Outreach

Overview

An integral component of the State's outreach plan, Covering Kids provided North Carolina with an opportunity to pilot strategies for reaching families and enrolling children. Successful strategies could serve as models to be replicated in other communities in the state. Strategies that showed promise could be refined, and possibly retried based on lessons learned. Ultimately our task at Covering Kids was to develop outreach strategies that were not only effective, but also affordable and sustainable in the long run. From the very beginning, we were particularly interested in developing an approach, or approaches, that appealed to busy, working families - especially those who may have had little or no contact with publicly sponsored programs - and specific segments of the population, such as North Carolina's growing Hispanic/Latino population.[1] The Covering Kids Pilot Counties --Buncombe, Cabarrus, Edgecombe, Forsyth and Guilford – served as the laboratories for developing these approaches through a series of "special initiatives." (See back cover for Pilot County lead agencies.)

In 1999, we began detailed planning for projects that targeted different segments of the community and specific populations - business, health care providers, the faith community, Hispanic/Latinos, and African Americans. "Gatekeepers" were the key to most of the initiatives. Through human resource managers, business owners, doctors, medical office managers, church leaders, staff in community-based agencies and others who could reach and help enroll many of those targeted, we felt we could leverage our limited resources, capitalize on connections that others already had in different sectors of the community, and put a network in place to sustain the effort.

With input from the gatekeepers, consultants and others we began to develop strategies, materials and messages tailored to the specific interests, concerns and needs of the gatekeepers and those within their organizations that would be involved in outreach and enrollment. Materials and messages were designed to build on and complement those created by the North Carolina Healthy Start Foundation (NCHSF). Later, pieces were designed and refined based on our own experience, the work of others and what we had learned from the research undertaken by Covering Kids nationally - including work by Greer, Margolis, Mitchell, Burns and Associates (GMMB) and Wirthlin Worldwide, the communications research firm that was involved in their effort.[2]

While Pilot Counties were developing and implementing "special initiatives," they were carrying out other outreach activities to enroll as many children as possible. Examples included: targeting recipients of food stamps, WIC, Emergency Assistance and childcare subsidies; training community-based agency volunteers to provide application assistance to families; and making the mail-in application available in many, many locations in the community. Some Pilots had outstationed Department of Social Services (DSS) eligibility workers at clinics, health departments and/or hospitals, and were working with the schools and childcare providers.

By the close of the year, the Buncombe and Guilford Pilots had kicked off their business initiatives. Buncombe County had produced a video, "Kids will be Kids" that the State adapted and distributed in early 2000 along with a video developed by Covering Kids (national) to local coalition coordinators and other key people in North Carolina's 100 counties. Pilots had created other marketing materials that complemented those designed by the State/NCHSF and could have broader use.

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[1] An initiative specifically aimed at enrolling Latino/Hispanics, African-American and Native Americans, which was funded by the Duke Endowment, was launched by the State at approximately the same time.

[2] As part of the Covering Kids national effort, Wirthlin Worldwide, a research firm, conducted a survey of parents whose children were enrolled in Medicaid or SCHIP and among parents whose children were eligible for the programs but not enrolled. A major finding from the survey was that many eligible parents do not believe that the programs apply to them. This misperception is most prevalent among eligible households in which both parents are working and among those making $25,000 a year or more. We used these findings in developing the messages of the campaign.

> ***At the end of 1999**, nearly **56,000** children statewide were enrolled in Health Choice statewide, 78% of those estimated to be eligible. Enrollment in the five Pilot counties, combined, approximated **6,500**. The penetration across Pilot Counties ranged from 51% to 88%.*[3]

During the first three-quarters of 2000, we rolled out other initiatives. The Cabarrus Pilot began visiting medical office managers and met with school nurses, familiarizing them with the program and providing them with a newly-created tool kit to help reach and enroll children. Customizing the materials and modifying the approach, other Pilots re-doubled their efforts to target medical offices in their counties.

With the materials developed for primary care providers as a guide, Cabarrus created kits to target dentists and vision care specialists. These included provider-specific Frequently Asked Questions guides (FAQs) developed with the input of local providers and the assistance of members of the NC Health Choice Provider Task Force.

Buncombe took the lead in developing strategies and materials that targeted pharmacists, collaborating with a KMart pharmacy in Asheville. Cabarrus and Forsyth began compiling data to help assess the impact of outstationed eligibility workers in a hospital and an outpatient department.

In the spring, Cabarrus kicked off its faith initiative with a prayer breakfast for pastors and other congregation leaders, and trained congregation Captains to reach and enroll church members. In the summer, Edgecombe rolled out its business initiative, mostly targeting small businesses. In the fall, Guilford County implemented a refined service-learning initiative that involved African-American high-school students who were taking a course on economic, legal and political matters. Forsyth forged ahead on its initiative to reach Hispanic/Latino families, arranging for compensation (financial incentives) to be paid to two community-based agencies that were well connected and trusted by families in that community.

Since the beginning, the State and Pilots have worked with childcare programs and schools.[4] But it was in the latter part of 2000 as we gained experience with different approaches, and learned from the experiences of other states and from those working at the national level, that we shifted more of our attention to strategies that involved the schools, particularly.

Much of what we did in the schools arena in 2000 was sparked by Covering Kids (national) and GMMB, who spearheaded a back-to-school campaign in the Greenville area. The campaign began on August 12 with a kick-off event/press conference at the Pitt County Public Schools Back-to-School Fair at Colonial Mall. Television and radio ads were test-marketed in August and September.[5] Edgecombe County (within the test-market area) held a back-to-school day at Kmart and Wal-Mart, distributed flyers to elementary and middle school students and purchased ad space in high school football programs. Drawing on the media kit designed by Covering Kids (national)/GMMB, Buncombe mounted its own campaign, running radio and television ads and distributing flyers to schoolchildren. Buncombe had a bike and helmet give-away at a Kmart where information about the program was displayed throughout the store.

The Guilford Pilot rolled out a School Meals Demonstration Project in late summer/fall – gaining parents' permission for information to be shared with the children's health insurance program on their school meals applications, electronically matching data obtained from the school meals application with Health Check/Health Choice enrollment, and contacting families

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[3] State officials provided Health Choice statewide enrollment figures. Pilot County figures were taken from reports on enrollment by county generated by the State. By "penetration" we mean children enrolled as a percentage of those estimated to be eligible.

[4] The Governor and State Superintendent requested that principals send a Health Check/Health Choice flyer (English and Spanish) home with students' first quarter report cards. Staff from school-based health centers was trained in the three regions of the State.

[5] Covering Kids and State staff, along with the NCHSF and the Pitt County Coalition, worked with GMMB on the test marketing campaign titled "Healthy Students." Greenville was among six mid-sized markets that were chosen for test marketing across the country. The campaign was primarily aimed at African-American families in the Greenville market.

with information and applications by mail. Also in Guilford, county-sponsored childcare nurses, who work with childcare centers, distributed Parent Packs to centers and spoke with program administrators about how the program could benefit their families.

In the latter part of 2000 as the State neared its enrollment target and faced a budget shortfall, it became likely that the State of North Carolina would declare a freeze on enrollment in Health Choice. Pilots worked feverishly to contact their partners and urge families to enroll their children. We at Covering Kids assisted the State in developing a question and answer guide for hotline staff and others who needed to respond to questions, and a letter to send to families whose children were enrolled assuring them that their coverage wouldn't end if they re-enrolled on time and encouraging them to re-enroll. We stepped up many of the outreach and enrollment initiatives that were in progress. Some, like Guilford's School Meals Project, were significantly modified in design and implementation.

> ***At the close of 2000**, there were **72,024** children enrolled statewide in Health Choice, nearly 700 more than originally projected to be eligible (target was 71,343).* [6]
> *Health Choice covered approximately 16,300 more children than a year earlier. At that time, enrollment in the Pilot Counties stood at **8,921**, 102% of the number targeted. Approximately 2,400 more children were enrolled in these counties than at the end of the previous year. Penetration across Pilots ranged from 73% to 114%.*

When the enrollment freeze took effect on January 1, 2001, many who had been involved in outreach cut back or stopped their efforts altogether, feeling that it was nearly impossible to target families whose children would be eligible for Health Check, an entitlement program that is not capped, without also "drumming up" business for Health Choice (from the very beginning, the programs were marketed as one.) They believed that it was misleading and unfair to actively market a product that they could not deliver; and that while children who were determined eligible for Health Choice and placed on the waiting list would hopefully be enrolled in the future, that this could not be assured. Some tried to target outreach efforts to those at lower income levels who would be eligible for Health Check. Others, convinced that it was better to place a child on the waiting list in the hopes that they would be enrolled in time, continued reaching out to the broader spectrum of families.

In response to the freeze, the State/NCHSF refocused its efforts, spearheading the development of a guide with frequently asked questions relating to the freeze; drafting letters and forms that explained the freeze, the waiting list and "reactivation" to families (to be used when the freeze was lifted); and providing technical assistance to local coalitions individually. During the freeze, the State/NCHSF focused on such high priority areas as re-enrollment and provided consultation and support to the Covering Kids project, including our schools initiative.[7]

As we dealt with the challenges of the freeze, we at Covering Kids wrapped up many of our special initiatives (prematurely in some cases), reflected on our experiences, and considered the future. In the summer/fall of 2001, based on our preliminary conclusions, our desire to develop approaches that were not only effective but could be sustained in the long run, and a new reality (that even if enrollment would be expanded, money for outreach was likely to be scarce), we decided to try to replicate Buncombe's school strategy in other Pilot Counties. Buncombe's low-tech and relatively low-cost approach to reaching families involved intensive follow-up and follow-through. The approach built on relationships that, in many Pilot Counties, were already established.

In early October 2001, the freeze was lifted and the legislature expanded Health Choice to allow for an average of 83,000 children to be enrolled. Statewide enrollment had slipped to approximately **51,300** children or 72% of those estimated to be eligible.

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[6] It was widely believed that the number of children projected to be eligible was significantly understated.

[7] Throughout 1999 and for a good part of 2000 (before the decision to freeze Health Choice enrollment), the State/NCHSF continued to develop promotion and information materials, e.g., income cards, flyers, other materials and ads targeting Hispanics/Latinos. They aired radio and television spots statewide, especially targeting areas where enrollment was lagging behind.

Roughly **6,300** children or 73% of those estimated to be eligible in the Pilot Counties, combined, were enrolled. Penetration ranged from 56% to 84% across Pilot Counties. Materials for our schools initiatives had been designed. School projects were underway in a couple of the Pilot counties; and other projects that had been planned were ready to be rolled out.

In the last quarter of 2001, the State and local coalitions reinvigorated outreach and enrollment efforts, working hard to regain lost ground.

> ***By the end of 2001**, statewide enrollment in Health Choice had increased to nearly **65,000** children. Over **8,000** children were enrolled in the Pilot counties, combined. **By the end of June 2002**, with nearly **84,300** children enrolled in Health Choice, the state had surpassed its "pre-freeze peak" by more than 12,000 children. The enrollment in Pilot Counties had climbed to nearly **10,900**, an increase of approximately 2,000 children from when the freeze went into effect.*

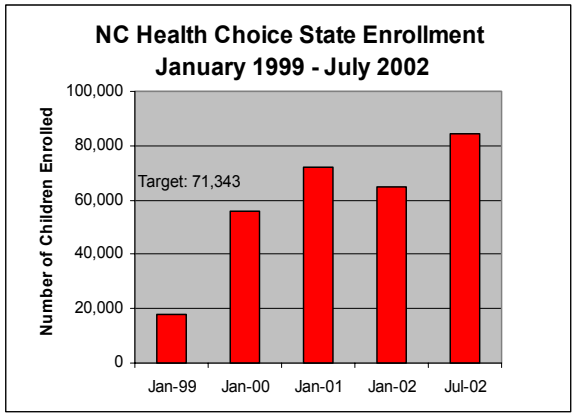
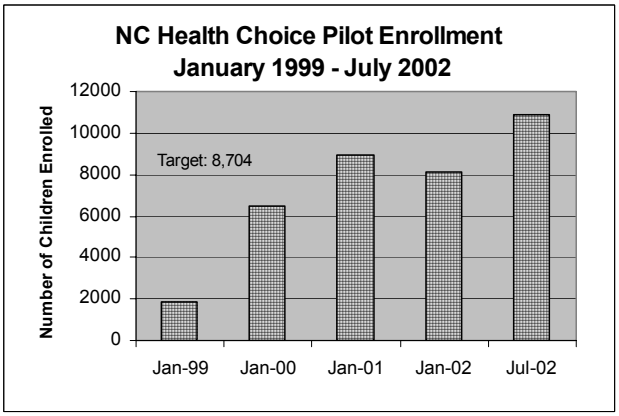


Exhibit A

Exhibit B



During the project period, enrollment in Health Check as well as Health Choice increased substantially. From the close of 1998 to year-end 2001, statewide enrollment in Medicaid – Infants & Children (M-IC), alone, grew by approximately 63,400 children while the combined Pilot County enrollment in M-IC grew by approximately 8,200 children. By the close of 2001, approximately 305,000 children were enrolled in M-IC statewide, roughly 38,000 of them in Pilot Counties. M-IC enrollment has continued to climb in 2002: At the beginning of June, approximately 319,000 children were enrolled in the state and more than 40,000 in the Pilot Counties.[8]

In the following pages, we look at outreach initiatives more closely – at the specific strategies Pilot Counties employed, and the results of these efforts. We highlight lessons that that we've learned, and share our conclusions and recommendations, which have been synthesized from the views of those who worked with the specific strategies along with others involved in the project.

[8] Medicaid "point in time" data are kept by categorical programs, e.g., aged; blind; disabled; AFDC; foster care; pregnant women; infants & children. While the number of children categorized as M-IC does not reflect the total number of children with Medicaid/Health Check (other categories include children as well as adults), we've presented M-IC enrollment data, as many believe that it is a good indicator of outreach and changes in enrollment of children in Health Check. This data is from State-generated reports on authorized Medicaid eligibles by county.

Special Initiatives

Businesses & Other Employers

Involving businesses in the effort to reach eligible children is logical considering that eight out of 10 (79 percent) of low-income, uninsured children have parents who work full- or part-time.[9] *When employers help enroll their employees' children in Health Check/Health Choice, they benefit not only their workers but also their own organizations. They reduce absenteeism and increase productivity, employee loyalty and retention – all at no cost to their businesses.*

Strategies

Three Pilot Counties - **Buncombe**, **Guilford** and **Edgecombe** - designed and implemented strategies to engage businesses and other employers in reaching and enrolling their employees and, to a lesser extent, their customers and vendors in their communities.

The **Buncombe** Pilot's major push to businesses began in the fall of 1999 with a "kick-off" breakfast for human resource and district managers, small business owners, insurance benefits administrators and others. The breakfast featured "Kids will be Kids," a video about Health Check/Health Choice produced by the Buncombe Pilot that profiles healthy, active children, and a presentation by a highly regarded local pediatrician. Coalition members met with small groups during breakfast. Packets of information were distributed about the Program, which included a brochure aimed at employers and suggestions for becoming involved. Outreach staff followed up with those who attended the "kick-off" breakfast and those who could not attend but were interested in learning about Health Check/Health Choice.

In Buncombe County, the Chamber of Commerce was on board very early on: Chamber representatives that did outreach for the Chamber itself carried Health Check/Health Choice messages and materials directly to its members; and the Chamber helped identify businesses for the Pilot to target. Local restaurants and stores from national chains supported the outreach effort in various ways. For example, McDonalds and Arby's used Health Check/Health Choice tray liners; Pizza Hut attached Health Check/Health Choice information to pizza boxes; Wal-Mart sponsored back-to-school coupons promoting Health Check/Health Choice; and Kmart had a bike and helmet give-away as part of a larger Health Check/Health Choice back-to-school campaign.

The **Guilford** Pilot sought input from local businesses, worked with the Chamber of Commerce and an organization of Human Resource Directors, initially targeting larger employers. Strategies included participating in an employee health fair, supplying paycheck "stuffers" with program information, attending special events and sending letters and business resource kits (tool kits) by mail. Many non-profit organizations were reached through a "roundtable" sponsored by the Chamber. Later, the Pilot focused on small business owners by working with an association of health underwriters. This approach used the brokers, who earn their living by creating insurance packages for business, to pass the word about Health Check/Health Choice to their clients.

The **Edgecombe** Pilot's business project, which began in the fall of 1999 with the strong endorsement of two Chambers of Commerce, was twice derailed – first as the result of Hurricane Floyd and then by a loss of critical staff. The project got fully back on track in June of 2000. While many of the larger employers were targeted (e.g., the County, manufacturers, utility companies, fast food chains, banks, motels, KMart and Wal-Mart), the Pilot's primary focus was on small businesses. The approach was largely door-to-door, and shopkeeper-to-shopkeeper. Among those targeted were beauty and nail salons, places that provide cash advances and check cashing services, video shops, cleaners, pharmacies, rent-to-own and realty companies.

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[9] Kaiser Commission on Medicaid and the Uninsured. (2000). Health Coverage for Low-income Children: Key Facts. Washington, DC: Henry J. Kaiser Family Foundation.

The State and the North Carolina Healthy Start Foundation (NCHSF) targeted businesses on a statewide level. Prior to the freeze on NC Health Choice, the State/NCHSF were actively engaged in outreach to and through business. Early on, the State/NCHSF tried to target smaller businesses and their employees through Caroliance, a partially state-supported health care purchasing alliance for small businesses. Pharmaceutical companies, the March of Dimes, CPAs/tax preparer associations, large discount stores (including KMart and Wal-Mart), and statewide trade associations for the hotel/motel and the restaurant industries were among the partners that assisted with outreach in different and creative ways. (For example, then- Glaxo Wellcome, Inc. helped develop radio public service announcements and paid for printing of materials, Hoffman-Laroche and Sepracor distributed information about Health Check/Health Choice to providers as part of their normal business operations.) The State worked through county coalitions on local business outreach as well. In January 2000, with the support of then-Glaxo Wellcome, Inc. the NCHSF convened a Business Advisory Council to guide the state in the development of targeted business outreach initiatives and materials. Because of the freeze, many of the activities were put on hold. When the freeze was lifted and the program expanded in the fall of 2001, the State once again began to work with the North Carolina Hotel and Motel Association, H&R Block (in conjunction with a national Covering Kids initiative) and others.

Materials and Messages

Buncombe, Guilford and Edgecombe County developed business tool kits to target employers. Buncombe's kit included a brochure, "Pass the Word About Health Coverage for the Kids of Working Families," that delineated the benefits to employees and to the company, e.g., employee loyalty/retention, and fewer missed workdays. The cover letter to Guilford's kit emphasized that an estimated 7,000 children in Guilford County are without health insurance, over 90% have parents who work, employers want their employees to have health insurance, the difficulties employers face in making insurance available to their employees and that now there is an answer. Along with other key pieces, the kit included some "quick start" suggestions to help employees learn about Health Check/Health Choice, a materials order form and Health Check/Health Choice promotional items, e.g., a pencil, post-it notes, and a computer screen cleaner. Edgecombe's kit contained later versions of pieces developed and tried out by Buncombe and Guilford plus some others, e.g., frequently asked questions for businesses. The kit was designed with the assistance of Epley Associates, a communications firm that has worked with us on different aspects of this project, as a possible prototype. As with the other kits, Edgecombe's kit complemented and included materials produced by the State/NCHSF.

