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Use of Outreach and Enrollment Strategies in California

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RESEARCH AT A GLANCE

Overview

Local entities organized at the county level in California have invested considerable resources into identifying and enrolling eligible families in public health insurance programs (Medi-Cal, SCHIP and Healthy Kids). This paper documents the outreach and enrollment strategies adopted by various counties in the state and investigates how counties organize these strategies. Through interviews with Children's Health Initiative (CHI) staff, 10 types of outreach and enrollment strategies were identified – six non-technology based approaches and four technology based approaches. The research also charts how those strategies differed over time.

Findings Include:

Counties have been creative in their approach. Although funding for these programs has been unstable, counties have been creative in piecing together a set of strategies that provide a comprehensive approach to outreach and enrollment. The deployment, however, has not been consistent over time.

County differences dictate their approach. Counties' population, geographical size, ethnicity, and income levels determined the approach that local entities followed to reaching out and enrolling eligible uninsured families. Many outreach and enrollment strategies and technological tools were utilized.

Counties attribute success to community-based outreach. Most counties qualitatively attributed their success with identifying and enrolling eligible uninsured children to their relationships with community-based organizations and the use of trusted, on-the-ground community health workers.

INTRODUCTION

California faces significant problems in identifying low-income families eligible for public programs, enrolling them and keeping them enrolled. The need for finding effective strategies will become even greater if state health reform is implemented and includes a significant expansion of public programs. Yet enrolling children in public programs is a complex process requiring families to navigate programs with varying income eligibility criteria, co-payments, periods of eligibility, benefits, and providers.

To assist families with enrollment, state and county governments and several foundations have supported innovative strategies for identifying uninsured individuals and helping them navigate the process of enrollment and re-enrollment, and even establish links with health care providers. These involve the media, certified assistors, participation in health fairs, in-reach with service providers, school based strategies, pre-populated re-enrollment forms, community health workers, the use of waiting lists, and a variety of technology-based strategies (See Table 1, p. 3).

While considerable investment in outreach and enrollment has been made over the past decade, little evidence exists regarding the effectiveness of various strategies. This study seeks to fill the gap by examining these strategies, particularly those that are technology-based, in relation to public insurance program enrollments. A critical question is which of these various strategies, if any, are effective at facilitating enrollment and retention of children in various public insurance programs? Do these approaches work in synchrony to reach families more effectively, or does their overlap add another layer of complexity to the system?

To answer this question, we documented which outreach/enrollment strategies have been adopted in California counties. This first report outlines the breadth of outreach and enrollment strategies employed county wide. We answer one critical question: How are counties organizing strategies for both identifying and enrolling uninsured children into public health insurance programs? In subsequent reports we will determine if variations in the deployment of these strategies affect enrollment and retention in Medi-Cal, Healthy Families, and Healthy Kids and how, specifically, the introduction of technology-based systems (One-E-App, etc.) affect enrollment and retention in these programs.

PUBLIC HEALTH INSURANCE PROGRAMS IN CALIFORNIA

There are three main public health insurance programs for children in low-income families in California: Medi-Cal (Medicaid), Healthy Families (SCHIP) and Healthy Kids. Medi-Cal and Healthy Families programs are collectively available to children in families with incomes up to 250% FPL who are citizens or legal-residents. As of 2005, Medi-Cal covers 27% of all children (or 2.8 million) in California and Healthy Families covers an additional 6.5% (680,000 children). Nonetheless, about 7% of children (760,000) remain uninsured. Of these, about half are currently eligible for either Healthy Families or Medi-Cal.[i]

Many low-income children are not eligible for either Medi-Cal or Healthy Families due to undocumented immigration status. In response, many California counties have formed local Children's Health Initiatives (CHIs) that not only enroll eligible children in existing public programs but also offer new health insurance products known as Healthy Kids that provide coverage for low-income children ineligible for public programs. Healthy Kids programs (See Appendix 1) exist in 25 counties and provide coverage to more than 80,000 children using a mix of public and private funds.[ii]

METHODS

A. Study Sample

The study was limited to those counties that have CHIs (n=25) because these counties collectively account for more than 75% of the uninsured children in the state and have a large imperative for improving outreach and enrollment (See Appendix 1). Of these counties, 23 have participated in the study so far. The remaining CHIs have not yet participated either because they refused (n=1) or because their organization's leadership (n=1) is currently in transition.

