics.org.

Duration: 10 minutes



Duration: 20 minutes
Talking points:

The purpose of reform in Washington State is for many reasons: to reduce disparities based on race and income, to simplify the application process and the programs available, and to reduce health care costs. Let's discuss some of the components of the Affordable Care Act to see if any of these objectives are not being met.

Additional information:

Ask each question and allow at least 5 minutes for each. Afterward state, "If you feel strongly about any of the issues we brought up about health care reform and how it will run in our state, we will talk later about how you can advocate for change to address these problems."

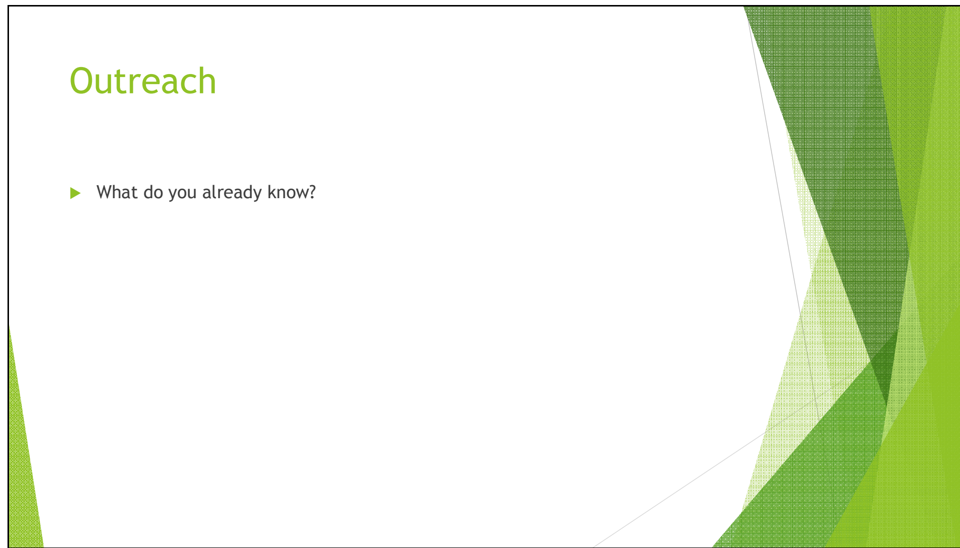
Duration: 7 minutes
Talking Points:

The Washington State Office of the Insurance Commissioner, headed by is a state agency that oversees Washington State's insurance industry to make sure that companies, agents, and brokers follow the rules and to protect consumers. In 2011, they recovered over $8 million that went back to consumers due to disputes with insures. They also have a network of volunteers who provide information on health care issues to thousands of individuals, which is the Statewide Health Insurance Benefits Advisors, or SHIBA. These volunteers are trained on the latest health insurance plans, particularly Medicare, and they are able to assist people in finding an affordable plan and enrolling them up for one over the phone. Their helpline number is 800-562-6900. If you are using this with someone you are signing up for health care, make sure the individual completely understands the insurance plan and encourage them to ask questions. People may forget what they signed up for it they are not fully engaged in the process.

The Health Care Authority is a state agency that runs various health care programs including Medicaid. Their website provides you with detailed information on health care reform and opportunities to make public comment about these programs. Most of the programs they run will be transferred into Medicaid in 2014.

The Department of Social and Health Services is the state-run agency that works in tandem with the Health Care Authority in providing programs for low-income individuals and families in Washington State. They are the one to contact for information on food assistance, medical and behavioral health services, financial aid, and other services. They are most notoriously known for child protective services, but it is important to point out that they have many programs beyond those programs.

We have already talked about the Washington State Benefit Exchange Program. I am mentioning them again just to point out that they do plan to implement their own outreach program, or navigator program, which is working to advise community clinics and organizations on the changes to the health care reform policy and how to do outreach in their own community.

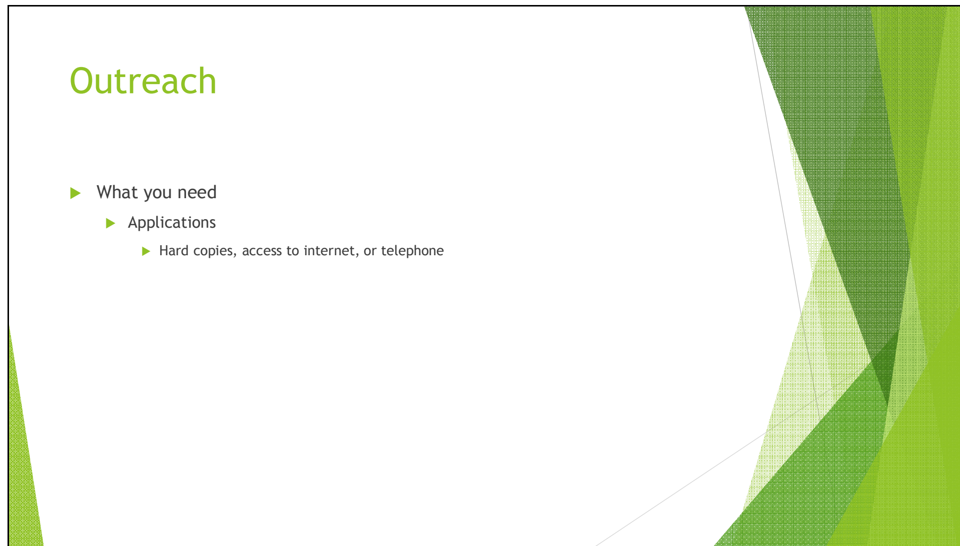


Duration: 5 minutes
Talking points:

Outreach is a tool used by individuals and organizations to reach out to populations that need information or services. It is a way to target those who slip through the gaps, those most vulnerable to experiencing hardships because they lack knowledge or access to programs or care. In this case, we will be doing outreach in our own communities. Some of you may have experience with this, let's start by talking about that. What do you know? (Allow participants to share how they have done outreach and ideas for how to do it in relations to enrolling people in health insurance plans).

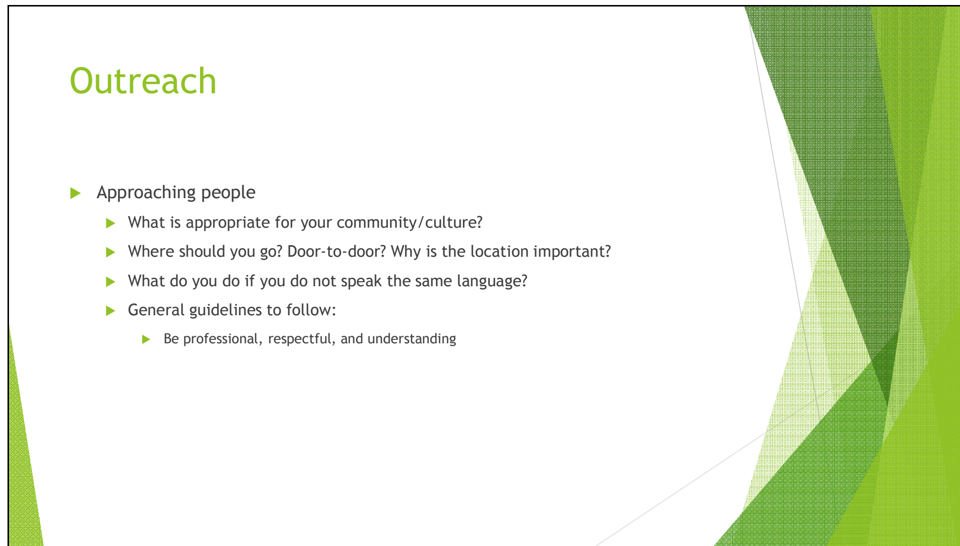
Additional information:

If the group does not have experience, spend time talking about how they have helped their families with various things (emotional support, planning activities, providing care, offering information on resources).



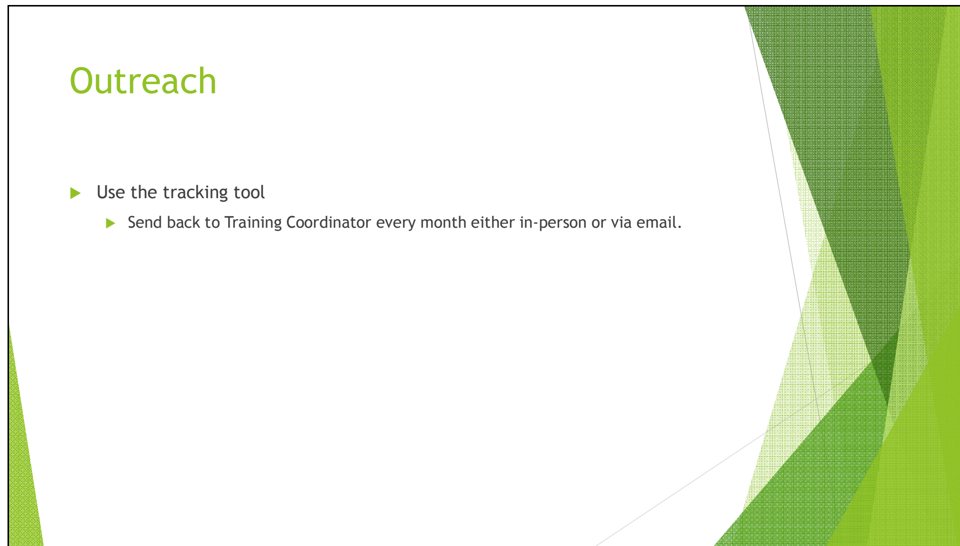
Duration: 2 minutes
Talking points:

So, first let's address what you will need while doing the outreach. Ideally, you will have access to the internet or a telephone to call SHIBA or one of the navigators established through the Exchange to enroll individuals in care. Through these two avenues of enrollment, you will not have to worry about storing the applications or even losing them. It reduces the change of confidential personal information being found by someone and used for criminal purposes, like identity theft. However, if this is not possible, you can request hard copies from the Exchange. It is unclear who you would contact for the new application at this time, so pay attention to the Exchange's website to figure out how you can do this.