Results

In **Buncombe** County, of the 1200 businesses/employers that were initially invited to the businesses breakfast, 200 attended. (Note: approximately 700 had been contacted by phone.) Roughly 300 employers ultimately requested information on the Program, about half of whom had been at the breakfast. Applications for approximately 80 children were coded specifically to the business outreach initiative over a ten-month period. Of these children, sixty-one children were approved for the program, 35 for Health Check and 26 for Health Choice. (Note: It is likely that these numbers understate the impact of this initiative, somewhat, in that they do not capture the applications that were prompted by but not coded to business, e.g., applications obtained through the state toll-free hotline, that resulted from information passed on by a friend or family member [10] or in instances where business outreach was one of several approaches that motivated a parent to apply.[11] This caveat regarding the likely

[10] One of the key messages Buncombe County uses is: "If not for you, please tell a friend". This is both non-threatening to a potential applicant and considered a successful marketing tool.

[11] This initiative was conducted simultaneously and in coordination with other complementary and reinforcing initiatives.

understatement of the effectiveness of initiatives applies to other initiatives described in this report as well.)

In **Edgecombe** County, over a six-month period, approximately 330 businesses were contacted; roughly 250 (76%) of those agreed to be involved and took materials (included fifty-five business tool kits). Smaller businesses were more likely to participate in this outreach initiative than larger employers. Twelve businesses agreed to enclose envelope stuffers in payroll statements, prescription bags or shoeboxes. Out of the 1,200 coded applications distributed among businesses, applications for 25 children were traced to this initiative; 21 children were approved (14 for Health Check and 7 for Health Choice).

Although **Guilford** did not track enrollments resulting from this initiative, we do know that five of 30 businesses contacted requested information to share with employees and some took the information to plant managers in other parts of the state. The health underwriters expressed a great deal of enthusiasm for the program and indicated that they would continue to incorporate information into their packages for clients needing help with coverage for children.

Lessons Learned

- Employer Barriers. For a number of reasons many businesses may not participate in this kind of initiative. Businesses are sometimes reluctant to admit that they have uninsured employees, and they may not be comfortable involving themselves in their employees "personal" business. Some are uncomfortable displaying or presenting information about "government-sponsored" programs to their customers and employees. Credibility of the program was sometimes a factor (whether one could count on it being continued). In addition, employers who already offer an insurance program may view Health Choice as a competitor. Although we assumed that helping employees secure insurance for their children would be of interest to businesses, for many it was too far removed from their primary concerns to warrant their involvement. This may have been because we were not able to communicate how insurance would make an important positive contribution to their bottom line, or it may have been because they had other priorities. Some believed that all of their employees were satisfied with the insurance the company had for them. Some feared that placing information in their business would open the door for other agencies and programs to do the same.
- Employee Barriers. Employees don't always like to share personal information with their employers and don't necessarily trust information received from their employer. This may account for why enrollment sites at businesses in our Pilots weren't more heavily utilized.
- Major Challenge. It is a major challenge to "get a foot in the door." Introductory letters did not stir much interest. A personal contact by the right person is key. In Buncombe, this person was an energetic outreach worker with experience in sales (insurance) and with public assistance programs. In Guilford, insurance brokers who work with small businesses and are affiliated with a local organization of insurance brokers appeared to be effective (common interest in finding health insurance for employees). The business tool kit helped staff in Edgecombe County to engage employers. It is important to deliver a consistent and effective message.
- Persistence. Outreach to the business community is labor-intensive. Multiple contacts are necessary to reinforce messages and gain trust. Businesses are busy and needs change. One effective technique is to send information to the employer and to ask permission to call back in a couple of months to check in and see if a need might exist. Businesses are accustomed to this practice and it serves to demonstrate a measure of stability to an employer.
- Realistic expectations. Not surprisingly, businesses/employers were most interested in activities that required a minimum of their time and energy such as hanging a poster in a break room and giving out information rather than helping to complete applications. It was important to have a reliable resource where employers could refer employees, to publicize any telephone assistance services on all printed materials, and to ensure that the employer

could easily contact knowledgeable program representatives with questions and as needs arose. These features reduce the burden of the gatekeeper's investment, eliminating the need for frequent retraining and allowing them to "get out of the loop" quickly.

- Useful tools/materials. The most effective tools and materials were: phone, outreach coordinator, business brochure, one-page summary of benefits, applications, posters, and in Edgecombe, the business tool kit. The state-produced materials were particularly helpful when they allowed space to insert a local contact number. See Appendix A1-10 for samples from the Edgecombe Pilot's business kit, which includes state-produced (NCHSF) materials identified by the Health Check/Health Choice logo. A sample of the Buncombe Pilot's business brochure begins this appendix.

Conclusions and Recommendations

Business outreach and enrollment, for us, was not a small, low-maintenance investment with quick, high returns. While we expected that our initiative might have limited success due to the fact that so many of those estimated to be eligible were already enrolled in Health Choice, we thought that it would yield better results than it did. After all, many, many employers were enthusiastic and seemed to quickly embrace the benefits of becoming involved in outreach.

As word has spread and economic circumstances have changed, requests for applications and information by businesses have continued. The initiative is therefore likely to yield more enrollments over time, as credibility for the program and trust in those who support outreach and enrollment are built. Future success will depend on continuing to build and maintain relationships, however this takes time and is relatively labor-intensive. Work should continue to find cost-effective ways to share information and promote the program on an ongoing basis with employers, large and small, e.g., through local chambers of commerce and other professional organizations such as insurance broker groups.

The program has benefited from ties with the business community in several critical ways. Our business partners have provided invaluable advice and other in-kind and financial support for outreach overall, particularly in conjunction with our back-to-school campaigns. As relationships have been built, old barriers and the stigma often associated with government-sponsored programs and departments of social services have eroded. The business community's backing may be key to sustaining public funding for the program as well. Although we would not recommend outreach through business as the primary method of reaching families or as a short-term enrollment strategy, we strongly urge others to cultivate relationships with those in the business community and engage them as principal partners.

Health Care Providers

Only one uninsured child in five does not have a usual source of care. About one-third of uninsured children who are Medicaid-eligible use a doctor's office as their usual source of care. Among the children who are potentially eligible for CHIP, the proportion grows to 41 percent.[12] *These statistics suggest that physicians' offices and other health care providers are critical access points for enrolling uninsured children*.

Outstationing Department of Social Services (DSS) eligibility workers in hospitals and clinics has been a longstanding practice in many communities. Often hospitals and clinics contribute financial and in-kind support for workers who help ensure reimbursement and provide a convenient service to their patients.

Strategies

Three pilots were involved in outreach in the health care community. **Cabarrus** and **Buncombe** took the lead on outreach to physicians, dentists, vision care specialists, school nurses, and pharmacies while **Cabarrus** and **Forsyth** assessed the impact of outstationing in a hospital and an outpatient department.[13] In February of 2000, equipped with its primary care provider resource kit (tool kit), Covering Kids staff in **Cabarrus** met with medical office administrators, and other staff in pediatric and family medicine practices to discuss the insurance program and to explore how the practice could help enroll eligible children. Materials directed at office staff and for the office to use with parents were included in the kit. In the spring, staff began making follow-up visits, replenishing materials and answering questions.

The Pilot also targeted school nurses by working in collaboration with the public health department that employs them, the Cabarrus Health Alliance. In a group training meeting and some individual visits, staff oriented nurses to the program and the kit.

In February 2001 armed with a kit designed specifically for dentists, the Pilot began to visit dental offices. A dentist, who is a convincing advocate for the Program and a member of the NC Health Choice Provider Task Force, met with area dentists to pave the way for outreach activities. In collaboration with the Cabarrus Health Alliance, outreach was also conducted through the health department's mobile dental units that screen children at elementary schools and day care centers. Along with a packet of information about the mobile dental unit, children received an application, brochure and fact sheet about Health Check/Health Choice.

An initiative directed at vision care providers began in May of 2001 with office visits and a tool kit customized for vision care providers. We decided to implement the dental and vision care provider initiatives, despite the fact that the freeze on enrollment in Health Choice was already in effect, because we felt we could learn much by doing so (qualitatively). We didn't expect to get meaningful quantitative results, however.

Buncombe's medical office initiative included internal medicine and specialty practices as well as primary care practices that serve children. As in Cabarrus, Buncombe used a provider tool kit (a notebook based on Cabarrus's kit) to familiarize office managers with the program and enlist the help of practices in enrolling children. In addition, staff worked closely with the office personnel who handle billing and insurance, calling frequently and arranging for applications to be picked up at their offices at the end of the month, ensuring that recently delivered care would be covered/reimbursed. An application specialist employed by the

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[12] Reschovsky, J.D. & Cunningham, P.J. (1998). CHIPing away at the problem of uninsured children (Issue Brief No. 14). Washington, DC: Center for Studying Health System Change.

[13] To some extent, Guilford targeted providers through a mailing and later a dinner/orientation (for medical office administrators). The response to each approach was meager. Later, the County enlisted the assistance of Health Check outreach staff, who maintain regular contact with Medicaid providers in the county to answer questions and restock materials. Training was provided to ensure that they were familiar with Health Choice. It is believed that outreach to/through the provider community could be ongoing through this approach.

Department of Social Services but based at the Medical Society office was easily available by phone to answer questions and help practices. Posters and other program materials were placed in waiting rooms for parents to read; parents could take or complete applications on the spot.

The Buncombe Pilot implemented an initiative that targeted pharmacists in the summer of 2000. Display racks with brochures and applications were wall-mounted or placed on the counters where prescriptions are left or picked up. Many of the pharmacists and their assistants recommended the program to customers.

During the year 2000, **Cabarrus** and **Forsyth** conducted studies on outstationed eligibility workers. These were not "special initiatives" undertaken by Covering Kids but were undertaken by Departments of Social Services in conjunction with a local hospital in one county and through the outpatient departments of a medical center in another county during the Covering Kids project period. The studies tracked the number of children enrolled in Health Choice and children and adults enrolled in Medicaid through a hospital and outpatient department. In both cases, the Departments of Social Services were the Covering Kids lead agencies and were involved in compiling and analyzing data and documenting and determining what might be learned from the efforts.

In **Cabarrus** County, three Department of Social Services, eligibility workers work full-time at a large (approximately 450 bed) community hospital that offers comprehensive medical and surgical services. Two eligibility workers are responsible for enrolling adults and children in Medicaid for Families and Health Choice; the other deals exclusively with Medicaid for adults. Worker salaries and benefits are financed through federal Medicaid dollars and the hospital, which pays the non-federal share. The hospital provides staff with workspace and equipment. Hospital staff members refer uninsured patients to the outstationed eligibility workers at the time of admission. (Note: Efforts are under way to also get referrals from the emergency room staff.) The eligibility workers go to patient rooms and take applications for Health Choice and Medicaid, assist families in gathering necessary verifications to process their application, and determine eligibility. In many cases, families know before the worker leaves the hospital room if they will qualify for Health Choice or Medicaid. If individuals do not appear to be eligible for Medicaid or Health Choice, workers take applications for the hospital's charity care program and forward it to the appropriate hospital staff.

Eligibility workers have direct access to the hospital's database – Meditech - in which they update patient information (e.g. a new address) and document the progress of the application (e.g. pending wage verification). Once cases are approved, the information is keyed into the system allowing billing staff to process claims.

In **Forsyth** County, DSS has one full-time eligibility worker outstationed at the clinical sciences building of a large medical center. The worker handles applications for Medicaid (adult, family and children) and Health Choice, and corrects Medicaid reports, facilitating payments for medical services. The worker's salary and benefits are financed through federal Medicaid dollars and the physician group, which pays the non-federal share. A workspace and equipment for staff are provided at the medical center. DSS is responsible for training and supervising the outreach worker, who began in November of 1999.

Patients are referred to the worker by clinic staff, ranging from the clerical staff to the physicians. As knowledge of the position has spread, the number of applications has increased. It has become policy for clinic staff to refer self-pay patients to the worker. If the worker determines the patient is not eligible for Medicaid or Health Choice benefits, she may refer the patient to another program available in the community.

Materials and Messages

As with other strategies, materials and messages were developed with input from local providers and consultants. The Cabarrus provider tool kits included such pieces as: a letter of introduction from a provider-leader; "prescription pads" telling patients who to call for more information on Health Check/Health Choice; a Frequently Asked Questions guide (FAQs) for

providers (specific to primary care, dental and vision providers); a "key contact" list with phone numbers; informational materials for providers to give to families (produced by the State/NCHSF); applications; and promotional items (such as magnets and buttons). The promotional items provide contact information and include the logo and "little doc" mascot. Key messages were: "Are your kids covered?" or "We care about covering kids." Messages aimed directly at providers were: "Covering Kids Just Got Easier…Easy for patients…Easy for staff…Easy for you."

Display racks (wall-mounted and counter-top) with brochures and/or flyers and applications were ultimately used for the pharmacy initiative. The possibility of "coupon dispensers with flashing lights and tear-off sheets describing the program and how to apply" placed near over-the-counter medicines were considered and discarded because of cost.

No special materials were designed for the outstationed eligibility worker. In Forsyth, staff prepared an information notebook for the outreach worker and workers used Forsyth County brochures, State/NCHSF fact sheets and income cards.

Results

In **Cabarrus** County, staff from 24 medical offices along with 29 school nurses was trained and given provider tool kits (the county has one school nurse assigned at least part-time to each school). Over a nine-month period, hundreds of applications were distributed. Applications submitted for 27 children were traced to this initiative; 18 children were enrolled (12 in Health Check and 6 in Health Choice). Applications for approximately 100 children were directly attributed to the medical office initiative in Buncombe County over an 11-month period. Of these, 67 children were approved (45 for Health Check and 22 for Health Choice).

In Cabarrus County, 19 of 25 dental offices were visited and provided with information (the other six were sent information). Six of 13 vision care specialists participated in the initiative (others either declined or were unreachable, e.g., no longer in business, in a different county). Hundreds of applications were distributed by dental offices or through the mobile dental program and 20 by vision care providers. As a result of the initiative, several dentists asked to be included on a list of dentists who accept Health Choice. While one dentist agreed to see Medicaid patients on a "trial basis" because of this effort, we feel the project has done little to increase acceptance of Medicaid overall. Over the time these applications were tracked, only one was traced to these initiatives (dental). The visits to dental and vision care offices, however, were made during the freeze on Health Choice. (Note: Based on feedback received from some dentists, we suspect that more enrollees probably resulted. But it is unlikely that the numbers were significant.)

The **Buncombe** pharmacy initiative, which began in the summer of 2000, ultimately included 35 pharmacies. Among them were: CVS, Kerr, PSA and pharmacies at KMart and Wal-Mart stores. Twenty-nine applications were traced to the pharmacy initiative during a 19-month period. (Up to 10 additional applications from Wal-Mart may have come from the pharmacy there as well.)

Results for outstationed eligibility workers were more dramatic. In **Cabarrus** County, during a twelve-month period (January 1, 2000 to December 31, 2000), 1013 applications were taken for children and 378 for adults through the hospital. During the period, 984 children (26 for Health Choice and 958 for Health Check) and 342 adults were enrolled.

During the same time period, the outpatient department in **Forsyth** County took in 37 applications for children (could include more than one child), resulting in 46 children being enrolled (6 in Health Choice and 40 in Health Check), and 60 applications for adults, resulting in 56 adults being enrolled in Medicaid. Seventy-three of the 97 applications (75%) were taken in the last 6 months of the year as awareness increased of the outstationed workers in the clinics.

Note: The numbers reported for many of these initiatives (children who applied and were enrolled) may understate the impact of the initiative somewhat in that they do not capture the applications that were prompted by but not coded to this initiative, e.g., applications obtained through the state toll-free hotline. Results were based on coded applications distributed locally and received by the DSS except in the case of outstationed eligibility workers where numbers were drawn from workers' logs/reports.

Lessons Learned

Outreach to and through Medical Provider Offices:

- Target the right people in the provider office. Meet with medical office managers; provide a compelling reason for them to meet with you (coverage for their patients and reimbursement for the practice); and keep the meetings short (no longer than 15 minutes). While it is important to educate the providers and managers, it is also important to focus on staff that handles billing/filing of insurance.
- Consistent, experienced and available staff, follow-up and follow-through are key. The Buncombe Pilot reported that successes were largely due to its staff (experienced, responsive, customer-oriented outreach worker and application specialist who was easily available by phone), and intensive follow-up and follow-through, e.g., outreach worker arranged to pick up completed applications so providers would be reimbursed for care recently provided. Cabarrus felt that changes in their own staff significantly undermined their effort.
- Don't minimize the investment in time. Like many other of our initiatives, our approach with medical offices was labor-intensive at start-up and required relationships and credibility to be built over time.
- The ease of implementing and effectiveness of the strategy seem largely determined by the climate of the medical community and previously established relationships. Staff felt the receptiveness of providers was critical to success and reported major differences among their counties. (Note: It is difficult to objectively compare outcomes from one county to another due to differences in target populations, time periods studied, outreach workers, strategy details and other factors.)
- Useful tools/materials. The most useful tools were the provider tool kit (loose-leaf notebook preferred), particularly the list of key contacts, the FAQs, and the endorsement of physician leaders or the medical society. Another useful tool was having an eligibility worker dedicated to working with medical staff. This provides a "safety net" for the practice and a ready resource for answering questions. See Appendix B1-5 for: Cabarrus's cover letter for primary care providers, a table of contents, a list of contacts, and the FAQs for primary care providers. Illustrations show a prescription pad (English and Spanish) used to promote enrollment.

Outreach to/through Dentists: Among dentists, this initiative seemed to help increase awareness about Health Choice, but it did little to increase acceptance of Medicaid. The enrollment freeze caused some providers to question their participation in Health Choice. Useful tools and materials included the tool kit for dentists, particularly the Frequently Asked Questions and letter of endorsement by a dental leader and a physician. See Appendix C1-3 to view these materials as well as the Cabarrus table of contents from the kit. The FAQs in the appendix are those adapted for statewide use and are posted on the Web site: www.dhhs.state.nc.us/dma.

Outreach to/through Vision Care Specialists: The approach was successful in introducing providers to the program and in developing relationships, however it did not seem to result in enrollments. While this may have been due to the freeze, it may also be because the number of vision care specialists is small. Useful tools and materials included the tool kit for vision care specialists, particularly the list of key contacts and the FAQs. The FAQs for vision care specialists have been adapted for statewide use and are posted on the Web site: www.dhhs.state.nc.us/dma.

Outreach to/through School Nurses: School nurses are extremely busy, but key partners. Teachers, counselors and other school personnel should be targeted along with nurses. (Refer

to schools initiatives for more information.) Useful tools and materials included applications and the list of key contacts.

Outreach to/through Pharmacies: While district managers should be the primary contact, busy pharmacists and their assistants must be sold on the program and really interested in recommending it to their customers. (There is no substitute for "one-on-one.") It is difficult to maintain a presence in a pharmacy for longer than a week at a time because the store needs advertising and shelf space for other products/services. Useful tools included wall-mounted displays. Because counter-top displays are often pushed behind other promotional materials, we preferred wall-mounted displays which pharmacies are more reluctant to accept. Note: Based on input from Buncombe, FAQs for pharmacists were ultimately produced for statewide use by Covering Kids staff working in conjunction with the NC Health Choice Provider Task Force and others. They are posted on the Web site: www.dhhs.state.nc.us/dma.

