



**Reaching Out and Reaching In:
Understanding Efforts to Identify and Enroll
Uninsured Children into Health Insurance Programs**

USC Division of Community Health

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Introduction

Since 1997, significant changes in child health policy have provided new opportunities for children in the United States to get health insurance and health care services. The most significant change was the introduction of the State Children’s Health Insurance Program (SCHIP). California also moved to implement SCHIP by establishing Healthy Families and also implemented changes in their Medicaid program and coordinated private programs as well.¹ In some parts of California, local coalitions have formed to develop simplified and comprehensive programs covering all children in the county, including those ineligible for Medi-Cal and Healthy Families due to income or immigration status. These generically have been called Children’s Health Initiatives or CHIs.²

As states and local governments move to implement these policies and programs, they invested millions of dollars in activities aimed at identifying and enrolling children, and in some cases their parents and other adults, into publicly financed health insurance programs. In California, the state allocated \$78 million between 1998 and 2001 for outreach and education.³ A prominent feature was the trained *Certified Application Assister* (CAA) and a \$50 incentive fee paid to these workers for a successful Healthy Families or Medi-Cal application. Private philanthropic organizations also participated by providing grants to community agencies throughout the state supporting outreach and enrollment. In some cases, local governments and First 5 Commissions augmented state grants by funding additional organizations or extending the contracts for additional years.⁴

In California, these investments led to the development of a broad network of agencies and individuals, coalitions and networks engaged in efforts to identify and enroll eligible children and their parents into some type of health plan, assist families with using health services, and facilitate re-enrollment at the appropriate time. They comprise a wide spectrum of community-based organizations, health providers, private physicians, schools, child-care programs, insurance agents and health departments. In Los Angeles County alone, there are at least 268 separate organizations distributed across the county’s eight Service Planning Areas (SPAs) providing outreach and enrollment. (See Exhibit 1).

Outreach and enrollment projects were funded often without information about what are likely to be successful and cost-effective strategies. Professional judgment in response to a proposal was all that many funders had in making these decisions. What resulted was more of a shotgun approach—supporting a wide range of activities hoping that some would be successful rather than a more targeted or strategic investment.

EXHIBIT 1. Number of organizations involved in outreach and enrollment in Los Angeles County by type of organization and Service Planning Area (2005).
 Source: L. A. outreach and enrollment database.

Agency Categories	Service Planning Areas								Total
	1	2	3	4	5	6	7	8	
CBO	1	28	2	20	5	14	6	9	85
Clinic	2	23	5	33	2	9	2	8	84
Insurance		5	3	4		1	2	5	20
Private		1	6	12		9	8	7	43
School		3	5	4	2	1	6	3	24
Child Care			1	1	1	3	1		7
Health Dept.			1	2				2	5
Total	3	60	23	76	10	37	25	34	268

Still, the growing outreach and enrollment system may have contributed to enrollment success: Both national and California studies show a steady increase in the number of children with health insurance coverage even while job-based coverage has declined. In 2004, about 7 million or about 9 percent of children under age 18 were uninsured in the U.S., compared with 10 million, or 14 percent, in 1997.⁵ Similar results have reported for California.⁶ Much of the increase was due to enrolling children into these public programs.⁷ In California, the number of Medi-Cal enrollees as a percentage of estimates of eligible children, ranges from 70 percent to 100 percent.⁸ Healthy Families enrollment has reached over 730,000,⁹ and 73,000 children have been enrolled in one of the 10 active county-sponsored Children’s Health Initiatives (CHI) programs.¹⁰ The specific effects of any one approach to outreach efforts strategy in bringing about this increase has not been established.

Today, many counties and their private partners and funders are refining and expanding their existing outreach and enrollment efforts to more effectively reach a broader range of families. To better inform this process, this report provides a review of what is known about the effectiveness of outreach and enrollment strategies, and a framework for ways to evaluate the future outreach and enrollment programs. This report is based on:

- a) information gathered from reviewing published studies and reports of outreach and enrollment projects;
- b) information gathered from scans of outreach and enrollment activities in California including those targeting children; and
- c) data collected by the Division of Community Health (DCH) during the past five years on projects that include, or are closely related to, outreach and health insurance program enrollment.

Conceptual framework for assessing outreach and enrollment

In this report we refer generally to outreach and enrollment as related to anything that helps to identify eligible uninsured children and assist them to enroll, stay enrolled and appropriately use health services. There is a myriad of distinct activities that are involved in this process. In an earlier review, the Barents Group defined outreach and enrollment to include nine distinct activities as part of a community-wide outreach and enrollment effort. Their framework included: identifying the target population, increasing public awareness and understanding of the program; educating people about the program and then assisting them in signing up; addressing access to care; addressing systemic barriers to enrollment; and finally, changing policies and program to reduce those barriers.¹¹ These activities can be described under four distinct categories that have been more commonly used to describe this work: *outreach*, *enrollment assistance*, *utilization* and *retention*. We merge these to create a new framework for assessing the structure and process of outreach and enrollment activities but adding the administrative, data collection and financing activities that support this work. (Exhibit 2). The components include the following:

- **Assessment:** activities to understand characteristics of the target population including knowledge and motivation to enroll in a health program and use services;
- **Outreach:** activities to increase awareness of the health programs, eligibility criteria, and steps needed to enroll and re-enroll;
- **Enrollment and retention:** activities to assist individuals to enroll or re-enroll in a health program including application assistance, follow-up and case management;
- **Utilization:** activities to assist in improving consumers' knowledge about and use of the health plan and the health care system;
- **Networking:** activities designed to build organizational partnerships, coalitions, joint training and information sharing towards system improvement;
- **Policy analysis and systemic change:** activities to identify and modify policy and regulatory barriers to enrollment and utilization; and
- **Program management and evaluation.**

This provides a useful framework for understanding the structure and process of outreach and enrollment systems, and assessing the effectiveness of various outreach and enrollment strategies on different population groups.

EXHIBIT 2. Components of outreach and enrollment retention and utilization

Barents et al components	Assessment	Outreach	Enrollment and Retention	Utilization	Networking	Policy Analysis and Systems Change	Program Management, Finance and Evaluation
Identify and understand the potential population	X						
Increase public awareness that the program exists		X					
Increase understanding of eligibility for the program		X					
Educate individuals about the program		X	X				
Motivate individuals to take action to learn about or enroll in the program		X	X				
Facilitate individuals' actions needed to enroll in the program			X		X		
Address access to care and use of services after enrollment				X			
Address systemic barriers to enrollment or action					X	X	
Change state policies and program characteristics to address barriers						X	

Assessment: identify and understand the target population

California's uninsured children and families. Understanding the effects of different strategies requires 1) understanding of the behavioral and cultural factors affecting an individual's decision to enroll in a health plan, and 2) components of the system that either facilitate or act as barriers to the enrollment, redetermination or utilization. Designing any effective strategy to affect change requires some understanding of these factors. California's uninsured is not a homogeneous population: Uninsured Californians span all ethnic and socioeconomic backgrounds, although a disproportionately high number of uninsured children are of low or moderate income, Latino, non-U.S. born and are from families whose parents work in businesses that do not offer an affordable health plan.¹² There is much evidence that uninsured children have less access to preventive and primary care compared to those who are insured, making them particularly vulnerable and at higher risk of having poor health status or poor health outcomes.¹³ The same factors that may define a group as "vulnerable" also tend to contribute to a lower likelihood of having health insurance coverage and poorer overall access to health care.¹⁴