Duration: 6 minutes
Talking points:

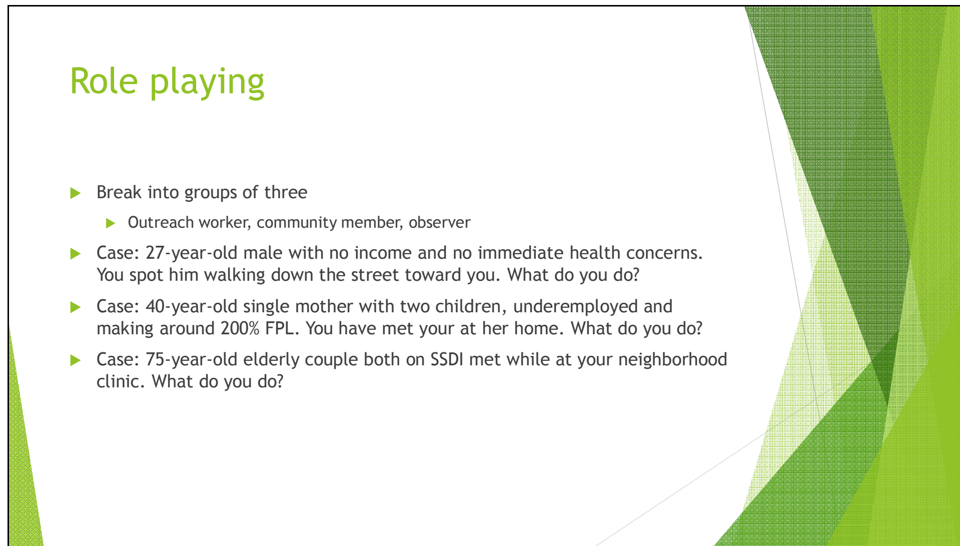
One of the unique aspects of the outreach we are encouraging is how it works to reach those who get missed by the clinics and other organizations that are already doing outreach. Here, we want to discuss further about how to approach people in your own community. Let's spend a few minutes talking about the unique features of your community (allow two minutes). Now, what are some popular places within your community that people often go to? Are there any business or centers that people frequent often? Would it be appropriate to stop by people's homes? Would you be able to help someone who doesn't speak the same language as you? (Ask these questions as needed. Allow another three minutes.) In general, it is important to be professional, respectful, and understanding. You are a leader of your community and by having these three attributes you will be able to make the biggest difference in your community. Try not to allow personal issues between you and others in the community cloud your ultimate goal of helping your community become insured.



Duration: 4 minutes
Talking points:

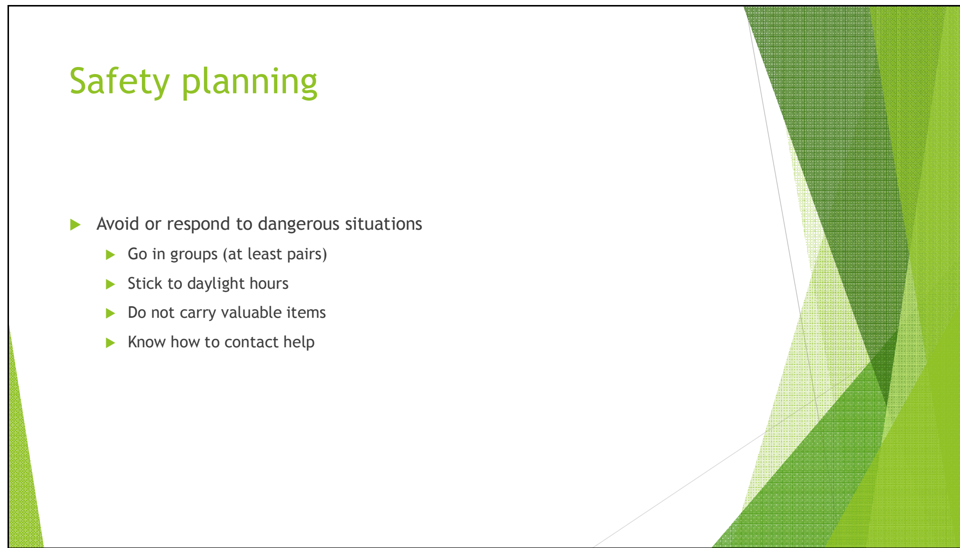
The last important aspect I want to talk about today is the tracking tool. (Pass out tracking tool.) This is a very important part of your outreach because it provides evidence that we are making a difference. Each of you will be able to track how many people you have helped enroll in insurance plans and will be able to easily see who you can follow-up with later on. Let's look over it together. Please ask questions for clarification at any time. You will ask for their name, address, and contact information. This is important, so that you can find them at a later date if needed. Then you will write in the last section "yes" or "no" depending on whether you signed them up for insurance. Make sure to provide additional information on the status of their application, which is how you submitted the application and whether you need to check up with them in a few weeks to see if they have been approved for an insurance plan. Use your judgment to determine who may need additional support to maintain their coverage. For those individuals, follow up with them in a year during eligibility review to make sure they stay on the program. Lastly, make sure to send your tracking tool to the training coordinator every month. By doing this, you are helping us improve this training and ultimately help the people in your communities improve their overall health.

Duration: 10 minutes



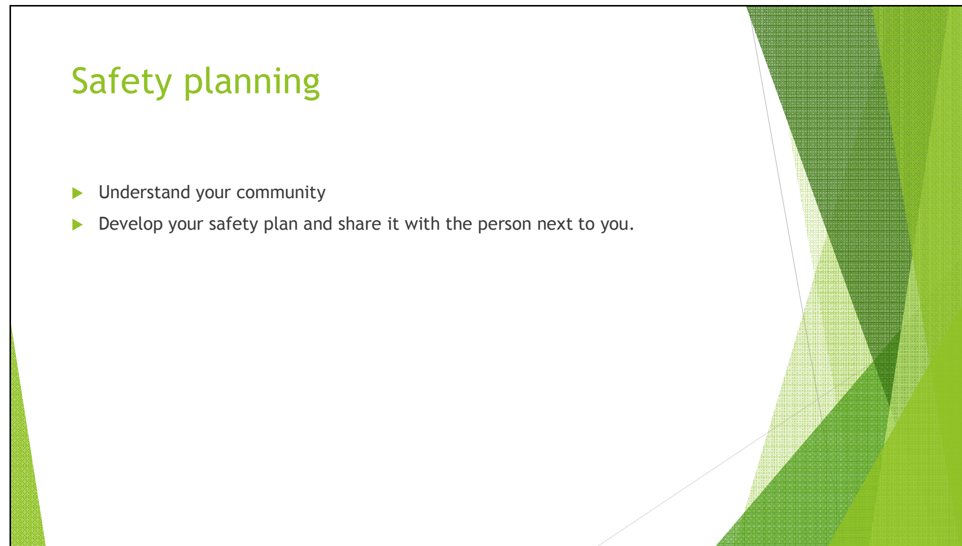
Duration: 25 minutes
Talking Points:

Now please break into groups of 3 for some role-playing. I want each of you to designate yourself as the outreach worker, community member, or observer. As a group you can either pick one of the cases listed here or make up your own. I want you to spend five minutes role-playing each scenario. After five minutes, you will switch roles and do it again with a different scenario. Switch again after five minutes so each of you have the opportunity to place each role. Once everyone has had a turn, we will come back together and discuss how it went. (Allow time for each person to try each role, then ask each group to talk about what came up and how they dealt with it.)



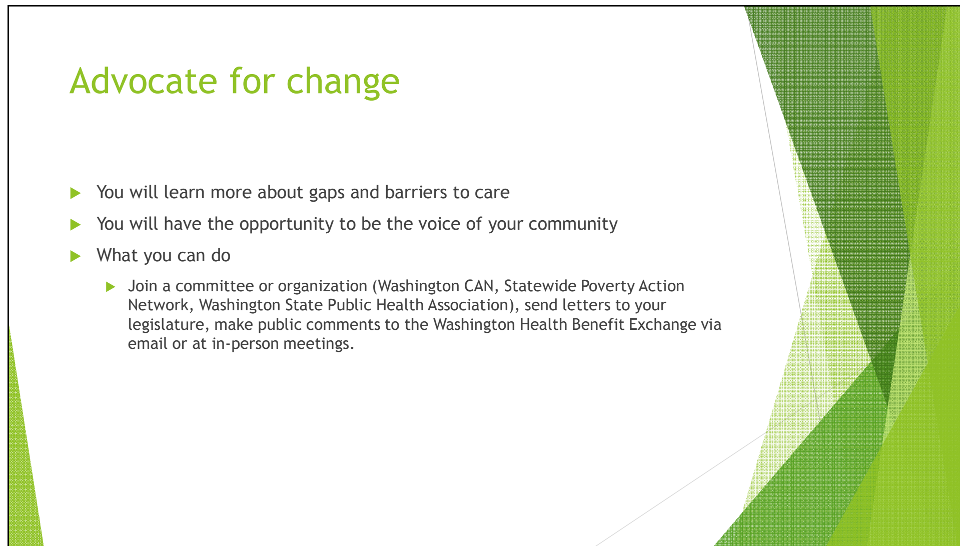
Duration: 3 minutes
Talking Points:

First, let's go over some basic criteria to avoid unsafe situations. Listed here are a few things to remember while doing your outreach. It is important to pay attention to your surroundings and never go alone. Go in pairs or groups of three or more, try to stick to daytime hours for outreach, remember not to carry valuable items (this includes documents that may contain confidential information on applications and on the tracking tool—if you must carry these documents, develop a way to conceal or hide them), and know how you will contact help if an emergency or dangerous situation arrives. Finally, watch the news and stay up-to-date on any crime or other dangerous activities happening in your community. Being informed will help reduce the chances of getting caught in an avoidable situation.



Duration: 15 minutes
Talking Points:

Now let's talk about your specific community and anything that you want to share about safety concerns that need to be addressed. (Allow 5 minutes). Okay, now I want you to take a few minutes to write down your safety plan and talk it through with the people around you. (Allow 10 minutes.)



Duration: 4 minutes
Talking points:

Finally, I want to ask you all whether you have or plan to advocate for change? (Allow people to respond.) In your own lives and in the communities you live, you undoubtedly know about needed change and hopefully today you have learned from each about gaps and barriers to accessing adequate health care services. I would argue that you will continue to learn more as you educate your community and enroll people in health insurance plans. Your unique understanding of the community you live in and the barriers to adequate health care for all people will leave you with a powerful voice that can be used to advocate for change. For those of you who have never participated in activities for change within our health care system, I want to share with you what you can do and organizations you can join. First, you can join organizations like Washington Community Action Network, the Statewide Poverty Action Network, or the Washington State Public Health Association who are already doing work to make positive changes to our health care system. You can also send letters to your legislative representatives. If you want to know who represents your specific community, you can go to leg.wa.gov to find your district. The Washington Health Benefit Exchange Health Plan Finder will also be asking for public feedback about how it is working, so you can email comments or attend in-person meetings to voice your concerns.

Duration: 13 minutes
Talking points:

Thank you all for participating and for your dedication to helping your community become a better, healthier place. Please take a few minutes to complete a final survey that lets us know what you have learned and how we can improve the training. (Pass out survey) Once you are done, bring it up to me and grab your certificate of completion. Also, we want you to know that this training will be altered overtime to reflect changes that occur in our health care system around insurance, particularly when it comes to eligibility and the enrollment process, so you will have the opportunity to attend again at that time. Thanks again for joining this course.