Outreach using Outstationed Eligibility Workers:

- Reaching new eligibles. At Cabarrus County DSS, the number of applications taken "in-house" rather than by outstationed workers did not drop during this initiative, suggesting that those who applied at the hospital might not have applied otherwise.
- Establishing relationships and referral pathways. As with other initiatives, it is important for workers to build trusting relationships with gatekeepers (in this case, hospital staff) and systems for easy referral.
- Cost-effectiveness. This is most cost-effective for a hospital serving a large indigent care population, where increased revenues from newly insured patients could easily offset the cost of an eligibility worker's salary. Cost-effectiveness may decrease over time as a larger portion of the population becomes insured. Although the outpatient setting generated fewer applications, this could be cost-effective if the eligibility worker were also engaged in other activities. For example, the Forsyth eligibility worker also enhanced reimbursement by correcting computer data-entry errors that would have delayed payment.
- Patient benefits. This approach is extremely convenient for patients (a worker to fill out the application onsite) and eases concerns about covering medical expenses prior to discharge (or leaving the clinic). If patients were not eligible for Health Check or Health Choice, they could easily be referred into the hospital charity care program.
- Useful tools/materials. The ability to check the hospital information system helped the worker identify patients admitted without insurance. The one-page application eased the application process. Having access to computer databases at the hospital, the physician organization (in Forsyth's case), and Medicaid facilitated enrollment and reimbursement, and resulted in more up-to-date patient information in the database. Note: In Forsyth, the worker was able to help with unpaid claims by correcting simple errors in the database, e.g., spelling of names.

Outreach through Health Departments:

Finally, while our provider initiatives didn't focus on health departments, we feel it is important to emphasize the major role that health departments, which have been at the center of outreach and enrollment from the start, have played in covering kids. In Buncombe County, 535 applications were identified as having originated from the Health Center Access Unit, Buncombe's health department, in 2000 and 568 in 2001. Note: In Buncombe, DSS staff is outstationed in the health department.

Conclusions and Recommendations

When we began our provider initiatives, we were very optimistic, knowing that our initiatives contained a combination of important ingredients. The right people were involved: The folks we were engaging in outreach were committed to helping families access health care and would benefit directly from their involvement; and they had personal relationships and face-to-face contact with the families who were likely to be eligible. The timing was right:

Providers and their staffs would be approaching families at the time that they most acutely felt the need for health insurance for their children - when their children were ill and they were facing medical bills. And assistance for families to complete the applications was available. In the case of the hospital, outstationed workers would interview and help families fill out an application for the family essentially at the "bedside" and, in some cases, determine eligibility immediately.

Clearly the hospital outstationed workers whose activities we tracked were successful - particularly in enrolling adults in Medicaid and children in Health Check. Enrollment through the medical center outpatient departments that we studied was less impressive - especially in the first six months and for children in Health Choice. As medical center staff become more familiar with the outreach workers and the services they provide, enrollment is likely to improve. Whether or not such an approach will be effective in other outpatient settings will depend on the volume of eligible patients that walk through the doors, referrals from staff and the workers ability to engage in other useful activities during "down times."

For those who are interested in outstationing workers, we advise: targeting adults for Medicaid as well as children; including staff from the hospital's Emergency Department; giving eligibility workers access to computer databases so that they can provide other services such as "cleaning the data" and updating the patient information; training staff that will be referring patients to eligibility workers early on and continually. (Note: These staff should be involved in designing referral processes that will work for them.) Cost-effectiveness should be monitored over time as the proportion of uninsured patients hopefully is reduced.

In reflecting on our initiatives that targeted office-based providers and their staffs, we concluded that we were on the right track with the one-on-one approach, i.e., visiting providers at their offices rather than relying on mailings or expecting office staff to participate in group trainings.[14] Some features unique to the approach undertaken in Buncombe seemed to have aided their efforts.

- An emphasis on getting families to fill in a few specific pieces of information, and date and sign the application "on-the spot," rather than wait to submit a completed application. This way, DSS can "get the ball rolling" and follow up with the family to gather the remaining information required to determine eligibility.
- Working directly with the billing and insurance folks in the office. While it is important to get physicians, medical office manager and front office staff on board, it is the billing and insurance staff that are more likely to know who needs coverage.
- Attentiveness of DSS staff to providers' needs. The Buncombe Pilot's outreach worker will pick up applications if it is near the end of the month. This way, recently delivered care will be reimbursed if a child is determined eligible. (Note: Applications are date-stamped when they are received by DSS. Reimbursements for services of those who are ultimately enrolled in Health Choice, for example, are retroactive to the first of the month that the application is stamped. Medical expenses of those who are approved for Health Check may be retroactive for three months.)

  The application specialist is readily available by phone to consult and provide assistance to providers and medical office personnel on a wide range of matters relating to Health Check and Health Choice. (See section, Simplification: Enrollment System/Process, for more information on infrastructure and follow up.)

Regarding cost-effectiveness, it is more difficult for us to justify our one-on-one approach to office-based providers (extremely labor intensive) than that of outstationed workers in the hospital. To those with limited resources who are interested in trying a one-on-one office approach, we suggest:

[14] This should not imply that outreach workers should refrain from conducting trainings to increase awareness of and build support for the program. But this may be more efficiently done by "piggybacking" on meetings where the turnout is likely to be substantial, e.g., meetings sponsored by the Pediatrics Society that involve medical office administrators.

- focusing on the practices that are likely to have the high volume of potentially eligible patients and where one is likely to get good cooperation, such as community, rural and migrant health centers and other subsidized and free clinics;
- targeting adults eligible for Medicaid as well as children;
- partnering with others who are already working directly with providers and families likely to be eligible for benefits and whose job it is to improve access and utilization of medical services, such as Health Check Coordinators. Training and careful coordination of partners is key. Note: Outstationing an eligibility worker may be worth considering in office and clinic settings where volume is high and the worker can assume other responsibilities in their "down time."

We expected the going to be tougher with dentists, who do not seem to be looking for business and may have negative feelings about Medicaid. We were convinced that one could only really engage providers in outreach and enrollment activities that are willing to accept these patients because they see the benefits of the program themselves. Therefore, our goal with dentists was to make them aware of the program and its terrific benefits for patients and dentists, and persuade some to begin to see patients that are enrolled. Among the selling points for dentists are: the range of benefits (prophylactic, evaluative and therapeutic services); ease of filing claims; and the reimbursement.

While the going was slow and fairly labor-intensive with dentists and their staffs, we began to break down some of the barriers and see progress. By the end of our initiative, some dentists asked to be included on a list of providers who accept Health Choice. Strong advocacy by a well-respected dentist who serves on the state Health Choice Provider Task Force, the in-office visits by outreach staff, and effective materials that clearly show the benefits and how hassle-free the program is for patients and providers were key. We believe that these elements are critical to raising awareness, gaining acceptance of the program and ultimately enlisting the assistance of other types of providers in outreach and enrollment efforts, e.g., pharmacists, vision care specialists and mental health providers.

Providers are interested and able to support outreach and enrollment to different degrees. As with the "gatekeepers" we targeted in our other initiatives, it is important to have realistic expectations regarding the roles they can play - and to tailor the task to what they can actually do/follow through on. It may be more suitable for providers who may not come in direct contact with parents, like those on the dental mobile van, to send home flyers home with the students they treat, rather than to deal with applications. Such flyers should refer families to a central phone number where they can obtain an application and receive, or learn how they can get, application assistance.

Some providers who are sold on the program may be interested in assuming a role in outreach that extends beyond patients in their own practices: to reach others in their field through their professional associations (already established lines of communication); to engage those in business, the schools and other key community sectors; and/or to work at the policy level, further developing the program and building support necessary for its continuation.

We know that if children are to truly have access to care, they need insurance and providers who wish to treat them. The most effective advocates for Health Check/Health Choice and provider participation are providers who are strongly committed to the program. Those involved in outreach should identify and assist such individuals in championing the program.

Faith Community

With their focus on fellowship and the inherent, fundamental value of every person, religious congregations are natural allies in the effort to enhance the lives of children and families.

Strategies

Two counties - **Cabarrus** and **Edgecombe** - engaged in Faith Community Initiatives. In **Cabarrus** County, the initiative began with a prayer breakfast led by a respected leader of the faith community and hosted at his church. Letters on the hosting church's stationery were mailed to 200 pastors inviting them and another representative from their church to attend the breakfast. A reminder post card was mailed and a follow-up phone call was made to the churches. At the prayer breakfast, the "Kids will be Kids" video about Health Check/Health Choice, produced by Buncombe County was shown and the lead pastor and Covering Kids staff made presentations.

Informational kits, which included a postcard where churches could indicate whether and how they wanted to be involved in the outreach and enrollment effort (menu of options) were distributed. A church, for example, could choose only to distribute program materials or could be actively involved by designating a "Captain," who would receive a kit with outreach tools and be trained to assist families in completing applications at a workshop held by Covering Kids staff. Later in the project, Hispanic Covering Kids outreach staff worked individually and on-site with several churches with a high concentration of Hispanics/Latinos. Following church services, the staff held information sessions and helped interested families apply. Where there was interest, he trained congregation members to take applications. In addition, the Pilot participated in Convoy of Hope, an event sponsored by congregations in the area, distributing program materials and applications. The Pilot also received assistance and advice from a respected parish nurse who works in a local hospital. The parish nurse linked staff with key leaders in the faith community and participated in task force meetings to plan the faith initiative. In collaboration with those in the faith community, the Cabarrus Pilot established a fund to cover enrollment fees for families who were unable to pay. (Note: An enrollment fee of $50 per child/$100 per family is required for families with incomes above 150% of the Federal Poverty Level.) The parish nurse was very supportive of the scholarship fund; her church was the first contributor.

The Neuse River Missionary Baptist Association and the Reddy Creek Missionary Baptist Association were key partners in the **Edgecombe** Pilot. The Associations helped identify which churches and ministers to approach. Ministers of churches were contacted by phone or in writing, informed about the program and asked if they would like to have someone come and speak to their congregations. They were offered faith community brochures, posters and other educational/promotional materials, and applications. Staff followed up with congregations to check and replenish their supplies. Some members of the Neuse River Baptist Association were trained in outreach and enrollment as well.

Materials and Messages

Several pieces were designed specifically for the faith community initiatives - for the prayer breakfast, the Captain's kit and/or to "stand alone." In Cabarrus these included:a letter from the local pastor to engage ministers in the effort; a handout, "How Can Your Church Get Involved"; a postcard for churches to indicate how they'd like to be involved; sample church bulletin inserts about Health Check/Health Choice, a Frequently Asked Questions guide (FAQs); information so that Captains could compute income and answer basic program eligibility questions; and a letter from leaders of Healthy Cabarrus (the county coalition) to churches in the community to solicit funds to cover enrollment fees for families who are unable to pay. A faith community brochure, which was developed by the Edgecombe Pilot, was later adapted and used in Cabarrus's initiative as well.

In his letter of appeal to ministers that accompanied the faith community kit, the local pastor from Cabarrus said: "The question now before all of us is will we make this opportunity of blessing known to our congregations. If you will become part of the communications process, more kids will be helped." Along with providing a brief description of the program (covered services and qualifications) and instructions for applying, the "Covering Kids through the Faith Community" brochure outlined the ways a church can help.

Items developed for other Covering Kids kits (e.g. list of contacts and a list of health and dental clinics, re-order forms, Covering Kids T-shirts, magnets, pins/buttons), materials created by the State/NCHSF (poster, brochures, fact sheets, envelope stuffers, income guideline cards, the NCHSF catalog) and applications were critical to the effort. Many pieces are also in Spanish. To target Hispanic/Latino families through the churches, the Cabarrus pilot also adapted materials that it had developed for its overall faith community initiative and reviewed those used in Forsyth County's Hispanic/Latino Initiative. (Note: The outreach worker in Cabarrus was a native Spanish speaker.)

Results

Of the 200 churches that we originally contacted in **Cabarrus**, thirty-five people (representatives from 10 churches) attended the prayer breakfast. Three of the 10 that were involved initially sent representatives to the "Captain's" training. Ultimately, fifteen churches (not including the Hispanic/Latino churches later targeted) and the parish nurse were actively engaged in reaching and enrolling families. Many were individually trained using the kit. Others were involved to a lesser degree, i.e., displayed information on their bulletin boards and handed out flyers and brochures to their congregants.

It is estimated that more than 1,000 applications were distributed through the faith community initiative in Cabarrus County, including approximately 500 applications given out at the Convoy of Hope. During the eight months that the initiative was tracked, applications for 22 children were traced to this initiative; 14 children were approved (8 for Health Check and 6 for Health Choice). Over $5,000 was contributed by those in the faith community to Cabarrus County's "scholarship fund" to cover Health Choice enrollment fees for families unable to pay.

Of the sixty-five ministers that were contacted in Edgecombe County, most agreed to be involved and make information available to their congregations, e.g., posters, brochures, applications. Three members of the Neuse River Baptist Association attended an outreach/ enrollment training session. Over 500 applications were distributed to churches. Few enrollees could be traced to this initiative.

Staff reported that because of their efforts in the faith community, the perceptions that some of the religious leaders had about government assistance have improved and that churches in the surrounding counties have contacted them requesting information about Health Check/Health Choice.

Note: As with other initiatives, the numbers (children who applied and were approved) may understate the impact of these initiatives as they do not capture the applications that were prompted by but not coded to the initiative, e.g., applications obtained through the state toll-free hotline. Results were based on coded applications distributed locally and received by the DSS.

Lessons Learned

- Significant time investment. Despite the enthusiasm of church associations and the involvement of key leaders in the faith community, a major effort was required to engage pastors of churches. A significant amount of time and effort was involved in getting representatives from 10 churches to attend the early morning, prayer breakfast in Cabarrus County, e.g., a motivational letter from a highly-regarded pastor/church co-sponsoring the event, postcard reminders and follow-up calls. Scheduling meetings with pastors/ministers, individually, was very challenging as well.
- Lesser role more appealing. Relatively few churches ultimately took on a major role in enrolling members. Not surprisingly, most of the congregations were willing/more

comfortable displaying information on their bulletin boards and distributing flyers and brochures to their members. And many invited Covering Kids staff to speak to their congregations. Like others, church staff/members are already stretched thin. Church staff/members may have been reluctant to obtain personal information such as income that is required on the application from fellow congregants as well.

- Parish nurses can be important allies. Congregations that have a commitment to health ministry may also have a parish nurse program. A parish nurse who is already familiar with the community and the health needs of specific congregants is a helpful referral resource. It may be unrealistic to expect parish nurses to provide application assistance given other demands on their time, however.
- Benefits from ties. Outreach staff felt that the initiative helped to improve the perceptions held by some religious leaders about government assistance and to lay the groundwork for future work together. Additionally, ties with the faith community led to the establishment and growth of the scholarship fund in Cabarrus County.
- Useful tools/materials. Useful materials included: the brochure, "Covering Kids through the Faith Community"; the postcard with a menu of options for how congregations might be involved in outreach/enrollment; the FAQs for families; and a display board for staff presentations. Staff in Edgecombe County reported that the faith community brochure was particularly helpful in establishing relationships with those in the faith community and in providing essential information about the program that pastors found useful for their congregations. In working with the Hispanic/Latino churches, the Cabarrus pilot found that it was extremely beneficial to have a DSS employee who was Hispanic, and able to take and process applications – and who could serve as a re-enrollment worker. As with other initiatives, the State/NCHSF materials in English and Spanish were invaluable particularly applications, posters, fact sheets, income cards. See Appendix D1-2 for a letter of endorsement by a faith community leader in Cabarrus County and Edgecombe's faith community brochure.

Conclusions and Recommendations

We expected the faith initiative to be relatively easy to implement and successful in the short term. Despite a high degree of enthusiasm from associations of churches and leaders in the faith community, this was not the case. A significant amount of time and effort was involved in getting 10 churches to attend an early-morning prayer breakfast in Cabarrus County (e.g., a motivational letter, postcard reminders, and follow-up calls) and in actively engaging 16 in the effort eventually.

As with other initiatives, we feel that the time and energy spent on establishing these relationships will yield more over time. We know that even the handful of advocates that we've engaged could have a significant impact on enrollment and that that efforts do have a ripple effect (have received requests from churches in neighboring areas). If continued, it will be important to find cost-effective ways to maintain the connections and to share information and promote the program on an ongoing basis.

If we were to undertake an initiative to engage those in faith community again, we'd work more directly with the Sunday school and vacation bible school programs and through the teachers and youth group advisors. Strategies, materials and messages that we've designed for the schools initiatives should be considered and possibly adopted or adapted. We'd once again actively engage parish nurses in the outreach efforts. We strongly recommend that those in other communities work with faith community leaders to solicit contributions to fund Health Choice enrollment fees for families who are unable to pay.

Hispanic/Latino

Statistics show that the Hispanic/Latino community is growing at a dramatic rate in North Carolina[15] and that low-income Hispanic children are far more likely, at 36 percent, to be uninsured than children in other racial or ethnic groups.[16]

Strategies[17]

To reach families in the Hispanic/Latino community, **Forsyth** contracted with two community-based organizations (CBOs) that were well connected to and trusted by the Hispanic/Latino community, and already involved in linking families to services. At the time, like many other counties, Forsyth's Department of Social Services (DSS) lacked sufficient Spanish-speaking staff. The initiative called for organization staff to actively engage in outreach and serve as DSS "extenders," assisting families in completing applications, obtaining necessary documentation and following up when problems arose. [18] The organizations were to document their activities and receive compensation/an incentive of $25 per approved application. With the help of consultants and others with Hispanic/Latino backgrounds, the Pilot developed a CBO resource kit ("tool kit") of culturally appropriate materials in English and Spanish to assist the agencies in doing outreach and enrollment and in tracking their activities.

Materials and Messages

The tool kit created for this initiative included materials to assist the CBO in their outreach efforts: transparencies and a diskette of slides for presentations in English and Spanish; posters with a tear-off information piece and flyers in Spanish to promote the program; items to deal with specific concerns that inhibit enrollment of this populations (e.g. INS Public Charge "Quick Guide" and Questions/Answers, translation cards); DSS forms, letters and notices translated in Spanish to aid the application/enrollment process; and materials to help the agency track and report on their activities. Other items were adapted from other kits, e.g., a list of key contacts and of free and low-cost medical and dental clinics.

The kit also included packets for CBOs to give to families. These packets contained the following materials in Spanish: a folder with an application; a Health Choice Handbook; a Carolina ACCESS brochure; lists of doctors and dentists that accept Health Choice; and other key pieces. State/NCHSF materials were also included.

The CBO tool kit featured an introductory letter from H. Nolo Martinez, Director of the NC Governor's Office on Hispanic/Latino Affairs, highlighting the program's comprehensiveness and some common misconceptions within the Hispanic/Latino community. Such misconceptions are that the plan is for the unemployed; the application process is burdensome; children aren't eligible if parents aren't US citizens; and that receiving benefits could affect a parent's immigration status. Additionally, the letter encouraged agencies to become involved and to assist with outreach to Hispanic/Latino families. The kit featured the same cover art used in other initiatives, i.e., photographs of children from different racial/ethnic backgrounds and of different ages, and messages of ease, affordability, and freedom from worry. In addition, it contained a message in Spanish emphasizing concern for children, i.e., "porque nos preocupan los niños." A T-shirt in Spanish with the following messages was also included in the kit: "un seguro médico gratuito or de bajo costo"; (free or low-cost insurance); "para niños y jóvenes hasta los 19 años de edad" (for children and teens

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[15] Johnson, J.H., Johnson-Webb, K.D. & Farrell, W.C. (1999, Fall). A profile of Hispanic newcomers to North Carolina. Popular Government. Chapel Hill, NC: Institute of Government.