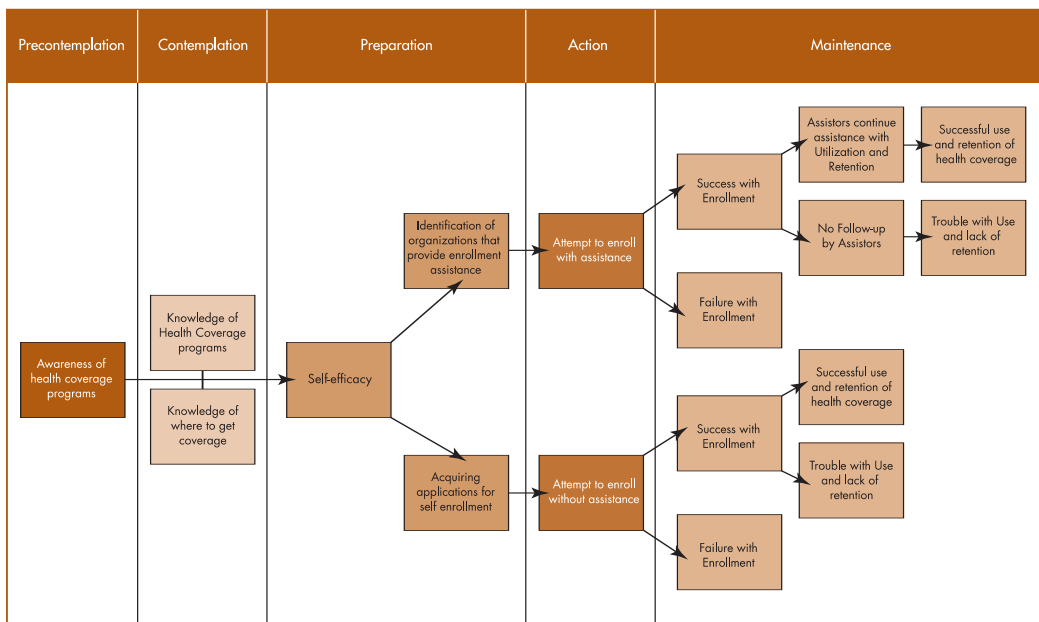
Given the diversity and the vulnerability of the uninsured, understanding the various socio-demographic and behavioral characteristics of the uninsured are important since they can affect how a family reacts to a specific appeal, or the amount and type of intervention that is needed to assist them with enrolling and staying enrolled in a program. To some extent, decisions to enroll in a plan are governed by social psychological factors affecting health behaviors in general. While there are many models of health behavior,¹⁵ the Transtheoretical/ Stages of Change Model of behavior change provides some clues for understanding the cognitive factors and stages that individuals go through in the process of deciding to take health action.¹⁶ This model proposes

that individuals move through cognitive stages of change that determines their readiness to take action; in this case, enroll or re-enroll in a health insurance program.

The model proposes that not all individuals are at the same stage of readiness to take the steps necessary to enroll in health care, stay enrolled and appropriately use health care services. (Exhibit 3) Those in what is described as the *Precontemplation stage* are unaware of the existence of health programs and may not yet understand the importance of having health coverage prior to getting sick. Those in the *Contemplation stage* are more knowledgeable of the programs and the need for coverage and are thinking about applying, but do not understand eligibility requirements and how to apply. As individuals move towards the *Preparation stage*, they are more aware of the need and are acquiring the knowledge and skills to begin and complete the application process (self-efficacy). In the *Action stage* individuals apply the tools and the self-efficacy to actively enroll in a program. In the *Maintenance stage* individuals that have been successfully enrolled in a health coverage program and are in the very dynamic stage of navigating through the health care system and continuing their health coverage at the appropriate time.

Uninsured families vary with respect to their knowledge and experiences with health insurance programs and providers, the health status of the child or the parents and/or immigration status. Experiences, beliefs and backgrounds are not the same for every group. The California Immigrant Welfare Collaborative conducted focus groups about health insurance in 2003 in various California counties involving different ethnic populations. Vietnamese-speaking individuals expressed the most concern about language as a barrier to learning about insurance programs. Immigration related concerns were greatest among Spanish-speaking individuals who were most likely to have had negative experience with Medi-Cal in the past. Korean-speaking individuals had concerns about not qualifying for health insurance programs because of making too much money. They were least likely to have heard about Healthy Families.¹⁷

EXHIBIT 3. Outreach and Enrollment Process Model



Many uninsured may be difficult to reach because of language and cultural barriers. Recent immigrants may be reluctant to enroll in public programs for fear that enrollment would disqualify them for citizenship on the basis that it would relegate them as a public charge and potentially lead to deportation. Others have general distrust of the medical system or governmental programs. Many uninsured families are also mobile due to seasonal agricultural labor, homelessness or may move frequently due to unstable housing situations and/or employment.¹⁸ The model suggests that in developing a more comprehensive strategy for identifying and enrolling children, it is important to consider who will be missed in the array of planned outreach strategies.¹⁹ For example, school-based programs may miss home-schooled children, youth who are not in school or those who reside in an alternative institution. Adolescents in general provide additional challenges. Homeless children are another group that could be missed by more traditional strategies. The transient nature of homeless families poses unique problems for these children not only in finding them but in establishing and maintaining their eligibility for these programs. Those living in very rural communities may be isolated from many of the outreach and enrollment venues we will discuss in this report.

The model suggests where individuals would be in terms of readiness and the level of assistance needed to affect enrollment, retention and utilization. On one end of the spectrum are those who are most ready to enroll and require the least amount of intervention. They have knowledge and self-efficacy and are motivated to be active consumers. They can be categorized within the Preparation stage of readiness. These families may respond to media messages on their own and require little to maintain their participation in a program or use services. They would also benefit from action-oriented messages and strategies that link them to enrollment assistance entities.

Individuals who are more reluctant to enroll may be unfamiliar with the health care system, are newly immigrated or do not prioritize health care. They would fall under the Precontemplation or Contemplation stages of readiness. For these individuals effective outreach and enrollment strategies would be more staff intensive and are based in community sites that they are already familiar and trusted.

A simple scheme would use the states of change model to create general categories of individuals, families or even communities to assess what type of outreach and enrollment strategy is likely to lead to success (Exhibit 4). Broad media campaigns may be effective for increasing awareness among general populations and for targeting those most ready to apply. Those individuals in the Maintenance stage are already enrolled or understand the importance of getting health care can benefit most from strategies that are at clinics and sites where they get health information. Specific ethnic and cultural populations have to also be considered when determining outreach strategies. Strategies should incorporate culturally specific media outlets as well as known community-based organizations that are trusted by each cultural or ethnic group. These general categories can be further defined into more specific sub-categories, but in this general form they serve to emphasize the complexity of the uninsured population and the strategies that would be effective in facilitating change.

While important, health behavior models provide only part of the overall picture because many of the factors that affect readiness are not solely under the cognitive control of the individual. Systemic barriers, and program regulations and systems can deter enrollment or redetermination. The complexity of the enrollment process, public charge regulations and premium payment systems, are all examples of barriers to enrollment that are not under the cognitive control of the individual. Efforts to reduce these barriers can help to increase the likelihood of an individual completing the enrollment process.

