

# *Successful Outreach Strategies: Ten Programs That Link Children to Health Services*



Laura Summer, M.P.H.,  
Mary Brecht Carpenter, R.N., M.P.H.,  
and Laura Kavanagh, M.P.P.

*Successful Outreach Strategies:  
Ten Programs That Link  
Children to Health Services*

*Prepared by*

*Laura Summer, M.P.H.*

National Academy on an Aging Society

*and*

*Mary Brecht Carpenter, R.N., M.P.H.*

*Laura D. Kavanagh, M.P.P.*

National Center for Education in  
Maternal and Child Health

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Georgetown University

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(703) 524-7802  
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World Wide Web: [www.ncemch.org](http://www.ncemch.org)

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2070 Chain Bridge Road, Suite 450  
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(703) 356-1964  
(703) 821-2098 fax

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*Laura Summer, M.P.H., is the Deputy Director of the National Academy on an Aging Society, Washington, DC. Mary Brecht Carpenter, R.N., M.P.H., is a Senior Policy Analyst and Laura Kavanagh, M.P.P., is the Director of the Office of Policy Analysis at the National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University, Arlington, VA.*

## EXECUTIVE SUMMARY

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Despite a number of efforts by families, states and the federal government over several years, many low-income children still lack health insurance coverage and, therefore, have limited access to health care services. To address these problems, Congress has created, and states are now implementing, the new State Children's Health Insurance Program (CHIP).

Policymakers and agency officials who design, operate, and sponsor health coverage programs such as CHIP must determine what constitutes an effective program. Although efforts to maximize the number of children with coverage are important, *a truly effective program must go beyond simply enrolling children in health coverage programs. Steps must be taken to ensure that enrolled children also gain access to the care they need.* While states and communities have created outreach strategies to find and enroll children in Medicaid, CHIP, and other health insurance initiatives, similar attention must be paid to outreach efforts that ensure that, once covered, children actually receive services.

As states implement CHIP, they will need reliable information on which to base their programming decisions. Much has been written about efforts to reach children and enroll them in health insurance programs, but less is known about what has been done to ensure access to care once they are enrolled. Even less information is available about whether these initiatives have been evaluated and how effective they have been.

This report presents effective practices from 10 established programs across the country. Each

of these programs views outreach as a *continuum* of finding children, enrolling them, and ensuring their access to care. These programs were selected based on interviews with key informants in the fields of health policy and maternal and child health. This report provides detailed information about these programs' efforts to ensure access to care and describes practices that can be adopted by other states and communities as they design, operate, and evaluate their CHIP programs. Program descriptions can be found in Appendix A; program contact information is in Appendix B.

This report also illustrates how these 10 programs collect and use data to plan and improve outreach strategies, improve day-to-day program operations, and evaluate whether their outreach efforts are making a difference in children's ability to gain access to the services they need. These experiences can be used by other states and communities to improve their CHIP programs.

### Enrolling Children in Health Insurance Programs

Helping families enroll their children in health insurance programs is the first step to ensuring access to a health care system that is readily available and of high quality. One of the most important problems that states and others must surmount as they implement CHIP is that eligibility for health care services does not guarantee enrollment. Families do not enroll their children in health insurance programs for several reasons, and all states have at least some experience trying to reduce the barriers facing

families whose children are eligible for Medicaid. Most states have simplified the administrative and application processes for Medicaid, developed outreach programs, and passed laws to facilitate enrollment. This report discusses these barriers and some promising strategies that have helped children and families obtain health coverage. These strategies are being adapted by most states as they plan and implement CHIP.

## Ensuring Access to Health Care for Children

Whether children have basic or complex health care needs, *health coverage programs are most effective when they work to understand the population they are serving in order to develop a comprehensive outreach strategy that responds to the population's needs.* Effective programs such as those in this report use a range of components:

- **Care coordination (case management)** can be broadly defined as activities to ensure children receive the full range of services they need. One approach, used by several programs described in this report, is to operate hotlines staffed with trained professionals who respond to a wide range of questions and requests. More intensive care coordination can be provided through home visiting and community health advisor programs that use nurses, social workers, or trained lay workers to visit clients' homes or neighborhoods and perform a variety of tasks.
- **Ensure that health care providers are available.** Access to care can be limited if providers are unwilling to care for certain patients, such as those with Medicaid coverage, and if providers' offices are not near

patients' homes. Several programs have used a variety of approaches to ensure that health care providers are available. Many programs actively recruit health care providers and work to maintain a good relationship with them. In some states with Medicaid managed care contracts, special provisions are made to ensure that the network of providers will be responsive to the needs of program enrollees.

- **Accommodate the special needs of target populations.** Programs that work to understand and accommodate the special needs of their target populations are more effective in achieving their goals to improve access than those who do not. For example, families who have not had previous health insurance may need help negotiating the health care system. Families who have difficulty speaking English may have trouble understanding questions or instructions and responding appropriately. Still other families may face problems getting to and from appointments. The programs described in this report have developed strategies to accommodate these and other special needs of their target populations.
- **Help families navigate the managed care system.** Children enrolled in subsidized health insurance programs commonly receive care from a network of health care providers who belong to managed care plans. Several programs in this report help families navigate the managed care system. At a minimum, they provide families with written materials about the plans. In addition, some programs have taken additional steps that include holding orientation or counseling sessions, publishing targeted newsletters for

enrollees, and periodically assessing enrollees' satisfaction with their care.

## Measuring Program Effectiveness

Data on program effectiveness are vital if program staff members are to gauge how well programs are functioning and whether they are making progress toward reaching their goals. Although program data are available, relatively little evaluation of outreach activities has been published in the literature. In fact, many programs—including those programs described in this report—are collecting data, but *the key is to use data routinely and effectively to monitor and improve progress.*

The 10 programs featured here operate differently from each other. Thus, there is no “best way” to reach families. Comparing techniques used by the different programs is less important than determining the effectiveness of a given strategy used by a program over time.

Outreach strategies can be much more effective when they are based on analyses of data that show who is eligible for coverage; who has been reached and who has not yet been reached; and who is receiving services and who is not. Some programs use data from the Census Bureau; other programs collect their own data or collaborate with other agencies to identify the target population and issues related to access to care.

Once an outreach program is established, data collection and analysis should be an integral and systematic part of program management to gauge the effectiveness of each outreach component and to improve day-to-day operations. This ongoing commitment can help ensure that programs reach their overall goals.

Efforts to evaluate outreach programs are fairly new, but each program in this report has conducted evaluations to demonstrate how effective it has been in reaching certain goals. The report describes the different kinds of evaluations being conducted and their sources of data. As more outcome evaluations are completed and the body of literature grows, it will become easier to gauge a program's relative success at ensuring access to needed services for children.

## Recommendations

As states design and operate CHIP, they have the opportunity to incorporate the best features of established programs that are effectively operating to ensure that children have access to care. Some lessons are already apparent from the 10 programs featured in this report. An effective program will

- use a comprehensive definition of outreach that identifies eligible children, helps them enroll, and ensures their access to care.
- use a collaborative approach to program planning, operation, and evaluation that includes key players who understand the target population.
- base outreach activities on a knowledge of the population to be reached.
- make data collection and program evaluation an integral part of a program's design and budget to improve outreach efforts and other program operations, to measure satisfaction, to gauge program effectiveness, and to sustain funding.
- work closely with managed care plans on an ongoing basis to ensure that families receive needed services.
- collaborate with colleagues across agencies to plan and conduct evaluations.

- examine not only what is occurring, but also why it is occurring.
- monitor all aspects of provider participation.
- use data on utilization of health care services to improve outreach and other activities.
- encourage leadership, vision, and commitment in program planning and operations.

With CHIP, this nation has an opportunity to greatly improve children's health insurance

## INTRODUCTION

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Despite efforts by families, policymakers, and government agencies over a number of years, many low-income children still lack health insurance coverage. Consequently, these children have limited access to health care services. To address these problems, states are now implementing the State Children's Health Insurance Program, known as CHIP, which was established as Title XXI of the Social Security Act in the Balanced Budget Act of 1997. CHIP allows states to provide subsidized health insurance to low-income children by expanding state Medicaid programs, establishing new programs to buy health insurance for children, or using a combination of these approaches.

Although the primary—and crucial—goal of all health insurance initiatives, including CHIP and Medicaid expansions, is to remove *financial* barriers to health care, children still face numerous other barriers to care. Outreach is needed to find and enroll children in health care programs. However, once children are enrolled, similar attention must be paid to ensuring that they actually receive the services they need. With the establishment of CHIP, the need for effective outreach to enroll children *and* ensure

status. If state agencies and others responsible for the design and implementation of CHIP understand that their role is to maximize enrollment as well as to ensure children's access to care, they will work to devise a range of effective strategies. The 10 programs described in this report offer examples that can help states and communities improve the health and well-being of children.

their access to services has increased. Congress directed states to include in their CHIP plans descriptions of how they will inform the parents of eligible children about the program and how they intend to enroll children in it. Thus, although states are clearly focused on this first goal of outreach, their intentions and level of effort to achieve the second goal of outreach—ensuring that enrolled children actually receive services—are not known.