[16] Kaiser Commission on Medicaid and the Uninsured. (2000). Health coverage for low-income children: Key facts. Washington, DC: Henry J. Kaiser Family Foundation.

[17] In Cabarrus County, Covering Kids targeted families in the Hispanic/Latino community through the churches. See the Faith Initiative for a summary of the activities.

[18] Agency staff were expected to provide after-hours information sessions, arrange needed transportation for those interested in learning about the program, and meet with potential applicants in places where those who may be eligible are likely to congregate (churches, recreation centers, etc.).

up to age 19) and "no dejes para mañana lo que puedas hacer hoy…asegure a sus hijos ahora!" (Don't put off until tomorrow that which you can do today. Insure your children now!)

Results

In Forsyth, of the eight organizations that we invited, two chose to participate. During a six months trial period that applications from the efforts were tracked, no applications were traced to this initiative and no incentive payments were made to the agencies. (Note: Because of the freeze on Health Choice enrollment, our plans to refine and retry the project based on what we had learned from the initial go-around were dropped.)

During the relatively short implementation period (approximately six months), some positive outcomes resulted from the Pilot's focus on this population and the initiative. Forsyth County DSS and others involved in the initiative gained valuable insights into the needs of and ways to help Hispanic/Latino families access services, and established and strengthened relationships with leaders and agencies in this community. Since the project began, the Forsyth County DSS has added interpreters and bilingual staff to assist families with the application process and other matters. Through the initiative, culturally appropriate materials were developed that have subsequently been used by others in reaching this population. Staff and consultants involved in the project assisted the State/NCHSF in creating radio ads and designing print materials to Hispanics/Latinos in the state and are bringing their experiences to a statewide work group established to continue to try to reach, enroll, and better serve this population.

Lessons Learned

- Engaging community-based organizations. Initially, CBOs were reluctant to work with us on this initiative. It was after staff attended Hispanic Services Coalition meetings and built relationships that organizations participated.
- Appropriate materials. Creating materials was very time-consuming, e.g., getting agreement on the key pieces that should be developed and on the wording. Materials must be culturally sensitive and meaningful, not merely direct translations. Paying attention to correct punctuation and wording is critical so that the intended message is conveyed. In Forsyth, the initiative's start-up was postponed because of delays in producing the materials and finalizing administrative processes.
- Incentives were not effective. Due to other priorities, CBO staff and volunteers didn't seem to have sufficient time to help families complete applications and follow up with those who needed additional assistance. The fact that there was some compensation for doing so didn't seem to change that. It is unclear whether the financial compensation approach would have been more successful if the incentive payment had been higher – or less paperwork was involved for tracking and reporting. Or whether the organizations may have been more apt to provide application assistance and follow-through if, before the project began, they hadn't assumed a different role.
- Paperwork too burdensome. After the trial period was over, participating organizations indicated that the follow-up we requested was too time-consuming.
- Useful materials/tools. Refer to Appendix E1-5 for the letter of support from the Governor's Office on Hispanic/Latino Affairs and samples of the following: brochure and fact sheet produced by the State/NCHSF, a poster with a tear-off information piece (available from "Insure Kids Now" at their web site, www.insurekidsnow.gov), and an INS "quick guide".

Conclusions and Recommendations

Organizations were motivated and engaged in spreading the word and materials. But because of limited staff/resources and other priorities they seemed unable to provide the labor-intensive, personal assistance and follow through that seems to be required. The incentive portion of this project was not successful in getting organizations to take these final steps, and to track and report on their activities.

If repeated, we would once again work with community-based organizations that are trusted by those in the Hispanic/Latino community and can offer children's health insurance in conjunction with other services that may be useful to families. (To speed the introduction process, we would have someone with a Hispanic/Latino background who is known and respected by the CBOs make the initial contact.)

In general, we would scale back on our expectations of the CBOs so they could focus on outreach and referral. We would find an alternative way to provide Spanish-speaking application assistance and follow through. We are not sure the extent to which such assistance and follow through could be provided by phone (relatively efficient) and whether it should be by someone external to DSS (issue of trust).

We feel that if this approach is to be effective, the family should be referred by the CBO staff (known and reliable resource) to the application assister. The application assister should: have a Hispanic/Latino background/be fluent in Spanish; be available to families at times that are convenient to them; view this role as an essential part of his or her job; and be adequately compensated.

We'd complement the person-to-person outreach approach by airing on Hispanic/Latino stations radio ads such as those created specifically for this population by NCHSF and GMMB (the communications firm that has been collaborating with Covering Kids nationally). And we'd target families of Hispanic/Latino children through schools and childcare initiatives using culturally appropriate materials that refer to a bilingual resource line, and through providers who serve a large number of Hispanic/Latino families.

African-American Adolescents

The uninsured rate for low-income African-American children is unacceptable at 23 percent. Low-income children 13 to 18 years of age, overall, are less likely to have health care coverage than those 12 and under.[19]

Strategies

This initiative, which began in **Guilford County** in the fall of 2000, took several months of planning and coordination between project personnel and school officials, targeted African-American families by engaging African-American high school students in a service-learning project.[20] It was undertaken in collaboration with the Director of Academic Community Service Learning at NC Central University (a historically black college/university) and a teacher and assistant football coach at a predominantly African-American high school. The community assignment was designed not only to improve "the chances that more eligible low and moderate income children would receive available health insurance," but to "show students how government works, while simultaneously teaching the valuable concept of civic duty, aimed at improving the quality of life for the citizenry."

Following a unit on government fiscal policy in a ninth-grade course on economics, legal and political matters where students examined the roles and responsibilities of government in providing for certain goods and services like health insurance for the indigent, students learned specifically about North Carolina's program for children, Health Check/Health Choice. After role-playing and demonstrating a good understanding of North Carolina's program to their parents, and developing strategies for getting information about Health Check/Health Choice into the community, the students educated other families about the program and encouraged them to apply. Students were to **provide information and distribute applications** to at least two families. They were **not to complete applications** with families (would have required obtaining income and other personal information).

Materials and Messages

Students were introduced to Health Check/Health Choice through classroom discussions about conditions or situations where children could benefit from the program.

For their outreach efforts with families, students received materials (assembled by another group of volunteers) that were developed for other campaigns in Guilford County. These materials, with the "Go Guilford – Get Healthy!" message, added a local message to State information. The students distributed "Parent Packs" which included an application, pre-addressed stamped enveloped, State-produced income card and descriptive brochure, as well as promotional materials from Guilford County: a pencil, magnet, and identifying sticker. In addition to these materials, students were also armed with an introduction script to use during outreach as well as a referral number and name from the local social services to use as a resource when families expressed interest or needed clarification.

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[19] Kaiser Commission on Medicaid and the Uninsured. (2000). Health coverage for low-income children: Key facts. Washington, DC: Henry J. Kaiser Family Foundation.

[20] The project described above was adapted from the Cascade Model by Dr. Theodore Parrish and colleagues at NC Central University. The model has been effective in disseminating student-gathered health information in other health initiatives in African-American communities. The initiative was tried in Guilford County in its purer form earlier on and simplified/redesigned because of difficulties of coordinating people who were at different institutions and geographically dispersed. In the earlier round, nursing students from North Carolina A & T, a historically black college/university in Greensboro, helped high school students develop presentations about medical problems (e.g., diabetes and sickle cell anemia) and children's health insurance programs. Those high school students, in turn, shared information and distributed insurance applications at community gatherings (e.g., public housing resident meetings) and Boy Scouts distributed information door-to-door. The redesigned effort involved one teacher and his freshmen students in a class project during the fall semester. The earlier round was a volunteer project at the end of the year for upper-classmen who, unfortunately, had other priorities.

Results

At least 120 families were reached through the initiative (approximately 40 students shared the information with their families and at least two other families). Health Check/Health Choice materials were distributed to the 80 families who were estimated to have been visited. Students reported that more than 40 families who received the information said they were interested in the program. Although coded applications were distributed, no specific applications/enrollees could be tracked to the initiative. However, according to those involved, "a lot of learning took place" which ultimately increased the awareness of this insurance program in a high school attended by a large number of eligible students. This will no doubt facilitate future enrollment efforts.

Lessons Learned

- Families who seem truly interested in the program are still likely not to follow through. While we can't know the specific reasons without following up with the families, project leaders offered the following possible explanations based on relevant theory and other work that has been done. Families were already enrolled in Medicaid or Health Choice but didn't wish to inform students of this fact. Families were not enrolled but determined that they were ineligible. Families were not enrolled and were eligible but they were "precontemplators"; or their attention was diverted to more pressing issues. Families may have encountered obstacles and were discouraged from applying (no transportation to the Department of Social Services where they could get assistance in completing the application or told by an acquaintance of the "negative attitudes" of some doctors towards Medicaid). In retrospect, it would have been helpful to have followed-up with interested families to determine the reasons why they didn't send in an application.
- Carefully target families and provide incentives. If 80 eligible and unenrolled families had been informed, project leaders believe it would have been reasonable to expect about 16 to be in the "action" stage and of those 16, at least four to five should have enrolled. To have gotten none suggests that either there were not that many unenrolled families contacted, or that these families needed greater incentives to pay attention to the issue of children's health insurance.
- Teachers and Students. If the project is to be integrated into the curriculum and successfully implemented, the teacher must be committed, attentive to details and willing to do additional work, e.g., to restructure the curriculum, get parental permission, develop safety protocols, and coordinate the community work. S/he should be recognized or compensated in some way for taking on the added responsibilities. Roles and responsibilities, expectations and rewards for all those involved need to be clear from the outset. (Note: We found that the initiative was more successful when conducted as a course requirement for lower classmen rather than a volunteer opportunity for upper level students.)

Conclusions and Recommendations

It appears that this approach succeeded in educating students and families about Health Check/Health Choice but not in getting families to apply. If repeated, we would target families more carefully to increase the likelihood that they are not already enrolled. In addition, we would follow up with those who said they were interested in applying. Students, for example, might ask families if they'd like someone to contact them (to answer questions and/or help complete an application by phone or in person) and to find out the best times and ways of reaching them. This information could be passed on to an application assister (DSS worker or adult volunteer) for follow-up. Such follow-up would not only facilitate enrollment, but would increase our understanding of the barriers that interfere with enrollment.

Incentives for families might also be considered – to move families from "precontemplation" to "action," e.g., cab vouchers to the Department of Social Services and a coupon to receive something concrete and of value once the family has applied. Materials that

are distributed should be carefully selected to ensure that they are effective in motivating families to take action, i.e., obtain input from parents.

Child care Providers and Recipients of Child care Subsidies

> *"Health Coverage is now available to nearly all of the nation's six million low-income, uninsured children through Medicaid or a State Children's Health Insurance Program (SCHIP). About two million of these children are younger than age six and – since their parents are likely to be working – they are likely to receive care in an early childhood program…Staff of early childhood programs – such as Head Start, child care centers, family child care homes, preschools, after-school programs, child care resource and referral agencies and others – have an important role to play in assuring the health of children in their care.….Parents often rely on early childhood professionals whom they know and trust for advice and help in finding health care for their children."*[21]

Strategies

The **Guilford** Pilot took the lead on reaching parents of younger children while the **Cabarrus** and **Forsyth** Pilots contributed additional efforts. Guilford worked with county-sponsored child care nurses to targeted child care providers and through them the families they served. Guilford and Cabarrus each targeted recipients of child care subsidies. Forsyth assisted others who received a grant to do outreach to child care programs.

In Guilford, County Health Department child care nurses visit child care centers providing guidance on issues that promote the health of children: communicable disease, safety, immunizations and routine health care.[22] During these visits, the nurses met with child care providers, including staff and administrators, to explain Health Check/Health Choice. In centers likely to have a large number of eligible children, staff were given Parent Packs that included an application and promotional materials (see Materials and Messages section below.) A re-order form was provided in front of the last three Parent Packs left for the center. This proved to be an easy and convenient way for the center to re-order when their supply was depleted, and created a mechanism for tracking those centers with the most interest in the program.

Guilford also distributed specially developed Health Check/Health Choice flyers to child care centers in two separate distributions and one mailing during 2000. Initially, child care nurses took the flyers with them as they visited the centers, sometimes along with more intensive conversations described above, and sometimes just leaving them with key staff. Later, the flyers were mailed to child care subsidy recipients in the child care newsletter distributed by Guilford County Department of Social Services (DSS). Finally, when it was apparent that Health Choice might be frozen these flyers were sent to targeted centers, along with a letter to the center's administrator describing the likelihood of the freeze and urgency of enrolling children.

In Cabarrus, families who were receiving child care subsidies but not Health Check/Health Choice were identified by caseworkers in the child care unit at the DSS. These families were mailed a memo with the header "Your child may be eligible for health insurance." Accompanying the memo was the Health Check/Health Choice fact sheet, an income card, and an application.

The activities that the **Forsyth** Pilot undertook were not a planned pilot initiative, but resulted from a successful grant proposal that they endorsed in the summer of 1999. The one-year grant, which was awarded to the Work Family Resource Center, funded a Child Care Health Consultant to conduct outreach to the child care centers and to families through the Center's child care referral service in Winston-Salem. One of the functions of this person was to provide information and application assistance on Health Choice. When the funding was approved and the position filled (in spring 2000), the Child Care Health Consultant visited the

[21] Cohen Ross, D.C. & Booth, M. (2001). Enrolling children in health coverage before they start school: Activities for early childhood programs. Washington, DC: Center on Budget and Policy Priorities.
[22] Child care nurses work with approximately 500 child care centers in Guilford county.

child care centers, providing information and outreach materials. In addition to endorsing the initial grant proposal, Covering Kids staff further assisted this effort by training the outreach worker as an application extender to assist families completing the application for Health Choice and providing her with materials to give to child care centers.[23]

Materials and Messages

Guilford created a Parent Pack for child care nurses to distribute to child care providers and for them in turn to give to families**.** Parent Packs include the following items: a current application with local address stamped inside; instructions about how to complete the application and where to get assistance; a pre-addressed stamped envelope; a brochure which explains the program and includes a separate card with income levels; a bright refrigerator magnet; a sticker and a pencil. The stickers and magnets publicized contact numbers and emphasized the health of the local community: "Go Guilford! Get Healthy! Get NC Health Check/Health Choice for Children." The state-designed brochure emphasized the ease of the program (e.g. "Finding Free or Low Cost Health Insurance for Your Children Just got Easier"). The Parent Packs were assembled by vocational students at Gateway Education Center and adapted as needed.

The flyers used in Guilford, which were designed to catch the eye of parents with young children, were adapted from flyers developed by the Cumberland County Coalition for Health Choice/Health Check. The colorful youthful flyers, in English on one side and Spanish on the other, were printed in Health Check/Health Choice purple and green in order to maintain a consistent look and a strong connection with other State materials. They featured the Health Check/Health Choice logo, the heading "Sign Your Child Up For Free or Low Cost Health Insurance," and a series of questions relating to eligibility under the overall question, "Can You Answer YES to the following three questions?" Also included were a listing of benefits, local numbers (to get an application and help in filling it out over the phone), locations where applications were available, and statewide toll-free phone numbers. The flyer included the statement "Easy to Apply!" and a graphic of a young girl jumping rope that looked like it could have been drawn by a child.

Other than the memo to child care subsidy recipients, no other new materials were used in Cabarrus. In Forsyth, the child care outreach worker distributed applications and Health Check/Health Choice fact sheets.

Results

From December 1999 - June 2001, **Guilford** child care nurses distributed approximately 300 parent packs to families who expressed interest in the program. Most of the flyers (from an initial printing of 25,000 flyers) were distributed to child care centers in one manner or another. **Cabarrus** sent at least 600 memos and applications to child care subsidy recipients. According to Covering Kids staff, the outreach worker in **Forsyth** County visited approximately 280 child care centers. We don't know how many applications and enrollees resulted from these initiatives.

Lessons Learned

- Choose the best messenger. This initiative demonstrated the importance of utilizing a messenger who could act as an enthusiastic advocate for the program while delivering the message. In Guilford, for example, child care nurses work well. They are respected for their knowledge and commitment to children's well-being; and are personally acquainted with the staff at the centers they visit. They understand the critical role of health insurance in safeguarding children's health, and are able to identify both staff and children who might qualify for the program. In addition, they are able to stay in contact with the families to assist them through the application process. It is interesting to note that at last count

[23] The Work Family Resource Center addresses work and families issues. Services include child care referrals and technical assistance to child care providers.

about 78 counties had at least one qualified Child Care Health Consultant (most of whom are nurses). Most of these consultants are employed by county health departments; they are funded by Smart Start and other sources.[24]

- Partner with "natural allies". We believe these partnerships worked because the agencies/organizations were very committed to the effort; already actively engaged in helping families access services for children; and known to those being targeted.
- Capitalize on relationships, structures and systems that are already in place. By partnering with these agencies and organizations, we were able to take advantage of existing relationships with child care providers and families, and "piggyback" on existing processes, rather than duplicating efforts. The DSS already have contact with child care subsidy recipients, and child care nurses with child care providers and families.
- Useful tools/materials. Parent Packs allowed Guilford to provide a consistent, reliable way to deliver current information in a manner that is sensitive to the need for privacy while providing essential tools that enable the recipient to complete the application. We believe the flyers were effective in that they looked like they had young children as the target. Families commented that they conveyed a happy, positive image with essential information in an "easy to read" format. See Appendix F1 for a copy of the flyer used in Guilford's Parent Packs. The flyer was adapted from one produced by the Cumberland County Coalition for HealthChoice/Health Check.
- Tracking is needed**.** If this were repeated, we would encourage putting mechanisms in place to track outreach activities and outcomes (applications submitted and enrollments that result). Obviously, this is important in order to evaluate the cost effectiveness of such an approach, but it is equally important to provide child care nurses with feedback about the value of their efforts. When asked, "What is the one thing you would change about the program if it were to be done again?" two nurses replied that they would want to track the applications so that they could intensify their efforts at centers that had responded, and discern the changes that would increase effectiveness at centers with a smaller response.

Conclusions and Recommendations

We are fortunate that in our Pilot counties and throughout the state there are agencies and organizations that are actively working with child care providers and low-income families with young children. By collaborating with them, we believe that we have been successful at getting Health Check/Health Choice information into the hands of families with eligible children. Critical to success is the strong commitment that these entities have to insuring children; the direct relationships that exist between them and child care providers and families; and the systems that are in place for sharing information.

We believe that by partnering with such natural allies and piggybacking on systems that are already in place, counties could institutionalize and therefore sustain outreach to families with young children in the long run. And we recommend the straightforward and relatively low-tech, low-cost strategies that we've tried. To those who are interested, we recommend putting mechanisms in place for following up and following through with families who are interested in the program (see section on Simplification: Enrollment System/Process). We encourage others conducting outreach to track activities and outcomes. As we enter another period of budget cuts, we underscore the importance of making it as easy as possible and having realistic expectations of those involved.

With respect to child care subsidy recipients, we recommend exploring a front-end approach rather than waiting until after families have been approved. These approaches might include: obtaining supplemental information needed for Health Check/Health Choice when applying for child care subsidy; or developing a joint application for child care subsidy and Health Check/Health Choice. Some counties such as Cabarrus are already asking child care subsidy applicants whether they would also like to apply for Health Check/Health Choice.

