CHILDREN'S HEALTH INSURANCE OUTREACH

# what works?

Arizona Governor Janet Napolitano has stated a goal of increasing the number of children with health insurance coverage by conducting more public outreach for the state's KidsCare and AHCCCS health programs.

The goal is laudable, and we support it. All Arizonans – and especially children – should have health insurance coverage and access to affordable, high quality care.

But what do we mean by *outreach*? What strategies are most effective? If additional resources were made available, how could they best be used?

St. Luke's Health Initiatives (SLHI) has been involved with children's outreach efforts for a number of years, and we've learned a few things that might be helpful to others. In this condensed overview, we draw on both national and Arizona experiences with health insurance outreach efforts targeting children: what works, what doesn't, and what strategies we all might profitably pursue in the future to ensure that our children get the care they need and deserve.

## BACKGROUND

Uninsured children are more likely to be in fair or poor health than their insured counterparts. To no great surprise, they have less access to health care, are less likely to have a regular source of primary care, and use both medical and dental care less often.[1]

Public policies have addressed comprehensive and affordable coverage for children for over forty years:

- Medicaid began providing coverage for children living in very low-income families, primarily those receiving federal cash assistance, in 1966. Over time, Medicaid eligibility income thresholds increased to include low-income, working families.
- Arizona began its Medicaid program in 1982 with an innovative plan called the Arizona Health Care Cost Containment System (AHCCCS).
- In 1998, the State Children's Health Insurance Program (SCHIP) expanded public coverage options to families with incomes up to 200% of poverty and beyond. Nationally, this change extended coverage for almost 4 million children, reducing the proportion of uninsured children from 15.4% to 11.4%.[2]
- In Arizona, the implementation of KidsCare (Arizona's SCHIP Program) resulted in making approximately 330,000 children eligible for either KidsCare or AHCCCS.[3]

Starting with the early days of SCHIP, there was a clear recognition that *outreach efforts* were needed to educate and assist eligible families about the benefits of enrollment. States used a wide variety of strategies supported by a combination of federal, state, and philanthropic dollars:

- Initially, $500 million in Medicaid funds were allocated to outreach. In FY 2000, Congress increased states' flexibility in the use of SCHIP funds outreach. It allowed states to spend 3% of program expenditures on outreach efforts on top of the 10% cap on overall administrative spending.
- In Arizona, public funding for outreach was invested in an initial public education campaign that included posters, brochures, participation in health fairs and some electronic media placements. In 2002, a year of funding support was invested in piloting a universal application, including outreach that resulted in efforts through most community health centers and a number of other community based organizations. Other than this, no public funds were directed to outreach in Arizona.
- There was significant commitment in the private sector, nationally and locally, to complement public efforts. In 1997, the Robert Wood Johnson Foundation (RWJ) established the *Covering Kids Initiative (CKI)* and expanded it in 2002 to *Covering Kids and Families*. RWJ has invested over $150 million toward the goal of enrolling more eligible children into Medicaid and SCHIP through outreach, enrollment simplification and health insurance program coordination strategies. The initiative was funded in all 50 states and more than 170 communities nationwide.[4]
- Local foundations in many states funded outreach efforts. In Arizona, SLHI partnered with Children's Action Alliance, the *Covering Kids Initiative* grantee, to fund 11 community-based efforts between 1999 and 2001.

## STRATEGIES

Outreach is a continuum of intensity that begins with educating families on the availability of health insurance and ends with providing direct assistance in completing the application forms. Past strategies, their implementation and resulting effects provide lessons for the next generation of outreach.

### Public Education Marketing Campaigns

A media campaign to educate and inform the public about the availability of programs and services is a typical first step in most public health efforts. The introduction of SCHIP (KidsCare) in Arizona was no different. A national, publicly funded campaign called "Insure Kids Now" included a toll-free hotline that connected parents to their own state's program, a national media campaign promoting the number, and a special web site that provided local links.

The Robert Wood Johnson Foundation continues to partner with local organizations to sponsor the annual "Covering the Uninsured Week" to create awareness at a national and local level.

States and even counties or local municipalities have used the media to advertise the availability of both Medicaid and SCHIP programs. These have included direct paid advertising as well as articles in local newspapers, flyers with contact phone numbers, etc. In Arizona, introducing the KidsCare logo and "brand identification" were part of the initial public education campaign. More recently Children's Action Alliance created the Covering Arizona Kids Campaign. Among other activities it included radio and television ads that announced a toll-free number for families to call to request an application for KidsCare/AHCCCS.