OUTREACH TRAINING REFERENCE SHEET

Health care reform:

- Washington Health Benefit Exchange: apply for all insurance programs through their health plan finder web portal. You can also apply on paper or over the phone. The web portal includes side-by-side insurance plan comparisons.
- Key points: Medicaid expansion (<138% FPL), tax credits and cost-sharing reduction for Qualified Health Plans (<400% FPL), streamlined application that will already refer individuals to cash or food assistance if eligible.

Health insurance programs available:

- Private Qualified Health Plans, Employee-sponsored, Classic Medicaid and Managed Care plans, CHIP, AEMP, Medicare (Part A, B, C, D).

About outreach:

- Be prepared! Have access to applications (online, telephone, or hard-copy).
- Develop your safety plan.
- Know your limits, maintain boundaries, and keep sensitive information confidential.
- Remember to be professional, respectful, and understanding.
- Use the tracking tool to record who you enroll in insurance plans.
- Know health-related community agencies and resources to offer to individuals.
- Keep up-to-date on changes to our health care system and insurance plans.

Key agencies and other resources:

- Washington Health Benefit Exchange (wahbexchange.org)
    - Navigator Program
    - Washington Health Plan Finder
- Department of Health (doh.wa.gov)
    - Healthy Communities outreach program
- Health Care Authority (hca.wa.gov)
- Washington State Office of Insurance Commissioner (insurane.wa.gov)
    - Statewide Health Insurance Benefits Advisors

Please remember to submit tracking tool monthly to ensure that we are meeting our goals!

Contact information for Training Coordinator:
Jeanese Hime
Phone: 509.551.4718
Email: jeanese.hime@gmail.com

Tracking Tool: Initial Visit

Name (individual or family)	**Contact information** (address, phone, and/or email)	**Health insurance status** (enrolled already, enrolled today, or other-explain)	Follow up required?
Example: Mary Smith	1213 3rd St. SW Seattle, WA 98119	Enrolled today (Medicaid)	yes

Tracking Tool: One Month Follow Up

Name (individual or family)	**Contact Information** (address, phone, and/or email)	**Health insurance status** (enrolled, not enrolled, other-explain)	Follow-up required?
Example: Mary Smith	1213 3rd St. SW Seattle, WA 98119	Other-application pending (Medicaid)	yes

Tracking Tool: Final Follow Up (12 month eligibility review)

Name (individual or family)	**Contact Information** (address, phone, and/or email)	**Health insurance status** (enrolled, not enrolled, other-explain)	Follow-up required?
Example: Mary Smith	1213 3rd St. SW Seattle, WA 98119	Enrolled (Medicaid)	no

Pre-Survey

Do you currently help individuals in your community enroll in health insurance plans?
(Circle one)

YES NO

If yes, please explain how you help people enroll in health insurance plans.

____
____
____
____

If no, please explain why you have not helped individuals enroll in health insurance plans.

.____
____
____

Do you know the changes that will take place due to the Affordable Care Act/Obamacare?
(Circle one)

YES NO

If yes, please list the changes that you know.

1. ____
2. ____
3. ____.

(Use back of paper if you need additional room to write)

Post-Survey

Did this training add to your knowledge on how to enroll people in health insurance plans? (Circle one)

YES **NO**

If yes, please provide an example of how you would enroll someone in a health insurance plan.

.____

____

____

If no, please explain what was missing from the training.

.____

____

____

Did this training add to your knowledge of the Affordable Care Act and health care reform in Washington state? (Circle one)

YES **NO**

If yes, please list examples of knowledge that you gained in the training.

1. ____

2. ____

3. ____

(Use back of paper if you need additional room to write)

INSURING THE UNINSURED

DOOR-TO-DOOR OUTREACH TRAINING

Learn about health care reform and how to enroll your community in health insurance plans.

70% of individuals eligible for insurance programs do not apply due to lack of awareness or not knowing how to enroll. We are asking you, as experts of the needs of your community, to participate in this free three-hour course. It will provide you with the knowledge of what health insurance programs and plans are available in Washington state, how to enroll individuals and families, and tips for doing outreach. Please contact the training coordinator via email or phone, if you are interested in learning more or want to join the training.

WANT TO DO SOMETHING TO HELP YOUR COMMUNITY?

ARE YOU A COMMUNITY HEALTH WORKER?

DO YOU LIKE TO DO OUTREACH?

JOIN THIS FREE TRAINING!

NEXT TRAINING: MARCH 10, 2013

Training Coordinator:
Jeanese Hime
jeanese.hime@gmail.com
509.551.4718

APPENDICES

APPENDIX A

Logic Model

Needs Statement: The public, particularly low-income individuals and families, need an increased awareness of health care reform policies and how it will impact them in order to reduce health disparities, increase preventative care, and improve their overall health.

Theoretical Influences and Assumptions: The intervention is influenced by both systems theory and critical theory. This intervention first draws from the systems theory, which exposes the various systemic barriers to accessing and receiving adequate health care. These include the following: socioeconomic status, health insurance affordability, transportation, and lack of information on health care reform. These factors within our health care system cause health disparities by limiting access to adequate care. Critical theory is used to pinpoint the changes that need to happen to reduced disparities in our health care system. By addressing the previously mentioned systemic domains through outreach and advocacy, the population impacted by inadequate health care will have improved health conditions.

RESOURCES	ACTIVITIES (Process Objectives)	OUTPUTS* (Outcome/Summative Objectives)	OUTCOMES (Short term goals)	*OUTCOME INDICATORS (Outcome/Summative Objectives)	LONG TERM GOAL
Partnership with Healthy Communities and Benefit Exchange Navigator Program community health workers resource pamphlets, training handouts, laptop, projector money for pamphlets, training handouts, laptop, projector Partnership with community based organizations (schools, food pantries, churches, ethnic restaurants, grocery stores, community centers)	Develop training for community health workers to do outreach build relationships with community stakeholders and organizations (e.g. Health Communities and Exchange Navigator Program) build relationships with community organizations to find and train community health workers. Collect data from CHWs	4 hour training completed by 15 community health workers in one targeted community per month 500 distributed pamphlets to individuals and families in each targeted community per month 10 individuals or families signed up for insurance per community health worker per month.	**Outcome #1: Improved ability to provide culturally appropriate outreach that reduces the number of uninsured people and families. (Pierce County Funders Group Mandated Outcomes List)** **Outcome #2: Reduced barriers to receiving health care services (Outcomes Catalogue)**	1A. Makes progress on plan (15 community health workers attend trainings each month) 1B.Statistics support effectiveness(increase insured population by 2% in every community targeted) 2A. Applications accepted for insurance coverage 2B. Location of operation meets patient's needs.	All Washington state residents will have health insurance.

APPENDIX B

Data Collection Worksheet

OUTCOMES/CRITERIA

Outcome 1: **Improved ability to provide culturally appropriate outreach that reduces the number of uninsured people and families.**
Criteria to achieve outcome 1: **(A&B)**

Indicator A: **Makes progress on plan (15 community health workers attend trainings each month)**
Criteria to achieve indicator A: Records of attendance at trainings; pre & post survey answers

Indicator B: **Statistics support effectiveness(increase insured population by 2% in every community targeted)**
Criteria to achieve indicator B: Tracking Tool compared to records of insured people from Benefit Exchange Navigator Program

Outcome 2 **: Reduced barriers to receiving health care services**
Criteria to achieve outcome 2 (**A&B)**

Indicator A: **Applications accepted for insurance coverage**
Criteria to achieve indicator A**:** Tracking Tool

Indicator B: **Location of operation meets patient's needs**
Criteria to achieve indicator B**:** Community Health Workers (CHWs) do door-to-door outreach

➡

TOOLS

Outcome 1**:**
Tracking tool: It will provide data on how many people the CHWs sign up for insurance

Exchange's Navigator Program: It will provide data to compare to the tracking tool to show how many additional people are being signed up by the CHWs

Pre and Post Survey: It will provided data on the how much the CHWs are learning (effectiveness of program)

Outcome 2**:**
Tracking tool: It will provide data on how many individuals and families are accepted for insurance plans

➡

DATA COLLECTION PROCESS

Who **- Who collects the Data?**
-The CHWs collect data through the tracking tools
-The Training Coordinator/Instructor implements the surveys

When **– At what points in time is the data collected?**

Survey data is collected at each training

Tracking tool information is emailed monthly to Training Coordinator

Training Coordinator compiles data and compares enrollment information with the Benefit Exchange Navigator Program every 6 months

➡

DATA COLLECTION METHOD

Do you gather data on ALL Clients?

YES

What is your RATIONALE for using the identified strategy?

By compiling data from all CHWs and those they enroll in the community, we will get a clearer picture of the effectiveness of the training, in other words how many more people are being enrolled in health insurance plans

➡

VALIDITY

Tracking tool-targets all community

Surveys-asks relevant questions to address needs statement

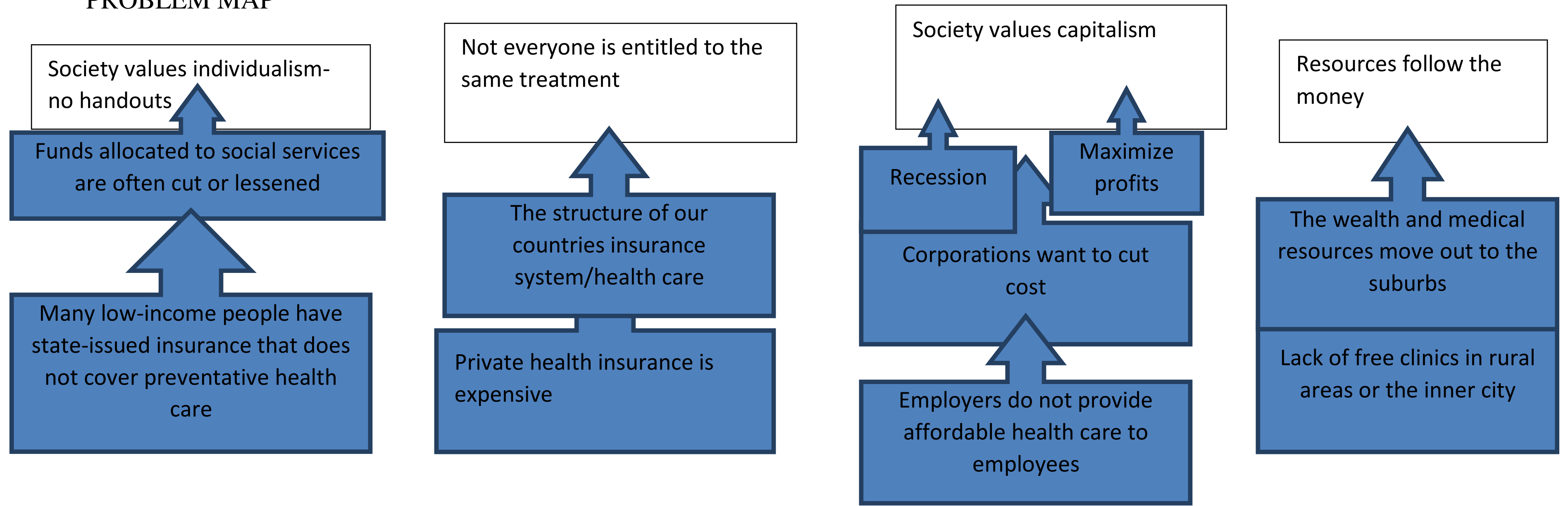
RELIABILITY

Surveys-distributed the same each time

Tracking tool-same one used by all CHWs

ADDENDUMS

PROBLEM MAP



People living in poverty are less likely to receive adequate health care

Emergency rooms are fuller

Emergent care take longer to be treated or seen

Hospital staff are overworked and less people can be seen

People are pushed out of hospitals quicker than ideal without proper planning or support