[24] K. Dail (personal communication to C. Sexton, June 10, 2002).

Note: Data maintained in Buncombe County DSS show that it is worthwhile to approach families about Health Check/Health Choice as they apply for food stamps as well. In 2000, nearly 80 Health Check/Health Choice applications were identified as resulting from the caseworker asking families whose children weren't already covered whether they'd also like to apply for Health Check/Health Choice when they applied for food stamps. Not included in this number are the applications that were distributed by DSS staff at the front desk to food stamp applicants and recipients.

Through computer matching of food stamps and Health Check/Health Choice, counties have targeted mailings to families whose children are likely to be eligible and not enrolled. Some work is being done to develop and test a combined application for food stamps, Health Check/Health Choice and other programs.

Schools

"…schools have become widely viewed as 'a natural setting' in which to reach out and enroll eligible children. Of the six million low-income, uninsured children in the United States, the majority – more than four million – are between the ages of six and 18, suggesting that well-conceived school-based outreach activities hold great promise…Efforts to enroll eligible children in such programs offer benefits for students – and for the schools themselves…Having health coverage can significantly influence a child's health status and school performance…School attendance is related to school achievement and can influence the amount of a school's education funding."[25]

Strategies

Initially, three counties –**Forsyth**, **Guilford** and **Buncombe** – were most involved with schools. In the fall of 1999, **Forsyth** focused on reaching families in a particular elementary school by attending all school-sponsored events - open houses, kindergarten registration, Saturday fair days, and PTO meetings. Covering Kids staff oriented school nurses to the program and provided them with information and applications to give to families as they did health care screening and provided other services. Staff provided information to the Department of Social Services (DSS) eligibility workers who were "outstationed" at two school-based clinics three half days per week. Initially, DSS workers, who rotated to the clinics, assisted parents of uninsured children with Health Check/Health Choice applications and determined eligibility as they registered their children at the clinics. Later on the workers became more proactive, contacting parents of uninsured patients by phone.

Then in the fall of 2000, schools in **Forsyth** distributed the locally designed Health Check/Health Choice brochure to parents of school children in their school orientation packets. The flyer included a tear-off portion that could be sent in to request an application. (Note: In Forsyth, there are 66 schools - 40 elementary, 15 middle and 11 high. Each school nurse covers three to five schools, and there are two school-based clinics, one serving children in two schools.)

The **Guilford** School Meals Outreach Pilot project was launched in the summer of 2000 following six months of active planning. Guilford is one of the state's largest merged systems. It has 64,000 students with more than 24,000 of these students participating in the School Meals Program. The Pilot was designed to test the effectiveness of using a computer match between students receiving School Meal services and those already enrolled in Health Check/Health Choice. The goal of the match was to identify and eliminate children already enrolled in public health insurance in order to target outreach to just those children believed to be eligible but not enrolled.

The initial step in implementing the pilot project was the addition of a statement on the School Meals application so that parents could give active consent to sharing application information with the children's health insurance program. Once permission was obtained, the computer-match, using a software program created specifically for the Pilot, identified the children already enrolled in Health Check/Health Choice. Parents of these children received a letter thanking them for their interest in knowing more about health insurance and informing them that records showed their children were actively enrolled in Health Check/Health Choice. A flyer was enclosed to remind them of basic features of the insurance. Parents of children identified as "not enrolled" were sent application packets. The packets included: a letter; an application; a pre-addressed postage-paid return envelope; and information on completing the application, income eligibility levels and Guilford's scholarship fund (pays the Health Choice enrollment fee required for some families). The large, white, outside envelope had the Health Check/Health Choice logo and the statements: "HERE IS THE INFORMATION YOU REQUESTED FROM YOUR CHILD'S SCHOOL. Don't Wait to Act!"

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[25] Cohen Ross, D. C. & Booth, M. (2001). Enrolling children in health coverage programs: Schools are part of the equation. Washington, DC: Center on Budget and Policy Priorities.

This pilot program benefited greatly from the strong support of a key administrator in the school district. This individual was an active member of the local Covering Kids Coalition from the beginning and was instrumental in planning and implementing all outreach through the schools, including the service-learning African-American Adolescent special initiative described in an earlier section.

As in Guilford, school system administrators were key members of **Buncombe's** local coalition, and were involved in outreach in the schools since early on. (City and county school systems are both represented on Buncombe's coalition.) By the beginning of school year 2000, the Buncombe Pilot had nearly perfected its approach of distributing flyers to parents in orientation packets at the school year's beginning and with report cards in January and mid-May. The packets featured the number to call for applications and assistance.[26] For the first distribution, the schools bore the expense for printing flyers and did the labor themselves. Responding to feedback that this was a burden on strained resources, Covering Kids staff put things in place so that DSS provided pre-counted flyers that school office staff only needed to put in teachers' boxes.

Buncombe's outreach coordinator had set the stage, educating principals about children's health insurance and discussing the plans for distributing flyers at the superintendents' meetings.[27] School nurses and school-based clinics were involved. In 1998 they mailed Health Check/Health Choice flyers to students seen in the clinic at the city schools. Applications were given to school nurses and other staff who requested them. Covering Kids staff did outreach at kindergarten registration and other school functions.

In the fall of 2001, the Buncombe Pilot also worked with the Asheville City schools to receive information about Free and Reduced Price School Meal applicants (with parents' permission) so that they could target those who are likely to be eligible but are not already enrolled Health Check/Health Choice. (Note: From its Food Stamps records - and in exchange for the information - DSS provided the school system with information that allows it to directly certify children for Free and Reduced Price School Meals.)

To increase awareness of Health Check/Health Choice and complement the communications through the schools, Buncombe conducted a "back-to-school" campaign in partnership with KMart and other businesses in the last three years. In August 2000, KMart had a display table at the entrance of the store with applications, flyers and a contest registration for a bike and helmet give-away. Posters were displayed throughout the store, including restrooms, water fountains, snack bars, children's clothing/shoes and school supply areas. The pharmacy mounted a rack on the wall at the prescription pick-up window with Health Check/Health Choice flyers and applications attached. KMart staff received training about the program; those in the pharmacy were encouraged to mention the program to parents who expressed difficulty in paying for their child's prescription.

Health Check/Health Choice tray liners were featured at Arby's and McDonald's, and ads aired on radio and television stations. Buncombe drew on the media kit developed by Covering Kids (national)/GMMB in mounting its back-to-school efforts.

During the spring and early summer of 2001, in the midst of the freeze on enrollment Health Choice, we at Covering Kids examined our mission in the light of this new reality – that even if enrollment was unfrozen and expanded, money for outreach and systems changes was likely to be scarce. We reaffirmed our commitment to determine approaches to outreach and enrollment that were not only effective, but would be relatively easy to replicate and could be

[26] Students are given orientation packs. Freshmen have orientation sessions in which their orientation materials are given and explained. The schools feel confident that these materials go home to parents. Report cards in January include Health Check/Health Choice flyers and are sent home with students for parents' signatures. The end of school year varies. Many schools mail reports cards and Health Check/Health Choice flyers; others send them home with students unless the family requests that they be mailed. If there is a request to mail, the flyers are to be included with the report card.

[27] For three years, Covering Kids staff has been speaking annually at city and county superintendents' meetings with the principals.

sustained in the long run. Note: While at the time there was a freeze on Health Choice, it is important to note that enrollment in Health Check was to continue.

Based on our experience with different outreach and enrollment strategies, the experiences of those in other states and work that was being done on the national level, we considered the future, and began planning a low-tech and relatively low-cost approach that would be fairly time-limited and easy for the schools to implement. The initiative - to be implemented in late summer/early fall of 2001 - was patterned largely on the work that Buncombe had been doing over the previous two years. While there would be variations among the Pilots that were involved, there were some key elements.

- Schools would distribute flyers that featured a local phone number (all Pilots) where parents could get more information or request applications (Buncombe) and get assistance (Cabarrus, Edgecombe, and Guilford). In some cases, the flyers included the name of a specific person to call (Guilford). A friendly and caring person who was knowledgeable about the program answered the phone. Callers would not get a "menu" or be transferred to different folks in the office. When they called, depending on the time, they could get a voice message of the staffer asking them to leave a message so that s/he could call back.
- Application assistance would be provided by phone for those who wished help. Staff could complete and send the application to the applicant to supply any missing information, attach pay stubs and sign.
- Follow-up would be provided through phone calls, personal letters, notes and/or postcards to those who had been sent applications.
- Results would be tracked, e.g., calls in, applications submitted and enrollment outcomes.

Drawing on what we had learned from the work done by GMMB, samples from other states, our experience, and input on materials gained from our re-enrollment focus groups, we decided on key messages and graphics, and designed three pieces: a general flyer, primarily intended for parents of elementary school children; a similar flyer intended for parents of teens; and later a brochure aimed at teachers, school nurses, coaches, guidance counselors and other school personnel. Cost and reproducibility (in black and white on typical office copy machines) were major factors in designing our final products. Note: Buncombe used its own flyer, which incorporated the theme, look and mascot that it had been using for Health Check/Health Choice since early on. (For more detail, see the later section on Materials and Messages.)[28]

In late summer when school was about to begin, the freeze on enrollment in Health Choice was still in effect. Knowing that our results would be impacted by the freeze, several Pilots planned to proceed anyway. These counties felt comfortable promoting the program even though it meant that children who qualified for Health Choice would be put on a waiting list ("the sooner that they got on the list, the sooner they would have a chance to get into the program") and wanted to continue to reach children who would be eligible for Health Check.

Through the initiative, they would continue to build - or establish - relationships with those in the schools and to learn about implementing this fairly straightforward approach in different school districts. Buncombe and Edgecombe kicked off their projects **during** the freeze. Cabarrus's project was rolled out in October **soon after** the freeze was lifted. Guilford implemented theirs in November, **after** the freeze had ended. Forsyth decided not to undertake a major school effort until the winter or spring of 2002.[29]

As noted earlier, school strategies varied somewhat across Pilots. Key elements of each Pilot project are briefly outlined below.

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[28] Based on research and input from Pilots and others, Guilford took the lead on creating and focus testing materials aimed at teens. Based on the focus groups, we decided that we needed to do more work in this arena in order to come up with materials to test on a wider basis.

[29] In the winter of 2002, after the initial Covering Kids grant ended, Forsyth once again became more actively involved in the schools. Forsyth County expanded its capacity to work in and with the schools, replacing the part-time outstationed position with full-time staff (former Covering Kids staff).

In Buncombe, student flyers were distributed to elementary, middle and high school students with their orientation packets in August.[30] Covering Kids staff (DSS) delivered flyers to schools in packets sized for homerooms according to the specifications given by the school contact (usually the school secretary).

The eye-catching flyer outlined health insurance benefits and income guidelines, and urged parents to call "250-5939" for more information. Parents who called were sent applications and/or triaged to the application specialist for help. Families who did not return the application within approximately two weeks of the initial mailing received a computer-generated follow-up letter from Linda Cruz, the Application Specialist, which included her phone number and an offer to take the application over the phone at a time convenient for the family. If there was still no response, Linda followed up with the family by phone a week or two later. The call line, which receives calls around-the-clock, provides assistance in English and Spanish. Calls are handled by a Spanish speaking person after hours and routed to a bilingual eligibility worker at DSS during business hours. (For details, see description of Call Center and role of Application Assister in the section, Simplification: Enrollment System/Process.)

In late summer/early fall, to complement the communications through the schools, Buncombe County displayed posters at KMarts and Wal-Mart, featured tray liners with Health Check/Health Choice information at Arby's and McDonald's restaurants and ran ads (paid) on cable television. The 5-minute video, "Kids will be Kids" that was produced by the Buncombe Pilot, was played on the Government Access Channel.

It is important to emphasize that Buncombe's strategies, described above, are parts of a more comprehensive approach. They were designed to work together and to have a cumulative effect. The intent was for families to hear about the program from a variety of sources, at different times and places over a relatively short period of time, e.g., from television, while shopping for school supplies or stopping to eat a hamburger. Flyers from the schools were key, but only one component of the "back-to-school" campaign.

In Cabarrus, flyers were to be sent home with students with report cards October 15th, just after the freeze on enrollment in Health Choice was lifted. The general flyer was to go to parents of elementary school students and the teen flyer to middle and high school parents. The Pilot tried to reach all children in Cabarrus County - including those who attended Kannapolis City Schools, which also serves Rowan County.

At the school district level, Covering Kids staff worked primarily with the Coordinator of School Counseling and Programs for At-Risk Students. It was the Assistant Superintendent who "paved the way" in the Kannapolis City Schools when the project was ultimately rolled out. As requested by the Cabarrus School System, Covering Kids staff placed flyers directly in teachers' boxes (flyers had been sorted/counted according to the grade and classroom size). Kannapolis Schools chose to distribute them to teachers themselves (Covering Kids staff had counted and pre-sorted flyers).

The flyers contained the phone number to call for an application and assistance. Manning the phone, was a casework assistant who provided application assistance by phone and sent families applications to complete. S/he encouraged callers to call back with any questions.

If a call came in after hours, callers received a message instructing them to leave information and telling them that someone would follow up with them. When receiving calls from Spanish-speakers, the casework assistant (who spoke limited Spanish) referred the callers to the bilingual outreach worker or got the interpreter who was stationed nearby. The voicemail message was only in English. Staff followed up with families who did not return applications with postcards (two were sent 10 days apart) and phone calls.

Covering Kids staff attended several PTO meetings, giving presentations, answering questions and distributing materials.[31] In early December, Covering Kids staff placed brochures aimed at teachers, coaches, school nurses and other school staff in the boxes of school personnel. Kannapolis schools chose to distribute brochures to staff themselves.

[30] The Pilot also worked with other schools/programs, including "Head Starts," charter and community schools, and some private schools.

[31] The Cabarrus Pilot did not make a concerted effort to do more with PTO meetings because of the freeze.

Brochures were distributed to school nurses through the health department, which employs the nurses.

In Edgecombe, newly-designed flyers were mailed with approval letters for Free and Reduced Price School Meals from the Nutrition Director's office beginning in August. (See later section on Materials and Messages for description and appendix for sample.) At the School Superintendent's meeting in August, Covering Kids made a brief presentation to principals about the program and the plan for distributing flyers with report cards. The Program and approach were strongly endorsed by the Assistant Superintendent who was leading the meeting. The flyers were to be distributed by teachers at the end of the 1st grading period (September 20 for middle and high school students and October 11 for elementary school children). The general flyers were to be used for elementary school children and teen flyers for middle and high school students.

In elementary and middle schools, flyers were to be attached to report cards and sent home with students. In the high schools, teachers were to give report cards to parents on report card distribution night. Flyers were distributed according to the plan in one of the three high schools. Report card distribution night was canceled in one school because of a bomb scare at another school earlier in the day. Consequently, flyers were attached to report cards and sent home with the students. When Covering Kids staff realized that the flyers weren't attached to the report cards in the third high school, they tried to hand flyers to parents as they left the school. (Covering Kids staff was set up to provide information and assistance.) Note: In Edgecombe County, there are 14 schools: 7 elementary, 4 middle, and 3 high schools.

The flyers featured the phone number to call for an application and assistance. The phone was generally answered by the voice mail of the outreach worker who was loaned from another organization to work part-time at the Edgecombe DSS to help with the project. If a call came when the outreach worker was not in, callers received a message. They were asked to leave their mailing address (if they wanted an application), or a phone number and a time that would be convenient for them to be called by the outreach worker if they had questions or wanted assistance. The outreach worker followed up with those who were sent and did not return an application - by phone approximately 10 days after the application was sent. Often several calls were made to the number. When the outreach worker filled out an application by phone on behalf of the caller, she sent it to the family along with a personal note, requesting the parent's signature and any additional information that was required, e.g., pay stubs. Spanish-speaking office staff returned calls from Spanish-speakers.

The Edgecombe Pilot supplemented the flyer distribution with other in-school strategies. In mid-August, Covering Kids staff oriented 35 student support services staff to Health Check/Health Choice, e.g., guidance counselors, social workers, psychologists and schools nurses. They were asked to help promote the program and provided with approximately 1400 flyers. (The brochure aimed at school personnel, "Students Need Health Insurance…You Can Help! Better Health..Better Grades..Better Future," was not yet ready. They were distributed to teachers and other personnel at a later time.)

In August and September, Covering Kids staff gave 5-minute presentations about the program at PTO meetings, distributing flyers, applications and other promotional materials (5 out of 7 elementary schools and 2 out of 4 middle schools; high schools don't have PTO meetings.) [32] Health Check/Health Choice ads were placed in school football programs.

To complement the communications through the schools, the Edgecombe Pilot held a back-to-school kick-off event at Wal-Mart on the first day of school. A drawing for a book bag with school supplies was held every 30 minutes for those who registered at a Health Check/Health Choice exhibit booth; "goody" bags with a Health Check/Health Choice flyer, notepad, pencil and sticker were handed out. Covering Kids staff followed up with shoppers, who registered for book bag give-a-ways, to determine whether their children had health insurance. (Note: In conjunction with the GMMB/Covering Kids, national, test-marketing campaign in the

[32] In early October, Covering Kids staff oriented eight home school contacts. They were shown the video, "Kids will be Kids," and provided with approximately 700 flyers and 125 applications.

Greenville area, the Edgecombe Pilot conducted its first back-to-school kick-off event at Wal-Mart and KMart in August of 2000.)

In Guilford, our newly designed Health Check/Health Choice flyers were sent home with **elementary** school children in their "Monday Envelope." (For a description see later section on Materials and Messages.) The Guilford Pilot decided **not** to target parents of middle and high school students this go-around. Because these students don't get "Monday Envelopes," a different method of distribution would have been required, e.g., having the schools mail the materials directly to parents.

The English side of the flyer urged parents to "Call Phyllis" for an application and assistance at a specific phone number. (Phyllis is a health department eligibility outreach worker well known to families.) Parents either spoke with Phyllis or left a message for her. Because Phyllis worked at the health department, she was able to access the State database in order to do a quick screening to determine if the child was already enrolled. If this check indicated that the children were not enrolled, parents were sent an application. If the application had not been returned in two weeks, Phyllis called the parents by phone. If the application was not returned in the following four weeks, a follow-up postcard was mailed to the family. The postcard featured the Health Check/Health Choice logo and colors, phrases and graphics that matched the flyer.

The Spanish side of the flyer urged parents to call the toll-free state hotline (North Carolina Family Resource Line) to apply, emphasizing that hotline workers speak Spanish.[33] Follow-up with Spanish-speaking families who called the hotline in response to the flyer was not done this go-around.

It is important to note that Guilford County Schools require that materials for parents which originate in outside agencies go through a system administrator, before being sent to individual schools. In this case the appropriate school administrator was an individual already serving on the Covering Kids Coalition. In her role as the representative from the schools to the Coalition, this administrator was familiar with and supportive of school outreach initiatives. She had helped design the School Meals project described earlier and was able to ensure that the correct procedures were followed. To further enhance the process and ensure that the distribution would proceed smoothly, the Covering Kids project staff worked with the printer to package the flyers according to the school system's specifications. All of these components helped to strengthen relationships between the schools and the Coalition.

Materials and Messages[34]

As noted earlier, three key pieces were created for the schools projects in the fall of 2001: the general flyer, the flyer for parents of teens, and the teacher/school personnel brochure. The flyers were in English on one side and Spanish on the other. Guilford created a sticker to use on the outside of mailing envelopes, as well as a reminder postcard.