A recent report based on reviews of 19 state CHIP plans submitted to the Health Care Financing Administration notes that

States are defining outreach and quality largely in terms of making it much easier for people to enroll in programs and developing standards related to quality of care for the health plans with which they contract. But there is more to health access than enrollment and quality monitoring. Initiatives that link children directly with primary care physicians, nurse practitioners, neighborhood clinics, etc., are also required. Very little activity is planned in this area. . . . A thorough review of the plans submitted to

HCFA finds a striking absence of direct service outreach.<sup>1</sup>

An earlier paper from the National Center for Education in Maternal and Child Health reviewed the literature concerning challenges to enrolling children in Medicaid and other health insurance programs and to ensuring that they receive care once they enroll.<sup>2</sup> This report incorporates and builds on portions of that earlier report. However, the goal of this report is to provide new information about effective outreach strategies to help children obtain the care they need. Much of this information came from interviews with officials from 10 current state or community programs that are recognized as being effective in helping families get the care they need. The programs were selected on the basis of recommendations from key informants in the health policy and maternal and child health fields. The programs vary considerably in their design, sponsorship, administration, and financing, but they all have one characteristic in common: a strong commitment to promoting care.

## ENROLLING CHILDREN IN HEALTH INSURANCE PROGRAMS: A REVIEW

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Helping families enroll their children in health insurance programs is the first step to ensuring access to a readily available, high-quality health care system. One of the most important and difficult challenges that states and communities must surmount is that eligibility does not guarantee enrollment. Despite Medicaid expansions since the mid-1980s and a number of outreach efforts, millions of eligible children still lack coverage. A recent study estimated that in 1996, 4.7 million children 18

Finally, this report examines how these 10 programs collect and use data to determine whether they are effective. In addition to using data to evaluate outcomes, many programs use data to improve day-to-day operations associated with enrolling children and ensuring their access to care. This report highlights these important evaluation findings.

States and communities can look to the practices described in this report as they design and operate CHIP. Since each state has a unique political and economic environment as well as an already established health care delivery system, it is not likely that they will replicate the practices of these 10 programs, or any others, in their entirety. However, as CHIP officials become more familiar with successful efforts to ensure access to care, they can learn from and build on the experiences of these programs to establish a more effective effort of their own.

years and younger were uninsured—even though they were eligible for Medicaid.<sup>3</sup> Better efforts are still needed to enroll children.

### Barriers to Enrollment

Families who do not enroll their children in health insurance programs or Medicaid have several reasons for not doing so. When designing enrollment systems for CHIP, it will be important for states, health plans, providers,

and other programs that serve low-income children to keep the following barriers in mind and to identify other barriers that may be unique to their targeted populations of children. In general, parents may not come forward to enroll children because

- they do not know they are eligible,
- they want to avoid the stigma of “welfare” associated with Medicaid,
- they cannot complete the burdensome application process,
- they do not believe health insurance coverage is important,
- they cannot complete the application process because information is not available in their language, or
- they are undocumented residents and are concerned about applying for government programs in fear of deportation, even though their children are eligible.

Other factors also make it difficult for programs to attract families and make outreach more challenging:

- Medicaid is a complex program. Families—and community organizations working with them—may lack information or have erroneous information about the availability of coverage and benefits. A family with a sick or chronically ill child has a greater incentive to navigate a complicated maze of paperwork to insure their child. But families with healthy children may not perceive coverage as worth their effort.
- Welfare reform poses challenges to enrolling families. Prior to welfare reform, most families that received cash assistance automatically received Medicaid coverage. This is no

longer the case. When women leave welfare for work, they—and their children—may continue to be eligible for Medicaid or other subsidized health insurance programs, but women may think they are not eligible because they are no longer part of the welfare system. Finding families and helping them enroll has long been a challenge facing Medicaid agencies, and welfare reform has

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*When women leave welfare for work, they may not realize that they and their children may still be eligible for Medicaid or other health insurance programs*

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increased this challenge. Similar difficulties will face CHIP, and states will need to identify working poor families and effectively encourage them to enroll.

- Although outreach to enroll children should be tailored to meet the needs of different target groups, local descriptive data about uninsured children are not readily available, challenging the abilities of states and communities to effectively design and target outreach strategies. Unfortunately, although national survey data are collected, this information is general and does not capture variations between and within states. Local data need to be collected to ensure that outreach efforts are appropriately targeted to local needs.

## Reducing Barriers: What Works

Most states have reduced barriers to children's health care coverage to some degree by simplifying the administrative and application processes for Medicaid, developing outreach programs, and passing laws to facilitate enrollment. Public health programs, particularly state Title V agencies that administer the Maternal and Child Health Block Grant program, have collaborated with state Medicaid agencies, community health centers, and other programs to develop and run outreach initiatives. Public health programs, especially Title V, are key partners for outreach efforts because they have programmatic experience and data sources that can be very useful in designing, operating, and evaluating outreach initiatives. Research is limited as to which outreach strategies are most effective, for which types of children, in which settings, and at what cost. Nevertheless, available evidence suggests that the following strategies are promising and have already helped children and their families obtain health coverage.

### *Develop Consumer-Driven Marketing Strategies*

Many states have designed health coverage programs that appeal to families. Some states have renamed their Medicaid programs, including North Carolina's Health Check and Rhode Island's RIte Care. A number of state programs have produced targeted advertising materials and clearly worded brochures or videos in various languages that explain the health coverage program and how to apply for it.

### *Simplify and Shorten Application Forms and Processes*

Simplification is crucial to the success of any effort to attract families to enroll their children.

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*With their programmatic experience and data, public health programs (especially Title V) are key partners in outreach efforts*

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Moreover, in most states, children in families with higher incomes than a typical Medicaid family will now be eligible for CHIP. Their parents will not be attracted to a program that resembles public welfare in any way. If a program wants to attract healthy children, the program needs to be simple and attractive. As states implement CHIP, they must be aware of barriers such as application forms, procedures, and questions that make the process more complex. Questions should be limited to only those necessary to ascertain a child's eligibility.

### *Put Medicaid Eligibility Workers in the Community*

States can use Medicaid administrative funds to find and enroll individuals by placing eligibility workers in community settings frequented by low-income families, such as federally qualified health centers, which are a predominant source of preventive and primary care for low-income children. State agencies in charge of CHIP implementation can make it a point to educate their staff and provide program materials to local health clinics, WIC clinics, schools, Head Start sites, child care centers, and other locations where eligible children can be found.

### *Establish Presumptive Eligibility for Children*

Presumptive eligibility is a process by which a pregnant woman, or parents on behalf of a child, can obtain temporary Medicaid eligibility at the location where health care is given or at centers where related services are provided, such as federally qualified health centers, pediatricians' offices, WIC programs, and Head Start programs.

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*Presumptive eligibility for pregnant women has been effective in boosting Medicaid enrollment*

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Presumptive eligibility for pregnant women is used by 25 states<sup>4</sup> and has been found to be effective in boosting enrollment.<sup>5</sup> States that choose to use their CHIP funds to expand Medicaid can use presumptive eligibility for

children, and many states have indicated their intention to do so.

### *Establish 12-Month Continuous Eligibility for Children*

Continuous eligibility is important both to enrolling children and to ensuring that children receive care. The law that established CHIP gave states the option of providing 12 months of continuous coverage for children under Medicaid regardless of changes in family circumstances that would otherwise render the children ineligible. Once ineligible, families often do not reapply. If children receive coverage for a full year, their families are more likely to establish a relationship with a provider, and children are more likely to receive preventive as well as acute care in a timely manner.

Continuous coverage is particularly important for children in managed care plans because it gives their families time to understand the system and use it appropriately. Continuous eligibility may also make it easier for other children's programs with 12-month eligibility (such as Head Start) to coordinate outreach and enrollment efforts with those for Medicaid.<sup>6</sup>

## **ENSURING ACCESS TO HEALTH CARE FOR CHILDREN: TEN PROGRAMS THAT WORK**

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Once children are enrolled in a health coverage program, they should be able to receive the services they need. Most children are healthy and their health care needs are basic, but they and their families may need help in a number of areas, such as learning how to use their coverage properly, and locating and obtaining transportation to health care

providers. Some children have chronic conditions such as asthma or diabetes that require special attention. A comprehensive, targeted outreach program can address a range of issues facing families and children who need services. The discussion below highlights practices in 10 established programs that can be adopted or adapted by states and communities as they

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*A comprehensive, targeted outreach program can address a range of issues facing families and children who need services*

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promote access to care for children.

## **An Overview of the Programs**

The 10 programs featured in this report were selected based on a review of the literature on outreach and on interviews with key professionals in the fields of health care policy and maternal and child health. These professionals were asked to identify programs with effective outreach components that span the continuum from identifying and enrolling children to ensuring access to care. In addition, they were asked to identify programs that effectively collect and use data. Information about the program officials and contacts who were interviewed is listed in Appendix B.