The study focuses on outreach/enrollment strategies over an eight-year period from 2001 to mid-2008. The unit of analysis is a "county-quarter" (four quarters in a given year for each county), such that each county-quarter has a description of the outreach and enrollment strategies implemented. Thus, there are 736 points of observation for the study (23 counties x 8 years x 4 quarters/year).

B. Study Procedures

Data about outreach and enrollment strategies were collected from the individuals most knowledgeable about the strategies in each county, which in most cases, was a staff member of the CHI (usually a coordinator for outreach and enrollment) and a representative from the county public health or health care services department. Other agencies were represented as well, and most often included school districts and contracted outreach agencies.

The data were collected in two parts. First, selected individuals were sent a pre-interview worksheet to complete that asked basic questions about the use of strategies, general timelines, number of full-time employees, and technology-based strategies. This worksheet was accompanied by a form defining the various strategies under investigation (see Table 1, p. 3) and a copy of a questionnaire to be used during follow-up on-site interviews.

On-site group interviews were then conducted with all identified individuals by one of the investigators or the Project Manager. The interviews gathered detailed information about the strategies, including qualitative information about their design and application as well as their strengths and weaknesses.

[i] Stevens GD, Tsai K, Cousineau MR. *Tracking changes in children's health insurance coverage in California: 2001 to 2005.* Alhambra, CA: USC Center for Community Health Studies; July 3rd 2007.

[ii] Stevens GD, Cousineau MR, Arpawong TE, Rice K. *Functioning at the Brink: The Children's Health Initiatives Have Grown but May Not Survive.* Alhambra, CA: USC Center for Community Health Studies; August 2007.

In addition, respondents were guided through county-quarter specific ratings of the extent to which each strategy was utilized. For example, with regard to community health workers, the group was asked to estimate what proportion of all new enrollees were being reached through this strategy in each quarter. The following ordinal response options were provided: all, 75%, 50%, 25%, or none. In all cases, a group response was eventually obtained; if respondents had differing opinions, these were resolved through discussion. Nearly all interviews required follow-up exchanges to obtain information that could not be remembered at the time of the interviews.

C. Measures

Ten outreach/enrollment strategies were studied and are divided into two main categories: non-technology and technology based approaches. Six non-technology based approaches were assessed: 1) media campaigns, 2) community health workers (or Promotoras de Salud), 3) provider in-reach, 4) school-based strategies, 5) Express Lane Eligibility, and 6) matching public program eligibility. Four technology based approaches were assessed: 1) Health-E-App, 2) One-E-App, 3) county-developed data systems, and 4) pre-populated redetermination/renewal forms. Other strategies were assessed if suggested by respondents. This study also assessed whether a waitlist had been used if and when the Healthy Kids program had closed its enrollment, though this is not strictly an outreach strategy. If enrollment opened again, this would be a specific source for contacting families that are eligible (or likely eligible upon re-screening) for the program.

D. Analysis

For this report, data were summarized across all counties for each yearly quarter to produce counts of the number of counties that were engaged in any way with the use of a particular outreach/enrollment strategy at a given time. The results are shown in a set of line graphs that depict the growth in the use of 1) non-technology strategies', and 2) technology-based strategies. Because the results are descriptive, no statistical tests were employed. The analyses for this report do not specify the extent of utilization.