The flyers were designed to grab a parent's attention and communicate that this is about health insurance (not welfare or public assistance), and the insurance is for all kinds of children (different ages and ethnicities, those who are healthy and active, those with special needs/disabilities). It was created to appeal to working families, including those who may think they earn too much to be eligible; to be practical (affordable and effective even if copied in black and white on a typical office machine); and to tie in with existing State materials

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[33] The three main functions of the hotline in relation to Health Check/Health Choice are: to provide information about the program both verbally and in writing (including the mailing of the application form to the family); referral to the local county department of social services providing address, phone numbers, and, when available, a Spanish-speaking contact name/number; and advocacy if the family has attempted to call or apply locally and faced barriers. In a county that has not provided a Spanish-speaking contact, hotline staff may serve as the intermediary interpreter in a three-way conversation with the local DSS.

[34] The Forsyth Pilot primarily used the following materials for its schools initiatives: the State/NCHSF fact sheet (with space for a local number), its locally-designed brochure (had a local phone number to call and a section to cut off and mail in for an applications), and "income cards" outlining eligibility levels (primarily as a reference for nurses and other school staff).

(colors and some messaging). The flyers incorporated information that parents feel is critical to know (the benefits/services that are covered and income guidelines). They included messages that resonate with parents ("Better health for your children, peace of mind for you"), were action-oriented ("In Edgecombe County, call 252-985-5085 for an application and assistance), and reinforcing (e.g., "Easy to Apply" "If your child is already covered by this insurance, remember to Re-Enroll each year to continue benefits"). And they prominently displayed the State's Health Check/Health Choice logo. (Note: The flyers were designed so that they could work with different strategies – in and outside of school. That is, messages were not tailored specifically to those who have been approved for school meals, gearing up to get back to school, or receiving report cards.)

The brochure for teachers and other personnel featured messages to enlist school staff in our efforts to insure students **("Students need health insurance. You can help!")** and to link coverage to better health, better grades and better futures. Along with general information about the program, the brochure featured messages to different school personnel (teachers/counselors, coaches, school nurses) and outlined specific actions that school staff could take to help.

The flyers, teacher brochures, envelope sticker and follow-up postcard were designed to closely tie in with other key pieces that we were creating for and with the State, i.e., the new application and reenrollment materials (see section on Simplification: Enrollment and Re-enrollment). Pilots used other promotional items for school events and related back-to-school activities. These included pencils, rulers, and boxes of crayons and book bags with schools supplies (Wal-Mart drawing). The video, "Kids will be Kids," was used in Buncombe for meetings with principals and played on the Government Access Channel (cable television). The video was also used in Edgecombe's back-to-school kick-off events at Wal-Mart and KMart in 2000 ("continuous loop").

Note: We considered and ultimately decided against printing a poster-size version of the flyer to display in key locations in the schools because of cost. In general, we felt that an 11x 17 probably made the most sense. Experience taught us that standard-sized posters would probably have limited use (took up too much space). A legal-size, which was easy for mailing, was thought to be too small to be effective. While somewhat inadequate, Pilots felt that this go around they would just post the flyer in some key places, e.g., on bulletin boards in teachers break rooms. Buncombe ended up producing a limited number of small posters by enlarging the flyer at a local copy shop.

Results

> *Note: In this section, we focus primarily on the school-oriented activities undertaken by Pilot Counties in the fall of 2001. But first we highlight some findings from strategies employed in Forsyth and Guilford in 1999 and 2000. Because Buncombe's approach in 1999 and 2000 was quite similar to that undertaken in 2001, we've included highlights of Buncombe's schools initiative from earlier years in the 2001 discussion.*

Forsyth, 1999 – 2000

According to Forsyth Pilot staff, the "phones rang off the hook" during the first couple of months after **the locally-designed brochures were distributed to students in the schools**. The tear-off portion to send in for information/application was hardly used, however. At the time of the initiative, a tracking mechanism was not in place so hard data regarding the number of calls, the applications submitted or enrollees were not available.

Forsyth found that parents attending **school-sponsored events**, which are often held for a specific purpose, were not really interested in hearing about/ receiving information about other programs. At an open house, for example, the parents wanted to meet the teacher, find out about the bus route and what school supplies were needed. Staff felt that had they

tracked the applications submitted to DSS from the various events, the results would have very disappointing and the approach not cost-effective.

Staff believes that **school nurses** were effective in identifying uninsured children and targeting information/applications to appropriate families. As with other initiatives, they felt that it was the follow-up and follow-through that was missing and that it is may be unrealistic to expect busy nurses to be responsible for this time-consuming task.

It is interesting to note that in 2002 the outstationed position (school-based clinics) was expanded to a full-time position (filled by a former Covering Kids staffer) and no longer rotated among different DSS workers. While enrolling children through the school-based clinics and wellness centers, which were recently established in two other schools, the outreach worker is proactively engaged in other outreach activities in the schools, e.g., targeting families approved for Free and Reduced School Meals. Her office is in one of the school-based clinics.

Guilford, Schools Meals Demonstration Project, 2000

In Guilford, parents of approximately 5,500 children gave permission to share school meals application information with the children's health insurance program. Approximately 40% of these children (2,274) were sent applications and a pre-addressed stamped envelope after being identified by the computer match as eligible but not enrolled. Applications were returned for 92 children, and of these, 74 were enrolled (54 in Health Check and 20 in Health Choice). Many were denied because they had other insurance; some were found ineligible because of citizenship issues.

The design and implementation of this project (in fall/winter) were heavily impacted by the anticipation of the freeze on Health Choice, which was announced in late November to take effect on January 1, 2001. The pilot design was revised, which eliminated original plans to have an outreach worker follow up with eligible families by phone. Those involved with the project believe that such follow-up would have had a significant effect on the results. It may also be that the design of the materials affected results. For example, because of the impending freeze, the flyers had a large amount of text so that parents would know deadlines and other key information. All of the information that was included was thought to be necessary, but project planners recognized that heavy text might detract from the effectiveness of the materials, and this may indeed have been the case.

Buncombe, Guilford, Cabarrus, and Edgecombe, Schools Projects, Fall 2001: Flyers and Follow-up, Other School Strategies, and Back-to-School Events

In Buncombe approximately 40,000 flyers were distributed with school orientation materials in August (during the freeze) through 37 schools (25 elementary, 6 middle and 6 high). Of 317 calls received by Buncombe's call center in August and September, over half (174) were traced to the flyer in the school orientation packet (compared to 120 school-related calls in August/September of 2000). It is important to note that during the three-year period, 1999 – 2001, over a third (35%) of the approximately 2700 callers said they heard about the program through the schools.

Applications for 93 children were traced to the initiative in September and October of 2002; 60 were enrolled or had been placed on the Health Choice waiting list (42 were enrolled in Health Check, 8 in Health Choice, and 10 on the waiting list). Outcomes included:11 pending, 4 withdrawn and 18 denied (10 were "over" income and 4 had other insurance). It is interesting to note that:

- Of the 93 children who applied, 59 were traced to flyers distributed in elementary and primary schools (63%), 15 to middle (16%) and 19 to high schools (20%).
- Approximately one-third of the children who applied were teens (13 years or older).

It appears that follow up letters and calls played a role in prompting/helping many families to apply. In August and September, Buncombe received 114 applications that were traced to

calls to the Call Center. [35] (Note: Not all these applications were in response to the flyers distributed through the schools.) Sixty-six of the applications were received after follow-up letters and calls.

The costs for the initiative in Buncombe are estimated at $4,600: approximately $3,100 for staff [36] and $1,500 for printed materials, postage, supplies, etc. The cost estimate does not include in-kind support from the schools or overhead.

Few applications or calls to the Call Center were tracked directly to events at KMart in the fall of 2001 - or in previous years. (It is interesting to note that during the month-long event in 2000, 200 applications were picked-up from the display table and the pharmacy, and 300 families registered for the bike and helmet giveaway. Those who registered were sent a flyer along with a cover letter thanking them for their interest. Relatively few calls or applications were traced directly to tray liners at McDonald's and Arby's or to cable television. Note: Buncombe experienced a better response from the over-the-air ads it ran through the local ABC affiliate in 2000 than on cable in 2001. Consequently, as part of its back-to-school campaign in the late summer of 2002, if funds allow, it plans to run ads over-the–air to help get the word out about Health Check/Health Choice.

In Guilford, where an estimated 38,000 flyers were distributed in 64 elementary schools, 299 calls were tracked to the initiative over the two-and -a half months of the pilot project (November 1 to January 15th). Of the applications for 239 children that were received through the end of January, nearly three-fourths of the children (178) were enrolled (98 in Health Check and 80 in Health Choice). Guilford reported mailing 171 applications in response to the calls received; making 132 phone calls; and sending out 74 reminder postcards. It is interesting to note that:

- Despite the fact that the initiative did not involve middle or high schools this go around, 30 of the 239 children who applied (12.5%) were in the 13-and- over age category. These teenagers were most probably siblings of the elementary school children.
- More than half (30) of the 58 denials were because the family's income was too high. (This suggests that the flyers attracted higher, as well as lower, income families, as intended.)
- Of the 239 children who applied and were traced to the initiative, 125 were African-American (approximately 52%); 95 (nearly 40%) were white; 5 were Asian and 9 Hispanic. It is important to point out, that because of the project's design these results are not likely to be a good indicator of the effect of the approach on the Hispanic/Latino community. As noted earlier, the Spanish side of the flyer urged families to call the State toll-free hotline. Only the applications that resulted from calls to the local number/Phyllis were tracked this go around. Applications that resulted from the calls to the State hotline were not tracked.
- Phyllis, who answered the local number and handled the follow-up with families, said she was able to clarify issues for families and assist them so the application process was much less challenging. She reported feeling a great sense of satisfaction in her role and is eager to participate in the same way next year.

The costs for Guilford's initiative have been estimated at between eight and nine thousand dollars (part-time staff for three months, printing and postage). Much of this was attributed to one-time charges and higher prices than might be negotiated with volume purchasing. It is likely that less staff time will be required as work becomes more systematic and routine. The cost estimate does not include in-kind support from the schools or overhead.

In Cabarrus, flyers were distributed with report cards on October 15th, just after the freeze on Health Choice was lifted. Approximately 24,000 flyers were distributed to thirty-one schools (19 elementary, five middle schools and seven high). The general flyers were to be sent home with report cards of elementary school children; the teen flyers were to be used for students in middle and high schools. Note: Approximately 20,000 flyers were given to

[35] The 114 relates to applications. This is to be distinguished from the children that applied. An application may include more than one child.

[36] A portion of salary and fringe benefits is included for the Outreach Coordinator, the Application Specialist and for clerical/phone support.

Cabarrus County schools (14 elementary, 4 middle, 6 high). The remaining flyers were delivered to the Kannapolis City Schools. Flyers were to go to Cabarrus County residents in the schools in the Kannapolis district (Kannapolis also serves Rowan County children). In Kannapolis there are 5 elementary schools, a middle school and a high school.

Between October 15 and December 5, 2001, 122 calls were received. For 90 of the 122 calls, Cabarrus was able to identify the type of school (elementary, middle, high) that prompted the call. The vast majority (80%) of callers received flyers from elementary schools; 20% and 16% were from middle and high schools, respectively. (Note: The percents total more than 100 because some callers identified more than one type of school.)

By the end of January 2002, applications for 75 children were traced to this initiative. Of these 52 children were enrolled (24 in Health Check; 28 in NCHC) and 23 were denied (15 because they were "over income."). Approximately 23% of children who applied were 13 years or older. Sixty-five of the 75 children (87%) that applied were white; one was Hispanic (1%); the other nine were African-American (12%). It is interesting to note that:

- Over a third of those who enrolled had incomes over 150% of the FPL - 18 of 52.
- It appears that approximately half of the applications were submitted in response to follow-up postcards and calls.

In Edgecombe, approximately 3,050 flyers were distributed with approvals for Free and Reduced Price School Meals. It is difficult to estimate how many of the 8500 flyers that were provided to the principals went to parents. (See challenges with report card distribution nights in description of strategies above.)

From August through mid-November of 2001, fifty calls were traced to the schools initiative. Of these 50 calls, approximately three-quarters (37) were from those with children in elementary schools. One quarter (12) was from parents of middle school students. One call was traced to the high school. Five callers reported that their children were on Medicaid. We were unable to reliably determine which school strategy prompted the call (e.g. flyers with School Meal approvals, flyers with report cards, or information received at PTO meetings).

Forty-five applications were sent out in response to the calls and applications for 18 children were returned by mid-November. Over three-fourths of these children (14) were enrolled (half in Health Check and half in Health Choice). Twelve of the 18 who applied (67%) were African-American. "Over income" was the reason that three of the four that were denied were not approved.

Staff reported difficulties in following up with families. Because the worker who received the calls was only in Edgecombe part time, she and callers "played a lot of "telephone tag." Frequently, the worker was unable to connect with the caller despite multiple attempts. In retrospect, the worker determined that she assisted 7 of the 18 who ultimately applied.

Lessons Learned

> *Note: We've organized our points into several sections. The first section relates to flyers and follow-up. Next we deal with other school strategies. Following that are several points relating to complementary back-to-school events/campaigns.*

Flyers and Follow-up:

- A program champion in upper administration and caring, committed and competent folks at other levels are crucial**.** We learned firsthand the importance of having a champion in upper administration that is willing to go the extra mile. Upper level administrators are likely to become program champions if they are involved in their local coalitions and they see the critical role schools can play in insuring kids.

  Principals, teachers and in Buncombe's case, school secretaries, are key to ensuring that families receive Health Check/Health Choice information and are linked to those who can help them apply. If possible, Pilots recommend discussing the program and the

importance of distributing the flyers with teachers at faculty meetings **before** the flyers are to be distributed - **particularly if teachers are involved in the distribution process**. (Note: This is not always possible as there are many schools; and as Buncombe discovered, faculty meetings in different schools are often held at the same time.) While the brochure (specifically designed for teachers and other school personnel) is likely to be helpful and a good resource, it is no substitute for a short presentation by a caring and dynamic person in bringing teachers on board. The more teachers understand the program, the importance of getting the flyers home to parents, who they should call with questions, and where to refer parents, the better.

- One size doesn't fit all. The method of distributing flyers to parents needs to be tailored to the school system; and in some cases to the type of school, i.e., elementary, middle and high. We saw that in Guilford, for example, that the distribution system, which had worked well elsewhere (sending materials directly to each school), was not possible because of school system policies. In the end, the alternative approach of working through a key administrator resulted in enhanced relationships all around.

  One can suggest different approaches that have been successful in other places, but the method ultimately will depend on school systems policies and practices. Along with different approaches, it can be helpful to outline challenges that can arise and hopefully averted through careful planning and implementation. One wants to arrive at a method that will get the flyers in the hands of the parents at a time that they are likely to be receptive to the information. (Note: This holds true for parents of children who are home schooling as well as those in public and private schools.)
- Easy does it. Pilots found that the job got done more reliably when they made it easy for the schools, e.g., pre-counted and delivered flyers to the schools with instructions.
- Practice makes perfect. The strategy of sending flyers home with students through the schools can be successful, but it may take several tries to build relationships with school officials and staff (trust, commitment, enthusiasm), and work out the logistics. According to Covering Kids staff, as school personnel have become more familiar with the program their interest in and support of the program has grown, and distributing flyers has become more routine. It is interesting to note that staff members from the Edgecombe Pilot are optimistic about this approach, despite being somewhat disappointed in the results of their fall 2001 effort. They believe that in time the strategy will pay off and are eager to continue to build their relationships with school personnel and refine their methods of distributing flyers and following up when calls are received.
- The devil is in the details. We learned that it is best to **start planning with the schools early** - **in the spring before the new school year begins.** If adopting Buncombe's method, **use a personal approach***, i.e.,* get to know office staff/your main contact at each school. Call them as you are gearing up and before you are ready to deliver the flyers to tell them about changes in the program. The more they hear and know you, the greater the level of cooperation**.** **Package the flyers** so they will be easy for the school to distribute, and **attach a brief memo to the outside of the package that you deliver.** The memo should include the name of the contact person (in large print); the number of packets enclosed; and a request/reminder to attach the flyers to each report card, if that is the plan. Changes in the Health Check/Health Choice program should be highlighted in the memo along with a word of thanks.
- Repetition pays off. Staff and others who have worked on our outreach projects are convinced that for many families it takes multiple "hits" before they respond. Distributing flyers repeatedly during the year (e.g., with report cards), they believe, can make a difference.
- Direct phone lines and application assistance by phone are critical. Calls can provide staff with an opportunity to establish rapport with the family, check whether the child is already enrolled (frequently a parent doesn't realize that Medicaid and Health Check are one and the same), answer questions, offer/provide application assistance and advise families on accessing health care. Pilots have learned that it is best to maintain the phone lines even after the school push as calls will continue to "trickle in." The lines provide nurses,

counselors and other key partners, who may have questions and want assistance, with direct access to staff as well. It is important that all staff in the agency/organization are made aware of the phone line and the project (not just those who are assigned to answer the phone) so that families who call in on other numbers can be routed to the person providing application assistance.

Application assistance by phone should be provided at a family's convenience (evenings and weekends) by friendly, knowledgeable and caring staff who can: answer questions; gather needed information from family over the phone; and send the nearly completed application to the parent to add missing information, attach pay stubs, sign and return in a pre-addressed postage-paid return envelope. The application assister should have access to the database so that s/he can check whether the child is already enrolled in Health Check or Health Choice, and be experienced and knowledgeable about Medicaid and Health Choice policy. The more that can be done the first time around the better.

- Follow-up and follow-through are key; a variety of approaches seem to be effective. From our work to date, we cannot say whether a particular approach or sequence of communications was significantly superior (e.g. letter, postcard, phone call, or personal note). Features that we believe contribute to success are:
  - The personal touch. Having letters, notes and postcards come from a specific person rather than an office or department. As Buncombe has demonstrated, efficiencies can be realized through automation. The computer system can generate personal letters and a list of families for follow up.
  - Sending applications in envelopes with the Health Check/Health Choice logo and a statement alerting the receiver that the requested application is enclosed. And using the logo and effective/consistent phrases and graphics on postcards and other materials.
  - A reliable method of identifying families who have not returned their applications so that they can be targeted for follow-up, and of assessing the results of follow-up.
- This approach is affordable, but not cost-free. We estimate that the cost of a 40,000 school-flyer effort with follow-up (phone, stickers on envelopes, postage-paid return envelopes and postcards) will run between $6,000 and $7,000 when some economies have been realized (e.g., volume purchasing, staff become efficient with practice). Not included in the cost estimate, are overhead and in-kind support by the schools.

  Costs, of course, will vary from county to county, depending on the salaries, the number of calls that result, economies achieved and other factors. Personnel expenses can be reduced if the county can provide telephone assistance and follow-up by reorganizing the work of staff already on board rather than bringing on additional personnel. (Note: When staffed by the DSS, administrative reimbursement from the federal government is available to offset the costs.) Local printing costs will be reduced to the extent flyers and other materials are provided by the State.
- Useful tools/materials. Flyers (general and for parents of teens), envelope stickers alerting families that "the requested application is enclosed" (used in Guilford); follow-up postcards and letters; the "Kids will be Kids" video (for orientations/training of school personnel); and the brochure aimed at teachers, school nurses and other school personnel. Note: The flyers were designed so that they could work with different strategies – in and outside of school. The messages were not tailored specifically to those who had been approved for school meals, were gearing up to get back to school, or were receiving report cards.