EXHIBIT 4. Outreach Strategies

Target Population	Broader populations including both the insured and uninsured	Hard to reach populations	Uninsured that are highly motivated to take action to enroll	Current health care users	Those within ethnic or racial groups	Notes
Broad media campaigns	+++	+	+++	+	+	Best early in campaigns when few people are enrolled
Targeted media campaigns	+	++	++	+	+++	Throughout the campaign
Technology	++	+	+++	++	+	
Community workers	+	+++	+++	+	++	
Health fairs	+++	+	+	+	+	Best early in campaigns when few people are enrolled
Churches	+	+++	++	+	+++	
Health consumer centers	+	++	++	+	++	
Neighborhood door-to-door campaigns	+	+++	++	+	++	
Toll-free hotlines	+	++	+++	+	++	Throughout the campaign
Incentive payments	+	+	++	+	+	Little is known about the effects of incentives on enrollment
School-based approaches	+++	+++	+	++	+++	
Provider-based	+	+	+++	+++	+	
Employer-based projects	+	+	+	+	+	
Reducing systemic barriers	+	++	+	++	++	

- +++ Recommended as an effective way of reaching the population
- ++ May have a moderate effect of reaching the population
- +
- ?

Approaches to Outreach, Enrollment, Retention and Utilization

In this section, we analyze various approaches to outreach and enrollment and try to assess what is known about the impact of these approaches on key outcomes: enrollments, retention and utilization. We cover media-based strategies, community-based organization strategies, toll-free hotlines, school-based strategies, community health workers, health providers and employers. Not all strategies are reviewed here in part because of a lack of data or reports that describe these activities or impact. Exhibit 5 shows for one county (Los Angeles) the impact of different outreach strategies on applications for the Healthy Kids programs. Clinics and health centers are the largest source of applications, followed by other types of community-based organizations, media-based hotlines, schools and child care centers, health plans and hospitals and then health departments. Data from exhibit 5 will be referred to in this section.

**EXHIBIT 5. Source of Applications for the
L.A. Healthy Kids Program, Los Angeles, 2004-05.
Source: L.A.Care, 2005**

Type of Organization	Number	Percent
Clinics and Health Centers	8,013	41%
Public health departments	329	2%
Community-based organizations	2,970	15%
Hospitals	1,108	6%
Media-based hotline (Nexcare)	2,597	13%
Schools	2,496	13%
Health Plans	1,852	10%
Total	19,365	100%

MEDIA-BASED APPROACHES TO OUTREACH AND ENROLLMENT

The past 20 years have seen a significant expansion in the use of media in increasing overall community awareness and changing societal norms related to key public health issues.²⁰ Media have been used to disseminate health messages and promote awareness of health risks for tobacco and smoking, HIV/AIDS, or other communicable diseases; promote immunizations, pregnancy prevention, and cancer screening and treatment.²¹ Because of the success of these strategies, funders have turned to the media as a way to advertise public health insurance programs to uninsured children and families. Yet there is no evidence that media success in one area will necessarily translate to outreach and enrollment for health insurance for children and families. Still, some projects did point to media marketing as a promising strategy in promoting new programs, or in advertising changes in policy and program rules and guidelines. For example, in Florida and Oregon, a combination of radio and television advertising about newly expanded eligibility for pregnant women and simplified application procedures were associated with increased Medicaid-financed deliveries.²²

Broad Media campaigns. Both nationally and later in several states including California, both government and private funders turned to the media to respond to the unexpected slow start in the SCHIP program. The Robert Wood Johnson Foundation's Covering Kids Campaign launched a \$26 Million multimedia ad campaign in 11 markets. In New York, the State Children's Health Program (SCHIP), adopted a multifaceted marketing approach in 1998, costing an estimated \$18.5 million. It included television and movie theater advertisements, advertisements on milk cartons, and with prescriptions given at drug stores. Shortly after the implementation of Healthy Families, California placed advertisements on billboards, bus placards and electronic media as statewide outreach strategies.

But what impact can be attributed to these campaigns and for which groups? After the Robert Wood Johnson's Covering Kid media Campaign, calls to a national hotline increased from 15,000 per month to more than 58,000 with more than 80 percent of callers to the Covering Kids Hotline saying that they intended to apply for coverage.²³ About 95 percent of callers to the Covering Kids Hotline had learned of the number from a television or radio announcement.²⁴ In response to the New York campaign, the number of children who enrolled in the SCHIP program increased from 70,000 in 1994 to more than 590,000 children by 2001. Nearly 30 percent of parents whose children enrolled in the program reported that they had first heard about New York's Children's Health Program as the result of at least one of the state's marketing strategies, and cited one of these media outlets as a primary source of information about the program.²⁵

These reports lend some credence to the media-based approach to outreach but less convincing for enrollment. Broader media campaigns seem more effective as a way of spreading awareness about new programs among a broader population. Broad media appeals may be especially important for reaching those who are sufficiently motivated to enroll in a health plan and who need a minimum level of intervention to move through the change process leading to application and enrollment. Media may have an indirect benefit as well: individuals who hear about a program through media campaigns pass information on to friends and family members extending the overall value of message.

But because of the expense of these large campaigns caution is urged in expanding these campaigns without an accompanying evaluation. A more systematic approach to marketing analysis that might include, for example, a carefully controlled study comparing increases in insurance rates in markets with media campaigns to relatively similar markets where there were none. In addition, broad media campaigns may have less effect over time as families who are motivated and hear messages become enrolled, leaving those who are more fearful, less motivated and have less access to media. These families, who are in earlier stages of change, will require a more carefully thought out media strategy that considers the potential impact of different types of media and messages on specific target populations.²⁶ In thinking about more difficult to reach populations, ad testing becomes very important.²⁷ Careful attention to translation and cultural specificity are critical in reaching target populations.²⁸ For example, messages developed for an English-speaking population and then simply translated into Spanish may be ineffective and indeed misleading.²⁹ Moreover, it cannot be assumed that people who are from different countries or region, but speak a common language, will respond similarly to a campaign message. Two groups may share the same language but differ in which they use and access services and products, or their cultural interpretation of those messages.³⁰ This is particularly relevant in large metropolitan areas of California that are home to Spanish-speaking population groups from different regions of Central and South America, and a very diverse Asian population.

Targeted Media. Some evidence suggests that a more targeted media campaign may be more successful in reaching more reticent families, those who are less engaged in more mainstream media, with less knowledge of English language, and especially some ethnic groups.³¹ Chinese radio and television announcements produced by a local community health clinic had a larger impact on raising awareness about the Healthy Families program in San Francisco's Chinatown than did the statewide marketing campaign.³² Similarly in Los Angeles, the Korean Health, Education, Information, Resource (KHEIR) Center use cultural media outlets in their outreach efforts. Specifically, KHEIR manages a monthly radio program on a Korean radio station based in Los Angeles but has a national audience. The program consists of a 30-minute discussion of hot health topics followed by 30 minutes of questions and answers from the audience. KHEIR also advertises in local Korean newspapers. KHEIR reports that these media spots have been the most effective mode of outreach to the Korean population in Los Angeles County. The Fontana Unified School District in San Bernardino County yielded a large response from advertisements for Healthy Start enrollment sites that ran on the district's cable station on specific days.³³ The Orange County Health Consumer Center routinely advertises on Vietnamese cable television stations.³⁴ They even sponsor programs and participate on panels with community leaders where a range of programs is discussed including health insurance. Health Consumer Center of Los Angeles notice significant spikes in calls to the 1-800 health consumer center hotline after advertising the program on Spanish-radio and television. Most called wanting information about health insurance and enrollment assistance. Similarly the Nexcare collaborative developed 30-minute segments on Spanish television stations in Los Angeles and reported that such advertisements led to spikes to calls to their 1-800 toll free number.³⁵

Earned media (e.g., radio or television interviews, newspaper articles) messages may leave more lasting messages than paid advertisements or free media since the messages (e.g., information about new eligibility requirements, new community-based programs, or how to access a service) are more likely to be interpreted as “fact” or “news”, especially if communicated through recognizable television or radio personalities.³⁶ Another strategy is to link health messages in the context of an episode of a television show or a news segment. At the end of the show or segment appears a Web site or telephone numbers where listeners or viewers can obtain more information.³⁷ In spite of the promise of these strategies, it is not known how successful these might be in facilitating enrollment. Caution is urged in supporting these approaches with a more careful assessment of their likely impact through carefully designed interventions with a strong evaluation component.