Four of the featured programs are health insurance programs for children that rely primarily on managed care plans for the delivery of health care: Colorado's Child Health Plan, Florida's Healthy Kids program, the Western Pennsylvania Caring Program for Children, and Rhode Island's RItE Care program.

The remaining six programs were specifically created to help families enroll in health insurance programs and to use available health care

services effectively: Blue Cross of California's Outreach Program, Connecticut's Children's Health Project, North Carolina's Health Check program, Pennsylvania's "Love 'em with a checkup" program, Virginia's Comprehensive Health Investment Project (CHIP of Virginia), and West Virginia's EPSDT Family Outreach Program. The programs in Virginia and West Virginia rely primarily on home visiting to assist families, while the others use several different approaches.

Appendix A describes the programs and reveals the great deal of variation in how they are structured, financed, and administered. Six of the programs are run by independent organizations; four programs are administered by state agencies. Some programs target families currently covered by Medicaid; other programs are geared to families that do not qualify for Medicaid. Statewide as well as community-based programs are included. Funding for programs includes federal, state, and local governments and private sources.

Examining such a wide range of programs has limitations. For example, certain practices, such as the use of specific language in managed care contracts that reflect one program's particular concerns, will not be of interest to all the programs. However, in most cases the innovations featured here can be adapted by all types of health care programs for children. For example, all programs can benefit from information about designing effective systems to collect, analyze, and use data to monitor, evaluate, and improve program operations.

## Common Elements of the Programs

### *Collaborative Program Development*

One important element shared by most of the programs described in this report is the participation of a number of different parties willing to work together to create, operate, and finance programs. In most areas of the country, the health care system is fragmented and families often need a wide range of services. It is logical, therefore, that programs that promote access will be more successful if they are inclusive.

Some examples of collaborative programs:

- The Connecticut Children’s Health Project started as a pilot project sponsored by the private Hartford Foundation. When the project proved successful, the foundation made a commitment to take the project statewide. Subsequently, the state legislature appropriated funds to continue the project.
- The Comprehensive Health Investment Project (CHIP) of Virginia was initiated as the result of partnerships among community action agencies, the state health department, local public health departments, and private health care professionals.
- North Carolina’s Health Check program is a cooperative effort involving the State Health Department’s Division of Medical Assistance; the Division of Women’s and Children’s Health; the Office of Rural Health and Resource Development; the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, in partnership with Head Start; the Primary Care Coalition; and other interested child advocacy organizations. Professional medical societies also played an active role in the

Program development for the “Love ‘em with a checkup” program involved members of Pennsylvania’s Departments of Health, Education, Insurance, and Public Welfare, provider groups, community advocates, and parents. The planning process emphasized establishing links among providers, community outreach programs, and state and federal payment assistance programs like Medicaid.

development of the program. In the program planning stage, focus groups of parents, consumers, health care providers, and other professionals identified barriers that they would have to overcome to ensure access to care.

### *Care Coordination for Children*

Care coordination, also called case management, can be broadly defined as activities to ensure children receive the full range of services they need. Care coordination can link children with other programs and services beyond health care. Care coordinators identify a child’s needs, plan necessary services, link their clients with those services, educate parents about their child’s health condition and needs, and review progress toward goals for the child’s care. Hotlines and home visiting are two examples of care coordination used by some of the surveyed programs.

*Hotlines* are staffed with trained professionals who are able to respond to a wide range of questions and requests. Some individuals incorrectly assume that families enrolled in managed care are provided with adequate support through the plan’s membership services office. But families may need more assistance—or

different types of assistance—than managed care plans typically provide.

- The Connecticut Children’s Health Project operates the Children’s Health InfoLine, a toll-free telephone service available to anyone who needs information about, or has a problem concerning, Medicaid managed care. Experienced care coordinators assist callers and answer questions about Medicaid policies, help families get health care services, and guide individuals through the process of appealing a health plan’s decision to deny or limit services. For example, care coordinators have resolved questions about the extent of coverage provided for home health care for children with special health care needs, made referrals to providers such as dentists, and helped with billing questions.
- The Colorado Child Health Plan operates a 24-hour-a-day Family Healthline. The coordinators who staff the hotline answer an average of 10,000 calls per month about benefits for which enrollees are eligible and the individual managed care plans that provide services.
- Pennsylvania’s Love ’em with a checkup program operates the Healthy Baby/Healthy Kids Helpline. A team of telephone counselors uses a statewide database of available services to refer callers to health care practitioners and agencies that provide direct health care or to health insurance programs, such as Medical Assistance or CHIP.
- The RIte Care program in Rhode Island also operates an InfoLine. The program reports that approximately 90 percent of callers are assisted on the first call. The

remaining calls require further investigation—a need to review medical records or to contact health plan staff or providers.

*Home visiting and community health advisor programs*

can provide more intensive care coordination, through nurses, social workers, or trained lay workers who visit clients in their homes or neighborhoods. These visitors can screen family members for health and social services needs, develop a plan of care, provide direct health services or make referrals for needed services, educate parents about the importance of preventive health care, and help them better negotiate the health care system on their own. Programs differ considerably in their intensity, duration, and scope of services:

- CHIP of Virginia links each family with a team comprising a public health nurse and a trained lay home visitor. Home visits are the primary method of service delivery. Nurses provide care coordination services to ensure early detection and intervention for health problems. The home visitors provide health education and make referrals for related community services such as the WIC program, housing programs, Medicaid, or cash assistance programs. Home visitors assess family needs and provide support to help each family achieve self-sufficiency.
- Outreach workers in West Virginia’s EPSDT Family Outreach Program contact by letter all families who have children eligible for—but not participating in—the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. The outreach workers visit the homes of families who fail to respond to the letters. They also visit the homes of families who fail to make, or miss,

medical appointments for their children. Finally, workers can make home visits at the request of health care providers. As part of an effort to encourage families to get routine health care, the outreach workers assist with tasks such as making appointments or arranging transportation for medical services. Outreach workers carry resource manuals on their visits that provide further information and details about available services in addition to health care.

- **Blue Cross of California's Outreach Program** employs trained, lay outreach workers who contact families by letter or telephone if they have not chosen a primary care provider within 30 days of enrolling in the plan. These outreach specialists also visit those families who do not respond to the letter, cannot be reached by phone, or who appear to need additional assistance. The specialists explain the health coverage system and help arrange visits for enrollees with physicians for initial health assessments. The goal of this effort is to establish a relationship between each enrollee and a health care provider that will increase the likelihood that preventive services will be arranged and provided and that enrollees will receive health care in the primary care provider's office rather than in the emergency room.

Several programs that employ outreach specialists to coordinate care have established certain skill requirements for the position and have developed training programs for both professional and lay workers. Several national organizations also have developed training materials for outreach workers and home visitors that can be used or adapted by other programs.<sup>7</sup>

The North Carolina Health Check program is establishing a statewide network of Health Check coordinators housed in local health departments and community and rural health centers. The coordinators' primary job is to ensure that children have regular health care providers and receive the care they need. In addition, the coordinators work closely with other programs in the county, thereby establishing referral systems. The coordinators follow children's participation in the health care system using data generated by an Automated Information and Notification System. When coordinators identify families who are having difficulties, particularly those who have missed screening or referral appointments, they contact the families and provide assistance by making appointments, arranging for transportation to medical care visits, or talking with health care providers. They also make referrals for other services the family may need. If every other means of contact with a family has failed, Health Check coordinators make home visits.

- **North Carolina's Health Check coordinators** are paraprofessionals who have at least 3 years of community-related experience and who participate in special training programs.
- **CHIP of Virginia** has developed training materials for project coordinators, nurses, and home visitors. The program sponsors statewide and regional training events each year for staff from all the sites. In 1994, the program established a career studies certificate program in Child and Family Support

Services through the Virginia Community College system.

- Blue Cross of California's Outreach Program, in conjunction with San Francisco State University, conducts a 2-week intensive training program for outreach specialists that includes training in communication skills and working with families, and teaches the basics of managed care. The course also includes training specific to Blue Cross Medi-Cal operations. Continuing education sessions are offered for outreach specialists as well.

## Ensuring the Availability of Health Care Providers

Health insurance coverage is of limited value if health care providers are not available.

Experience with Medicaid has shown that access to care can be limited by providers' unwillingness to care for Medicaid patients and by the proximity of providers to Medicaid beneficiaries' homes. In addition, Medicaid payments are typically lower than private insurance

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*Health insurance is of limited value if health care providers are not available*

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payments and frequently involve burdensome paperwork. Providers often view families on Medicaid as difficult and noncompliant compared with commercially insured patients. The percentage of pediatricians who are limiting their Medicaid caseloads has been growing. In

response to this trend, programs have used a variety of approaches to recruit health care providers and to maintain a good relationship with them.

### *Using Managed Care Networks*

To a great extent, the problem of finding a health care provider who accepts a particular type of insurance is mitigated when managed care plans contract with networks of health care providers. However, difficulties may still arise, which is why some programs make special provisions to ensure that the network will be as responsive as possible to the needs of program enrollees.