Increased/greater costs incurred for emergency services

Larger debt for individuals

Further fall into poverty

Larger debit for hospitals

Hospitals create harder criteria for financial assistance or accept fewer insurance plans

Lack of preventative health care

People may die or have shortened life from curable/treatable health issues

Family loses a source of support/ a relationship

Cost to taxpayers for social security payments

Low-income people have poorer health

These individuals are unable to work or be self-sufficient

Individual resorts to disability or other supplemental benefits from the government

Force Field Analysis

100% --- (elimination of the problem)

Restraining

Forces

"Every person should pay out of their own pocket"

People fear unknown consequences caused by change to the current health care system

Political and social opposition to Affordable Care Act

People distrust politicians and insurance companies

Regressive taxes

Society questions who deserves affordable health care

Changing demographics of the U.S has raised the health care costs (more older adults)

Affordable health insurance to reduce health disparities

Driving

Forces

Affordable Care Act and the flexibility of how plan can be implemented by each state

Change in tax structure to redistribute health care costs

Increase awareness that health care costs are too high

Changing demographics in the U.S. means we can expect older population to advocate for needed change

Increase awareness of structural barriers to obtaining or affording health insurance

Develop campaigns that engage people in the discussion of developing affordable health care

0%____no improvement to problem intensity

TOPICAL TEMPLATES

Venue: (citation)	Theme	Critical Comments & Connection to Project
Miller, E. A. (2011). Affordability of health insurance to small business: Implications of the patient protection and affordable care act. *Journal of Health Politics, Policy and Law, 36*(3), 539-546. doi: http://dx.doi.org.offcampus.lib.washington.edu/10.1215/03616878-1271225	The Affordable Care Act will impact whether small businesses provide employer-sponsored health insurance to their employees.	"Between 1999 and 2009, premiums paid by small-to-medium-sized employers (3-199 workers) increased by 123 percent…and coverage declined from 65 to 59 percent." P. 539 Several provisions in ACA attempt to increase employer-sponsored insurance (i.e. small business tax credits- 40 billion in the next 10 years), still likely that the percentage of small business that provide coverage will shrink. Will ACA increase coverage? Depends on subsidies and premiums: -subsidies: only eligible for two years of federal assistance, so not likely unless they find affordable coverage in private market or the Exchange "The Congressional Budget Office (2010) estimates that between 8-9 million people covered by predominantly small, low-income businesses will lose their employment-based coverage" pg. 542 Is this a problem? Maybe not. These people may be eligible for Medicaid or subsidized coverage from the Exchange. "Ultimately, whether individuals in the small-group market will be better off under the ACA hinges on the effectiveness of the exchanges and what state you live in" Pg. 546 Time will tell…

Notaro, S. J., Khan, M., Bryan, N., Kim, C., Osunero, T., Senseng, M. G., . . . Nasaruddin, M. (2012). Analysis of the demographic characteristics and medical conditions of the uninsured utilizing a free clinic. *Journal of Community Health, 37*(2), 501-506. doi: http://dx.doi.org.offcampus.lib.washington.edu/10.1007/s10900-011-9470-7	Demographically, who is utilizing free clinics and why and do they decrease health disparities	Uninsured people in the US- 50.7 million in 2009 (steadily rising) -reasons? Decrease in employment-based health insurance and increased cost in health care Free clinics-created to provide safety net for underserved populations 2009-US spent 2.5 trillion on health care (3X what was spent in 1990) The ACA will still leave many uninsured. Over 1000 free clinics in US-aim to decrease health disparities among people of different socioeconomic statuses; Other benefits? “Community involvement and the cost effective decrease in inappropriate usage of emergency departments.” P. 502 Who uses them? Low-income, uninsured and mostly female. Usually 20-44 years old and half from rural areas. Primary reason? =Lack of insurance. Reasons for visit?= “73% for a medical condition, 21% for physical exams or tests, and the remaining 6% for prescription refills” p.503 Reason for other health disparities (obesity) could be due to “limited access to care and education on prevention as well as poor communication between patients and physicians” p. 506

Pitkin Derose, K., Roan Gresenz, C., & Ringel, J. S. (2011). Understanding disparities in health care access-and reducing them-through A focus on public health. *Health Affairs, 30*(10), 1844-1851. doi: http://dx.doi.org.offcampus.lib.washington.edu/10.1377/hlthaff.2011.0644	Using a public health framework, we can discover evidence of disparities and access to health care and ultimately influence policies with the findings	Public health=”what we as a society do collectively to assure the conditions in which people can lead health lives.” P. 1844 Factors beyond individual characteristics affect health disparities Barriers to health care utilization=individual factors (income, health insurance, source of care) But, also “the degree of “fit” between the client and health care system.” Pg. 1845 Fit…availability, accessibility, and affordability Public health agencies and programs can identify and address disparities in health care access - Assurance: spot disparities and provide culturally competence care (also address undocumented immigrants needs not covered by ACA) -Assessment: by seeing disparities, they could see exactly where access to care problems exist; then public health departmens can work with key stakeholders to address them. And, assist non-profit hospitals in conducting assessments of needs under ACA -policy development: partner with community orgs “to more effectively develop and disseminate evidence-based prevention programs.” P. 1848 Role from ACA-to educate the public about choices available to them for obtaining health insurance. Ultimate role, ensure equitable access to health care-“linking the underserved individuals to other providers and the health care system in general.” P. 1849 Develop a shared understanding of disparities and develop specific policies or

		mobilize the community-including residents, providers, and other stakeholders-to address them" p. 1850 Address both "upstream" (social, economic and environmental determinants-ensure accountability in health care system) and "downstream" Look beyond access to other programs as well (monitoring water quality, inspeciting restaurants, etc.) Community-based approach (media, stakeholders, businesses-not just public health) to reduce health disparities
Saloner, B., & Daniels, N. (2011). The ethics of the affordability of health insurance. *Journal of Health Politics, Policy and Law, 36*(5), 815-827. doi: http://dx.doi.org.offcampus.lib.washington.edu/10.1215/03616878-1407631	Affordability of health care is an issue of social justice. This article provides an understanding of how it is possible to obtain.	How to get truly affordable coverage: contain the cost of health care, health insurance financed progressively (those best able to pay, should pay largest share) ACA falls short of the above, but still makes important strides through subsidies and regulations. Main issue of ACA="insufficient protection against burdensome cost sharing" p. 816 Article makes recommendations about how to make appropriate expansion. Other countries with universal health care-tax-financed system (not ACA) Emphasis on the fair sharing of burdens; different than other health policy and requires departure from common meaning of affordability. Article argues that what households should pay "must be understood in relation to broader social obligations" p. 820 Why health care for all= it is a huge financial burden that will either take from other needs or people will feel other needs and avoid health care concerns (shelter,

		edu, food, leisure). Also, w/o health insurance, we are keeping people from pursuing what they would in good health Social obligation to provide health insurance-it would provide "appropriate access to needed care and protection from financial deprivation when health needs arise." P.821 Protecting opportunity can explain what is considered affordable insurance. Poor families are impacted by other opportunities, education and work, which means they may forgo health needs. Small amounts of cost sharing is challenging for families (many live month to month). When confronted with large expenses, many opportunities are impacted (may lose, car, house, bankruptcy, other debt) "We're all one broken leg, one bad fall, or one case of pneumonia away from the house of cards completely falling down." P. 825 Does ACA protect opportunity?: does some, but not enough to meet our social obligation to protect equality of opportunity. What should be done?: -make health insurance affordable by leaving enough financial resources to get fair share of normal opportunities -increases in subsidies for those who need it, which requires greater taxation on higher-income earners (this will have many opponenents, so the angle of social justice needs to be used to win over people)
Ito, H. (1979). Health insurance policy	Retrospective analysis of two	Why did it work in Denmark and not in Sweden?; Both were considered similar,

development in denmark and sweden 1860-1950. *Social Science and Medicine, 13C*(3), 143-160. Retrieved from http://search.proquest.com.offcampus.lib.washington.edu/docview/61464965?accountid=14784	similar universal health care systems that had different results	but Sweden developed a hospital-based health care system Both were voluntary health insurance systems Denmark-well recognized that the physician-patient relationship improves with the elimination of money transferred between them
Kirby, J. B., & Kaneda, T. (2010). Unhealthy and uninsured: Exploring racial differences in health and health insurance coverage using A life table approach. *Demography, 47*(4), 1035-1051. Retrieved from http://search.proquest.com.offcampus.lib.washington.edu/docview/856405082?accountid=14784	Being uninsured has many implications on people's lives. This article uses a life table approach to examine the effects of being uninsured, including racial and age disparities in overall health.	2008-46 million in US uninsured (wide racial and ethnic disparities in this pop.) Consequences of being uninsured? More frequently go withought needed medical care, receive lower quality care, therefore, have worse health. Also, have financial issues (debt) Public programs (Medicare, Medicaid) help, but not enough Questions asked with life table approach: 1. How often insured over a year and what are the age and racial differences? 2. Life expectancy influenced by insurance? 3. How large a different between whites and blacks in mortality/life expectancy? Most insurance private (62% in 2006 from employer), but has been dropping since the 90s b/c of increase costs of premiums; 7% private insurance outside of employer (hard to obtain and expensive) Public programs: for elderly, the disablied, and poor individuals with dependent children. 60s-creation of Medicare & Medicaid Medicare-federal program for 65+ and the disabilied. Provide hospital inpatient and outpatient coverage. Medicaid-federal/state program insurance for poor and low-income 1997-SCHIP-federal program to cover children whose families don't qualify for