  Refer to Appendix G1-6 for copies of: a general use flyer and one for parents of teens (English/Spanish), the Buncombe flyer as revised for the spring of 2002, a brochure for teachers and other school personnel as adapted for use statewide, and a sticker and postcard reminder produced by the Guilford Pilot.

Other School Strategies:

- School-sponsored events didn't yield much in the way of direct results, i.e., applications. While staff members generally feel that it is useful to expose parents to the program repeatedly, Forsyth saw little direct result from attending and participating in school-sponsored events, which are usually designed for specific purposes. At school open houses, for example, parents want to meet the teacher, and learn about the bus routes and needed school supplies rather than health insurance. While Edgecombe staff strongly agree and cite example after example of school events that were "unproductive," they believe that PTO meetings are worthwhile, providing valuable opportunities to reach teachers, counselors, coaches and parents simultaneously. Some believe that non-school staff, like the president of the PTO and the student body president, could serve as effective champions for the Program and be effectively involved in getting the word out, and enrolling children and teens in Health Check/Health Choice.
- Many school nurses will need assistance if they are take full advantage of their unique position. While school nurses are eager and in an ideal position to identify and help enroll eligible children, they are extremely busy and frequently not able to do much more than refer families whose children are potentially eligible. Providing nurses with a phone number, where s/he could quickly contact an outreach worker that s/he knows and trusts, was invaluable in Forsyth and Cabarrus Counties. If nurses are to be more proactive, systematically reviewing students' insurance status and reaching and enrolling those who are eligible, they may need additional help (consider college/graduate school interns). In many places, it is best to work with school nurses through the health departments (they are employed by the health department in many counties in North Carolina). Refer to health care provider initiative for work done with school nurses in Cabarrus County.
- With regard to guidance counselors, social workers and other key school personnel, it is "slow and steady" that is likely to win the race. Recently Pilots have begun focusing on other school personnel who, like school nurses, are in unique positions and motivated to reach and help enroll eligible children (direct/personal contact often when children need medical attention and parents are likely to be receptive to obtaining coverage). To enlist the assistance of these folks, Pilots have begun to use our newly created brochure, "Students Need Health Insurance…. You Can Help!"

  According to staffers in Buncombe, it has taken some time and more than one meeting with guidance counselors before "the light bulb went off."[37] But things have begun to pick up; and folks are "starting to think Health Check/Health Choice." Staffers report that individual counselors have been requesting materials as they perceive the need and schools are asking for the brochures for the first faculty meetings in the next school year (2002-2003). Cabarrus reports that counselors, teachers and nurses have begun calling about children they know - when a child needs insurance or medical attention.

  We see the newly-created brochure as a tool that will help educate and motivate school personnel, and facilitate referrals. But we believe that it is not enough – and that personal contact and repetition are also necessary. (A lot of things come across the desks – and into the boxes – of these busy folks!) Although results have been unimpressive to date, we are cautiously optimistic. While such linkages are unlikely to yield a large number of enrollees over the short-term, we believe that over the long run, many of the eligible children who can benefit most will be identified and enrolled.
- Linking with Free and Reduced School Meals Programs may be effective but it cannot be assumed. After a lengthy process to target outreach by utilizing information available from School Meals applications, Guilford hoped to have much better results than were realized on the first go-round (as has been described, 74 children were enrolled). It is likely that the number enrolled would have been greater if follow up with families had occurred as originally envisioned (implementation was altered as a result of the freeze on enrollment in Health Choice). But unless the results were far greater, some feel the value of using a computer match is questionable. However, linking insurance outreach with School Meals

[37] This has not been the experience in all Pilots.

programs clearly provides opportunities to streamline the enrollment process for families. We continue to be interested in exploring the experiences of states that have worked with School Meals Programs on Express Lane and Presumptive Eligibility approaches. Both of these strategies capitalize on the fact that School Meals and Health Check/Health Choice offer assistance to families with very similar incomes.

- Lower-tech school meals approach has potential. A less cumbersome and costly approach tried in Edgecombe - sending the flyers with the approval letter for School Meals with follow-up and follow-through - is appealing. We cannot, however, recommend it based on our fairly limited experience. We'd like to give this strategy another try, and for others to join us, and to track and share their results. Because school resources are strained, Edgecombe learned, it is important to be available to (literally) lend a hand, i.e., to stuff envelopes. In the next go-around, we'd include a short letter of endorsement from someone influential.
- Keep it simple. In looking back at their various schools projects, Guilford staff concluded that they probably would have had a better response for the school meals project if their print materials had contained less text, more graphics, and the name of a personal contact. From the distribution of its locally-designed flyers with orientation materials early on in the project, Forsyth learned that parents preferred to request an application by calling in rather than mailing back the tear-off section of its brochure. While small promotional items are popular, they may not produce the biggest bang for the buck, in the view of many of our pilots. Scarce resources may be better spent on directly distributing flyers to parents.

Back-to-school events/campaigns:

- Back-to-school events/campaigns with businesses and advertising help to set the stage and reinforce the message to parents. Based on their experience in the last three years and what they have learned about marketing, Buncombe believes that their back-to-school activities with businesses (Wal-Mart, KMart, McDonald's, Arby's) and ads (radio, television, newspaper) contributed to enrollment in ways that are significant and are not reflected in the numbers, i.e., calls and applications tracked to these sources. While it may be a school flyer that ultimately prompts a parent to call for an application (and it is the flyer which they have in hand that the parent remembers when asked about how they heard about the program), Buncombe believes that the call is often the result of multiple hits.
- Brief campaigns give businesses a feasible way to contribute to the effort. These events/campaigns provide businesses with a valuable opportunity to be involved in promoting Health Check/Health Choice in concrete, but time-limited ways. While our work was greatly facilitated by Covering Kids and Greer, Margolis, Mitchell, Burns & Associates (nationally) - who have established relationships with businesses at the corporate level and have developed resources and tools to support these events - these events/campaigns require substantial time and effort by local staff. (Note: Despite spending much time and effort, Buncombe had limited success in getting press coverage at kick-off events, i.e., free media coverage.) We would recommend that others pursue such back-to-school campaigns when there is genuine enthusiasm and support, but not at the expense of our basic strategy: flyers through the schools, direct call-in number, assistance and follow-up.

  With large chain stores, Buncombe learned that it is best to start with district managers and get their permission for the store manager to be contacted. Because each store manager operates differently, it is useful to propose ideas, but best to "let managers lead." Buncombe Covering Kids staff found that a month is too long for an in-store campaign (plans to try a week in the next go-around); and that it is important to meet directly with employees/staff of each store so they understand the program and enthusiastically support the campaign (employees children may be eligible as well). Covering Kids staff believes that the outreach effort dropped in the year that they didn't meet with employees directly.

  While flyers seem to work fine for the kick-off events and short-term campaigns, Buncombe advises using posters for more permanent displays (remain in place and don't require constant replenishing).

Conclusions and Recommendations

When we rolled out our schools projects late last summer, our question was fairly straightforward: Can a relatively simple, time-limited approach which involves distributing flyers through the schools, telephone assistance and follow-up be effective, replicable, affordable and sustainable?

After Piloting variations on the approach that has evolved in Buncombe County, we conclude that it can be **effective** – but not necessarily the first time around. Like other approaches, it requires time and effort to build relationships and work out the logistics. And, "the devil is definitely in the details." The approach is **replicable** in that the method of distributing flyers can be standardized to a great extent; however, we have seen that it must be customized to the school district. Program champions, buy-in at different levels, diligent follow-up and follow-through, all, are essential.

For many, the approach will be **affordable**. We roughly estimate the cost of a 40,000-flyer effort at about $6,500, but have seen that it could cost significantly less with volume purchasing and with efficiencies gained from experience. As we've learned, there are many ways to minimize costs. Because it is time-limited, agencies may be able to reorganize work and reconfigure existing staff to accommodate the seasonal campaign rather than adding personnel. Local costs can be significantly reduced to the extent flyers and other materials are supplied by the State.

When assessing costs, we suggest reviewing what is currently being spent on outreach and enrollment and deciding whether some reallocation might be worthwhile. Direct and indirect costs that are being borne by county agencies, coalition members and other partners might all be considered. For those with more limited resources who are interested in trying this approach, we suggest focusing on schools with a large number of children from low-income families, i.e., schools with large percentage of kids receiving Free and Reduced School Meals.

The "flyer and follow-up" strategy can be fairly easy to **sustain over the long term.** By implementing it on an ongoing basis, one should be able to continue to appeal to families who may have received the flyer previously but were not yet ready to apply, as well as those who are newly eligible. 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. These include working closely with school nurses, guidance counselors and other key school personnel, and possibly sending flyers with approvals for School Meals. (For some thoughts concerning these approaches, refer to the section, Lessons Learned.)

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 each other along with the in-school activities. **Whether a county undertakes one strategy or a more comprehensive approach, we strongly believe that it is important to have a mechanism in place to ensure follow-up with those who express an interest in the program.**

As we look back at the various strategies that we have undertaken to cover kids, it is this basic schools approach (flyers and follow-up) that we recommend first and foremost to those involved in outreach and enrollment. With increased pressure on schools in this state to take steps to improve student performance, the time is right. And much of the groundwork has been laid. Note: The Department of Public Instruction has been an active partner since early on (particularly the State Superintendent and those who have worked with the "Healthy Schools" Initiative and Child Nutrition Services). As members of local coalitions, school officials are on board in many counties. In moving forward, care should be taken to carefully coordinate state and local activities aimed at the schools and businesses that might be involved in complementary back-to-school activities.

To those who are interested in developing this strategy further, we recommend testing a modified, slightly centralized approach where the flyers would direct callers to the State hotline

for information and to request applications, and hotline staff would obtain contact information needed so that counties could provide personal follow-up and application assistance by phone. Such an approach might be helpful and more efficient in serving Spanish-speakers.

We also recommend examining follow-up techniques more closely in order to determine the most effective and efficient way of prompting and assisting families who have expressed an interest in applying, i.e., the sequence, timing and materials to use in communicating with callers (postcards, personal notes, letters, and phone calls).

Simplification

Enrollment System/Process

When the Covering Kids grant was awarded, the State had already done much to simplify the enrollment process for families: It had adopted a two-page mail-in application that combined Health Check and Health Choice and had eliminated an assets test. Our job was to take things a step – or two – further.

Buncombe County took the lead on refining the application to be more appealing and user friendly, and putting a local "infrastructure" in place that provided families with ready access to Health Check/Health Choice applications and information, assistance in completing applications by phone, and follow up. This infrastructure essentially took over where outreach left off - in facilitating enrollment for families. A Call Center, an Application Specialist and a computerized database system that relies on Microsoft Access were its key components. Buncombe also established a method of covering enrollment fees for families unable to pay.

The Application. Working with consultants, the Buncombe Pilot designed an alternative application in 1999 that it field-tested in 2000. This application served as the starting point for a new State application that was created with input from a statewide work group. We at Covering Kids assisted the Division of Medical Assistance (DMA) with the new application by providing literacy and graphic design assistance, focus group testing with parents (in Cabarrus County) and other input. The new application eliminates unnecessary information included in the earlier application and incorporates new requirements. (See the State's revised application in Appendix H)

Buncombe Call Center. Twenty-four hours a day, families can call to obtain an application by mail and get answers to basic questions. The number is widely publicized on flyers and other outreach materials. During the day, the Call Center number rings into the Department of Social Services (DSS). After hours, information and referral staff from the United Way of Asheville-Buncombe County (who "man" the 211 phone line) answer calls to the hotline. 211 staff can mail applications and answer basic questions.

With the aid of a computerized system, calls are logged, applications are mailed with a letter thanking the caller and giving the caller the option of contacting the Application Specialist for further assistance, and follow-up is conducted. If a caller has a question that the Call Center staff cannot answer or if s/he wants assistance in completing an application, staff refers the call to the Application Specialist (described below). The Pilot created a customer-service manual/notebook to train and serve as a reference for call staff that respond to calls.

The Call Center has proven to be very popular. During the period January 1999 through December 2001, the Center received approximately 2700 calls. The Call Center has provided valuable insights into various outreach strategies employed by Buncombe County. Each caller is asked how s/he heard about the program. These results are logged in the database and strategies are evaluated for effectiveness. This process has helped to define and refine strategies for implementation/replication throughout the state.

The Application Specialist. The Application Specialist, a customer-oriented eligibility worker (DSS employee), works out of the local medical society's office and is readily accessible by phone. She answers detailed questions for families referred by the Call Center, the outreach worker who actively markets the program in the field, and those involved in outreach and enrollment in medical offices, schools, businesses and elsewhere. She completes applications with families by phone (mails to parents for signature and needed documentation) and determines eligibility. She is available to call families at their convenience (after hours and weekends) and follows up with families who have been sent but have not returned their applications.

In addition, the Application Specialist provides a direct link to funds that cover enrollment fees for Health Choice eligible families who are unable to pay. (See later section, Assistance with the Health Choice Enrollment Fee.)

Technology. A computerized system that relies on a Microsoft Access database helps the DSS provide the follow-up and follow-through that seems to be needed with many families - in a personal, timely and efficient manner. The system: stores call center information (name, address, telephone number, and application number); prepares customized letters with consistent information and messages that are readily identified with the program (logo, mascot); logs applications received through the mail; prepares letters to applicants acknowledging receipt of the application (including the name of the caseworker); tracks applications mailed but not received; sends follow-up letters; generates a list of families for the Application Specialist to call; creates an enrollment fee letter; and tracks enrollment fees for the finance department. As discussed later, this system is also utilized in the re-enrollment process.

Assistance with the Health Choice Enrollment Fee. Early on it became apparent that for many families the Health Choice enrollment fee was a significant barrier to enrollment ($50 per child/maximum of $100 per family whose incomes are greater than 150% FPL)**.** With funding from the Eblen Foundation and Mission St. Joseph's Health System, in 1998 Buncombe County began to link needy families with scholarships to pay enrollment fees. A total of $23,650 was awarded for scholarships in Buncombe County for 324 applications over a 37-month period.[38]

Scholarship funds or other mechanisms to pay for enrollment fees were later established in all of the Pilot Counties. With funds from the Moses Cone-Wesley Long Community Health Foundation, the Guilford Pilot awarded nearly $80,000 in scholarships to cover enrollment and re-enrollment fees for children over a 21-month period. Largely with the support of area churches, Cabarrus Pilot paid out $8,500 for 111 applications over a 19-month period. With the help of a special grant and funds from various other sources, Edgecombe awarded $11,600 for 168 applications over 20 months. In Forsyth County, a $5,000 scholarship fund was established through the Forsyth Early Childhood Partnership to assist families who have a child under age five. A mechanism to pay enrollment fees also was established by one of the medical centers.

Lessons Learned

- Redesigning the Health Check/Health Choice application proved to be a time-consuming and difficult task. The final product was a result of compromise. As with other materials, the application should be viewed as an evolving document that will need to be refined periodically as it is used. DSS income eligibility workers and others who have worked closely with applicants should be oriented to the new application and the reasons for changes.
- Elements of enrollment success. The Buncombe Pilot attributes much of its enrollment success to getting the word out and widely publicizing a single Call Center phone number where families could request the mail-in application and information around the clock. Buncombe recognized early on, however, that getting the phones to ring and children enrolled were not one and the same. Other elements that were key to enrollment success were: customer-oriented service; qualified and caring staff; and follow-up and follow-through at the convenience of families, including after hours and weekends (often requires assistance and persistence). Also important were program materials with simple and consistent messages and graphics that are readily identified with the program. Note: At the close of 2000 when the freeze on enrollment in Health Choice went into effect, nearly 2,200 children were enrolled in the program in Buncombe County, 114% of those originally projected to be eligible. Enrollment of children in Health Check (18 years and under) had increased by nearly 530 children from the beginning of 1999 to the start of 2001 (from

[38] An application can include more than one child.

10,931 to 11,458). It is interesting to note that by January 1 of 2002, the number enrolled in Health Check had increased by another 1,234 children to nearly 12,700.[39]

- Usefulness of Technology. Technology/automation can help personalize communications and ease tracking and following up with families who have requested applications. The software that has made this possible in the Buncombe Pilot can be affordable and packaged for use by many other counties. Appendix H1-3 presents a series of letters sent to families - when an application has been requested and received, and when an application has not been returned.
- Importance of administrative support. Putting an infrastructure in place, similar to the one in the Buncombe Pilot (customer-oriented call center, staff, and technology) requires strong, administrative commitment and support.
- Further reducing financial barriers. Scholarship funds established to cover Health Choice enrollment fees can help a tremendous number of families obtain insurance. This very worthwhile activity can be made possible by a variety of partners including community-based foundations, hospitals, businesses and faith-based organizations. The support is likely to come in response to a specific request. While helping families, scholarship funds also have helped maintain interest and support for the program within the organizations that have contributed to them.

Conclusions and Recommendations

Applying for Health Check/Health Choice is relatively easy, thanks to the mail-in application. For many parents, the application and information about the Program are all that are needed to prompt them to apply, and to enroll their children. But for others, these tools are not sufficient. These parents may require application assistance, follow up, or financial help in order to complete the process.

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 letter or the availability of application assistance by telephone can make all the difference. Buncombe's approach of encouraging families to call for an application makes any required follow-up and follow-through possible. At the time of the call, the Pilot obtains addresses and phone numbers along with the names (i.e., gets them into the system). Buncombe's computerized database facilitates the process by generating letters and the names of families who need follow-up by phone (often on evenings and weekends).

For many parents, the barrier may be financial. Help in covering the fee (required of some families) can make the difference between enrolling and not enrolling their children. Developing a fund or another mechanism to cover the fee for those who are unable to pay can be relatively easy. Pilots have received generous support from a variety of different sources.

For counties that are interested in helping more children to be covered under Health Check/Health Choice, we recommend an emphasis on follow-up and follow-through with the families who have expressed an interest in applying but may need additional prompting or assistance. While not essential, a computer system, like the one developed in Buncombe, can make following up and following through more efficient for workers. With regard to establishing a scholarship fund or other mechanism to cover enrollment fees for those unable to pay, we advise counties not to underestimate the generosity of partners. From our experience, we have learned: Ask and you are likely to receive!

[39] The Medicaid data was extracted from a Buncombe County-generated report on Medicaid recipients by age.

Re-enrollment System/Process

*After enrollment took off, the State turned its attention to re-enrollment with much in its favor. Because North Carolina had adopted **continuous eligibility**, children would only need to re-enroll annually. The State could adapt a process and materials that were being used for Medicaid. As with enrollment, the State adopted a mail-in re-enrollment form, which it sent families two months before coverage was scheduled to end. Follow-up notices were sent from the local DSS and the State at designated times. If the re-enrollment form was not returned by the 25th of the 11th month, the local DSS sent a **timely notice** to the family advising them that they risked losing benefits unless the form was returned. Four workdays prior to the end of the 12th month, the State mailed a **termination notice** if re-enrollment had not occurred.*[40]

Despite all this, there was concern that re-enrollment would be a major challenge and that additional steps would be needed at the state and local levels to encourage families to re-enroll.