- Over 90 percent of the primary care providers in Rhode Island participate in RIte Care, in part because of a "mainstream clause" in all contracts that specifies that doctors who wish to participate in commercial managed care plans must also agree to see RIte Care patients.
- Children enrolled in the Western Pennsylvania Caring Program for Children can use the same network of providers as anyone else who is enrolled in Highmark Blue Cross Blue Shield.

### *Ensuring the Proximity of Providers*

Even with an adequate number of health care providers in a managed care network, some participants may have difficulty with the distance from and transportation to providers. To contend with this potential problem, some programs have established standards related to accessibility:

- Rhode Island's RIte Care requires plans to

have primary care providers located within 15 minutes' driving time—and pharmacies within 40 miles—of enrollees' homes.

- Florida's Healthy Kids program has similar requirements related to location. Providers in plan networks must be located not more than 20 minutes by car from the families enrolled in the program.
- Blue Cross of California's Outreach Program has established the standard that families should be able to reach health care providers within 5 miles of their homes. The program maintains a provider database that is used to refer members to providers near their homes.

### *Waiting to See a Health Care Provider*

Another potential problem is that families may have to wait to see a health care provider. To address this issue, some programs include requirements in contracts with managed care plans. To be effective, these requirements must be paired with monitoring systems that are reviewed on a regular basis. Rhode Island's RItCare's contracts with managed care plans require that appointments be available within 24 hours for any urgent need, and within 30 days for a nonurgent need. The program gets information about the time families have to wait for appointments from focus groups, satisfaction surveys, a consumer advisory committee, and callers to the program's "InfoLine."

### *Improving Provider Participation and Relationships*

Programs use a variety of approaches to encourage health care providers to participate, including raising reimbursement rates and sim-

Contracts between the Florida Healthy Kids program and managed care plans specify that emergency care must be provided immediately, chronic or acute care within 48 hours, and other appointments within 4 weeks. The program routinely monitors plans by having program staff members call to request appointments.

plifying or streamlining the billing process. In some cases, programs work collaboratively with medical societies to encourage members to provide care to program enrollees.

- The North Carolina Health Check program improved payment rates, streamlined procedures, and provided financial incentives to practitioners who agreed to accept significantly more children with Medicaid coverage. In addition, a foundation—the Generalist Physicians' Medicaid Assistance Program—was established expressly to increase provider participation in the Medicaid program. Foundation staff members serve as a liaison between physicians, the state Medicaid office, and the fiscal agent of the Medicaid program, identifying and remedying administrative problems that might discourage physicians from participating in the program.
- The Colorado Child Health Plan worked with the Colorado Chapter of the American Academy of Pediatrics on a "Reach Out" effort to recruit physicians willing to accept Medicaid and Child Health Plan children as patients. Like other programs, Child Health Plan staff members, travel to local areas to meet with practitioners at community and

rural health centers to explain the program and encourage participation.

- West Virginia's EPSDT Family Outreach Program employs pediatric program specialists who recruit physicians across the state. Twice a year the specialists visit physicians enrolled in the program, checking whether the providers are having problems and assisting them with equipment needs. The state also increased reimbursement rates for EPSDT examinations and improved the process used to pay claims. All medical providers serving children enrolled in the EPSDT program receive program instruction, technical assistance, and a program manual. The Program Specialists serve as the point of contact for the medical community.
- Staff members from CHIP of Virginia meet one-on-one with physicians and dentists who are potentially willing to see CHIP enrollees, to explain the program and answer any questions. Staff have found that physicians need to feel that their voices are being heard.

Often, efforts by program staff to help families keep appointments and follow their provider's

**E**arly in the development of CHIP of Virginia, physicians and dentists indicated that they were hesitant to see Medicaid patients because the patients were more likely than other patients to miss appointments. As a result, CHIP of Virginia places a great deal of emphasis on helping families make and keep medical and dental appointments.

advice also help recruit and retain providers (see the box on CHIP of Virginia).

### *Other Tools for Communication between Programs and Providers*

Other methods of communication are also effective in building and improving relationships between programs and providers:

- Connecticut's Children's Health Project sends a quarterly newsletter to providers. The newsletter and its "Provider Update" section contain information on such topics as "What is included in a complete EPSDT screening?" and "How do I accurately report it?"
- Colorado's Child Health Plan sends information packets to all participating providers and holds in-service training programs for providers' staff members, to help them better understand the program and update them on any changes. The program also publishes a provider newsletter.

Some programs use special incentives. Giving awards offers some recognition for providers who do a particularly good job, and reminds them that their performance is being monitored.

- Pennsylvania's Love 'em with a checkup program sponsors an annual "best and brightest" provider recognition award based on feedback from clients. Providers receive plaques and are honored at six press conferences and luncheons across Pennsylvania.
- Florida's Healthy Kids program gives awards to health plans that perform especially well.

For example, one health plan received an award for developing the most “user-friendly” directory. The program also monitors the services that are provided for different diagnoses. Awards may be given to plans that go above and beyond what they are required to do to care for children.

### ***Helping Families Identify Available Providers***

In some cases, there are providers available to treat children in state health insurance programs, but families do not know which physicians accept their health insurance. To address this problem, several programs collect information from providers and make it available to families.

- The Pennsylvania Love 'em with a checkup program sends surveys to approximately 1,300 health care providers in Pennsylvania every 6 months to gather information. The program maintains a database that is used to refer families to appropriate care providers.
- Outreach workers in West Virginia's EPSDT Family Outreach Program refer families to providers and services in their communities when needed. In addition, a statewide, toll-free line is available for families and providers. The line is linked with a database containing health, social service, and community resource information.

### **Accommodating Special Needs**

Some families who are newly eligible for CHIP have not had health insurance before and are more likely to have difficulty understanding the health care system. Reasons for their difficulties vary: They may have less education, rely on the

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*Some families newly eligible for CHIP have never had health insurance and may have difficulty understanding the health care system*

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emergency room for their primary care, or speak a language other than English. They also may have difficulty getting to medical appointments. Several programs have made efforts to accommodate these special needs.

### ***Overcoming Language Barriers***

The ability to communicate in a common language is one of the most obvious challenges in reaching diverse populations. Most of the programs discussed in this report are staffed with individuals who speak languages other than English. These staff members are available to speak with potential and current enrollees. Many programs have a contract with AT&T for interpretation services for languages they cannot accommodate. Programs must first determine which languages will be in demand before considering their staffing needs. Rhode Island's RIte Start program includes a question about language on the enrollment form for each health plan. If a plan has 50 or more members who speak a particular language, all materials must be printed in that language.

Information about the program in a variety of languages is supplemented with efforts to reduce difficulties families may face when needing care:

**B**lue Cross of California's Outreach Program uses demographic data to identify "threshold languages" according to the number of people who speak a given language in a given region. The program has the capacity to provide translators for the current 10 threshold languages, and program materials are produced in the 10 languages.

- Pennsylvania's Love 'em with a checkup program has counselors on staff who will make appointments for people whose language abilities prevent them from making their own health care appointments or contribute to their reluctance to deal with the health care system.
- When Blue Cross of California contracts with physicians, it asks about the languages other than English spoken by office or clinic staff members. The program then provides this information to their members to help them select health care providers with whom they can best communicate.

### *Assisting with Transportation*

Some families face difficulties getting to health care appointments. Without a car, some enrollees must rely on public transportation to keep appointments at medical offices, clinics, or hospitals. Others live in isolated communities that lack adequate public or commercial transportation. Probably the most effective—but also most resource-intensive—solution is to provide transportation for families when they need it. For example, home visitors and nurses with CHIP of Virginia use agency vehicles to transport families to medical appointments.

CHIP of Virginia sites that allow staff members to use their private vehicles to transport families are required to have proper automobile insurance coverage.

In communities where public or commercial transportation services are available, a common practice is to provide tokens or vouchers that can be redeemed to pay for transportation. Programs can take steps to help ensure that these efforts will be as effective as possible.

- The Pennsylvania Love 'em with a checkup program's database has information on how to obtain transportation tokens in various communities. Helpline staff can then provide callers with this information.
- West Virginia's EPSDT Family Outreach Program works with the state's Right From the Start perinatal program, which has established a transportation program that combines both state and Medicaid dollars. Traditionally, Medicaid has provided funding for transportation, but the enrollee must pay first and be reimbursed later. Some families cannot afford to do this. In the West Virginia system, communities are funded with a "transportation pool" of dollars that are distributed to families at facilities such as county health departments and community health centers. When patients use the funds to pay for transportation to medical appointments, they complete nonemergency medical transit forms, which their doctors must sign. Subsequently, the form is submitted to Medicaid for reimbursement. Those funds are returned to the pool of funds that is administered by a community service organization. The funds are then available for the next patient. This program is an important

and effective way of ensuring the early participation of infants in the EPSDT program.

Another approach to transportation problems is to bring health care services to the community. A local physician in the Denver metropolitan area operates a van to deliver services to children covered by Medicaid and the Colorado Child Health Plan at five sites in the Denver area. The Colorado Child Health Plan reimburses him for his services.