Table 1. Definitions of Studied Outreach/Enrollment Strategies

Term	Definition
Media Campaign	An outreach strategy that uses the media (e.g. internet, radio, newspaper/magazines, television, and billboards) as a way to disseminate a central message regarding a public health insurance program, changes in policy and program rules and guidelines, and/or health messages to promote awareness of the health insurance program.
Community Health Workers	Individuals from the target communities who are linguistically and culturally compatible with the target population and are trained in or knowledgeable about outreach and enrollment procedures. Community Health Workers (CHWS) are also known as "promotoras de salud", "health aids", "health advocates", "community workers", "peer leader", and "lay health adviser". Promotoras may also be Certified Application Assisters (CAAs) but are not required to be CAAs for purposes of this study.
Provider In-Reach	Any effort to approach clients who are already known by the agency or program; for example, patients in a clinic.
School Based Strategies	A collection of strategies that use school resources to identify and enroll children and families into health programs. They may include unique approaches such as expresslane enrollment, or may deploy other strategies (such as promotoras) in a school setting. They may be school-organized (such as using school counselors or teachers), or be based on partnerships with community based organizations.
Health-E-App	An interactive internet-based application used to simplify and expedite the enrollment process for Healthy Families and Medi-Cal coverage for children and pregnant women. The web-design allows the application, signature, and supporting documents to be transfered electronically from the local enrollment site through Single Point of Entry to the appropriate agency for final processing and eligibility determination.
One-E-App	Similar to the Health-e-App and provides online enrollment for a broader, more comprehensive range of health insurance and public health programs. The system is used in conjunction with community-based organizations and assisters who work with the family to complete the application. It is designed to eliminate the need for families to complete numerous applications for programs that require the provision of duplicate information to determine eligibility.
County Developed Data System	A system used by administrators and application assistors that is designed to track and document issues and/or activities pertaining to outreach, enrollment, retention and/or utilization.
Matching Public Programs	Analyzes, matches, or cross-references data sources with similar eligibility requirements to identify children that may be eligible for a particular public health insurance program. For example, emergency or limited scope Medi-Cal enrollment is cross-referenced with Healthy Kids enrollment to send Healthy Kids eligibility notifications to EMC children, not already enrolled in Healthy Kids.
Pre-Populated Redetermination or Renewal Forms	A form generated by the public health insurance program, county or state department, or outreach and enrollment agencies that contains patient demographic information and is designed to ease and minimize the administrative paperwork associated with renewing in a program.
Waiting List	A database/list of pre-screened, eligible clients that have expressed interest or willingness to apply to a program for which enrollment is currently closed or is no longer accepting applications. The list is intended to be a future reference to target enrollment.

RESULTS

Counties across California vary in their structural organization and funding for outreach and enrollment strategies. They also vary in when and how an organized approach to outreach and enrollment was launched. In some counties, outreach and enrollment assistance was established as far back as 1998, shortly after the Healthy Families program was implemented in California. In many cases, the establishment of a Children's Health Initiative (CHI) corresponded with the launch of new or expanded outreach and enrollment efforts. While CHIs are governed by a variety of agencies—a county Department of Public Health, health plan, community-based organization, or a combination of agencies—most CHIs formed coalitions that developed coordinated outreach and enrollment activities.

Non-Technology Based Approaches

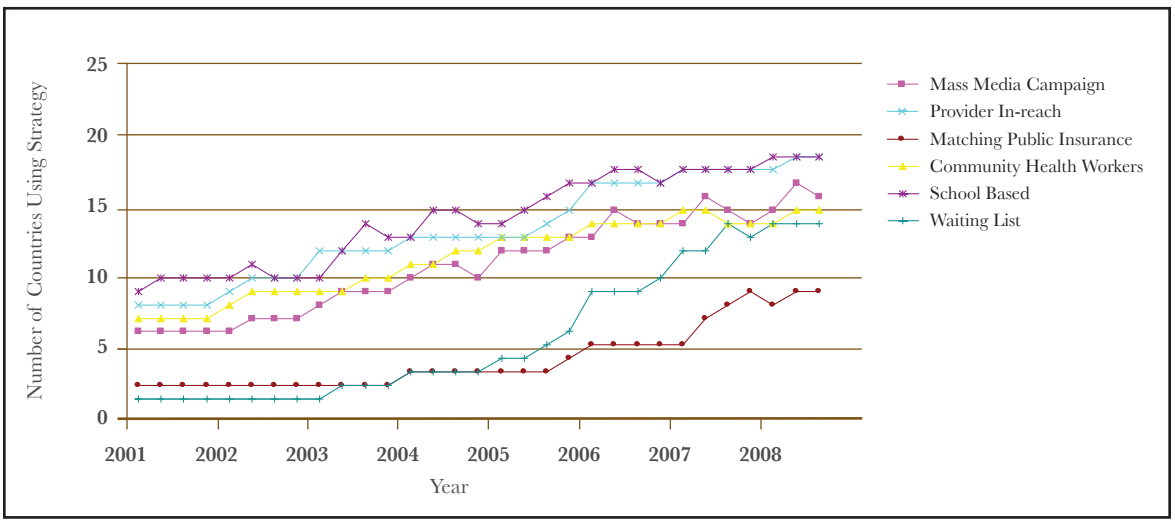
The breadth of outreach and enrollment strategies across California has increased dramatically over the past 10 years (see Exhibit 1). Counties are now using multiple strategies to identify and enroll eligible children into public health insurance programs and subsequently monitor their use of health care services. Prior to 2001 and the implementation of most CHIs, staff members at community agencies and clinics participated in the Certified Application Assistor (CAA) Program, in which individuals were trained and certified to complete the Healthy Families application. Organizations (or in some cases individuals) were paid a $50 fee for each completed application to Healthy Families, thereby encouraging active outreach and enrollment.

