Final Observations

In the previous sections, we outlined lessons learned, conclusions and recommendations on specific outreach initiatives and our efforts to simplify, and enhance enrollment and re-enrollment processes and materials. Below we present some overall lessons and conclusions, and offer some final recommendations and thoughts.

Overall Lessons and Conclusions

Coalition and Program Champions

We found that **broad-based coalitions and program champions** supported by staff that can follow through were critical to getting the program off to a successful start, both in generating enthusiasm for the program and getting the word out through many different channels quickly. However, we believe that coalitions should not be relied upon as the principal way to sustain outreach and enrollment activities on a day-to-day, long-term basis.

Over the course of the project, coalition members and other partners have provided in-kind and financial support for outreach and funds to cover Health Choice enrollment fees for many families, and served as strong advocates for expansion of the program when state funds were strained.

Outreach Strategies

Our experience testing different approaches has led us to believe that **there is no magic bullet.** No single special initiative that we tried resulted in enrolling more than 178 children in any county. (The effectiveness of each approach, however, must be considered within the context of high initial enrollment, short project periods, and changes in implementation and design in response to the freeze. Project staff frequently commented that had project periods been longer, and had they had an opportunity to refine and repeat certain projects, results would have been greater.)

Most of our initiatives were designed to leverage limited resources by enlisting others to carry out much of the outreach and enrollment. Pilots worked with and through **gatekeepers** - human resource managers, business owners, doctors, medical office managers, church leaders, staff in community-based agencies, school and child care personnel and others who have relationships and direct contact with a broad range of families whose children might be eligible. Through this approach, we believed, we could capitalize on connections that others already had established in different sectors of the community, putting a network in place to sustain long-term efforts while efficiently using resources. But we learned firsthand that there are major limitations to conducting outreach and enrollment efforts on an ongoing basis through such gatekeepers.

In addition to the major investment that is needed at the start-up, substantial effort was often required to sustain such arrangements. Folks, initially very enthusiastic and motivated, eventually had to divide their time among competing demands and other priorities. Changes in staff and restructuring of organizations were not uncommon and required constant reorienting of partners.

Despite the limitations, we found that some approaches are more likely than others to yield results and be sustainable. We also found that some strategies worked differently in different places. Their relative success seemed to be influenced by the local environment and previously established relationships, as well as the details of their implementation.

Through our efforts, we learned that in order for strategies that involve partners to be effective, personal contact, time and repetition are often needed to build trust, relationships,

knowledge about and a strong commitment to the program. Repeating approaches over time allows those involved to arrive at reasonable roles and responsibilities, to work out logistical details, and to resolve problems.

Given the investment and commitment required, and the limited resources available, we've come to believe that it may be best to concentrate on developing relationships and systems with carefully selected partners – especially if one wants to arrive at a method that will be sustainable over the long run. Such partners, for us, are schools; those who work with child care providers and the families they serve; and some health care providers. Although our initiative to enroll Hispanic/Latino children fell short of our expectations, we continue to believe that the key to reaching special populations is through the community-based organizations that serve them. The relationships established through the outreach initiative have built the foundation for future efforts. All of these potential partners share a deep concern for getting health coverage for children, are trusted by families, and have established lines of communication to a broad range of families whose children may be eligible for coverage.

Like others, we believe that it is also worthwhile to collaborate with entities that work with public assistance programs, e.g., childcare subsidies, food stamps. Through such partnerships, one can capitalize on structures and systems that are already in place to reach families who are applying for or already receiving benefits and who are likely to be eligible for Health Check/Health Choice.

Not surprisingly, we learned that individuals can make or break an effort. Administrators who championed the program and committed, competent people at different levels of an organization who would **carry the ball** were essential. We learned how important it was to identify and work with the **right people**. This might be the insurance and billing clerk in a medical provider's office, or the school secretary in a particular school district. Our success depended on having realistic expectations regarding the roles others could play and tailoring the task to what they were willing to do. Many partners did not have the time or feel comfortable providing application assistance. In general, they were more willing to distribute information and refer families than provide this type of assistance.

Materials and Messages

As we developed materials and messages for outreach, enrollment, and re-enrollment, we learned several important lessons. We learned that developing appropriate materials is a time-consuming task; that consumer input is invaluable when creating new materials; and that it is not realistic to expect to design the perfect piece that pleases everyone, especially given time and financial constraints.

Our most effective materials had **simple, consistent messages** that included a **call to action.** These pieces focused on **essential** information, clearly explaining what the reader needed to know and do, how and when to do it, and **who to call for help**. We found that our outreach materials evolved as they were used - and that our messages got simpler and more straightforward.