## Helping Families Use Managed Care Plans

Children with subsidized health insurance commonly receive care from a network of health care providers who belong to managed care plans. In many of the insurance programs, families may choose among several different plans. But once a family has joined a particular plan, family members are usually required to choose a primary care provider and become familiar with the rules regarding their coverage. Programs featured in this report have developed a variety of strategies to provide assistance to families learning to navigate the managed care system. At a minimum, programs provide enrollees with written materials about the plan, and as noted earlier, some programs maintain telephone hotlines to answer questions about insurance coverage plans. In addition, programs sponsor—or require plans to sponsor—orientation sessions for new members.

- Blue Cross of California's Outreach Program invites enrollees to new-member orientations at field offices throughout California and provides transportation and baby-sitting services to enable members to attend. These orientation sessions are quiet, focused small-

group sessions that explain the process of the managed care environment to new members. At the sessions, new plan members are encouraged to have initial checkups with their new physicians to establish a relationship with the provider before an emergency occurs.

- Since enrollment for the Florida Healthy Kids program occurs through schools, orientation sessions are held at the schools, either as part of PTA meetings or on school grounds for parents after work. An unforeseen benefit has been that the school-based orientations attract eligible families who have not yet enrolled in the program.
- New enrollees in Rhode Island's RIte Care program are encouraged to attend a counseling session where they learn about managed care, how to choose from the four health plans offered in Rhode Island, which providers are associated with the plans, what kind of coverage each plan offers, and how to use RIte Care's transportation benefit.

The Colorado Child Health Plan publishes a family newsletter that contains information on a variety of topics, such as program procedures, questions and answers related to working with managed care plans, and information about optimal health care for children. The newsletter is printed in English and Spanish.

## MEASURING PROGRAM EFFECTIVENESS

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Since effectiveness is the key to the success of any program, collecting and analyzing data on outcomes and operations are crucial if program staff members are to judge a program's overall effectiveness. Funding for programs designed to improve access to health care for children is generally tenuous, but programs that can demonstrate accomplishments and progress toward goals are more likely to receive support from the organizations, public agencies, foundations, and others who authorize, fund, and administer programs. Data collection and analysis can also help guarantee sustained funding. Another important and practical reason to

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*Collecting and analyzing data on outcomes and operations are crucial to determining a program's effectiveness*

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collect and analyze data is to better understand how a program functions and identify areas for improvement.

Relatively little information is available on evaluations of outreach programs. Nevertheless, program data are available, and many programs that collect useful information have developed systems for analyzing and using the data effectively.

Outreach strategies can be more effective when based on data analyses that show which popu-

lations are and are not being reached. For example, if programs understand the eligible population as well as the enrolled population, targeted efforts to identify and enroll new children will be easier to develop and more likely to succeed. Similarly, if programs can identify enrollees who are not using services or who are using services inappropriately, staff members can contact families and help them get the care they need. State CHIP programs can collaborate with other state agencies, such as the Title V office that administers the Maternal and Child Health Block Grant program, which has considerable information and data on children and families in the state and on service providers. This data can help CHIP programs target their outreach efforts and monitor their effectiveness.

The 10 programs interviewed for this report collect, analyze, and use data in numerous ways to plan, monitor, evaluate, and improve their outreach efforts. Their strategies can be adopted by other programs to ensure that eligible children enroll and obtain needed services.

### Using Data to Identify and Enroll Children

Some programs use data from the Census Bureau to determine the number and characteristics of people eligible to participate in the program. Once programs know the population they want to reach, they can tailor their outreach efforts. The Connecticut Children's Health Project analyzed data from the Current Population Survey to estimate the number of

uninsured children who may qualify for Medicaid or the new CHIP. The data were also used in planning outreach initiatives.

Data on families already participating in programs are also useful. Although many programs collect demographic information about enrollees as part of the application process, using the data to plan outreach efforts is less common.

- Counselors for Pennsylvania's Love 'em with a checkup program record demographic information about each caller so the program can profile the racial and ethnic composition of callers, their age, and their family income. As a result, the program reports that more than 90 percent of the referrals made by the program's Helpline staff are for families with incomes at or below 185 percent of the poverty line.
- The Love 'em with a checkup program also tracks the rate of phone calls made from individual communities, which allows program staff to determine who responds to specific outreach campaigns. In one instance the program planned to conduct outreach efforts in counties that had the fewest responses to a media campaign. However, by tracking phone calls, staff members learned that in one of the counties with the fewest respondents, most people did not have to call the Helpline because they already knew about and used a family clinic. As a result, staff were able to direct outreach resources to counties where residents had greater needs.
- West Virginia's EPSDT Family Outreach Program uses printouts regarding Medicaid eligibility to identify children who are eligi-

ble for EPSDT. The program has used mail surveys and interviews with outreach workers to determine why families do not get services. Results show that most of the non-participants have their Medicaid card, know about the program, and are glad to have coverage. One common reason enrollees give for lack of participation are problems with transportation. Staff members also discovered that some families were reluctant to return to see practitioners who they thought were unfriendly or rude. Outreach workers address these issues to encourage participation; program specialists address concerns related to the medical community.

Some programs base outreach efforts on data they have collected on how families hear about the program. If they learn, for example, that the majority of referrals to the program come from a particular source, they will continue working with that source, even as they develop and work with new sources. Similarly, if few applicants indicate that they heard about the program through a major media campaign, program staff can then spend funds on other outreach strategies. Information of this type is relatively easy to collect. A question about how the applicant heard about the program can be included on the application form, or applications can be coded (by color or by number) to show the referral source.

- The Colorado Child Health Plan includes two marketing questions on its application: (1) How did you hear of this program? and (2) Where did you get this application? The data have shown that the primary referral sources are Federally Qualified Health Centers. Public health programs, such as WIC, Title V and its Children with Special

Health Care Needs program, and public health nurses, are the second-largest referral source. Schools and school-based health centers rank third, and primary care providers' offices fourth.

- The Florida Healthy Kids program, which has school-based enrollment, also asks applicants how they learned about the program. More than 75 percent of families say they learned about the program at school.
- The North Carolina Health Check program uses surveys of participating families to learn how families find out about the program. More than half of the surveyed families who had heard of the program said they learned about it when they received letters describing it. Health care providers were the next most common referral source. Only a small proportion of respondents said they learned about the program from billboards or from television or radio advertisements.
- Pennsylvania's Love 'em with a checkup program reports that only 6 percent of the calls to the program's Helpline come in as a result of mailings about the program, while 76 percent of the responses come in as a result of television ads.

These practices and their results indicate that there is no "best way" to reach families. Each program operates in a different way to reach different populations in different communities. Comparing techniques used by the different programs is less important than monitoring the effectiveness of their outreach strategies over time. But to be most effective, programs should continuously collect and frequently analyze data about how and from whom peo-

ple learn about the program and from whom they receive applications. Such information will give program staff members a sense of which strategies are working and which they should try next.

## **Using Data to Develop Marketing Strategies**

Some programs have worked with marketing professionals to identify target populations and develop outreach methods suited to them:

- The Pennsylvania Love 'em with a checkup program works with social marketers from an advertising agency to develop paid television ads. The ads are placed in spots that draw particular populations. The advertisements feature different racial/ethnic groups, and the ads are run in different areas of the state. The primary funding source for the media campaign was the Title V program, but several other programs also provided funding, including Medicaid, income maintenance, Part H, and the State Department of Education.
- The Florida Healthy Kids program hired a specialist in not-for-profit marketing to assist with focus groups and with the selective scheduling of radio and television time directed at the target audience.

## **Using Data to Help Families Access Services**

Reliable information on the use of health care services is valuable on (1) an individual basis, in identifying people who need assistance obtaining services, and (2) a collective basis, in identifying patterns of care in a population.

Some programs have developed their own data systems, while other programs' data are part of integrated data systems in state health departments that provide information on services offered in a variety of programs. Managed care plans also can be an important data source. Most plans have the capacity to collect detailed encounter data on each enrollee. Such information can be extremely helpful to program staff, but only if the program has access to the data and has the capacity to analyze it.

Programs that have contracts with managed care plans can require the plans to routinely submit data on specific measures for each child. As a practical matter, program staff need to ensure that the managed care plans' data systems are compatible with other systems the program uses. Data that are submitted regularly should be analyzed regularly to provide timely feedback.

- The Connecticut Children's Health Project gets enrollment data on each child enrolled in the Medicaid program from the state Department of Social Services. Moreover, health plans submit medical encounter data for each child. The project monitors "on-time," well-child visits based on the dates of birth of enrolled children. When a care coordinator receives a call from a parent, the coordinator reviews the child's encounter records, regardless of the reason for the call. If the child is overdue for a screening visit or any other service, the coordinator can remind the family that the child is due for care.
- Blue Cross of California's Outreach Program examines claims to make sure people visit a doctor within 120 days of enrolling in the plan. An outreach worker contacts those

who have not sought care to arrange an initial visit with a health care provider within the allotted time. Claims data for each child at 9 months of age are also examined to monitor immunization status. Outreach workers contact families whose children do not have up-to-date immunizations.