Public education/marketing efforts appear to be most effective when:

- Collateral materials are developed at a national or state level and disseminated at multiple levels (national, state, local).
- Combined with other strategies, e.g., combining an electronic campaign with local press releases and a Back to School Enrollment effort.[5]

### Direct Contact with Families

These are more community-based efforts that use a variety of means to contact families directly. Some are information only, and some actually assist families with the application process. Typical examples include:

- **Event-type community model.** This popular approach uses vehicles such as health fairs, swap meets, booths at fairs, etc. to educate families about the availability of affordable health insurance. Activities are typically limited to passing out informational flyers with a toll-free number. They tend to be episodic, and participants are random. There is little opportunity for follow-up or direct intervention. Generally, evaluators do not find a direct correlation between this tactic and increased coverage.

  There are some surprising exceptions to this, however, that were discovered through Arizona's outreach efforts.[6] The Phoenix Swap Meet proved to be an excellent site for educating families about KidsCare and assisting them with the eligibility/enrollment process. Kids' rodeos in northern Arizona had similar success. The key seemed to be that these were regularly scheduled activities attended by the same group. Families might learn about the program one week and bring their paperwork the next. Also, it is necessary for the "enrollers" to have all the tools required to complete the process (scanners, applications, etc.).

- **School, businesses and other community organization model.** This approach uses schools, churches, businesses and other community organizations where there is a consistent population that receives program information through flyers and presentations. These approaches build on the reputation of an established community organization, and make intuitive sense.

  Such programs, however, have had varying degrees of success, both in Arizona and other states. Problems differ based on the site. In the case of schools, programs face an amazing amount of bureaucracy and the issue of the backpack. While schools are seen as the place "where the kids are," information disseminated from there often disappears into a "black hole," a.k.a. the child's backpack, and is usually never seen again. In the case of businesses and church sites, there were also logistical difficulties. Businesses and faith communities recognized the importance of health coverage, but outreach was not perceived as core to their mission or bottom line. In addition, the stigma attached to applying for public programs continues to be a barrier.

  These sites do have the advantage of being "trusted institutions" in the community. Efforts are most effective when there is a champion on site who can work through the logistical and bureaucratic barriers inherent in many of these organizations, or when it is coordinated with other enrollment activities. In schools, class registration and enrollment in the free and reduced lunch program are good opportunities. In a work context, regular insurance enrollment would be a better time for employees to be educated about public options (as long as they are not presented as an opportunity to drop the employer's family coverage).

- **Health provider model.** This is an opportunistic approach, where parents are informed of the program at the time the child is being seen by a health care provider. The advantage is the immediate relationship between care and coverage. The disadvantage is that parents do not generally carry the financial information needed to complete the application process to a health care visit, so follow-up tactics are needed to make this approach work. Further, the provider must have the infrastructure to support the eligibility and enrollment process. As a result, this works best in clinic or large practice settings.

- **Personal contact model.** In this approach, staff of community-based organizations – sometimes called promotoras or community health workers – intentionally seek out families to educate and assist them. Its effectiveness pivots on trust between the outreach worker and individual families. It is further enhanced when adapted to the language and culture of the specific community, with the outreach worker providing assistance and support through the eligibility process and helping the family connect with a primary care provider. This approach is particularly effective with hard-to-reach populations. Many families have had negative experience with the "system" or may be intimidated by it. This model helps bridge that gap. It is the most time intensive and – in the short term at least – most expensive model.

The *Congressionally Mandated Evaluation of the State Children's Health Insurance Program*[7] reported that most states, including Arizona, developed some type of media campaign to promote general awareness about the availability of public programs as well as one or two other approaches. Outreach through schools and face-to-face local contact were the most frequently cited. The local efforts most likely included outreach at community and school events and presentations to community groups.

## LESSONS LEARNED

***Did these efforts result in more children with coverage?*** Absolutely! SCHIP covered 6 million low-income children in 2005 (about 4 million at any point in time), and Medicaid covered 28 million. The number of children without coverage decreased from 15.4% 1998 to 11.2% in 2002. However, progress is stalled and may even be deteriorating nationally as well as in Arizona. In both raw number and percentage terms, the proportion of children without coverage has not changed in the past four years.[8,9] Currently, approximately 250,000 children in Arizona lack health insurance. It is estimated that somewhere between 40% and 60% of these children are eligible for existing public programs.[10]

***What happened?*** First, almost all states had significant budget constraints in 2002 and 2003. As a result, state funding for outreach activities was eliminated or significantly cut. Second, the efforts that were implemented from 2002-2006 generally were those that were the least costly, but arguably the least effective – brochures, posters, etc. We are well past the point of harvesting the "low hanging fruit." At best, these efforts maintain the status quo.