The State began by plugging re-enrollment messages into state-sponsored television and radio public service announcements, and by encouraging providers and their staffs to check health plan cards for termination dates and remind families to re-enroll. The State also encouraged local coalitions and agencies to undertake complementary strategies to enhance the efforts that were already underway. A survey conducted by the State in the spring of 2000 indicated that counties were actively engaged in such activities. Among them were: discussing the annual re-enrollment process at the time of enrollment; sending personalized letters and postcards; deputizing volunteers and/or other community agency staff to do personal follow-up with families due to re-enroll; conducting personal follow-up through departments of social services; encouraging outstationed workers to assist families complete re-enrollment forms; and having local Health Check Coordinators (outreach workers) encourage families to re-enroll.

In the summer of 2000, the State added a reminder postcard to its sequence of communications. Approximately three weeks after they had been sent their-enrollment form, families were sent the postcard emphasizing the importance of access to medical care for their children and urging families to return the form if they hadn't already. When the freeze on enrollment in Health Choice was to take effect, the State stepped up its efforts further, sending families a letter notifying them of the upcoming freeze and the importance of timely re-enrollment so that their children would not lose coverage.

We at Covering Kids assisted the State with re-enrollment in a number of different ways. We examined the re-enrollment process and communications to families, identifying ways to better coordinate and improve on the materials and messages that were being sent by the State and local departments of social services.

The Buncombe Pilot focused on retaining children in the program, trying out various strategies, including a personal reminder letter, an auto-dialer message, follow-up by phone, and hanging posters in provider offices. Results from a 22-month study suggest that the personal reminder letter sent with a second re-enrollment form had an impact on re-enrollment. Approximately 22% of those who received the reminder used the application that was attached to re-enroll in the program.

To facilitate communications with families and support workers in their efforts to re-enroll children, Buncombe adapted its infrastructure, including its computer system that had aided enrollment. Caseworkers could use the system to log receipt of re-enrollment forms, and to generate the reminder letters, notices and the automated telephone calls to families who had not returned re-enrollment materials. More recently, the Pilot also developed a method of downloading re-enrollment information from the State's **Data Warehouse** into its local Access database. Over time, other Pilots took steps to enhance re-enrollment as well. Strategies

[40] Families have a grace period, i.e., the first 10 calendar days of the month following the end of the enrollment period.

employed by Cabarrus and Edgecombe, primarily in response to the freeze, are described in the next section where we look at re-enrollment rates.

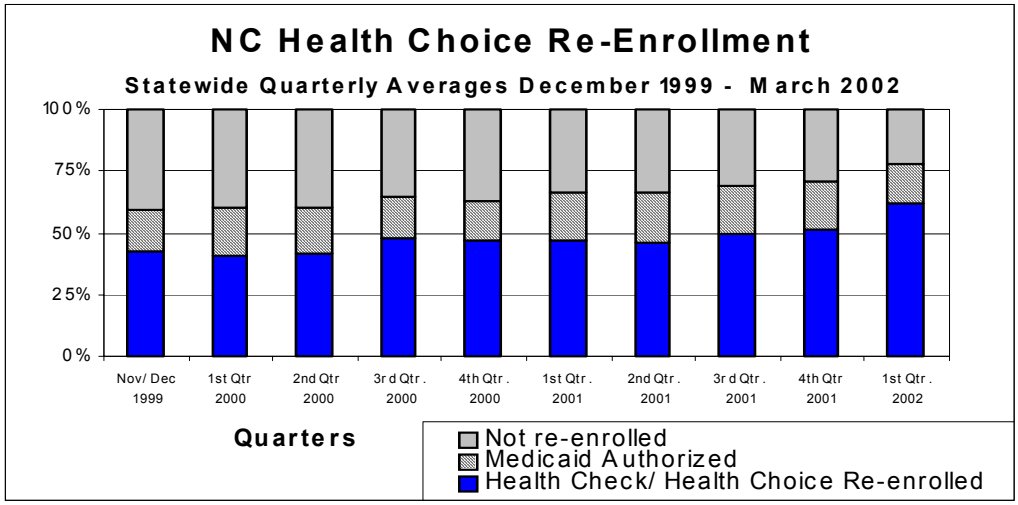
In addition to examining the enrollment process and existing materials, and trying out various strategies, we at Covering Kids compiled and analyzed data to monitor the re-enrollment experience and designed new re-enrollment materials. To gain a better understanding of how families perceived the program, the reasons families were not re-enrolling their children, and to get feedback and ideas on the renewal process and materials, we conducted focus groups. Based on our findings and input from other sources**,** we recommended and helped the State implement some modifications to the re-enrollment process and the materials.

Below we highlight some of what we have learned about re-enrollment from the data, our experiences, and the focus groups. Then we outline the re-enrollment process ultimately adopted by a State Re-enrollment Work Group based on our recommendations and the input of others.

State and Pilot County Experiences.

We examined re-enrollment by looking at the outcome for children who are "on file for recertification" in Health Choice. As shown on the graph (See Exhibit C), a large percent of children were authorized for children's Medicaid (Health Check), rather than re-enrolled in Health Choice. Of the children who were due for recertification in Health Choice in 2001, approximately 20% were authorized for Medicaid (approximately 49% were re-enrolled in Health Choice). One can see that the percent of those that remained covered (re-enrolled in Health Choice or authorized for Medicaid) is fairly significant (approximately 69% in 2001); and that it has increased dramatically over time - from 59% in November/December 1999 to nearly 71% in the 4th quarter of 2001 and to 78% in the 1st quarter of 2002. (Note: When we look at re-enrollment, we include those who have re-enrolled within a month of the time they are due for re-certification. In the remainder of this section, re-enrollment rates include children who were authorized for Medicaid along with those who were re-enrolled in Health Choice, i.e., those who remained covered in the publicly funded programs.)

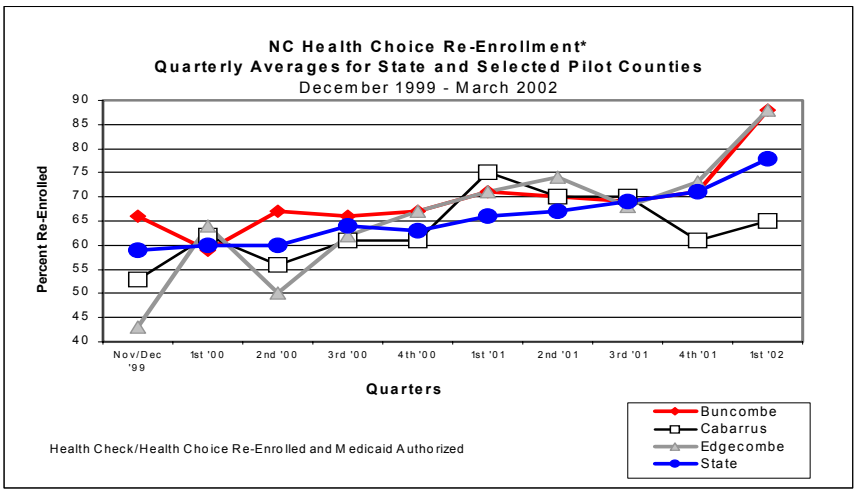
Exhibit C



Not surprisingly, the re-enrollment rate for Buncombe - the Pilot County that incorporated re-enrollment strategies and an infrastructure to facilitate communications and follow up with families early on - was relatively high. The County achieved a re-enrollment rate of 66-67% in the 2nd, 3rd and 4th quarters of 2000. In the 1st quarter of 2001, re-enrollment reached 71%. The rate in subsequent quarters tracked has ranged from 69 – 88%. The high of 88% was achieved in the 1st quarter of 2002. (See Exhibit D.)

In looking at the graph, one can see that in the quarter after the freeze on enrollment in Health Choice went into effect (1st quarter of 2001), the State re-enrollment rate began to rise. It increased from 63% in the quarter prior to the freeze to 66% and 67% in the two quarters after the freeze. The rise in the State's overall rate was undoubtedly largely due to a letter that the State sent families telling them of the freeze on new enrollment and the importance of re-enrolling on time. It is interesting to note that the State rate continued to climb to 71% in the 4th quarter of 2001 (the same as Buncombe's) and to 78% in the 1st quarter of 2002.

Exhibit D



With re-enrollment at 75%, Cabarrus exceeded the Buncombe and State rates in the quarter after the freeze went into effect. And with a rate of 71%, Edgecombe equaled Buncombe's rate and exceeded the State's. The major jumps in the 1st quarter in Cabarrus and Edgecombe presumably resulted from the measures undertaken to encourage families to re-enroll their children. In addition to the letter that was sent by the State to families noted above, the Cabarrus Pilot sent a letter to enrollees telling them the importance of completing their re-enrollment form and warning them that they would lose medical coverage for their children if they did not re-enroll on time. Families who had not re-enrolled received reminder phone calls and, in some cases, home visits. In Edgecombe, an outreach worker called families whose children were due to re-enroll and sent reminder letters to those not reached. Like Buncombe, Edgecombe achieved a re-enrollment rate of 88% in the 1st quarter of 2002.

As evident from above, State-generated reports have been useful in tracking re-enrollment rates over time. The reports have helped us to begin to understand the reasons some families did not re-enroll as well. From the data, it appears that a substantial number of those who were "on file" for Health Choice recertification were determined ineligible for the program. Some were deemed qualified for "extended coverage" (available to those who earn 200-225% of the federal poverty line, for purchase); others were determined ineligible for such reasons as income, age, they had other insurance, they had moved out of North Carolina, or were deceased. In the last six months of 2001, for example, approximately 6.8% of those who did not re-enroll were qualified for "extended coverage"; and approximately 8.6% were determined ineligible for such reasons as income, age, they had other insurance, they had moved out of North Carolina, or were deceased. (During that period, approximately 30% of those "on file" for Health Choice recertification were not re-enrolled in Health Choice or authorized for Medicaid.)

The results of a national study on retention and disenrollment in SCHIP and our own work with focus groups leads us to believe that many of the other disenrollees probably self-

determined that they were no longer eligible and didn't submit renewal forms for determination.[41]

Focus Groups

In the winter of 2001, we conducted focus groups with parents in order to gain a better understanding of how families perceived the program and the reasons some families were not re-enrolling their children; to get feedback on re-enrollment materials; and to generate ideas to enhance retention. Two focus groups were conducted in Buncombe County, and one in-depth dyad (two-person interview) in Forsyth County. Among our findings were the following.[42]

Level of satisfaction with the program was not a factor in participants' decisions not to re-enroll. Participants said they were very satisfied with the care their children received under Health Check/Health Choice and that they wanted to keep their children insured under the program. They felt their children were healthier and they had more peace of mind as a result of the insurance.

The decision not to re-enroll often was based on the family's circumstance at re-enrollment time. Their reasons for failing to re-enroll related to their unpredictable and unstable life situation, which impacted their real or perceived eligibility for Health Check/Health Choice. One woman said her husband moved back into the house, and she believed his added income made the children ineligible for benefits. (Her husband, subsequently, moved out again.) A man's grandchildren were covered under Health Check when they were living with him. When the re-enrollment application came in the mail, the children were living at their mother's home so he didn't fill it out. A woman said she was unable to pay the $50 re-enrollment fee. Another woman was in the hospital for 3 months and did not see the re-enrollment letter until the deadline was past.

Some participants determined on their own – or based on conversations with DSS staff - that they were not eligible. They didn't send in their paperwork for an official determination.

When they initially enrolled, participants knew that they would have to re-enroll each year. They recalled receiving the existing re-enrollment materials in the mail.

Participants were asked to review existing re-enrollment materials: the re-enrollment packet; a postcard reminder; the **8110/timely notice**[43], and the **termination/adequate notice**.[44] In general, they felt that existing re-enrollment materials looked complex and uninviting ("gobbledygook" and "bureaucratic"). This first impression, led some to put the re-enrollment packet aside and forget about it until they received the "cancellation" notice in the mail. Many said they were confused by the State's reminder postcard that arrived even if they had already returned the form and for some before the form was received. Participants appreciated the mail-in re-enrollment form. For many, the form itself was not difficult to complete.

Participants examined newly created (draft) materials: postcards with different graphics and messages alerting them that a re-enrollment packet would be arriving soon; a re-enrollment letter and a cover to the re-enrollment form; a **time is running out/personal note**; and an auto-dialer telephone message intended for those who had not yet sent in their re-enrollment form.

Participants preferred high contrast, simple materials with concise messages and more "white space." They liked brightly colored graphics and favored using the same graphic themes throughout the materials in order to make them readily identifiable. They thought that: "less was better"; bare-bones information essential to the task at hand should be

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[41] Riley,T., Pernice, C., Perry, M., & Kannel, S. (2002). Why eligible children lose or leave SCHIP: Findings from a comprehensive study of retention and disenrollment. Washington, DC: National Academy for State Health Policy.

[42] For a description of the focus group study and more detailed findings see: Bloom, D. & Teplin, S. (2001). NC Covering Kids Re-enrollment Focus Group Report. Raleigh, NC: The North Carolina Foundation for Advanced Health Programs, Inc.

[43] Informs the recipient that benefits will stop unless they respond or ask for a hearing within 10 days.

[44] The "termination/adequate" notice was included in the Buncombe County focus group packets, not in the packets distributed to the Forsyth dyad.

featured up front and in everyday language; and that the exact date the re-enrollment form needed to be returned and the date the current health insurance would expire should be presented in a simple, straightforward way, and made to stand out. They felt that parents/guardians should be told what they needed to do, by when, why, and who to call with questions (name and number).

Participants wanted materials to include a list of specific benefits and the ages covered (presented so stand out/easily noticed). Some Health Check participants did not know that prescription drugs, mental health benefits or medical equipment and supplies were covered under the plan.

Favorite phrases included: "Better health for your children…peace of mind for you" and "Re-enroll now! It's one of the best things you'll ever do." Participants were drawn to images of active children and for Buncombe participants "little doc" (Buncombe County's mascot).

Participants liked the following sequence of communications: a postcard alerting them to watch for the re-enrollment packet; the re-enrollment packet in an envelope with the Health Check/Health Choice logo and the message that important re-enrollment information was enclosed; a small and concise, personal note that could be posted on a refrigerator telling them that "time is running out" in an envelope with the Health Check/Health Choice logo and a message alerting them that this was their last chance to re-enroll; and an auto-dialer telephone message directed at those who had still not re-enrolled. Participants suggested offering opportunities for group re-enrollments and re-enrollment on-line.

Lessons Learned

- The re-enrollment situation for Health Choice is significantly better than it first appears. When one considers the children who are authorized for Medicaid along with those re-enrolled in Health Choice, the re-enrollment rate is substantially higher than if one considered Health Choice alone. Approximately 70% of those "on file" for Health Choice recertification in 2001 re-enrolled in Health Choice or were authorized for Medicaid. As discussed earlier, based on the State data that is available, a re-enrollment study published by the National Academy for State Health Policy and our own work with focus groups, we believe that a significant portion of the 30% who didn't re-enroll is probably not eligible.
- The re-enrollment rate has improved dramatically over time. The positive trend for the state has continued through the freeze – and after it was lifted. The re-enrollment rate in the 1st quarter of 2002 for the state overall was 78% (compared with 59% in November/December 1999). The rate in both Buncombe and Edgecombe was 88% during the 1st quarter of 2002**.** In November/December 1999, Buncombe's rate was 66% and Edgecombe's was 43%. (Rates include Health Choice children who were authorized for Medicaid.)

  Strategies undertaken by Buncombe County prior to the freeze on enrollment in Health Choice, and by the State and other Pilot Counties in connection to the freeze, appear to have had a major impact on re-enrollment.
- There are some concrete steps that can be taken to reduce confusion and encourage families to re-enroll. These involve changing the sequence of communications and redesigning materials to be clearer and more appealing. Refer to the previous section for the input we received from focus group participants. As we think about enrollment and taking steps to enhance re-enrollment, we are reminded of a poster with a picture of a needle in a haystack with the caption "Customer Care. It Takes Months to Find A Customer…Seconds to Lose One."[45]
- Technology/automation can help personalize communications and ease tracking and follow-up with families who have not re-enrolled. The software that facilitated communications with families and assisted staff with re-enrollment in the Buncombe Pilot could be packaged, affordable, and usable by other counties.
- Close coordination (the **seamlessness**) between Health Choice and Health Check appears to play a critical role in keeping children covered**.** As we examined the Health Choice re-

[45] Corporate Impressions 1997, Successories, Inc.

enrollment data, we were struck by the critical role that the seamlessness between the two programs seems to play in keeping children covered. (Children who are up for Health Choice renewal can be easily authorized for Medicaid if the family situation has changed and they meet the income eligibility guidelines for Health Check rather than Health Choice.) While we don't have comparable re-enrollment information for Health Check enrollees, other data suggest that many children are also moved from Health Check to Health Choice. According to data from the Medicaid eligibility files, 38.48% of the children that were in Health Choice during the first year of the program – or 22,912 - came directly from the Medicaid program (defined as having 31 days or less between the last covered day on Medicaid and the first covered day on Health Choice).[46]

Conclusions and Recommendations

Through our work, we saw how we can enhance re-enrollment by adopting various strategies; making some changes in the sequence of communications and materials sent to families; better coordinating state and local systems so that they are complementary and reinforcing; and through the use of technology.

While we feel that personal phone calls (and home visits) that remind and assist families in re-enrolling can boost re-enrollment rates, we recognize that it is unrealistic for county agencies to maintain such labor-intensive activities on an ongoing basis. Consequently, in the sequence of communications recommended to the State Re-enrollment Work Group, we suggested the less costly auto-dialer with its pre-recorded message as an alternative to the more personal touch.

The process, ultimately developed by the State Work Group with input from Covering Kids, is outlined in Exhibit E. The Workgroup, which is now taking the lead on improving re-enrollment in North Carolina, is broad-based and includes former staff from the Covering Kids project.

The State has moved quickly to implement recommendations that are cost-neutral and fairly easy to adopt e.g., sending a eye-catching postcard that alerts families to look for the soon-to-arrive re-enrollment form and encouraging them to re-enroll (replaces a postcard that was being sent later in the process), and adding a re-enrollment message to the outside of the envelope that contains the re-enrollment form. The State has been rewriting notices that families receive regarding the ending of their benefits to be more understandable, redesigning the re-enrollment form and developing a "time-is-running out"/personal note.

Currently, the reports that are generated by the State, which have allowed us to monitor re-enrollment rates for Health Choice, are not being produced for Health Check. These reports would be extremely helpful in determining re-enrollment levels and trends within that program as well. We encourage the State to generate comparable reports for Health Check.

See Appendix I1-4 for re-enrollment materials: the State's re-enrollment postcard (based on focus-group tested postcards/adapted to comply with budget and design constraints); the State's re-enrollment envelope (also based on focus-group tested materials); Time-is-Running-Out/Personal Note (based on focus-group tested materials); sample auto-dialer message developed by the Buncombe Pilot (focus-group tested).

[46] This data was taken from the Annual Report of State Children's Health Insurance Plans that North Carolina submitted to the federal government for the FFY 1999.

EXHIBIT E

Refinement of Re-enrollment Process

All materials should have consistent graphics, messages and colors.

 # 1
Advance Postcard
"Keep Your Kids Insured"
State Material

 # 2
Re-Enrollment Form
Pre-printed, re-enrollment form.
(Revised DMA 5063).
Outside envelope with logo & message.
Return envelope: addressed/pre-paid postage.
State Materials

#3
Reminder Packet
Personal note and DSS 8110 (new/timely notice) or merged version of these two forms.
Outside envelope with logo and message.
Another re-enrollment form/return envelope.
State Materials, Sent Locally

#4
Optional – Auto dialer

Local Materials

#5
Re-write Final Termination Notice

State Materials

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.