- Blue Cross of California's Outreach Program also tracks claims data to identify inappropriate use of emergency rooms. If a family uses the emergency room three or more times in 3 months, an outreach worker contacts the family and counsels them on appropriate use of the health care system. Tracking continues after the counseling to ensure that behavior has changed.
- The North Carolina Health Check program uses a new Automated Information and Notification System to collect medical and participation data directly from providers' claims. The system is also used to notify families of the need for immunizations or screening visits. Health Check coordinators contact families if the data reports show that services have been missed even though families had received notices of appointments.
- The Florida Healthy Kids program requires their managed care plans to provide data on every child for five diagnostic and five procedural codes. The data are examined for changes in the utilization rates. The program also monitors the balance and appropriateness of services, per condition, per child, on a plan-by-plan basis. For example, the program has studied services for children with juvenile (type I) diabetes and for children with asthma to learn if care has been appropriate and sufficient.

## Using Data to Improve Program Operations

Often, program staff members can provide anecdotal examples of policies or procedures that are, or are not, working well. However, if programs collect and use information in a systematic manner, they will have a much stronger basis for proposals to modify operations.

Although each example below is different, they all demonstrate how data can be used to promote program improvements.

- Staff at the Children’s Health Council and the Connecticut Children’s Health Project InfoLine document problems as they hear about them and then pass on recommendations to the Department of Social Services. The Department in turn has developed new policies for the managed care plans that have contracts with the state. For example, in response to a number of transportation problems, the Department of Social Services now requires health plans to transport children over age 12 (whose parents are not available during work or school hours to escort their children) to health care appointments.
- Rhode Island’s RIte Care program has based some policy changes on feedback received from managed care plan members. Bus passes are now distributed in a different manner, for example. Moreover, some health plans are now required to increase provider capacity in some areas of the state.
- West Virginia’s EPSDT Family Outreach Program routinely monitors the quality of health care services clients receive. An independent monitoring unit in the Office of

The Florida Healthy Kids program uses data on the populations they serve and on service use to monitor the care children receive and to negotiate premium rates. During the first 2 years of operation, the Healthy Kids program negotiated three premium reductions.

Maternal and Child Health visits physicians’ offices to ensure the facilities meet certain standards, to conduct chart reviews, and to observe exams. The monitoring unit submits reports to the program’s administration and to the facility being monitored. If necessary, the results of the on-site evaluation are used to devise formalized plans of correction for the providers.

- The Children’s Health Council in Connecticut reports EPSDT “on-time” visit rates by health plan and age group. Rates for the third quarter of 1997 ranged from just under 10 percent to more than 50 percent. Low rates may indicate problems with the system used to report data, or they may indicate that children are not getting the services they need. When the rates are used to evaluate the health plans, the Council can then work with the plan to improve performance. Results of a specific study that examined the extent to which babies age 6–18 months received screening visits revealed that few children were receiving all of the recommended care. As a result, the Children’s Health Council recommended to the Department of Social Services that incentives and sanctions be tied to EPSDT requirements in the next set of contracts with Medicaid managed care plans.

## Using Data to Measure Satisfaction

One indicator of how well a program is functioning is client satisfaction. Programs use a variety of methods to gather information from current enrollees. Some programs also ask families who leave the program to indicate why they have left. Administering surveys is perhaps the most common method of measuring client satisfaction.

- A satisfaction survey conducted for the Colorado Child Health Plan showed that most families who had not renewed their coverage left the program for reasons other than dissatisfaction.
- In West Virginia, a research unit within the Office of Maternal and Child Health mails surveys to participants in the EPSDT Family Outreach Program. Based on the survey responses, the research unit creates a report card on the program that can be used to improve operations when necessary.
- The North Carolina Health Check program mails surveys to families participating in the Health Check program to gauge their level of satisfaction.

The Western Pennsylvania Caring Program for Children conducts an annual satisfaction survey by mail of a statistical sample of enrollees; letters are followed up with telephone calls. The University of Pittsburgh School of Public Health assists with the survey.

Some programs measure client satisfaction by making follow-up calls to individuals who have called telephone hotlines.

- Pennsylvania's Love 'em with a checkup counselors routinely ask callers if they would be willing to receive a follow-up telephone call. Follow-up calls give staff members the opportunity to confirm whether—and how—callers followed up on the advice or referrals they received. The follow-up calls also can provide families with additional assistance, if needed, and can gauge whether callers were satisfied with the help they received.

On a random basis, staff members from West Virginia's EPSDT Family Outreach program pull records of callers to the state's toll-free hotline and make follow-up calls to ask about satisfaction with the services they received.

- All families enrolled in the Florida Healthy Kids program for 1 year or longer are asked to participate in a 45-minute interview. Approximately three-quarters of families agree to participate in the interview, which includes questions about patient satisfaction with providers and about the health status of the children participating in the program. Survey data indicate that 96 percent of families interviewed said it was easy to obtain needed care. Families that leave the Healthy Kids program receive an "exit interview" by mail, asking them why they are leaving the program. The most common response is that families have moved on to other types of coverage.

## Using Data to Evaluate Program Outcomes

Each of the programs described in this report has conducted evaluations to demonstrate how effective it has been at reaching certain goals. The approaches used to evaluate outcomes differ among the programs, but collectively, these examples provide a good indication of the types of activities that are occurring. Efforts to evaluate access to care are fairly new, but as more programs undertake evaluations, others will find it easier to use the results to gauge their program's relative success.

In many cases, programs regularly analyze data from reporting systems to examine specific outcome measures. Some programs have conducted one-time evaluations that are based, wholly or in part, on data collected during the course of day-to-day operations. In other instances, surveys or chart reviews are used for evaluations.

Some programs employ data analysts to examine outcome data on a regular basis. Other programs contract with outside professionals to perform independent program evaluations. Using outside consultants who are associated with academic institutions is a fairly common practice. Consultants can help programs by establishing systems for data collection and evaluation, by routinely analyzing program data, and by conducting independent evaluations for the program. A wide range of approaches are used to evaluate program outcomes:

- Statistics from Rhode Island's RItE Care encounter data reporting system are analyzed quarterly to show trends in the use of

various types of services. A report from the first quarter of 1998 compared utilization of services among current RItE Care enrollees with utilization among Medicaid enrollees before the RItE Care program. Data analyses revealed that hospital days per 1,000 enrollees decreased from 760 before the program to slightly less than 400 in the first quarter of 1998. Emergency room visits decreased and are now just over 300 per 1,000 enrollees, compared with about 750 per 1,000 Medicaid enrollees before RItE Care. At the same time, the number of physician outpatient visits has increased from just over 2,500 visits per 1,000 Medicaid enrollees to about 4,000 visits per 1,000 RItE Care enrollees. Program staff have concluded that these trends reflect increased access to outpatient services and an increased emphasis on ensuring that each enrollee has a "medical home."

- The Connecticut Children's Health Council has commissioned a series of studies to examine access to EPSDT services. A 1997 study examined the extent to which a group of infants enrolled in Medicaid managed care received timely recommended screening examinations over a 13-month period. The results indicated that not all children received the recommended well-child visits required by the Department of Social Services. Only 8 percent of the children received the recommended five or more screening visits on time, while almost 20 percent did not have any screening visits at all. Another study examined the use of preventive dental services by children enrolled for 1 year in Medicaid managed care plans. The results indicated that less than one-

third of the children received preventive dental services during the study period. Factors were identified that may have affected access, such as race and ethnicity, place of residence, and health plan. Data for both studies come from the project's enrollment and encounter databases, and analyses were conducted by the Connecticut Children's Health Project.

- Blue Cross of California's Outreach Program examined the patterns of approximately 400 Medicaid enrollees who were identified as frequent users of emergency department services. As a result, enrollees received education on nonemergency alternatives to the emergency room. A comparison of claims filed 6 months before the education with those filed 6 months after revealed a 46 percent decrease in the total volume of emergency department visits.
- Using data from the Automated Information and Notification System for North Carolina's Health Check program, researchers compared the use of health care services by families living in counties with Health Check coordinators with families in counties that did not have Health Check coordinators. Over a 4-year period, counties with coordinators had a significantly greater increase in the number of families participating in the Health Check program. Also, the ratio of screening visits to enrolled program participants increased significantly more in counties with Health Check coordinators than in those without.
- West Virginia's EPSDT Family Outreach Program has used encounter data from medical reports completed by every provider to

document a gradual increase in the use of health care services over the years.