In summary, some descriptive data exists demonstrating the value of broad media campaigns in expanding awareness and facilitating enrollment. But these reports do not allow a good understanding of the effects of these contributions relative to other activities, the effects of one type of media over another, or effects on different ethnic or economic groups. While broad campaigns might be helpful in reaching more motivated families early in implementation of new programs, more targeted campaigns may be helpful for more difficult to reach or less knowledgeable and motivated families. Still, the impact of these approaches particularly as an enrollment strategy remains uncertain and requires further study.

TECHNOLOGY

New technology, including the Internet, provides new opportunities and challenges for outreach and enrollment projects. As computers become less expensive and more available, they may become cost-effective ways of reaching the general population much like broad media campaigns were designed to accomplish. In order to target specific populations, more research is needed to understand how many within the target population of uninsured families have access to computers or who use them for obtaining information about health care in general. At least one case, the Internet has provided surprising results as an outreach strategy. In Florida, 14 percent of families who signed up their children for Florida Kidscare learned of the program through the Internet.³⁸

For enrollment and retention, online application projects are also more common. Online enrollment programs have been implemented in Colorado and Massachusetts. In California, many agencies now use Health-e-App for applying to Medi-Cal and Healthy Families, and in some counties a broader more comprehensive One-e-Application is being implemented or tested that use a single application that covers a broad range of public services. This technology is being used in conjunction with community-based organizations and assisters who then work with the family to complete the online application. The cost of purchasing and maintaining the One-e-App project remains high and a barrier for several small counties.

Internet-based programs may prove helpful for highly motivated individuals and those ready to enroll. They may be also helpful for current clinic users although we still not know how the effectiveness of these methods would vary among ethnic and racial groups. Indeed, technology-based programs have not been adequately studied, and it is not at all clear that they provide a cost-effective approach relative to other strategies. More information is needed about which populations would benefit from a technology approach and who would be left out. Does technology work on its own or does it require the assistance of a community worker or CAA? To what extent can privacy be protected? Does it work better when it is dedicated to health insurance or when it is coordinated with other services and modules? How helpful will technology be in assessing utilization, or how can it be used to facilitate retention, including automatically issuing reminders and passive pre-populated Web-based applications?

In summary, the use of technology for outreach and for enrollment is a promising strategy and specific activities should be explored, but accompanied by a systematic analysis of its costs and benefits.

USING COMMUNITY-BASED STRATEGIES

The development of a network of community-based organizations has been a hallmark of the efforts to enroll uninsured children. CBOs include social service and advocacy groups, child care agencies, all of which use a variety of activities to increase public awareness and enroll children in programs. Many use community health workers. As Exhibit 6 shows, health fairs (74 percent) and distributing flyers (64 percent) are among the most common activities, followed by presentations at churches and schools (57 percent and 50 percent respectively), street outreach (33 percent), and the media (36 percent). How effective are these activities in facilitating enrollment? For which population groups are community-based strategies most likely to be effective?

EXHIBIT 6. Outreach strategies among community-based organizations in Los Angeles
(based on interviews conducted from stratified random sample of 51 CBOs).
Source: L.A. inventory

	Number of agencies	Percent
Health fairs and enrollment events	31	74%
Distributing flyers	27	64%
Presentations at schools	24	57%
Presentations at churches	21	50%
Street outreach	14	33%
Media	15	36%

Community health outreach workers and promotoras de salud. Many community approaches rely on a workforce broadly defined as “community health workers” (CHWs). Different from broad-based approaches, the CHW approach is based on establishing personal and sometimes ongoing contacts with families.³⁹ Community health workers have a variety of titles (community workers, lay health advisors, promotoras de salud, health aids or advocates). CHWs have been used for many types of community health interventions⁴⁰ and are typically individuals who come from the target communities, who are language and culturally compatible with the target population, have strong interpersonal skills and develop a thorough knowledge of program procedures and requirements.⁴¹

Using lay community health workers may be particularly important in California that is home to many immigrants from throughout the world. The interpersonal relationships that are formed by community health workers can help overcome barriers created by fears associated with their immigration status and help to persuade a family to apply for a program; otherwise the family may not voluntarily respond to an ad or even an appeal at school or a similar venue due to such suspicions. They also provide an important service by following up on more difficult cases or at the time of renewal.

Many programs rushed to use CHWs in their outreach and enrollment programs. But because the activities of community health workers are varied, we do not know much about what specific aspect of their work can be attributed to enrollments. Some use CHWs to walk local neighborhoods, knock on doors, visit churches and other settings. Some are trained assisters while other serve only as outreach workers and refer families to another office for enrollment assistance. It is not anticipated that CHWs will by themselves yield high numbers of enrollees. Indeed, CHW approach is likely to be an expensive approach to conducting outreach and enrollment especially if they rely on one-on-one or door-to-door strategies. One of the earliest outreach and enrollment programs using community health workers was the First Things First Project (FTF), which was implemented in California from 1998-1999. The evaluation of the FTF showed that the use of trained outreach workers who are members of the targeted community was key to the successful enrollment of 31,000 children into Medi-Cal and Healthy Families. Utilization of community members, organizations and local media were all part of their successful outreach and enrollment efforts conducted by the coalition of individuals involved in the FTF program so it is not clear exactly how the work of the CHWs are attributed to these enrollments.⁴²

Yet the work of CHWs is likely to become an increasingly important part of the outreach and enrollment puzzle as the number of uninsured children continues to decline and as those left may be in early stages of change, not current consumers of the health system (for example, clinic users), the most distrustful or apathetic towards government programs, or have little or no knowledge of the programs.⁴³ Because CHWs are culturally compatible with the communities, they can help to alleviate fears, build trust and provide accurate information to families who otherwise would not respond to broader appeals.⁴⁴

Health fairs. Interviews with CHIs show that health fairs are used extensively as an outreach strategy by nearly every local county CHI (Tables 2). At these fairs, outreach workers distribute flyers, and talk to participants about the programs. At one level, it made sense to attend health fairs and *spread the word* because of the large number of individuals circulating who one might assume have at least a small interest in health. Both insured and uninsured individuals are likely to be exposed to information distributed at health Fairs. In Los Angeles, nearly three quarters of CBOs use health fairs as a strategy and these projects report more than 8,400 contacts from health fairs (Exhibit 6). The include events called enrollment fairs that are organized by health plans such as L.A. Care. To facilitate enrollment, some projects have staffed the fairs with CAAs who then begin the process of assisting families apply for programs on the spot. Some use incentives and other services to attract families to the enrollment booth and table.⁴⁵ In El Dorado County, the health department was able to purchase child car seats at discounted rates and offer them to families attending the health fair as a way to attract them to the enrollment booth.