In addition to consumer materials, we developed tool kits that were customized to different partners. Along with providing **gatekeepers** information to use to reach families and enroll children, these kits were intended as a recruiting and public relations tool. We found that in general it was not cost-effective to send resource kits without first making a personal (or telephone) contact and determining whether the kits were wanted; and often it was best to provide gatekeepers with the specific materials they requested rather than the entire kit.

In the last phase of our project, we tended to give partners flyers, rather than applications, to distribute to families - providing applications only to those who felt that they would use them. The flyers featured a local and direct number for families to call for an application and assistance. Their call provided us with the opportunity to determine what prompted the call, to provide application assistance if desired and to get the caller's address and phone number to conduct follow-up. (Note: Applications are now available on the Web as well as from the State hotline and through local sources.)

Customer-service-oriented infrastructure

As our projects evolved, it became clear that **getting the word out (the phones to ring) and enrolling children were not one and the same**. We saw how a customer-service-oriented infrastructure in a Department of Social Services can successfully pick up where outreach leaves off. Key components are:

- Direct access for families by phone to qualified and friendly staff (for mail-in applications and information).
- Application assistance and follow-up and follow-through. (For families who have set aside the application as they attended to other matters, or because they got stuck on a question or two, a simple reminder or the availability of application assistance by telephone from a knowledgeable, caring person at a time convenient for the family can make all the difference.)
- Technology/automation to help personalize communications and ease tracking and follow-up with families who have requested applications.

For families whose barrier is financial, help in covering the Health Choice enrollment fee, which is required of some families, can make the difference between enrolling and not enrolling their children. We have seen the tremendous impact that scholarship funds and other mechanisms established to fund Health Choice enrollment fees have had in covering families in all five of our Pilot Counties.

Re-enrollment

Much of what we learned about enhancing enrollment, we found also applied to re-enrollment: reminders can make a difference; and technology/automation can facilitate and personalize communications with families and support workers in their efforts to get and keep children covered. Through our work we identified ways to reduce confusion and encourage families to re-enroll. These involved changing the sequence of communications that were sent to families from the State and the local DSS, and redesigning materials to be clearer and more appealing.

Based on State reports, we concluded that the Health Choice re-enrollment situation is significantly better than it might first appear when one considers the children who are authorized for Medicaid along with those re-enrolled in Health Choice. We saw that the statewide re-enrollment rate improved dramatically over time, particularly after the freeze on Health Choice went into effect. State data and other evidence also suggest that many who are not re-enrolling are probably not eligible.

Over the course of our project, we've come to truly appreciate the important role that close coordination (seamlessness) between Health Choice and Health Check appears to play in enrolling children in Health Choice and in keeping children covered. One system and agency determines eligibility and recertification, lessening the likelihood that children will fall between the cracks. From State data we've learned that a large number of Health Choice enrollees have come directly from Medicaid and that a large percent of children who are "on file for Health Choice recertification" become authorized for Medicaid.

Recommendations

To those who are just embarking on outreach and those who want to institutionalize an approach that will reach a broad range of families, we strongly recommend working with the schools. Specifically, we suggest the **flyer and follow-up** strategy that we pilot-tested. It is time-limited, relatively affordable and we believe can be sustained over the long run. By implementing it on an ongoing basis, one can reach those who are newly eligible, along with

those who have been eligible but have not yet sought coverage. To parents whose children are already enrolled, the flyer serves as a re-enrollment reminder. The repetitious, cyclical nature of this approach allows refinement over time.

Depending on the level of interest and the resources available, this strategy can be augmented by other **in-school** strategies, which include working closely with school nurses, guidance counselors and other key school personnel, and possibly the school meals program. Those with additional resources should consider a more comprehensive **back-to-school approach or campaign**, that encompasses select strategies with businesses and the media to both expand the reach and complement the in-school activities.

We believe that the key to reaching families whose children are not yet in school is partnering with agencies, organizations and individuals such as Child Care Health Consultants, who have direct relationships working with child care providers and the low-income families of young children in our state. By piggybacking on systems that are already in place, counties may be able to institutionalize and sustain outreach to families with young children. As with other initiatives, one needs to have realistic expectations of those involved, tailor the task to what individuals are willing to do, and decide on materials that are affordable and that participants feel they will actually use. For some, these will be flyers with a call-in number, for others, a parent pack like those used by the Guilford Pilot.