During this same period, a number of evaluation efforts took place on a national level. These included the evaluations of RWJ's "Covering Kids and Families," the Los Angeles Healthy Kids Program, Santa Clara County Children's Health Initiative, the evaluation of SCHIP required by Congress, and the Three-Year Evaluation of the KidsCare Outreach Projects in Arizona. While all of these lack a measure of definitive quantitative "proof" of the effectiveness of various approaches, the consistency in qualitative conclusions across this body of work supports a number of lessons learned:

### Enlist Trusted Messengers

Known and trusted community based organizations (CBOs) are most likely to be successful in helping parents understand the importance of health insurance, and moderate any concerns about applying for a government program. Trust is of particular importance for communities of color. CBOs are the most likely to have established that trust and can develop linguistic and culturally appropriate approaches.

### Location, Location, Location

A number of evaluations conclude that outreach efforts linked to a health care provider agency are effective in both enrolling children in the insurance program and creating a medical home. Health coverage has high relevance for both the parent and the provider in this context. It is in the best interest of both to establish a source of coverage.

### Hands-on Follow-Through Matters

Virtually everyone needs assistance to understand health insurance coverage and the enrollment process. Those with employer-based coverage have a human resource staff; those with public insurance frequently do not have a similar resource. Application assistance has proven itself to be successful in keeping enrollment on track, whether it is provided by trained staff in CBOs or clinics, or by out-stationed eligibility workers. Overwhelmingly, parents find the assistance helpful. One study found that there was a 28% higher rate of enrollment when there was application assistance in the community compared to another community without assistance.[11]

## Support and Family Advocacy Reconnects Families to the Health Care System

Personal contact with families is important on a number of fronts. Trust is built through outreach workers (case manager, promotora, etc.) establishing new relationships with local families. Direct assistance is provided in helping parents gather materials, understand the process and complete the application. Troubleshooting is also enhanced as outreach workers become intermediaries with the eligibility agency. A randomized, controlled trial among uninsured Latino children found that families that received community-based case management were substantially more likely to obtain health insurance coverage when compared with children whose families did not receive this type of assistance (96% vs. 57%).[12]

## Coalitions are Important

The involvement of local coalitions in the planning of outreach efforts, sharing of resources and materials, and solving of problems is important to the efficacy of organizational efforts. It prevents "turf battles" from developing, maximizes resources by reducing duplication and targeting efforts, and ensures power in numbers for the staffing of events and large activities. Coalitions have the potential to assist state agencies in identifying barriers in the eligibility/enrollment process.

### LESSONS LEARNED

A number of evaluation efforts support several lessons learned:

- Enlist Trusted Messengers
- Location, Location, Location
- Hands-on Follow Through Matters
- Support and Family Advocacy Reconnects Families to the Health Care System
- Coalitions are Important

## KEY ELEMENTS IN AN EFFECTIVE OUTREACH STRATEGY

Ian Hill, Senior Researcher at the Urban Institute, identified three key criteria for an effective outreach strategy:[13]

1. **It is community-based.** While it may be augmented by a media effort, it must be embedded in the community.
2. **A Health or social service CBO leads the effort.** That organization can and should partner with other community organizations or institutions such as schools, churches or businesses.
3. **Application assistance and follow-up is a must.** It isn't sufficient to provide information and education only.

Our children can and should have access to high quality health care that is reasonably available, affordable and culturally appropriate. Arizona's outreach programs need to embrace lessons from past efforts, because coverage is integral to that goal. The available evidence reveals that what is most cost-effective is – as is often the case – not necessarily what is initially "budget-efficient" or convenient to implement in the short term.

Long term, however, the message is clear: involving communities and tapping into their institutional and cultural assets will make the best of any investment. Implementing a less well conceived program would be a cop out.

### REIMBURSEMENT STRATEGIES

Reimbursement drives how the work is done. While virtually everyone agrees that one-on-one assistance is fundamental to any outreach effort, there is some controversy as to which reimbursement mechanism is the most successful.

- One approach is to compensate an outreach worker based on a "finders fee" for each completed application.
- Another approach is to grant or contract with a community based organization to implement an outreach program that includes education, one-on-one assistance and follow-up from a consistent outreach worker.

Which is more cost-effective? Efforts that measure activity (such as the number of completed applications) may consider the first approach to be the answer. However, given that the ultimate goal is increasing access to care, the second approach is clearly more effective. Here, the outreach worker's job is not complete when the application is submitted. There is clear incentive to help the family navigate through the system and connect them with care.

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***Our Mission***

*To improve the health of people and their communities in Arizona, with an emphasis on helping people in need and building the capacity of communities to help themselves.*

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