Still, it is not clear whether health fairs actually generate many applications. While many people attend these fairs, it is not known whether they include many uninsured individuals. Secondly, beyond spreading some awareness, it is far from certain they have much of an impact on families' decisions to enroll especially among the harder to reach families who are in the contemplative or even earlier stages of decisions. Third, early in the campaign, health fairs may have been an important part of the overall effort to increase awareness, they may be less important as information becomes more widespread and the population more knowledgeable about the programs, and more people are enrolled.

Door-to-door solicitation. One strategy involves the use of community health workers (CHWs) who conduct outreach by walking in targeted neighborhoods and knocking on doors. The CHWs inform residents of Medi-Cal and Healthy Families and refer interested families to agencies who can assist with the application and enrollment process for the health program for which they have been deemed eligible. The Get Enrollment Moving (GEM) project uses the door-to-door strategy as an outreach mechanism and refers individuals to a centralized office for application assistance. Preliminary data shows this strategy is working in hard-to-reach Latino populations residing in the San Gabriel Valley. The cost-effectiveness of this strategy has not yet been determined. The GEM health leaders are effective because they have had similar experiences of the population they are trying to reach, they live in the same neighborhoods and are faced with many of the same challenges. This one-on-one approach may allow the agency to identify those families who are not likely to respond on their own to a broader campaign. Interviews with staff suggest that many of these families may be harder to reach require more education about the benefits of a program, and more contacts in order to persuade them to apply for a health program. The one-on-one approach involving community workers may be an important mechanism for these families many of whom would not otherwise enroll.

Churches and other faith-based organizations are not as widely used as a venue for outreach and enrollment although this also could be an untapped resource for spreading awareness especially among those who are very fearful to apply for a government program. One example where churches are used is the Vida Project in the northeast San Fernando Valley. The Vida Project uses a network of mostly Catholic parishes in the San Fernando Valley to advertise insurance programs and provide ways to explain programs to individuals and

assist them with enrollment and utilization. The trust associated with the churches has been key to the successful engagement with these families. Over the course of the project, more than 1,300 families (3,000) individuals were enrolled in Vida. At the time of enrollment, few had any type of insurance, but by the end, one-third of the participants were eventually linked to Medi-Cal, in addition to about a third of the children in the members' home.⁴⁶ Vida members repeatedly have told evaluators of the importance of the churches in serving as a non-biased and trustworthy venue for receiving assistance with enrollment in health insurance programs.

Child care centers. There are also examples of partnerships that have formed for targeting specific populations. The Health Consumer Center of Fresno and the Children's Services Network (a child care referral center), teamed up to identify and enroll children whose parents call CSN requesting information about child care. More than 35 children were identified and eventually enrolled in Medi-Cal as a result of this partnership.⁴⁷

In summary, community-based strategies seem attractive venues for agencies doing outreach and enrollment work but their value as a strategy remains uncertain. Health fairs can reach many people, churches reach congregations and build on the support and trust inherent from churches. Door-to-door campaigns are costly and may not yield large numbers of applications. But community-based projects may provide an important mechanism for reaching those in the contemplation and preparations stage – those who require more assistance and trust to be able to take important steps towards enrollment.

SCHOOL-BASED APPROACHES

Just as health fairs are attractive strategies because of the volume of participants, schools have also been seen as providing many opportunities for increasing awareness of public insurance programs.⁴⁸ To expand awareness, schools often partner with other organizations that come on campus to give presentations at back-to-school nights or PTA meetings, distribute brochures, post information on school Web pages and or place articles and announcements in newsletters. Others, such as the L.A. based CHAMP program, uses staff from the school district to identify and enroll uninsured children. Some school-based programs are designed to increase awareness on the part of teachers and parents. The Teachers for Healthy Kids program is a statewide program that utilizes teachers and the classroom environment to conduct outreach to uninsured families. This program is in operation in 120 individual schools and 43 school districts in California. It has resulted in increased knowledge among teachers although the effects on enrollment are still being studied.

In addition, several school-based programs have been established to identify uninsured children and assist them with enrollment. The Express Lane Enrollment program is designed to streamline enrollment by linking Medi-Cal enrollment with the federal school lunch application process. It is being piloted in six school districts in the state.⁴⁹ The program has shown some limited success. Through the second year, about 10 to 15 percent of parents of children eligible for free lunch provided consent for forwarding the proposal to Medi-Cal, and of those that did provide consent, more than half of the children were already enrolled. Of the approximately 1,000 children who were received temporary Medi-Cal through the ELE program, one-third were eventually enrolled in ongoing, regular Medi-Cal.

In California, school districts can request Request For Information (RFI) Flyers in 11 different languages to disseminate in back-to-school packets, at back-to-school nights and with the National School Lunch Program meal application. In California, since 1999, more than 550 schools, community-based organizations and local partners have used the RFI process resulting in more than 50,000 forms returned to the state by parents requesting information and applications for the state-sponsored health insurance programs. Some evidence exists that schools are an effective vehicle for outreach and enrollment. In Los Angeles, about 13 percent applications for Healthy Kids come from schools. (Exhibit 5). In Florida, the KidCare Program evaluation found that 45 percent of parents with children enrolled in the Florida Healthy Kids Program reported that they heard about KidCare through schools, a finding consistent across all race and ethnicity groups.⁵⁰

These results show the potential of schools as high-yield opportunities for educating parents about health and persuading them to take the first step towards enrollment. When screening programs are linked with school-based or school-assisted follow-up, it does result in many individuals enrolling in a health program. In Alum Rock Union Elementary School District in Santa Clara County, Calif., application assisters worked during Healthy Family Application Assistance Days to screen all children for eligibility for available health programs. Once children were identified, CAAs assisted the families with the appropriate application and as a result enrolled more than 1,000 children.⁵¹ In Contra Costa County, Calif., outreach workers made personal telephone calls to families, sent brochures and mailings to parents of school-age children, and conducted other activities designed to heighten awareness of the new programs. Once a family expressed interest, the outreach workers made home visits or set up appointments at school with parents and assisted them in completing the application.⁵² In San Diego, a school-based outreach project is yielding higher follow-through rates with applications than other strategies, a finding they attribute to the access outreach workers have to parents' names and phone numbers and the option school-based outreach workers have to call at various times during the school day.⁵³ An evaluation of this approach found that after 15 months in 18 different schools, the outreach workers provided a total of 12,878 hours of outreach/assistance, resulting in 1,466 completed applications that represented 3,754 children.⁵⁴ Alabama sends out application packets regarding the state's children's health insurance programs to all public school children at the start of the school year. In 1999, after sending out more than 850,000 applications packets, nearly 23,000 eligible children were enrolled halfway into the school year.⁵⁵ Without the resources for follow up, effective outreach strategies become missed opportunities for enrolling children into health programs. In California many districts have been unable to follow-up with the submitted RFIs. It can not be assumed that the schools will have the resources for effectively following up with families who need assistance.

While schools are an obvious choice for outreach and enrollment activities, not all schools are anxious to take on the new responsibility especially in the face of pressure to increase test scores and comply with new state and federal regulations. Any school-based enrollment program should consider the impact of adding programs and services to an already overworked school staff. Still, studies that demonstrate how health insurance increases school readiness, reduces absenteeism and improves educational outcomes are likely to have a positive effect of developing on going partnerships with schools and teachers.