		Medicaid (income too high) -Research shows that those with public insurance are disadvantaged compared to those with private (i.e. Medicaid individuals more frequently diagnosed later with certain types of cancer) Uninsured-more frequently hospitalized and charged more (so higher medical debt) Impacts whole family "85% of uncompensated care is estimated to be paid for with public funds." P.1040 "Safety-net providers, such sas hospital emergency rooms and community clinics, can become overburdened in communities with large pools of uninsured and publicly insured individuals, and this can adversely affect the quality of care for all community residents" pg. 1040 Racial disparities: blacks and Hispanics 3X less likely to be insured (partly due to drop in employer-sponsored health insurance) Minorities more likely to rely on public insurance programs Cyclical disadvantages: socioeconomic disadvantages-> poor health and inadequate insurance->further socioeconomic disadvantages Age disparities: most frequently between 25-60 (before Medicare eligibility) Perspective looks at effects of being uninsured over time and its impact on life expectancies Americans w/o health insurance is a social problem Using a life table approach, we address these issues by providing estimates of the number of years that blacks and whites

		spend during a typical lifetime with different types of health insurance coverage and in different health states, given prevailing age-specific rates of mortality, subjective health, and insurance coverage. Further research: costs of living w/o health insurance on families, communities, and society at large? What does one year of life w/o it costs individuals in terms of financial loss, poor health, and emotional distress?
Chen, Z., & Crawford, C. A. G. (2012). The role of geographic scale in testing the income inequality hypothesis as an explanation of health disparities. *Social Science & Medicine, 75*(6), 1022-1031. doi: 10.1016/j.socscimed.2012.04.032	Using the income inequality hypothesis, this research finds that rejecting it at one level of the geographic scale doesn't mean that it should be rejected at a different level. Geographical scale should be more frequently considered in health research	Context must be considered when determined if the income inequality hypothesis (IIH) should be reject or not Study finds that southern states have higher levels of income inequalities, along with California, New York, Connecticut and Massechusetts. –However, at the county level, all southern states still have it, but CA, NY, CO, MA, it differed by county-reason? Variation in Medicaid spending by state could be one If income inequality and health insurance coverage does not exist in some counties, still should look at state-level because that is where policies are often made. Policy: "bounded by economic and political considerations and may differ across health outcomes"p. 1029. Therefore, must be careful of how IIH is viewed and at what geographical level. "Whether politics at the state or the county-level are preferred depends on which health outcomes and target pop are in consideration." P. 1029

Kao, D. (2010). Factors associated with ethnic differences in health insurance coverage and type among asian americans. *Journal of Community Health, 35*(2), 142-155. doi: http://dx.doi.org.offcampus.lib.washington.edu/10.1007	Asian Americans are often grouped together, however, each Asian population is unique, with different outcomes when it comes to health insurance coverage. This article asks why and provides information for future policies.	Heterogeneity in Asian American populations, need more targeted policy approaches; localized studies may provide a stronger understanding of health issues affecting specific Asian ethnic groups High uninsurance rates found in the Korean and Vietnamese American population. 2008-31% Korean and 21% Vietnamese uninsured compared to 12% Japanese and Asian Indians. In CA, 1/3 of Koreans and 1/5 of Vietnamese are uninsured. Study uses 2003 and 2005 California Health Interview Surveys (CHIS) b/c large population of Asians in the state. Reasons for differences? Socioeconomic (educational attainment, household income, household employment status and type) and immigration-related (nativity, duration in U.S., citizenship status, and English language proficiency) factors Key differences in coping with limited access to employer-based insurance (i.e. Korean Americans were more likely to purchase private insurance, while Filipinos and Vietnamese Americans more likely rely on public programs Policy: improve access to Medicaid and other public programs for low-income families; encourage more affordable insurance options for small business owners; public coverage for people who do not meet income-eligibility for Medicaid
Kifmann, M., & Roeder, K. (2011). Premium subsidies and social health insurance: Substitutes or complements? *Journal of*	Using a welfare perspective, this article examines premium subsidies and	Premium Subsidies or social health insurance? Depends on correlation of health and productivity Uniform premiums will not work (shift

Health Economics, 30(6), 1207-1218. doi: http://dx.doi.org.offcampus.lib.washington.edu/10.1016/j.jhealeco.2011.08.007	social health insurance to find what would be superior. The results suggest social health insurance	costs to the low-risk from the high-risk; i.e a young healthy worker and an older wealthy man with health issues) Most appropriate strategie:redistribute to the double disadvantaged (high-risk, low-income) Zweifel and Breuer suggest policy to address the above problem: premium subsidies that "target individuals whose expenditure on health insurance exceeds a given share of income." P. 1209 However, research shows that social health insurance because it redistributes to high risk population and the poor. (positive correlation between health and income) In other countries, "equal access" or "solidarity" are important. Social health insurance provides this. Switzerland combines premium subsidies w/ social health insurance. Results show that they complement each other when health and productivity are positively correlated; social health insurance with subsidies is better because it introduces non-linear taxation. (welfare advantage) Morally-social health insurance because it provides equity
Galambos, C. (2005). The uninsured: A forgotten population. *Health Social Work*, *30*(1), 3-6. doi: 10.1093/hsw/30.1.3	This editorial answers the who and why questions of the uninsured population and suggests what social workers can do	Who are they? -80% working families, in jobs with low-wages and no benefits. Of this group, 20 million are full-time workers and 6 million have part-time jobs -most often Hispanic or African-American and the non-elderly (specifically between the ages of 25-44); 4 out of 5 are US Citizens. -(2/3 of the 43 million uninsured are members of low income families)

		Why uninsured? -economy-unemployed or underemployed (2/3 are offered health insurance by employer, but often times it is too expensive) -due to life transitions (going off parents plan, losing a job, losing a spouse-divorce or death, retirement before age 65) -cuts to public insurance; not qualifying for these public programs -chronic illness Consequences: 4X more likely to use emergency care and decreased accessibility to health care Study from Institute of Medicine (2002)-"uninsured have worse clinical outcomes for health and mental health chronic conditions and lack access to preventative services and screenings" p.4 –increase rates of morbidity and mortality -high rates of uninsurance absorbed by health care system may result in a reduction in services What has been done? -Initiatives (i.e. Robert Wood Johnson Foundation and other national foundations-public awareness campaign, "Covering the Uninsured." -NASW: fighting for single-payer system of health care -Institute of Medicine- reports urging the gov to implement universal health insurance by 2010 -Community Clinics that offer free care What social workers can do: -Join NASW and get involved -learn more about advocacy initiatives to promote universal health coverage; become informed of how lack of health coverage affects individuals, families, and communities -contact your reps and senators -join a coalition

		-volunteer at a free clinic (offer free discharge planning, info and referral, counseling or mental health services) -write a letter to the editor -organize a workshop on health care disparities and universal access to services
Friedrich, J. M. (2009). *Systemic barriers for latina women accessing healthcare services in louisville, kentucky: An assessment of social indicators in order to disclose social injustices.* University of Louisville). *ProQuest Dissertations and Theses,* , 469. Retrieved from http://search.proquest.com/docview/304916628?accountid=14784.	Author uses both critical theory and feminist theory to identify oppressive structures and processes	Policy-critical theory-modern law lacks moral foundations that would justify the right to health care (human rights) -Viewpoint of health as a basic human right: -U.S. factors health as a privilege that depends on ability to pay rather than a human right Barriers for Latinas-social policies related to immigration; infrastructure of city work and family obligations (i.e. childcare); language and cultural differences; not accessible (transportation issues); unemployed or jobs w/o health insurance Feminist perspective: power held by decision makers, so those who aren't in that role are oppressed and must comply to the decision-makers rules; the power is out of touch with the oppressed.
Hafner-Eaton, C. (1994). Patterns of hospital and physician utilization among the uninsured. *Journal of Health Care for the Poor and Underserved*, *5*(4), 297-315. doi: DOI: 10.1353/hpu.2010.0318	Although nuanced differences exist in physician and hospital utilization, the main issue is the existence of disparities between the insured and uninsured	Findings: being uninsured does not alter utilization uniformly (depends on illness) Insured may receive too much health care Reasons for different utilization: individual decision-making and system-level factors Chronically ill may learn to live with impairments or pain What needs to be done: a broader, more comprehensive coverage of preventive care and early intervention; "establish financing system and delivery incentives that place everyone on equal footing for receiving care" p. 310

Francis, L. E., Berger, C. S., Giardini, M., Steinman, C., & Kim, K. (2009). Pregnant and poor in the suburb: The experiences of economically disadvantaged women of color with prenatal services in a wealthy suburban county. *Journal of sociology and social welfare* , *36*(1), 133-157.	Suburbs often overlook the needs of the poor living within their community; which leads to health disparities, specifically in infant mortality	Barriers for the poor: economic, psychosocial, health insurance/reimbursement, transportation, housing, and getting need information Suburbs: predominately white middle to upper class -minorities in the suburbs are often poorer and less safe Many studies show that disadvantaged women and women of color receive inadequate perinatal care due to discrimination, lack of transportation, language barriers, and alcohol and drug abuse -single largest barrier?!-finding a physician willing to accept low-income women (along with issues of health insurance and inadequate childcare) Barriers to health coverage-extreme difficulty and long delays getting Medicaid (avg. of 6 months in this suburb of NYC) Commentary: "U.S. is one of the wealthiest countries, yet ranks poorly on health status by race, class, socioeconomic status, and infant mortality." P. 154
Gorin, S. H. (2011). The affordable care act: Background and analysis. *Health & Social Work,* *36*(2), 83-86. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=swab&AN=80985	History of health care reform efforts and specifics on the Patient Protection and Affordable Care Act	1912-Theodore Roosevelt's Progressive Party called for "the protection of home life against the hazards of sickness, irregular employment, and old age through the adoption of system of social insurance adopted to American use" p. 83 -Jane Addams support it and helped develop the party's platform 1930s-FDR attempted to include health insurance as part of his social security legislation, but abandoned it for fear of opposition NASW historically advocating for it

