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.[1] *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.[2] 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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[1] 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.

[2] 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.[3] 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:

[3] 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.