It is possible that schools are becoming less effective over time as a high-yield strategy as the pool of uninsured children diminishes. Interviews with CHIs report that while most counties report using schools as a source of distributing information to families, not all counties have been able to effectively *enroll* children through schools. Staffing schools with CAAs during back-to-school sessions has been moderately effective, but some of the counties have reported that parents are swamped with too many other things to take the time to complete the applications on-site. One county has even decided that enrollment in schools does not yield enough new enrollments to continue this approach.

TOLL-FREE HOTLINES

Several programs have used toll-free numbers as an outreach and enrollment strategy. Toll-free lines are designed to make it as easy for families to begin the enrollment process and provide a “next step” for those responding outreach campaigns. There is a wide range of ways in which hotlines are used for health insurance expansion. Toll-free numbers are generally linked with media or other types of outreach mechanism. Referring to a national hotline was key to the success of the RWJ Covering Kids and Families media project that was dedicated to health insurance expansion. Toll-free numbers are also used by most Health Consumer Centers that are dedicated to provide assistance in solving health problems for consumer including enrolling in health insurance programs. There are currently eight HCCs in California that are based at legal services agencies, and more than half of the calls they receive are from those who need assistance with enrollment or redetermination. In Los Angeles, the local First 5 Commission funded Nexcare Collaborative, a widely advertised phone-based program providing information on a range of child health and welfare issues including health care.

But are programs using toll-free lines effective? A broad assessment does show that people do call these numbers in response to specific media appeals. As previously described, calls to toll-free numbers increased significantly after RWJ-sponsored media campaigns were deployed in 11 markets of the Covering Kids Campaign. Both the HCAs and the Nexcare has linked their program with local media outlets that resulted in numerous calls after the segments were aired. During the demonstration period, the HCA received more than 16,000 calls from uninsured individuals who wanted information or assistance in applying for health coverage. We know that about 2,600 children (13% of all first year Los Angeles Healthy Kids applications) were linked to Nexcare (Exhibit 5). The Health Consumer Centers worked with more than 4,000 individuals whose cases had been terminated, or whose applications had been denied or delayed. More than half of these cases were eventually resolved either completely or partially to the satisfaction of the consumer.⁵⁶

To complete the enrollment process, however, requires sufficient motivation and skills on the part of the family to follow through with the next steps to begin and complete the enrollment process. But it also provides a support system that can assist the family. Systems for follow up are quite varied. Some programs provide callers with basic information about health programs and refer eligible and interested individuals to appropriate agencies for enrollment assistance. Others assess eligibility on the phone before making a referral. Some have their own staffs that assist callers with their applications usually connecting them to electronic application program like One-e-App or Health-e-App.

Toll-free numbers have the advantage of simplicity but require costs in advertising and promotion of the number so that it can become widely disseminated.⁵⁷ Setting up separate programs may be a more expensive alternative to adding health modules to existing programs. For example, existing hotlines such as Infoline in Los Angeles have been in operation for more than 20 years and the marginal cost of adding health modules to Infoline is undoubtedly lower than setting up a dedicated program.

But broader programs such as Infoline cannot provide assistance directly. Rather they can only refer families to another agency for enrollment assistance. The Nexcare and HCAs have counselors that can provide assistance by making follow-up calls to interested families to begin and complete the enrollment process and troubleshoot difficult cases.

Still, little is known about how toll-free lines are most effectively used and an enrollment strategy. Are these more simple approaches best used for the most motivated and simple of cases? Are dedicated health programs that market their toll-free numbers better than those that add health insurance resources to existing programs that offer a broader range of services or information resources? What is the best way to provide support and follow-up for those that call? What are the costs of these approaches? Is it better to refer clients to an agency for follow-up or to provide support services directly? If assisting an individual or family, how many calls are required to secure a successful enrollment? What happens to those individuals who have more complicated case?

While we do not know the answers to these questions, toll-free telephone systems are nevertheless challenging to organize and manage. Calls do not come in to the centers at a consistent rate and call volume increases after targeted marketing efforts. Thus it requires a staff large enough to accommodate volume fluctuation. In addition, they are challenging when targeting multicultural communities that require multiple languages and referral resources that are appropriate to the language and culture of the caller. These increase the cost of operating the hotline systems. These phone systems require ongoing monitoring of customer satisfaction to ensure that information given to families is accurate, and communicated correctly to the caller. Saunders reported the overall quality of interactions on the phone improved over time but that deploying operators in some languages were less consistent than others in providing accurate information to the caller.⁵⁸

In summary, toll-free numbers show some promise as an outreach and enrollment strategy; however, the wide variety of system designs and activities, ways in which they marketed and support systems for responding to inquiries make any general conclusion about this strategy difficult to draw. More rigorously designed studies that can tie program design to outcomes is clearly needed to understand the efficacy of this approach to outreach and enrollment.

IN-REACH: PROVIDER-BASED ASSISTANCE

Several clinics, health centers and physicians' offices use application assisters to identify uninsured families among their patients. For the most part, in-reach strategies are enormously effective in identifying those who are already active health consumers. They, in fact, may be the most ready to help enroll in a health program. Using assisters at clinic sites is akin to the practice of out-stationing Medi-Cal eligibility client workers at clinics and hospitals.⁵⁹ In New York Americorps volunteers, assigned to staff an information table in the waiting area of a treatment center in Utica, assisted patients in the waiting room with Medicaid applications and answering questions. Similar strategies have been successfully employed in Boston⁶⁰ and in clinics throughout California.⁶¹ Provider sites represent a significantly large source of new applications. In Los Angeles, more than 40 percent of all L.A. Healthy Kids applications came from health care providers, more than twice the number that came from CBOs (Exhibit 5). Interviews with CHIs confirm that provider-based enrollment strategies are among the most effective way of reaching uninsured families. Since many uninsured families tend to seek health services from community clinics, many counties have enhanced their outreach and enrollment in these settings. Many CHI counties have increased the number of CAAs located in these clinics, or have strengthened linkages between the clinics and local enrollment centers. For example, in San Mateo County, one CAA is stationed in every free clinic in the county.

Health care providers may have seen the value in enrolling children into health programs, particularly Medi-Cal (thus improving their potential for reimbursement) and thus justifying the use of their own funds to support outreach and enrollment after losing state contracts. In some cases, the outreach and enrollment costs were included as a part of the clinics' overall cost structure and partially reimbursed to the clinics through the federal and state FQHC program.

EMPLOYERS

Some projects have been funded statewide to focus outreach on employers to expand awareness of public programs. Indeed, the concentration of uninsured among employees of small companies makes focusing on employers a reasonable approach to identify and enroll children. However, the results suggest that the effects are not strong. One project, the San Diego Business Health Care Connection (BHC) markets health insurance broadly to employers through newsletters, partnerships with chambers of commerce and business improvement districts, and by making presentations at business meetings and conferences. Nearly 10,000 businesses were reached by the BHC and its partner organizations.⁶² Employers, who were initially contacted through outreach and expressed an interest in health coverage, were then called for one-on-one appointments for in depth education; and then, if interested, a referral is made to a broker for private insurance or to a certified assister for Healthy Families or Medi-Cal. An evaluation of the BHC during its demonstration period did not show the model to be a successful strategy for enrollment: Fewer than 15 businesses either switched or purchased a plan and only two had taken advantage of public programs.⁶³

Businesses have been the focus of outreach and enrollment projects throughout California, although with only limited success. The Los Angeles-based Worksite Wellness program deploys outreach workers to businesses where they give talks to workers during lunch and coffee breaks. Appointments are made for the workers to come into the office and begin the application process. One interesting component to the program involves a partnership with one company who helps support the program financially and uses it to assist their employees obtain coverage for their children. But how many of these contacts have resulted in an enrollment? The latter project does suggest that a carefully designed employer strategy might be helpful in reaching more difficult populations. However, entering the workplace is a costly enterprise requiring substantial trust between the CBO, the employer and the employee. The costs may be relative to other ways to reach the same population.