		ACA is not prefect it addresses key concerns, coverage and costs -what ACA does- -2010, provide funds for preexisting condition insurance plans; adult children can stay on parent's insurance until age 26; and individuals under 55 are now eligible for a reinsurance -2014, Medicaid expansion to 138% of FPL; employers with over 50 employees must pay for insurance or pay a 2000 fine per employee; health benefits exchange (get premium tax credits) Controversy-individual mandate (buy insurance or pay a tax) Polls show opposition (one said 76% oppose it) -why it exists-so people don't buy insurance only when they need it, therefore, it will spread risk and reduce costs -both parties have supported it ACA will reduce uninsured pop by 32 million (according to Congressional Budget Office) w/o mandate more will be uninsured (39 million est. in 2019) Cost-CBO says it will reduce deficit by $124 billion in 2019 Real issue-whether we can pay for it -how bill is financed= fees from insurance, pharmaceutical companies, increase in Medicare tax for the top 2 percent earners, reduced payments to MedAdvantage plans, also reduce Medicare payments to hospital who will in turn, figure out how to increase productivity
Gorin, S. H. (2010). The patient protection and affordable care act, cost control, and the battle for	ACA has many flaws, but the implications on the health of	Opponents of ACA-worsen health care inflation (Paul Ryan states it would exacerbate the economic crisis by adding trillions of dollars to US debt); but CBO

health care reform. *Health & Social Work, 35*(3), 163-166. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=swab&AN=79596	ourselves and our clients make it worth fighting for	says it will not It will increase life of Medicare Part A by 12 years and slowly get rid of the doughnut hole experienced by Part D Political-more Republicans are in opposition and less likely to understand hardships experienced by the uninsured

OUTLINE: Health care coverage for low-income individuals and families

I. **Historical and current understanding of health care reform and coverage for residents of the U.S.**

a. 1912-Theodore Roosevelt's Progressive party forwarded the need for sickness insurance covered by the state, but idea was defeated (Gorin, 2011)
b. 1930s-FDR was going to include health insurance in social security legislation, but it was abandoned (Gorn, 2011)
c. Throughout the years, NASW has advocating for universal health care (Gorin, 2011)
d. 1960s- The creation of Medicare and Medicaid (Kirby & Kaneda, 2010)
e. 1997-SCHIP created-a program to cover children whose family don't qualify for Medicaid (Kirby & Kaneda, 2010)
f. 2010, Affordable Care Act (aka Obamacare)
    i. Coverage for pre-existing conditions, adult children can stay on parents insurance until 26, Medicaid expansion, employers must have insurance or pay fine, health benefits exchange (Gorin, 2011)
g. In 2008, 46 million in the U.S. are uninsured. This number is growing. An overwhelming disparity exists based on income and race/ethnicity (Kirby & Kaneda, 2010)
    i. The consequences of no insurance is people go without needed medical care, they receive lower quality care, increased debt from health care costs

II. **The impact of economics, difference, and/or diversity**

a. Economic concerns of the affordability of health care reform (ACA):
  i. Conservatives says it will worsen health care inflation; Paul Ryan says it would add trillions of dollars to U.S. debt (Gorin, 2010)
    1. Counter-argument: Conservatives are out of touch with the needs of the uninsured; CBO says this will not happen, but will actually reduce deficit by $124 billion by 2019 (Gorin, 2011)
  ii. Arguments of how it can be financed: fees from insurance, pharmaceutical companies, increased Medicare tax fro top 2% earners, reduced payments to MedAdvantage plans, and reduced Medicare payments to hospitals, who will in turn, figure out how to increase productivity (Gorin, 2011)
  iii. Outcomes include an increase life of Medicare Part A by 12 years, a slow elimination of the doughnut hole experienced by Part D, and 32 million will gain insurance. (Gorin, 2011)
  iv. A potential drop in employer-sponsored insurance because of penalities for not covering employees. However, this may not be a problem. These people can get insurance through the Benefit exchange. (Miller, 2011)

b. Racial disparities exist in health care coverage and they must be addressed:
  i. Blacks and Hispanics are three times less likely to be insured and more likely to rely on public insurance programs (Kirby & Kaneda, 2010)

1. This causes cyclical disadvantage: socioeconomic disadvantage leads to poor health and inadequate insurance, which spirals back to further socioeconomic disadvantages (Kirby & Kaneda, 2010).

ii. High uninusrance rates found in the Korean and Vietnamese American population. In California alone, one-third of Koreans and one-fifth of Vietnamese are uninsured (Kao, 2010)

iii. Paradox: U.S. is one of the wealthiest nations, "yet it ranks poorly on health status by race, class, socioeconomic status, and infant mortality"(Francis, Berger, Giardini, Steinman, & Kim, 2009, p. 154).

III. The impact of relevant developmental stages

a. Certain age group is most commonly uninsured

i. Most frequently between the ages of 25-60 (Kirby & Kaneda, 2010)

ii. The 1000 free clinics in U.S.are used by low-income females, usually between the age of 20-44 years old and half are from rural areas. (Notaro, Khan, Bryan, Kim, Osunero, Senseng, &Nasaruddin, 2012)

b. Most uninsured are working in low-wage jobs without benefits or with benefits that are too expensive

i. 80% are working families (20 millon are full-time and 6 million are part time) (Galambos, 2005)

c. Two-thirds of uninsured are low-income families. Others are uninsured because of cuts to public insurance, not qualifying for public programs, and chronic illness (Galambos, 2005)

d. Life transitions are a key reason for not being insured

i. Examples are going off parents plan, losing a job, losing a spouse through divorce or death, and retiring before age 65. (Galambos, 2005).

IV. The cultural, systemic, and global influences as they apply to health care coverage

a. Systemic barriers to health care utilization at all levels (Pitkin, Derose, Gresenze, & Ringel, 2011)

i. Individual factors (income, health insurance, source of care)

ii. Mezzo factors (access to health care and availability)

iii. Macro factors (cost of health care)

1. Undocumented population impacted in all areas (citizenship, income, duration in the U.S., English language proficiency) (Kao, 2010)

b. Other countries have universal health care

i. Denmark and other countries health care system is tax-financied (Saloner, et al., 2011)

1. Denmark's health care system has had the some form of universal coverage since the early 19th century. Research shows that

physician-patient relationship improves with the elimination of money transferred between them (Ito, 1979).

ii. "Equal Access" or "solidarity" are important to them (health care is aspect of basic human rights) (Kifmann & Roeder, 2011)

iii. Switzerland combines premium subsidies with social health insurance (Kifmann & Roeder, 2011).

V. Discussion of the NASW ethical practice guidelines

a. NASW primary mission is to "enhance human well-being and help meet the basic human needs of all people…" (NASW code of ethics)

  i. Health care is seen as a basic human right according to other countries, but is seen as a privilege that depends on an ability to pay in U.S. (Fredrich, 2009)

b. Social Justice is an ethical principle of Social workers**-** "Social Workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people…Social workers strive to ensure access to needed information, services, and resources, equality of opportunity; and meaningful participation in decision making for all people." (NASW code of ethics)

  i. We have a social obligation to provide health insurance. By doing so, we provide access to needed health care and protection from financial deprivation (Solaner & Daniels, 2011)

  ii. Poor families are impacted by other opportunities, education and work, which means they may forgo health needs (Solaner & Daniels, 2011)

    1. Small amounts of cost sharing is challenging: "We're all one broken leg, one bad fall, or one case of pneumonia away from the house of cards completely falling down (Solaner & Daniels, 2011, p. 825.)

VI. Relevant theoretical frameworks and research frameworks

a. Public health framework

  i. Public health agencies and the community can work together to address disparities in health care access through:

    1. Assurance: spot disparities and provide culturally competent care

    2. Assessment: by seeing disparities, they know where problems exist and how to approach them

    3. Policy development: partnering with community organizations will lead to development and dissemination of evidence-based prevention programs (Pitkin, et al., 2011)

b. Life table approach

i. Address disparities and lack of insurance by providing estimates of the number of years blacks and whites spend during a typical lifetime with different types of health insurance coverage and in different health states (Kirby & Kaneda, 2010)

c. Feminist perspective

i. Power held by decision makers, so those who aren't in that role are oppressed and must comply to their rules. The power is out of touch with the oppressed. (Friedrich, 2009)

d. Critical Theory

i. Modern law lacks moral foundations that would justify the right to health care (human rights) (Friedrich, 2009)

e. Systems theory

i. Systemic barriers of access to health care due to the following issues: economic, psychosocial, health insurance/reimbursement, transportation, housing, and getting needed information (Francis, Berger, Giardini, Steinman, & Kim, 2009)

VII. Action at the micro, mezzo, and macro levels

a. Micro level: Increased education on personal health concerns (patient activiation); linking with affordable health insurance programs; practicing health habits

b. Mezzo level: Free health clinics that reduce disparities, increase community involvement and the cost effective decrease in inappropriate usage of emergency departments. Notaro, et al., 2012); Public awareness campaigns in communities (Covering the Uninsured) (Galambos, 2005).

c. Macro level: Influence policy on health care reform by:

i. improving access to Medicaid and other public programs, encourage more affordable insurance options for small business owners, and public coverage for people who do not meet income eligibility (Kao, 2010)

ii. Increasing health insurance subsidies for those who need it by greater taxation on higher income earners (Saloner & Daniels, 2011)

VIII. Ideas for the project to be developed

a. Learn more about advocacy initiatives to promote universal health coverage and become more familiar with first-hand experience of being uninsured.

IX. Challenges, opportunities and what still needs to be answered

a. Common theme: low-income individuals and families who are uninsured often have poorer health than those who are. Health care reform may positively impact the overall public health of our country.

b. More research needs to be done to answer how one year of life without health insurance costs individuals in terms of financial loss, poor health, and emotional

distress along with families communities and societ at large (Kirby & Kaneda, 2010)

c. Need to learn who all the local stakeholders are in regards to health care reform and the role I can play in making necessary changes.

X. Feedback from focus group and interviews

a. Interviews-Medical Social Workers

- **i.** Equal health care is a moral imperative
- **ii.** Charity care and cost shift through uncompensated care already pays for the uninsured or underinsured
- **iii.** People over-utilize the ED, therefore, there is a need to prevent hospital re-admission for that reason and others.
- **iv.** There is waste in our current health care system
- **v.** There is a lack of racial diversity in care
- **vi.** Social determinants play a role in people's health

b. Focus Group- Online Community, Reddit

- **i.** For health care reform
  1. Many recognize a need for and want a single-payer system/universal health care
  2. Health care costs are too high with current system
  3. People overuse emergency room
  4. Large cost burden with current insurance plans.
  5. Prescription drug costs are too high
  6. Lobbyist increase costs of care and drugs
  7. Universal health care is a right
  8. Other countries have successful universal health care
- **ii.** Against health care reform
  1. Shift costs to those who can afford it
  2. Changes to the system will cost too much
  3. Universal health care will worsen quality of care
  4. Health care reform will increase taxes and increase the U.S. debt.