- CHIP of Virginia has developed a series of data collection forms that home visitors routinely complete. With the data, program staff members can determine which health care services are provided, when, and to whom. Staff members also can ascertain changes in family circumstances, such as health or employment status. The intake form and a household composition sheet are completed at the time of enrollment. Annual update forms are completed at 12-month intervals. Some questions are based on the National Health Interview Survey and solicit information on health status, use of health care services, and sources of health care services.
- CHIP of Virginia program staff also keep logs of encounters in which they record information about services they provide. The data collection and analysis process was developed early in the program with the help of consultants from the Department of Maternal and Child Health at the University of Alabama. The process was designed as an integral part of CHIP of Virginia program operations. Results from a 1997 evaluation show that, among children participating in the program for 1 year, those with up-to-date immunizations increased from 79 percent to 91 percent. The proportion of children who had a regular source of health care also increased. Initially, 63 percent of children received care from a private physician or a health maintenance organization; 1 year later, after the children joined CHIP of Virginia, the proportion increased to 85 percent. CHIP of Virginia is currently working with Virginia's Medicaid agency on an

analysis of the impact of CHIP services on the use of Medicaid services, in terms of the types and sources of care and its cost.

- The managed care contracts for the Florida Healthy Kids program require that the plans provide data tapes on utilization information on a quarterly basis. Healthy Kids then forwards the data to the Institute for Child Health Policy at the University of Florida, which analyzes the data for the Healthy Kids program. The Institute also interviews families who have been enrolled in the Healthy Kids program for 1 year or longer to learn about service use and satisfaction with the program.
- An independent evaluation by the Department of Health Outcomes at the University of Colorado Health Sciences Center compared the care received by children enrolled in the Colorado Child Health Plan with care received by children enrolled in Medicaid or private health insurance. Medical auditors reviewed medical records in physicians' offices and health centers. With respect to preventive care, researchers found no significant differences between children enrolled in the Colorado Child Health Plan and children with Medicaid or private coverage. The measures studied included the proportion of children with up-to-date immunization rates, the mean number of health maintenance organization office visits, and the mean percentage of visits that included developmental assessment, height and weight measurement, injury prevention counseling, and routine screening for anemia and tuberculosis. With respect to acute care, the number of office visits for acute illness did not differ among the three

groups, but children enrolled in the Colorado Child Health Plan had significantly fewer emergency room visits. A study of the children with asthma in both groups demonstrated that all had comparable rates of outpatient office visits, emergency room visits, and hospitalization.

- Researchers at the University of Pittsburgh studied families enrolled in the Western Pennsylvania Caring Program for Children and in a companion program, the Children's Health Insurance Program of Pennsylvania. (The Western Pennsylvania Caring Program for Children administers both programs.) Researchers conducted telephone surveys of families as they enrolled in the health insurance programs but before the families received their insurance cards. These same families were surveyed again 6 and 12 months later. The findings indicate that access to health care services improved after enrollment in the program. One year after enrollment, 99 percent of the children had a regular source of medical care compared with 89 percent at enrollment. The proportion of families reporting any unmet need or delay in care over the previous 6 months decreased from 57 percent at enrollment to 16 percent at 12 months after enrollment. The proportion of children seeing a physician increased from 59 percent to 64 percent, while the proportion visiting emergency rooms decreased from 22 percent to 17 percent.
- A 1997 evaluation of Pennsylvania's Love 'em with a checkup program conducted by researchers at Albert Einstein Medical Center in Philadelphia examined program outcomes related to pediatric care. Study

results indicated that 71 percent of children referred for pediatric care sought care; of those who sought care, 53 percent reported receiving care. Eighty percent of families

referred to Medicaid for pediatric care sought to enroll their children; of those who sought enrollment, 33 percent were found eligible and were enrolled.

## RECOMMENDATIONS

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As states design and operate their CHIP programs, they have the opportunity to incorporate the best features of established programs that have been effective in ensuring access to care for children. The following lessons learned from the 10 programs examined in this report are especially noteworthy:

**1. Use a comprehensive definition of outreach that includes identifying eligible children, helping them enroll, and ensuring their access to care.**

Ideally, outreach encompasses not only finding and enrolling families, but also helping them obtain health care services. Truly effective programs understand outreach as a continuum of activities: from identifying children to enrolling them in health coverage programs to helping them obtain needed services. Several outreach strategies, such as telephone hotlines and home visiting, can be used both for helping enroll children and for ensuring their access to health care services. Continuous monitoring determines if program activities are effective or—if not—how they should be modified.

**2. Use a collaborative approach to program planning, operation, and evaluation that includes key players who understand the target population.**

Families often need a wide range of health care and other services. Unfortunately, health service

systems are usually quite fragmented and difficult to negotiate. Programs will be more successful at promoting access if they draw on the experience of a variety of agencies and community groups. Programs also can benefit from the involvement and support of political leaders, foundations, businesses, and health care providers. When these individuals and organizations are involved from the start with program planning, they are more likely to be supportive of the program later and willing to be involved. Families should always be represented when program plans are made.

**3. Base outreach efforts on knowledge of the population to be reached.**

Census data, focus groups, and surveys of families that do and do not participate in programs are helpful in defining the population to be reached. Collaborating with individuals and organizations that work with and understand the target population can enlighten program planners and have the side benefit of helping with “buy-in” from these key groups. Subsequently, outreach activities can be better tailored for the population.

**4. Make data collection and program evaluation integral parts of the program’s design and budget to improve outreach efforts and other program operations, measure satisfaction, gauge program effectiveness, and sustain funding.**

It is generally more difficult and more costly to collect information after a program is implemented. If sufficient funds are available from the start, reporting systems can be established early and used routinely to ensure that a wealth of program information is available from the first day of the program. Problems can be identified and improvements made in a timely manner if staff routinely analyze data that are collected as part of day-to-day operations. For example, evaluations of outreach activities indicate that there is no one best method for reaching and enrolling families; thus staff should consider using a variety of approaches. What is clear, however, is that data on how and where people learn about programs and receive applications should be collected continuously and analyzed frequently to give program officials a sense of which approaches are working and which are not.

**5. Work closely with managed care plans on an ongoing basis to ensure that families receive needed services.**

If programs contract with managed care plans, compliance should not be left entirely to the plans. Expectations about access should be clarified, and contracts must include specific requirements, such as the type of orientation and customer service plan members will receive, the proximity of providers to where enrollees live, and the waiting time for appointments. Monitoring plan performance and working with plan officials to correct deficiencies are important responsibilities of the program. It is useful to provide independent resources for families, such as well-staffed telephone hotlines where individuals can receive help navigating the managed care system and, as a side benefit, program staff can get feedback on the performance of the plans.

**6. Collaborate with colleagues across agencies to plan and conduct evaluations.**

Collaborations with academic institutions and others can help programs establish a system for collecting and analyzing data. The analysis should be ongoing and can be performed by program staff or in collaboration with consultants. Such information provides helpful feedback for managers and can be used to garner additional funds and build community and political support.

**7. Examine not only what is occurring, but also why it is occurring.**

Programs that understand why families are not participating are more likely to succeed in enrolling new families. Similarly, it is important and useful to know not only what proportion of enrollees have adequate access to care but also to know why other families are not receiving care. Focus groups or surveys of families can provide program staff with this type of information.

**8. Monitor all aspects of provider participation.**

Although it is important to monitor the number of providers who participate in programs, those numbers can be misleading if consideration is not given to the distribution and types of providers and to the number of enrollees they are willing to see.

**9. Use data on health care service utilization to improve outreach and other activities.**

Programs that can generate and use data about the utilization of health care services will be able to identify families in need of care and assist them. The programs can then determine whether the health care delivery system available to enrollees is adequate and what improvements may be needed.

## 10. Encourage leadership, vision, and commitment in program planning and operations.

The recommendations contained in this report cannot happen without leadership from program management and other decisionmakers. The ability of a new program like CHIP to make a lasting difference in the lives of children and parents in working poor families requires broad thinking and the willingness to

try new approaches for finding and enrolling children and for ensuring they get the care they need. Commitment and perseverance are necessary if adequate funds are to be dedicated for outreach and if such funding is to be sustained over many years. If data analyses indicate that program changes are needed, these qualities are also necessary to continue to fine-tune program operations.

## CONCLUSION

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Individuals and organizations who design, operate, and sponsor health insurance programs such as CHIP must consider and define what constitutes an *effective* program. To increase the number of children with health insurance is an important goal, but an effective program should go further and develop outreach and other strategies to ensure children have access to health care services they need after they are enrolled. These efforts must be monitored and data collected and analyzed on an ongoing basis to determine if outreach is effective and, if not effective, how outreach efforts can be improved. Several well-established programs, including the 10 programs reviewed for this report, are good guides that new state CHIP programs can use to develop effective outreach strategies to enroll children and to ensure their access to needed health care services.

One hallmark of effective outreach programs is that program staff collect and analyze data on a regular basis. Often such data collection and analysis are neglected initially by staff members preoccupied with the details of operating a program. But to more effectively guide and sustain

programs, these activities should be a part of day-to-day operations.

Many programs may already collect a great deal of information, but may fail to conduct routine analyses that could help determine how well the program is working for participants. The examples of program efforts in this report indicate that it is possible to use basic program data to improve outreach efforts and other program operations, to measure satisfaction, and to gauge program effectiveness. Moreover, it is generally easier to sustain program funding and support if data are available to demonstrate that a program has been effective. As states and communities continue working toward enrolling and serving children in CHIP and other health insurance coverage efforts, implementing the steps discussed in this report could make a significant difference in a program's success and, ultimately, in the health and well-being of children and families.