INCENTIVE PAYMENT TO ASSISTERS

Paying assisters and incentive fee has been proposed to return as a strategy for funding outreach and enrollment. The state's experience with the \$50 incentive fee has not been well-studied. Questions remain about what key elements of outreach and enrollment would be lost if the financing for outreach and enrollment converted to this form of payment. The fee, while simple to administer and track, may not find its way to those organizations and individuals who are assisting the most difficult, vulnerable and hardest-to-reach cases. The fee might produce some benefit among insurance brokers who might see it as an incentive to market these programs to employers and employees. However, in conducting interviews among brokers in San Diego as part of the Business Health Care Connection evaluation, the \$50 provided little of any incentive to market public programs to employers. Those brokers who did promote these programs did it as a courtesy and charitable effort to build good will among his or her clients; many continued the practice (albeit small) even after the \$50 incentive payment was terminated.

MULTIFACETED STRATEGIES

Although we discuss these projects as independent strategies, applying a multipronged approach is warranted given the diversity of the population. The California Kids program adopted several outreach strategies and no one strategy stood out as particularly effective in identifying enrollees including word of mouth, flyers and similar techniques.⁶⁴ A study of the Boston Medical Center's (BMC) HealthNet Pilot project similarly used many methods including mailings, advertisements through radio, television and billboards and a toll-free number. The multifaceted outreach effort was so successful that BMC no longer had an outreach and enrollment problem; the main challenge became one of providing needed services to meet the increased demand.⁶⁵

Developing networks and partnerships

Many agencies developed some type of networks that enabled them to approach outreach and enrollment collaboratively.⁶⁶ Typically, CBOs work closely with schools, WIC, clinics, churches and even employers to enroll children in various programs. Larger networks have formed as a way to disseminate outreach materials and information about programs. In San Bernardino and Riverside counties, the Healthy Kids Information Network was started to educate the community about the Healthy Kids program and as many as 50 organizations attend these meetings including school districts, faith-based organizations, clinics and CBOs. Similar strategies have been found in Los Angeles, Alameda, San Mateo and Santa Clara. In general, networking improves the coordination of outreach and enrollment activities, enables projects to share best practices and common problems, learn updates on programs, policies, funding opportunities and challenges. While networking is an important part of the outreach and enrollment quilt, every effort should be made to make networking efficient by collapsing coalitions where more than one exists, using technology to maximize participation and disseminate information, and have a way to communicate between meetings.

Addressing policy and program barriers

So far we have discussed approaches that assist children and their parents navigate the complex enrollment system. These relatively active interventions are costly and many are designed to help families overcome administrative obstacles to enrollment and retention. Another solution is to simplify the process by removing unnecessary and burdensome steps in the enrollment or re-enrollment process. Advocates have considered how to simplify the process by linking health program enrollment to other programs. The no wrong door concept is designed to send applications to a single location, but linked to multiple sites, services and programs. Linked gateways have been established through the Express Lane Eligibility program, the CHDP gateway and food stamps. The state's single-point-of-entry ostensibly reduces the steps for enrolling for individuals applying through the mail for one program but who eligible for another. Most county-based Healthy Kids programs require substantial screening of individual to ensure an application is submitted to the correct agency thus reducing denials and enrollment delays. Removing administrative obstacles is likely to increase the efficiency and productivity of the outreach and enrollment system by decreasing or even eliminating much of the trouble shooting that CAAs engage in to secure enrollment or re-enrollment in a health program.

The Health Consumer Alliance of health consumer centers provides one model for systems change and simplification. The programs not only provide direct services but also track problems that consumers are confronted with through a data and information system. The agencies are staffed with policy experts who collectively discuss cases and identify the underlying structural problem that may be keeping many families out of the system. In response, they work with local and state program to solve these problems. Because structural obstacles affect so many more than the individual who calls with a problem or complaint, the HCA is a potentially cost-effective approach to solving many of the structural problems that low-income families face.

Program monitoring, evaluation and finance

Data. A key element to many outreach and enrollment programs is a system of collecting and disseminating data. Data systems are important because they allow managers, policymakers, funders and others to systematically gauge progress in achieving goals and objectives. The Children’s Health Outreach Initiatives (CHOI) database system in Los Angeles is used by the county’s 15 outreach and enrollment contractors and their sub-contractors, and projects funded by The California Endowment to track their outreach and enrollment activities related to the local CHI. The CHOI system provides a way to gauge inputs (number and types of outreach encounters, number of contacts in assisting in the enrollment process) as well as outcomes (number of applications and enrollments). Linking the data system with a case management protocol provides a way to promote systematic interaction with client families but also collect data on the encounters. The system collects data on problems that families encounter in the application process but also after enrollment in trying to use health care services. Other local children’s health initiatives are also using data systems but it is not clear how many or how comparable these systems are across data elements.

EXHIBIT 7. Funding options for outreach and enrollment in California

Funding Type	Type of Agency Using This Form of Payment
Medi-Cal administrative activities	School districts, community clinics
Medi-Cal reimbursement through FQHC	Community clinics
Local grants and contracts (county or First 5)	Clinics, CBOs, school districts
Foundation grants and contracts	Clinics, CBOs, school districts
CAA Fees	None
Private company subsidies	CBOs

Financing. Funding outreach and enrollment activities fall into four broad categories. They include government and private contracts with community organizations and schools, reimbursement and cost-recovery programs, and through government-sponsored incentive payments to certified assisters based on successful applications (Exhibit 7). Cost-recovery strategies fall within two general mechanisms: Medi-Cal Administrative Activities funding (MAA) and cost-based reimbursement under the Federally Qualified Health Center (FQHC) program. MAA funding is used by school districts and some public health organizations. Under the program, 50 percent of the costs of administering the Medi-Cal program can be claimed by qualified recipients with the other 50 percent coming from other governmental sources. Generally, any activities that support the identification and enrollment of children into Medi-Cal program can be included as a MAA expense. School districts generally undergo a time study to log claimable activities. Not all districts participate in the MAA program because of the long lag time (as much as 18 months) in receiving reimbursement or because they have not done the time studies. FQHC funding is another possible way to recover costs. Under this model, CAA costs are included in a claim in the overall costs of providing care to Medi-Cal patients. A few clinics reported in previous scans of outreach and enrollment activities that they were attempting to recover their CAA costs through this mechanism. However, it is not clear how many clinics and health centers take advantage of this approach. Moreover, the state's capping of FQHC reimbursement through the Prospective Payment System may have reduced the financial incentive to include these costs.