In 2008, surveys found that 46 million people in the U.S. are uninsured and this number continues growing. Within this population, health disparities exist in abundance for minorities and low-income people. Without insurance many people forgo needed medical care, receive lower quality care, and incur exorbitant debt from health care costs (Butterfield, Butterfield, & Rocha, 2010). There is no simple solution to the health care problems faced by people living in the U.S. As system theory suggests, all aspects of society are interrelated and play a role in the function of the whole society, including our health care system. In the following paper, the author examines the health care system as a whole, extrapolating on the existing disparities and how they interrelate with issues from the individual, community, and national level. The author will look at the components of our health care system, with an emphasis on health insurance, to expose the current pitfalls and suggest possible solutions to better the overall health of the U.S. population.

Historical context

Across the world, countries have developed systems of health care for their people. Many industrial countries have implemented single-payer or universal health care. Throughout history, the U.S. has politically struggled with developing a program that is supported by the people and politicians. In 1912, Theodore Roosevelt attempted to introduce sickness insurance, but the idea was defeated. In the 1930s, Franklin Delano Roosevelt sought to include health insurance in social security legislation, but it stood up to much opposition, so he later abandoned it (Gorin, 2011).Medicare and Medicaid were implemented in the 1960s and in 1997, SCHIP, a program created to cover children whose family do not qualify for Medicaid, went into effect (Kirby & Kaneda, 2010). Over the years, these programs have come under political scrutiny on how they are issued and who qualifies for them. For this reason, we have seen many changes in the programs and we will continue to see more.

Current situation

Throughout the years, the National Association of Social Workers has advocated for universal health care and at this time in history, they have something to rejoice about (Gorin, 2011). Our country has passed a law that brings the U.S. closer to universal coverage. The law, called the Patient Protection and Affordable Care Act (better known as Obamacare), has changed many components of health care, including a health insurance program that provides coverage for people with pre-existing conditions, extended health coverage for adult children 26 years of age and younger, expanded Medicaid eligibility, requirements that some employers provide insurance or face fines, and the creation of health benefit exchanges, which offer commercial insurance to be purchased by anyone (Gorin, 2011).

Economic Impact of Health care Reform

Changes to our current health care system through Obamacare are financially concerning to some individuals. Many conservatives say it will worsen health care inflation. Paul Ryan, former Vice President Candidate and current Wisconsin Representative, has stated that the act would add trillions of dollars to the U.S. debt (Gorin, 2011). In fact, participants from an online focus group conducted by the author echoed similar concerns, saying that reform will increase taxes and the overall U.S. debt. They further argue that it shifts costs to those who can afford health care coverage and it will worsen quality of care. These individuals also believe that the changes in health care will drop the amount of employer-sponsored insurance plans. This is a possibility, but it should be noted that those who lose insurance from their employer may then qualify for insurance through their state Benefits Exchange (Miller, 2011).

On the other hand, some health care experts argue that reform will be affordable and they offer ways in which it can be financed. The examples given are fees from insurance and pharmaceutical companies, increased Medicare tax for the top 2% earners, reduced payments to MedAdvantage plan,

and reduced Medicare payments to hospitals. These cost savings also have the potential for increasing productivity and decreasing unnecessary services and tests done by physicians. With health care reform in full implementation, the Congressional Budget office says the U.S. deficit will be reduced by $124 billion by 2019. Furthermore, health care reform through the Affordable Care Act will increase the life of Medicare Part A by 12 years, slowly eliminate the doughnut hole in Medicare Part D, and 32 million people will gain insurance (Gorin, 2011). The participants of the online focus group conducted by the author noted many positive changes within the reform. They gave compelling first-hand stories explaining the exorbitant cost of health care without the reform and mentioned how the underinsured and uninsured are already costing others more through uncompensated care, also known as charity care, which is offered by many hospitals and clinics. Others mentioned the unreasonably high costs of prescription drugs, the overwhelming large cost burden with current insurance plans, and, in their minds, the deplorable work done by pharmaceutical lobbyists who play a role in increasing the cost of prescription drugs.

Racial Disparities in Health Care

Racial Disparities abound in our current health care system. Blacks and Hispanics are three times less likely to be insured and more likely to rely on public health insurance programs (Kirby & Kaneda, 2010). High un-insurance rates are also found in the Korean and Vietnamese American populations. In California alone, one-third of Koreans and one-fifth of Vietnamese are uninsured (Kao, 2010). These disparities are often cause by cyclical disadvantages. This means that these populations' socioeconomic disadvantages lead to poor health and inadequate insurance, which spirals back into further socioeconomic disadvantages (Kirby & Kaneda, 2010). Paradoxically, the U.S. is one of the wealthiest nations, "yet it ranks poorly on health status by race, class, socioeconomic status, and infant mortality" (Francis, Berger, Giardini, Steinman, & Kim, 2009, p. 154).

The Impact of Relevant Developmental Stages

Within the U.S. health care system, certain age groups are most commonly uninsured. These populations of uninsured people are most often between the ages of 25-60 (Kirby & Kaneda, 2010). The 1000 free clinics in this country are utilized by a majority of low-income females, usually between the ages of 20 and 44 and half are from rural areas (Notaro, Khan, Bryan, Kim, Osunero, Senseng, & Nasaruddin, 2012). The uninsured are mainly working individuals in low-wage jobs without benefits or with benefits that are too expensive. In fact, one health care article says 80% are working families, with 20 million who are full-time and 6 million who are part-time (Galambos, 2005). Others are uninsured because of cuts in public insurance, changes in eligibility for public programs, and chronic illnesses. Overall, life transitions are a key reason for being uninsured. For example, the loss of insurance can be equated to going off ones parent's health plan, losing a job, losing a spouse through divorce or death, and retiring before the age of 65 (Galamobos, 2005).

The Cultural, Systemic, and Global Influences on the U.S. Health Care System

Many systemic barriers exist that reduce health care utilization at all levels. At the individual level, ones chance of using health care is reliant on their income and whether they have, qualify, or can afford health insurance. At the mezzo level, people are less likely to get care if they cannot access a health care provider because of their geographical location. And, macro factors include the cost of health care and qualifying for public insurance programs (Pitkin, Derose, Gresenze, & Ringel, 2011). One population greatly impacted by our current health care system is the undocumented immigrants who lack citizenship and are hinder by their income, duration of time spent in the U.S., and English language proficiency (Kao, 2010). Unfortunately, current reform through Obamacare will not extend health care to this population.

As mentioned previously, we see globally that many countries have already implemented universal health care. Denmark, for example, has a tax-financed single-payer system with private insurance as an additional option (Saloner & Daniels, 2011). Denmark has had universal health care since the early 19th century. Research shows that physician-patient relationships are significantly improved by their system because of the elimination of money transferred between these two groups (Ito, 1979). Switzerland, which also has relatively successful universal health care, combines premium subsidies with social health insurance. Other countries, including these two examples, value "equal access" and "solidarity" in their health care system. They deem health care as an aspect of basic human rights (Kifmann & Roeder, 2011). Informal interviews conducted with medical social workers by the author and many focus group participants found agreement that equality in health care is a moral imperative. Furthermore, a majority of the focus group participants argued that our country needs a single-payer health care system.

Discussion of the NASW Ethical Practice Guidelines

The National Association of Social Workers' (2010) primary mission is to "enhance human well-being and help meet the basic human needs of all people…" Furthermore, social justice is an ethical principle of the NASW code of ethics. It says, that "social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people…Social workers strive to ensure access to needed information, services, and resources, equality of opportunity; and meaningful participation in decision-making for all people (NASW, 2010). The NASW and most social workers would support that health care is a basic human need and parity in its distribution must happen. Health care is seen as a basic human right to many other countries, yet our country sees it more as a privilege that depends on ones ability to pay (Fredrich, 2009). As social workers, we are obligated to create equal access to health care, including making sure all people have health insurance. By doing so, we provide access to needed services along with protecting individuals and families from financial deprivation. Poor

families are more heavily impacted by other financial opportunities, like education and work, which means they often forgo health needs. Even more so, small amounts of cost sharing is challenging for low-income people. As quoted from Solaner and Daniels (2011, p. 825), "we're all one broken leg, one bad fall, or one case of pneumonia away from the house of cards completely falling down."

Relevant Theoretical and Research Frameworks

As noted in the introduction to this article and throughout the different sections, we can see how systems theory comes into play as we look at all barriers to health care. Other systemic barriers not yet mentioned include issues related to transportation, housing, community, environment and health education (Francis, Berger, Giardin, Steinman, & Kim, 2009). In addition to systems theories, other theories help explain why our health care system functions as it does today. The feminist perspective recognizes that those in power are often out of touch with the needs of the oppressed and continue to further oppression through the decisions they make regarding health care. And, critical theory points out that modern law lacks moral foundations that would justify the right to health care, such as naming it as a basic human right (Friedrich, 2009).

Two frameworks used in research on health care are the life-table approach and public health framework. The life-table approach addresses racial disparities and lack of insurance by providing the number of year's blacks and whites spend during a typical lifetime with different types of health insurance coverage and in different health states. The results further show that blacks have more sporadic health insurance coverage and an overall lower life expectancy and higher death rate (Kirby & Kaneda, 2010). The public health framework is used to show how public health agencies and the community can work together to address disparities in health care access through first, spotting the disparities and providing culturally competent care, then by assessing why and where the problems exist

and how to approach it, and finally, by leading the way in policy development, especially through the implementation of evidence-based prevention programs (Pitkin, Derose, Roan Gresenz, & Ringel, 2011).

Action at the Micro, Mezzo, and Macro Levels

The issues faced at the above levels have been briefly enumerated in previous sections; therefore, the author will now discuss action to be taken at each level. At the micro level, individual health can be improved by an increased education on personal health concerns (patient activation), individual practice of healthy habits, and access to affordable care. At the mezzo level, free clinics can further reduce health disparities in their communities, communities can promote general education on health care to reduce usage of emergency departments (Notaro, et al., 2012), and public health organizations can establish public awareness campaigns like “Covering the Uninsured,” created by the Robert Wood Johnson Foundation, in order to change the overall health of a population (Galambos, 2005). At the Macro level, policy in health care reform will reduce health disparities by improving access to Medicaid and other public programs, providing incentives for small businesses to offer affordable insurance options, offering public coverage for all people who don’t meet the criteria for other public programs (i.e. Medicaid or Medicare) (Kao, 2010), and finally increase health insurance subsidies for those who need it by implementing greater taxation on higher income earners (Saloner & Daniels, 2011).