In addition to working with the schools and those with connections to childcare providers, we suggest partnering with health care providers, particularly hospitals, health departments and other primary care providers who serve a high concentration of low-income families. Outstationing eligibility workers in health care settings may be advisable where the volume of potential enrollees is high, and where workers enroll adults in Medicaid along with children in Health Check/Health Choice and can perform other tasks during "down time."

We also encourage others to develop relationships with those providers who demonstrate a special interest in Health Choice. Many may be interested in assuming a role in outreach that extends beyond their patients and their own practices to others in their community and their colleagues around the state. Such **champions** are critical to the long-term viability of the Program. They help resolve problems as they arise, build support among their colleagues (to ensure that an adequate supply of providers is available to serve covered children), and serve as effective advocates in the political arena for the Program's continuation and expansion.

We urge others to cultivate relationships with those in the business community and to engage them as principal partners. Business partners, we have learned, provide invaluable advice and other in-kind and financial support for outreach overall, particularly in conjunction with our back-to-school campaigns. Based on our experience, we do not recommend outreach through business and employers as a primary method of reaching families and enrolling children, however.

We'd recommend that others continue to develop and test approaches for reaching the Hispanic/Latino community and other special populations after considering our experience and the experiences of others who have undertaken such initiatives in the state and elsewhere. If we were to continue in this arena, we'd once again partner with community-based organizations. We'd work out more realistic roles and jointly arrive at effective ways for providing application assistance and follow-up. We'd consider airing radio ads on Hispanic/Latino stations such as those created specifically for this population by the North Carolina Healthy Start Foundation and Greer, Margolis, Mitchell, Burns and Associates, the communications firm that has worked with Covering Kids nationally. And we'd refine our school **flyer and follow-up** approach to ensure materials were appropriate and that follow-up and application assistance were readily available in Spanish from trusted sources.

Along with others, we believe that counties should continue and possibly refine and expand on their efforts to target families who are connected to other public assistance programs. Until more work has been done to develop and test joint applications that serve multiple programs, we suggest the straightforward approaches that are often being used. These include helping those who are applying to such programs as food stamps, child care subsidies and WIC to also apply for Health Check/Health Choice; and sending letters and flyers to those who are applying or have already been approved for benefits (including Free and Reduced School Meals.) We

recommend that departments of social services use the State **Data Warehouse** to target those who are receiving food stamps and childcare subsidies and who are not already covered by Health Check/Health Choice.

Needless to say, communities must first consider their local environment before investing in relationships and choosing strategies for outreach and enrollment. Regardless of the strategies chosen, we recommend that communities put a mechanism in place to ensure application assistance by phone (at times convenient to families) and follow-up with those who express an interest in the program. We also strongly urge those who undertake initiatives to track their activities and the outcomes.

With regard to re-enrollment, much of what we recommended has already been done. The State has changed the sequence of communications to families and redesigned many materials to be clearer, more appealing and reinforcing. We encourage the State and local DSSs to continue to implement changes to the re-enrollment process as adopted by the State Re-enrollment Workgroup; and encourage the State to generate re-enrollment reports for Health Check, like those currently produced for Health Choice, so re-enrollment in that program can be monitored.

Finally, we encourage the State to seek outside support and the assistance of experts in order to refine state and county projections of uninsured children.

Final Thoughts

As we look back at the last several years, we can see that the State and our Covering Kids project have accomplished a great deal. The State and Pilot Counties have twice exceeded enrollment targets in Health Choice and have continued to make great gains in covering children who are eligible for Health Check.

Covering Kids has designed and tested strategies and materials to reach, enroll and re-enroll children into the Program. Through our experiences we have learned lessons that may be useful to those who are interested in undertaking similar approaches; and have arrived at some recommendations for those with limited resources who are interested in long-term sustainable approaches.

As we conclude our project, we recall many of the challenges North Carolina and our Pilot projects have faced. These have included such natural disasters as Hurricane Floyd and the floods that followed, changes in organizations and staff at the local level, converting information received from national, state and local agencies into action at the grassroots level, an economic downturn, and most notably, the freeze on enrollment in Health Choice.

Achievements and the ability to overcome obstacles– both minor and major - have been due to strong partnerships and committed individuals who have worked tirelessly at the state and local level, and the tremendous support of national organizations.

As we celebrate the tens of thousands of children who have insurance coverage and access to health care through Health Check/Health Choice, now is not a time to be complacent. Despite having reached targets, we know that there are still those who are eligible and without coverage. As in the past, North Carolina will face major challenges in its efforts to cover eligible children. If we are to truly have better health – and a better future - for **all** of our children, organizations and individuals will need to stay the course.