## NOTES

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2. Carpenter MB, Kavanagh LD. March 1998. *Outreach to Children: Moving from Enrollment to Ensuring Access.* Arlington, VA: National Center for Education in Maternal and Child Health.
3. Selden TM, Banthin JS, Cohen JW. May-June 1998. Medicaid's problem children: eligible but not enrolled. *Health Affairs* 17(3):192-200.
4. National Governors' Association. September 1997. *MCH Update: State Medicaid Coverage of Pregnant Women and Children.* Washington, DC: National Governors' Association.
5. U.S. General Accounting Office. February 1991. *Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions.* Washington, DC: U.S. General Accounting Office.
6. Ross DC. August 18, 1997. *New Medicaid Funding for Outreach and Enrollment Activities.* Washington, DC: Center on Budget and Policy Priorities.
7. Many of the federally funded Healthy Start sites have developed training materials for lay outreach workers, which include resource manuals, curricula, protocols, and, occasionally, videotapes and audiovisual materials. Most of these are available to other programs free or for a modest charge. Further information is available from the Healthy Start National Resource Center, National Center for Education in Maternal and Child Health, Arlington, VA. In addition,

the MotherNet program (part of International Medical Services for Health in Sterling, VA) has developed a series of materials that include manuals on implementing a community resource mothers program, training and supervising resource mothers, program evaluation, fundraising, and a resource mothers handbook. A third example is the North Carolina Baby Love Outreach Worker Project in the state's Division of Maternal and Child Health, which also has developed program implementation and training materials.

State	Program	Established	Statewide	Administration	Funding	Program Description
Health Insurance Programs						
CO	Colorado Child Health Plan	1990	Yes	University of Colorado Health Sciences Center	Federal, state, and private	The Colorado Child Health Plan was established by the state legislature. It is a community-based health care plan that provides health insurance coverage for preventive care and outpatient services for low-income children under the age of 18. A newer plan, CHP+, provides coverage for inpatient hospital care, mental health care, and some other services not covered by the original plan. In addition to insurance coverage, important program goals are to teach families the value of a medical home and to help them use the managed care system.
FL	Healthy Kids Program	1992	No	The Healthy Kids Corporation	State, local, and private	The Healthy Kids program is a community-based program that provides health insurance for school children and their siblings. The program enrolls children at schools. Healthy Kids contracts with managed care plans for health care services.
PA	Western Pennsylvania's Caring Program for Children	1985	No	Western Pennsylvania Caring Foundation for Children	Private	Western Pennsylvania's Caring Program for Children provides health insurance for children who would otherwise be uninsured. Most children receive coverage through Highmark Blue Cross Blue Shield managed care plans.
RI	RIte Care Program	1994	Yes	State Department of Human Services, Office of Managed Care	Federal and state	The purpose of the RIte Care program is to provide health insurance and to ensure the availability of care to families enrolled in the state's Medicaid program. RIte Care is designed to increase access to primary care, improve the continuity and quality of care, and control the rate of growth in Medicaid expenditures. Enrollees receive care through managed care plans.

State	Program	Established	Statewide	Administration	Funding	Program Description
Programs to Help Families Get Health Insurance and Use Services Effectively						
CA	Blue Cross of California's Outreach Program	1994	No	Blue Cross of California	Private	Blue Cross of California trains and uses outreach workers who assist families enrolled in their Medicaid managed care plan. The program operates in 10 of the 13 counties where Medi-Cal beneficiaries are covered by managed care plans. The goal of the program is to ensure that families already enrolled in the plan use health care services.
CT	Children's Health Project	1996	Yes	Children's Health Council	Federal, state, and private	The Children's Health Council was created by the Connecticut General Assembly to ensure that children enrolled in the Medicaid managed care system get the health care services to which they are entitled through the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. The Connecticut Children's Health Project operates a Children's Health InfoLine and uses encounter data to track children's health services. The Children's Health Council works with providers, state agencies, and Medicaid managed care plans to facilitate effective provision of health care services to children.
NC	Health Check Program and the Health Check Outreach Project	1993	No	State Department of Health and Human Services	Federal, state, and local	North Carolina's Health Check Program replaces and enhances the state's EPSDT program. The program features a provider recruitment campaign; a consumer outreach campaign; a toll-free hotline; television, radio, and billboard advertisements; and an automated information system. The Health Check Outreach Project employs specially trained county-based Health Check Coordinators who work with individual families that need assistance with care.

State	Program	Established	Statewide	Administration	Funding	Program Description
Programs to Help Families Get Health Insurance and Use Services Effectively (continued)						
PA	Love 'em with a checkup	1993	Yes	State Department of Health	Federal and state	The Love 'em with a checkup program is a comprehensive outreach program that uses a Healthy Baby/Healthy Kids Helpline to provide families with information about health insurance and health care services in the state. The program also sponsors a statewide media campaign that encourages families to call for information about health care. The program works with health care providers to ensure that a network of providers is available.
VA	Comprehensive Health Investment Project, or CHIP of Virginia	1988	No	CHIP of Virginia	Federal, state, local, and private	CHIP of Virginia is the headquarters for a network of 11 diverse projects across Virginia that provide comprehensive services to families with children between birth and 6 years of age who are eligible for Medicaid or the CHIP program. CHIP teams of nurses and home visitors provide home visits to assist families in coordinating health care and improving family self-sufficiency. CHIP staff members work closely with primary care providers to coordinate the medical home, follow up on recommendations, and provide guidance and parenting education to families.
WV	EPSDT Family Outreach Program	1991	Yes	Department of Health, Office of Maternal and Child Health	Federal and state	The EPSDT Family Outreach Program was designed to encourage families whose children have Medicaid coverage but who are not receiving EPSDT screening visits for preventive care. The program also links families with health care providers who offer EPSDT and other services. Outreach workers visit families that need assistance.

## APPENDIX B—PROGRAM CONTACTS, BY STATE

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### **Chris Champlin**

Director  
Health Education and Promotion  
Blue Cross of California's Outreach Program  
5151-A Camino Ruiz  
Camarillo, CA 93012  
Phone: (805) 384-3614  
Fax: (805) 383-1714  
E-mail: [chris.champlin@wellpoint.com](mailto:chris.champlin@wellpoint.com)

### **Bonnie Sherman**

Program Director  
Colorado Child Health Plan  
PO Box 469022  
Glendale, CO 80246  
Phone: (303) 692-2960  
Fax: (303) 692-0876  
E-mail: [bonnie.sherman@cchp.org](mailto:bonnie.sherman@cchp.org)

### **Mary Alice Lee**

Policy Analyst  
Children's Health Council  
Children's Health InfoLine  
85 Gillett Street  
Hartford, CT 06105  
Phone: (860) 548-1661  
Fax: (860) 548-1783

### **Rose Naff**

Director  
Healthy Kids  
223 South Gadsden Street  
Tallahassee, FL 32301  
Phone: (850) 224-5437, ext. 100  
Fax: (850) 224-0615  
E-mail: [rnaff@healthykids.org](mailto:rnaff@healthykids.org)

### **Carol Tant**

Preventive Services Program Manager  
North Carolina Department of Health and  
Human Services  
Division of Women's and Children's Health  
Health Check  
1330 St. Mary's Street  
PO Box 29597  
Raleigh, NC 27626  
Phone: (919) 715-3424  
Fax: (919) 715-3049  
E-mail: [carol\\_tant@mail.ehnr.state.nc.us](mailto:carol_tant@mail.ehnr.state.nc.us)

### **Milo Woodward**

Director  
Maternal and Infant Health Section  
Division of Maternal and Child Health  
Department of Health  
Love 'em with a checkup  
PO Box 90  
Room 725 Health and Welfare Building  
Harrisburg, PA 17108  
Phone: (717) 772-2762  
Fax: (717) 772-0323  
E-mail: [mwoodwar@health.state.pa.us](mailto:mwoodwar@health.state.pa.us)

### **Charles LaVallee**

Vice President and Executive Director  
Western Pennsylvania Caring Foundation for  
Children  
Caring Program  
Penn Avenue Place  
501 Penn Avenue  
Pittsburgh, PA 15222  
Phone: (412) 544-1689  
Fax: (412) 544-1686

**Ron Ek**  
Chief of Program Development  
State of Rhode Island Department of Human  
Services  
RIteCare  
600 New London Avenue  
Cranston, RI 02920  
Phone: (401) 464-3054  
Fax: (401) 464-1876

**Angie Francis**  
Executive Director  
Comprehensive Health Investment Project  
145 West Campbell Avenue  
Suite 440  
Roanoke, VA 24011  
Phone: (540) 345-9370  
Fax: (540) 342-4161

**Pat Moss**  
Director  
Office of Maternal and Child Health, Bureau  
for Public Health  
Family Outreach Workers Program  
1411 Virginia Street, East  
Charleston, WV 25301  
Phone: (304) 558-5388  
Fax: (304) 558-2183