Challenges, Opportunities, and What Needs to be Answered

A common theme from both research on health care in the U.S. and the author’s interviewees and focus group participants is low-income individuals and families who are uninsured or underinsured often have poorer health than those who are wealthier and adequately insured. Health care reform, including the changes implemented by Obamacare, will positively impact the health of people living in the U.S. But, many more actions can lead to improving our countries overall health. This includes more

research on how different programs, specifically related to health insurance, cause financial loss, poor health, and emotional distress for individuals and families (Kirby & Kanda, 2010). Additionally, in order to make appropriate changes to reduce health disparities, the author needs to learn who the stakeholders are in regards to health care reform and how they play a role in making changes. The author must also learn more about advocacy initiatives that promote universal health coverage, especially those that recognize the social determinates that play a role in people's health and the lack of racial diversity in the service delivery of health care. A potential intervention idea for future development is to implement a public awareness campaigns with the help of community organizations to education the public on health care reform and its impact on individuals at all systemic levels.

Venue	Themes	Critical Comments & Connection to Project
Online Community Focus Group and secondary data analysis (Reddit.com)	• Those who get government assistance shift the cost to those who can pay for it. • Health care costs are too high; they are the number one cost of bankruptcy • People overuse the Emergency Room • Current private insurance still leaves large medical bills to be paid • Changes to US health care system will cost too much • Prescription drugs are too expensive • Lobbyists are an issue • Many US residents desire a single-payer system • Health care should be an equal right for all • Many residents of countries with universal health care think the US is backward in the way they provide health care • Universal health care will worsen quality of care • With health care reform taxes will go up and our country will fall into more debt • Christianity and politics overlap and play a role in how people view who deserves health care 3.a-d a. The main theme emerging from these responses is the recognition that our current health care system is too costly and other countries have developed systems that	"No one deserves health care or has a right to it. Providing health care (especially emergency care) for those who cannot afford it is still a good charitable thing to do, and is really just an extension of being a kind neighbor, regardless of relative location to each other. Just because someone doesn't deserve a good deed done for them doesn't mean they shouldn't have any." "Because it is proven that nations with socialized health care have longer life expectancy and lower infant mortality rate." Comments on being a Christian: "What would Jesus say about it?"-caring for the sick and needy is important as a "Christian Nation" "U.S. views of health care are plain backwards thinking that you've somehow talked yourself into thinking is acceptable." "it seems like one of the big election topics Why do people deserve health care by simply being people? to me that sounds an awful lot like saying everyone deserves fuel because they are people." "The problem is, (at least in America) a very large sum of people who would use the health care are already on government assistance, which leaves the people who can afford health insurance to pay for them. Disregarding the elderly of course, why do we need these people in our society if they contribute nothing?" "but do i deserve to have aid sent my

	seem to work better than our own. b. The results reinforce the literature's findings that being underinsured or uninsured in this country has a negative impact on your overall health and that we need a new health care system. c. The needs are to reduce the cost of health care and re-educate the public on how to use health care, but make sure the changes that are done do not worsen the quality of care or increase the nation's debt. d. I will include in Assignment #4 the bulleted points in the outline (please see TSOCW 532-Health insurance outline)	way? Why? as much as I would love some help paying the bills around here why should my neighbor have to take on the responsibility of caring for me when I can't? (Middle-aged white male discussing health care reform)" Charges on health care are exorbant- i.e. 2tsp's of children's tylenole costs $8.00,when you can get a bottle at Rite Aid for $6.99 People are conditioned to go to ER with every illness. There is a need to re-educate people into using doctor's office more frequently. One individuals cost of c-section was $50,000. And, increased to $140,000 while son was in NICU. Welcome to American health care. I do have insurance so with that it will be about $20K out of pocket for me. And most importantly my son is now 5 weeks old and thriving. Our society is very polarized in our thoughts on who deserves health care. "I was in the military, which is the closest to socialized medicine the US has and I really didn't like it. When we had our son, the hospital was pretty shitty, the staff and care we got was shitty as well. We felt like cattle really. There were a bunch of complications, they waited too long for the epideral and my wife essentially had a natural birth... which was not what she wanted. There was a good amount of tearing, which she needed repeated surgeries to repair... but it was free." "I spent about two months in Spain. As a foreigner you do have to pay for

		government insurance for non-emergency care. It cost me 30 dollars or so for the two months I was there and I had better coverage than here in the US, and at a much lower price." The premiums and deductables are so large for insurance, it leads many people into debt just through that. "'Nobody is uninsurable' they say. My mother is insurable but she will have to pay premiums of $800 a month, pay 100% of all treatment up to a $5,000 deductible, and then pay 20% coinsurance after meeting said deductible. On a retail clerk's salary (when she's not laid off, which she has been twice this year) The doctor that did her colonoscopy gave her shit for not getting screened in seven years when she should have gotten screened in two because of her previous result." With 40 million un-insured or under-insured, that leaves a good bit over a quarter of a billion people that have some kind of health insurance in the US (more specific numbers welcomed), including myself. "For the brain tumor part, I can give a little information. My father is a oncologist and deals with this a lot. He'll have a referral from the Emergency Room and determine there's cancer. If the person has insurance, they can start treatment and the company will pay most of it. However, what's common with cancer is that it's so expensive to treat that the person will blow right through their Lifetime Maximum, basically the most your insurance company will EVER pay out. Past that you're SOL. So mark that as even with insurance you're bankrupt. If

		something like that happens, or you don't have insurance, some doctors, my father included, donates the care." "That's what we have in Canada. Nobody between a sick person and a doctor. Not the government, not the insurance company, nobody. I'll happily pay a few dollars more a year in taxes (and I feel my taxes are fairly reasonable) to live in a country where I can feel proud of the way we take care of sick people.". Do universal health care, but allow extra insurance for people who can afford it. Reasons against universal health care: -Universal health care provides a service, which does not come without costs, to citizens, for free. This service has no potential of generating revenue for the government, which would help offset the already existing deficit, and a very high potential of becoming yet another great expense for our government. -Universal health care requires that *someone* pay for medical bills, it's just no longer you directly. Either the government takes the loss, and our country falls into more debt, medical workers take the loss, and no longer receive fair wages, or taxes are raised for all of us, regardless of whether or not we need health care. -In the private sector, customers usually win, because the law of supply and demand regulates the market, and goods always go for a

		fair price in a fair market. Competition creates an ideal market for the consumer. With a government run program, there is no competition. If the service doesn't meet the demands of the consumer, there's no alternative. The government will waste or lose your money. And, the regulations will cost more than the services. “Private insurers are greedy son of bitches who could care less if someone lives or dies. They have no morals, just want to see a big profit and pay their CEO's millions of dollars. A public option would hopefully allow the uninsured to be insured at a reasonable rate, would not have to suck up to shareholders and pay CEO's outrageous salaries, and would get rid of pre-existing conditions, while making the playing field more competitive and lower costs for everyone. Case closed.”

Venue	Themes	Critical Comments & Connection to Project
Interview with Inpatient Medical Social Worker	• Moral imperative • Paying for the underinsured or uninsured care already through uncompensated care • Over-utilize the ED • Issues of waste • Need for an increase patient's	Comments on overuse of ED (emergency department), stating that it is due to being underinsured or uninsured as well as not taking preventive measures. “I believe it is a moral imperative help people who are sick and I think this includes public options for insurance Uncompensated care-waiting for an emergency costs more than preventative care “The ED does not replace a need for Universal Health Care”

	knowledge of own health	The cost of care should be transparent. Increased need for "health literacy." The patient needs a stronger understand of their health in order to better respond to their needs.
Interview with Outpatient Oncology Social Worker	• Issues with fee-for-service • Social determinants of health • Lack of racial diversity in health care • Uncompensated care shifts costs to those who can afford it. • Hospitals write-off billions of dollars in health care costs. • EMTALA • Changes of health care will impact role of medical social workers • Preventing hospital readmission 3 a-d (for both interviews) a. The emerging theme is the need for change in how health care is	Because of laws requiring hospitals to provide emergency care regardless of whether they are able to pay, means that hospitals write-off services in the form of "charity care" or "financial assistance." In turn, this increase the cost of care for those who can afford it. Discussion of EMTALA and the consequences on hospitals finances- (Emergency Medical Treatment and Labor Act-emergency services regardless of whether the patient is insured or not) Patient's may receive worse care because of the fee-for-service model. Specialist are more inclined to order up more tests rather than getting to know the patient and their needs. With the changes of ACA, more people will be accessing medical services. This is a chance for social workers to further show the link between person-in-the-environment and the overall biopsychosocial perspective. Areas of growth By addressing social determinants of health, such as socioecominc status, community, employment, and access to care, can lead many vulnerable people to healthier lives. Many health care providers are not culturally competent, which could play a role in why minorities do not access care as much. Readmission can be reduced through psychosocial support and educating the patient to understand their medical needs and learn how to communicate with their physician.

	currently accessed and reduction in its costs. b. The interviews add to the concern that health care is currently inadequate and that there are certain actions that can be taken to address health disparities, re-admission, etc. c. The interviewees see that uncompensated care is very costly for hospitals and it often shifts the burden of baring the cost to those who can afford it. d. I will include in Assignment #4 the bulleted points in the outline (please see TSOCW 532-Health insurance outline)	

Responses to Box 9.7 Questions

1. The needs assessment will help me understand the blight of the uninsured and know how they get health care. I will learn who they are, what they value, and their views on universal health care.

2. I am doing this needs assessment to discover ways to change the way health care is distributed in the U.S. in order to address health disparities. I am focusing on the issue of affordability of health insurance.

3. So far, I know about the upcoming health care reform through the Affordable Care Act, aka Obamacare. I know how our countries health care differs from others. I know about health disparities and what populations are impacted most frequently by inadequate health care. And, I know about the cost of health care and the concerns around this issue.

4. Most people have an opinion on health insurance and everyone is affected by health care. But, low-income individuals, especially minorities, are most affected by the issue of being uninsured or underinsured. Also, medical social workers and other health care providers are knowledgeable about these issues.

5. In Seattle's Swedish Cancer Institute with medical social workers and on an online community known as Reddit.

6. On Reddit, I asked them to comment and converse on their own time through an online forum. As for the two medical social workers, I asked for an hour of their time during working hours.
7. Time constraints for the social workers were a concern because the interviews are conducted during their work hours. There are no time constraints for the online forum, but there will be a concern about participation because the community does not comment on all forums either because they are uninterested or they have responded to other forums on the same issue.
8. Yes. A focus group is essentially what posts on the Reddit site already are. The interviews with staff are effective because I am flexible for when to meet and they are willing to make time for me.
9. Yes, Reddit will provide information from a world-wide audience that has knowledge of a wide-range of forms of health care and the social workers provide a wealth of information because they play a direct role in the U.S. health care system.
10. One of the main ethical issues considered was the use of clients and the concern of confidentiality and exploitation. Also, social work is limited by the role it will play in the health care reform. Although it will be a strong advocate for change, many decisions are out of their hands, particularly what private insurance companies plan to charge for insurance.

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