School Based Approach: In 2001, about 39% of the counties in the study used some type of school based strategy. Although the approach varied, counties recognized the importance of identifying uninsured children in schools and made efforts to collaborate with school administrators, teachers, staff, and parents to identify and enroll children into Medi-Cal and Healthy Families. Some developed a plan to systematically reach each school in the District, screen students for eligibility, and refer their families to an agency to complete the insurance application.

Other counties used the Expresslane Enrollment system authorized under AB 59, in which children are screened and enrolled through the federal school lunch program. Still others use a separate form called a *Request for Information* that asks parents if they want information about a health program for their children. School-based strategies increased as Healthy Kids programs expanded. By 2008, 19 of the 23 counties reported using a school-based strategy as their approach to outreach and enrollment efforts (See Exhibit 1). However, the ability to get buy-in from school administrators is commonly noted as a challenge and buy-in is often taken wherever possible, whether it be at the school district level, at the individual school, or even with a specific classroom or school nurse.

Provider In-Reach: Community health clinics and safety net providers were identified as other places conducive to reaching out and enrolling children in public health insurance programs. The use of provider in-reach as a strategy increased from 2001 to 2008. In 2001, approximately one-third of all counties in the study utilized the strategy and by 2008, 79% of counties had developed some means

EXHIBIT 1. County Outreach and Enrollment Strategy Use, 2001-2008



*Yuba and Solano County data not available
** Kings County data not available for school-based strategy

for screening and enrolling children within a community clinic setting (See Exhibit 1). The outreach and enrollment strategists reported that identifying uninsured children in need of health care services at the clinics was important in getting parents to successfully complete the enrollment process, since presumably these children are already in the health care system and both they and the clinics that serve them would benefit from enrolling in these programs. A common challenge with this strategy is the burden on individuals to sit down with clients and complete the application.

Community Health Workers: In 2001, 29% of the counties turned to Community Health Workers (CHW), sometimes referred to as Promotoras De Salud, Community Health Advocates, or Health Advocates, contact, screen, and enroll children in health insurance programs (See Exhibit 1). The CHWs are trained to screen applicants and are commonly, but not always, certified application assistors (CAAs). The use of CHWs as a strategy was highlighted because of their involvement with the target population and community-based and faith-based organizations. In most counties, CHWs are community-based, culturally and language competent individuals who have established relationships with many enrollees and are trusted by the communities they serve.

Media Campaigns: The use of mass media campaigns as a strategy to reach uninsured eligible families is common among the counties. In 2001, one in four counties used some form of media to advertise that public health insurance was available to children. When the Healthy Kids Program was introduced, Children's Health Initiative (CHI) administrators focused on name branding the program and marketing that coverage was available for children, whether it was Medi-Cal, Healthy Families, or Healthy Kids. The use of the media is important because many of the Children's Health Initiatives are organized within a local community health plan that conducts media campaigns on an ongoing basis to recruit enrollees. As more CHIs became active, the use of mass media campaigns increased. By 2008, one in three counties used some type of media to reach out to eligible families. The most commonly utilized media strategy was flyer distribution. A majority, if not all, of the counties distributed some kind of flyer through out the investigation period. Unpaid radio and television commercials were also utilized, though, newspaper op-ed or radio interviews were rarely used by any of the counties. A few counties developed and employed unique media strategies. For example, one county created a website that families can visit to find resources on available programs and contact information for application assistance.