IMPROVING OUR UNDERSTANDING OUTREACH AND ENROLLMENT

There are challenges in designing well-controlled studies of the effectiveness of outreach and enrollment strategies. Like other studies of social innovation and social marketing, most designs will be unable to meet many of the criteria for understanding causality and achieving internal, external and measurement validity. Studying any social marketing approach that has multifaceted strategies is difficult for investigators who may have little or no control over messages and thus making it difficult to isolate an individual effect of a particular strategy from other or confounding factors.⁶⁷

Experimental studies. Experimental designs or case control studies are particularly challenging since random assignment to one intervention over another is nearly impossible and there is little control over what messages an experimental or control group is likely to be exposed to in most communities. Most outreach and enrollment projects will require a quasi-experimental approach because investigators will have little or control over who is exposed to the intervention. Quasi-experimental designs including time series studies, a non-equivalent control group or other approaches. They are more appropriate and have a long track record as an evaluation strategy for social programs.⁶⁸ Still, the designs require at least a thorough understanding of the variables used in the intervention, and a systematic approach to the development of a comparison group that minimize, although not entirely eliminates, threats to validity and reliability. Another issue is that experimental and quasi experimental designs are best implemented when assessing relatively stable programs in which the intervention or the population is not changing. But many of these strategies are new and thus subject to change.

Effectiveness and benefits of outreach and enrollment. Cost effectiveness studies require breaking out the various components of outreach and enrollment activities and linking them to costs and outcomes. These studies have often been implemented for evaluating social marketing interventions. Funders are particularly interested in cost effectiveness because they want the most value for their investment. In its simplest form, these studies assume that all of the costs of a program can be measured, not just the investment by a funder. Once costs are understood, they are connected to outputs or outcomes. In the case of outreach and enrollment projects, outcomes could include total number of applications submitted, or enrollments or re-enrollments. A ratio is then calculated with outcomes expressed as a numerator divided by dollars spent, or as a ratio of cost per outcome unit. Cost effective studies are important and should be considered as one way of comparing one strategy over another. However, understanding total costs is also challenging since many programs use grants from multiple sources and have indirect costs that differ among organizations but should be included in the cost calculations. Cost-benefit studies place a dollar value on both inputs and outcomes. It provides some information about the overall cost savings or social benefit accrued from an investment. Cost benefit studies are important, but they are challenging when trying to assign a dollar value to outcomes. In addition, it has to be clear to whom a value accrues. Providing health insurance to children may afford value to the family, but increase the cost to government agencies that are responsible for the premiums.⁶⁹

The following will provide some better approaches to studying outreach and enrollment efforts:

1. Developing a standardized data collection system across the counties that link an outreach contact of an individual through the process of enrollment, re-enrollment and utilization for all programs.
2. Institute targeted outreach and enrollment projects in different communities based on similar, if not identical, outreach strategies. This would allow some comparisons of the impact of similar strategies but in different locations.
3. Conduct selective time studies to track activities and costs of the outreach and enrollment process, an estimated dollar figure for each activity and outcomes (applications submitted or enrollments). This would provide one way of assessing the costs of various types of outreach relative to specific outcomes (applications, enrollment and re-enrollments).
4. Conduct retrospective studies of individuals enrolled in programs. This can be done by drawing samples of children enrolled in a program within a time frame that would cover their experiences in outreach, enrollment, re-enrollment and use of health care services.
5. Conduct analysis of enrollment data from MRMIB and L.A. Care and other health plans that track enrollment and re-enrollments, by assisters.
6. Conduct follow-up surveys of individuals enrolled in a health plan.
7. Conduct a prospective study of individuals contacted during outreach events and follow these individuals at various stages in the enrollment process.

Conclusions and Summary

Since 1997, a large and diverse set of organizations, networks, programs and policies has been evolved for the purpose of finding uninsured children and helping them enroll and stay enrolled in health insurance. These organizations have developed a complex and innovative set of outreach strategies ranging from broad media-based projects to door-to-door campaigns. This review of nearly 60 articles and reports however reveals that most outreach and enrollment efforts have been studied using process evaluations that do not adequately link strategy types to outcomes.

Early in a campaign to expand enrollment, broad media campaigns combined with toll-free hotlines are likely to yield large volumes of responses. Provider-based strategies also provide an effective and high yield way to identify and enroll many individuals especially those who are already using the health care system. For new users, school-based programs are also likely to be an effective way of reaching out to families, but to facilitate enrollment requires an effective case management and follow-up system to assist families enroll in a health program. As enrollment increases in a community, harder to reach families and those who are less knowledgeable and more concerned about immigration and other issues will require more one-on-one assistance. Community-based strategies—particularly those that use community health workers, and partnerships involving schools and other social service agencies—are part of the puzzle that needs to be assembled and supported to be able to respond to the diverse populations of families in need. Attending health fairs, making presentations at meetings and events, linking with child care and food assistance programs generate many contacts but it is not clear whether they are effective strategies for enrolling individuals. Technology may provides new ways of outreach and enrollment that are cost effective.

We also conclude that relying on only one strategy is unlikely to succeed given the diversity of the uninsured population both geographically and socio-demographically, and differences in the capacity of communities to respond to outreach materials or information about health programs. There are also many variations in communities' knowledge of and experiences with the health care system in the U.S., particularly public programs, and the resources that they have to begin and complete the enrollment process. Moreover, the strategies may change over time as market penetration increases.

In spite of these general trends, we conclude that there are not enough data to clearly paint a picture of effectiveness based on linking outreach strategies with enrollments, health care utilization or other outcomes. What is clearly missing is a concerted effort to place outreach and enrollment projects into a systematic data collection framework that allows us to understand the value of one strategy over another; how effectiveness is changing over time; or comparing a strategy in different communities and particularly for different population groups.

Recommendations

Based on our assessment, there are some things that can be done to improve the outreach and enrollment delivery system.

1. Funding for outreach, enrollment, retention and utilization should be distributed so as to support a range of strategies. Outreach strategies should be as comprehensive as possible, but designed based on evidence of success and cost-effectiveness.
2. Both broad and local media strategies should be backed up with case management and support systems that allow families to easily link into the enrollment assistance program. Market research should be used for constructing and targeting messages.
3. In-reach or provider-based strategies should be expanded because they are likely to yield large number of applications and enrollments. Provider-based strategies can also facilitate retention and utilization because of the relationship that potentially could be built between the health provider and the enrolled child. However, provider-based strategies should be as neutral as possible, encouraging families to apply while not excluding those who do not choose the clinic as their primary health care provider.
4. Health Consumer Centers should be supported to provide backup to the outreach and enrollment networks and assist agencies and CAAs for difficult cases. HCCs are also able to help address the policy and systemic sources of the problem.
5. Statewide outreach and enrollment data systems with comparable data fields and collection protocols are important and should be developed and used by all projects for the purposes of management and program evaluation and monitoring.
6. Outreach materials should be fully available in languages other than English that are common among the targeted uninsured. Marketing efforts may be most effective if tailored in culturally appropriate ways (e.g., reflecting images of the targeted populations, obtaining community support from critical community organizations and marketing in the most frequented settings).
7. Outreach strategies should minimize reference to public nature of any programs and rather promote local aspects of a program (e.g., county or regional Children's Health Initiatives).
8. New outreach strategies should be considered that focus on specific vulnerable populations such as homeless and rural families. New strategies for enrollment and retention should be pursued that provide additional personal contact with families to encourage on-time payment of these premiums, use of services, and maintaining this contact throughout the year so that if families move, they may be able to better update their contact information.
9. Expand the use of technology for outreach, enrollment and re-enrollment strategies.

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