Matching Public Program: A novel approach that quickly came into use towards the end of 2005 was matching the enrollment lists of public programs with similar eligibility requirements (restricted scope Medi-Cal to Healthy Kids enrollment) to identify eligible children not yet enrolled in a more comprehensive health coverage program (Healthy Kids). By 2008, 38% of the counties in the study had done or continue to do matches on a monthly, quarterly, or yearly basis. Once the match is completed and names of eligible clients are identified, families are mailed a letter informing them that they can apply to the more comprehensive insurance program along with a list of agencies that they can go to for assistance. This proactive outreach strategy identifies children already enrolled in a restricted program and offers them the option of switching or applying to a more comprehensive insurance program. However, the coordination for the match was often between two separate agencies and privacy issues often interfered with the process.

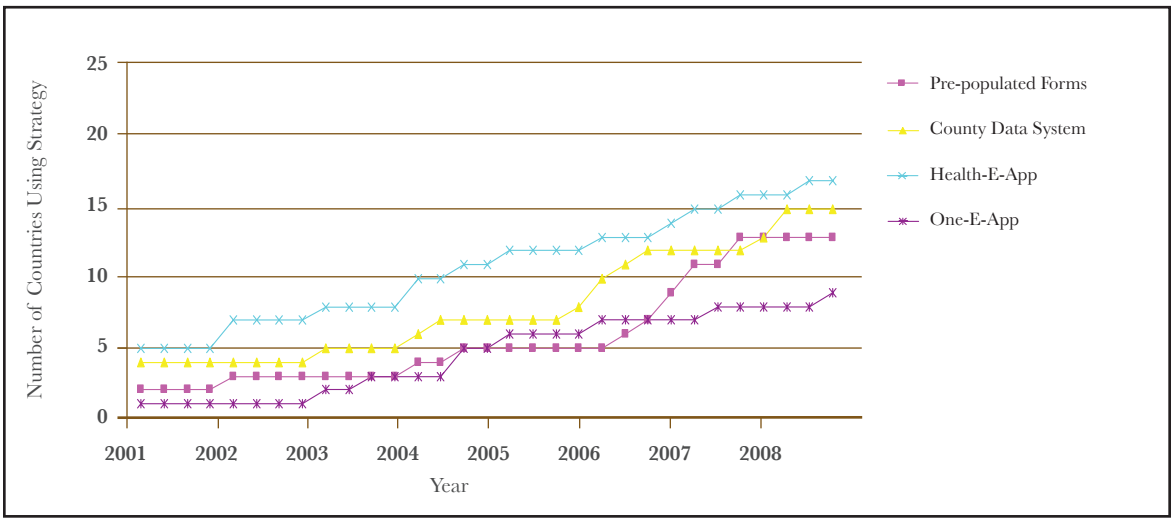
Waiting Lists: Over time, the demand for enrollment in the Healthy Kids program exceeded the programs' financial capacity. Waiting lists were established in many counties, particularly for the population of children ages 6-18, which was not directly funded by state and local First5 coalitions that provided consistent funding only for children ages 0-5. In 2008, 58% of the counties had established a waiting list. These waiting lists provide counties with a standing list of eligible, uninsured children who could readily be enrolled if new slots were open. Some counties, including Los Angeles, have closed their waiting list and individual community based organizations have established *interest lists* as a way of tracking eligible uninsured children without giving them hope that they were waiting to be enrolled into a public insurance program.

Technology-Based Approaches

Counties in California are increasingly using technologically based tools to enroll children into health insurance programs. Technology-based approaches are designed to streamline eligibility screening and enrollment processes by expediting the processing of the application and its movement to the appropriate government agency.

Health-E-App: In 2001, one in five of the counties studied used Health-E-App as an enrollment tool. Health-E-App was restricted to new enrollments into Medi-Cal and Healthy Families and linked to the State's single point of entry system. Health-E-App is a state program that can be accessed by a certified assister on behalf of his or her client. It is not a screening tool and only expedites enrollment after a person is identified as potentially eligible for Medi-Cal or Healthy Families. By 2008, about 71% of the counties in the study were using the Health-E-App system to some degree.

EXHIBIT 2. County Enrollment/Technology Tool Use, 2001-2008



**Yuba and Solano County data not available*

One-E-App: Health-E-App was followed by a more comprehensive program called One-E-App, which categorizes an individual into one or more programs based on various eligibility criteria. One-E-App is county-based, tailored to a county's needs, and linked to the county's public assistance data system. One-E-App has become an important tool for counties to enroll children (See Exhibit 2). By 2004, a year after One-E-App was launched, four counties had implemented One-E-App as an enrollment tool. Today, 9 counties are in some phase of implementing One-E-App. Nevertheless, the utilization of One-E-App and Health-E-App has grown slowly as many counties still rely on CHWs to work with parents that are not comfortable with using a computer. Most counties indicate computer glitches with both enrollment tool systems and costs for maintenance for One-E-App as a barrier.

County-Developed Data System: In addition to One-E-App, some counties have developed their own data systems that help outreach workers manage their clients, initiate reminders for renewals, and record their contacts with families. Many counties have also developed a system to pre-populate re-enrollment forms to ease the administrative burden associated with the process of re-enrollment for families. By 2008, 63% of the counties had established their own county-wide data system to track enrollments and follow-up with clients. Counties noted that while this data system does not track all new enrollments of children in public insurance programs, it does serve as an administrative and follow-up tool.

Pre-populated Redetermination Forms: The use of pre-populated redetermination forms for Healthy Families is handled at the state level by MRMIB, which has used repopulated forms since 2007. Re-enrollments for Medi-Cal are handled by each county's Department of Public Social Services, which does not use this approach for redetermination and retention. For the Healthy Kids program, enrollment and retention are handled by the health plan that administered the program. In 2001, only 13% of all the counties utilized pre-populated redetermination forms for Healthy Kids to ease the renewal process. By 2008, over half of the counties used the strategy for Healthy Kids.

DISCUSSION/CONCLUSION

In this brief, we described the extensive deployment of outreach and enrollment strategies in counties in California. We note two important policy shifts: the Healthy Families (SCHIP) program and the establishment of the Children's Health Initiatives and their Healthy Kids programs. Both programs had a profound impact on outreach and enrollment strategies. Although funding for these programs has been unstable, counties have been creative in piecing together a set of strategies that provide a comprehensive approach to outreach and enrollment. The deployment was not consistent over time. Early on, counties used a shot gun approach to the problem, hoping that the use of many strategies would lead to some being more successful with

certain populations and other strategies being more effective with others. The lack of data on the effectiveness of the strategies was apparent in our discussions with the counties and, as a result, coalitions tended to rely on anecdotal information or impressions rather than data to make decisions about outreach strategies. However, counties were constantly rethinking strategies and developing new ones as their impressions about effectiveness changed.

Most counties qualitatively attribute the success of identifying and enrolling eligible uninsured children into public health insurance programs to their relationships with community based organizations and the use of trustworthy, on-the-ground CHWs or CAAs. The administrators indicated that because the community based organizations provide a wide range of helpful services to the target population, these organizations already have established relationships with clients, who are then more inclined to complete the enrollment process. Other strategies that were noted as particularly effective were provider in-reach and school based outreach and enrollment. Additional analyses of these strategies will be discussed in future reports.

The state's launch of the Health-E-App program and the private sector's One-E-App provided technology-assisted enrollment tools designed to streamline the application system. These were part of a legislative push for simplification and streamlining of the application process. Future briefs will describe the success of these systems and the on going issues and problems that have emerged as these systems have been implemented.

Outreach and enrollment strategies and technological tools are often utilized simultaneously and overlap. For example, the community health workers were often only stationed within a clinic setting (provider in-reach) and were therefore synonymous. Initially, the main focus of the Children's Health Initiative coalition in each county was to screen every uninsured child and enroll them in the appropriate public insurance program. Since the closing of the 6-18 age groups for Healthy Kids, the focus of many of the CHIs has shifted to retaining the children currently enrolled. As such, the counties' focus has shifted from strictly outreach and enrollment to a more comprehensive approach that involves constant follow-up with the families for troubleshooting, linking families to appropriate and convenient primary care provider, scheduling appointments, and reminding them of their annual/semi-annual redetermination.

APPENDIX 1

California Counties with Active Children's Health Initiative, Healthy Kids Program

Alameda
Colusa
El Dorado
Fresno
Inland Empire – Riverside and San Bernardino
Kern
Kings
Los Angeles
Merced
Napa
Orange
Placer
Sacramento
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Solano*
Sonoma
Tulare
Yolo
Yuba*

**Not participating*