



Evaluation of the Health Care for All Coalition Community Outreach Program

June, 2000

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EXECUTIVE SUMMARY

In July 1998, the California Department of Health Services launched Healthy Families as California's version of the federal State Child Health Insurance Program (CHIP), offering families between 100 and 200% of poverty level low-cost health insurance for their children. Since its inception, the state has focused a good deal of effort on enrollment, however, uptake of the Healthy Families program during its first year was very low. At the same time that Healthy Families was launched, Medi-Cal rolls across the state continued a precipitous decline, despite that fact that transitional Medi-Cal became more readily available to families leaving TANF. In the face of decreasing Medi-Cal enrollment coupled with estimates of the growing uninsured, San Mateo County sought to develop ways to maximize uptake of available public health insurance coverage for low-income, uninsured children.

In June 1999, HSA formally contracted with El Concilio of San Mateo County to act as the lead agent in the San Mateo County Health Care for All Coalition, funded in concert by the Peninsula Community Foundation, the David and Lucille Packard Foundation, and the California Department of Health Services. The Coalition's mission was to conduct a comprehensive outreach campaign to enroll low-income children and families in three no or low-cost public child health insurance programs: Healthy Families, Medi-Cal, and AB 1931(b), a new Medi-Cal category designed to ensure that families eligible for Medi-Cal under the old AFDC program remain eligible for Medi-Cal after implementation of CalWORKs.

The Coalition backed its support of this effort by sponsoring an independent evaluation of the campaign's success. The SPHERE Institute was awarded the evaluation contract following a competitive RFP process, and evaluation activities began in January 2000. The evaluation of the outreach campaign includes two components:

1. A process/formative analysis to document program activities and identify factors that facilitate and impede enrollment in these low-cost health insurance programs;
2. An impact analysis to examine outcomes regarding Healthy Families enrollment and health care utilization in San Mateo County under the campaign.

Research Objectives

The San Mateo County Health Care for All Coalition set three specific goals for the first year of program operations: (1) to plan and implement a comprehensive outreach program; (2) to maximize enrollment in Healthy Families, Medi-Cal, or AB 1931(b) for eligible children and their parents; and (3) to ensure that enrolled families remain insured and have established a medical home at six months following enrollment.

Consequently, this evaluation of outreach activities was designed to focus on assessing the coalition's success in meeting these aims. Specifically, the evaluation of the Coalition's campaign sought to address four sets of research questions directly related to the campaign's explicit goals:

1. What were the planned outreach activities and how were the activities actually implemented?
2. How did systematic issues and client specific issues such as personal values impact enrollment in public child health insurance programs and how can enrollment procedures and policies be improved to increase uptake of public health insurance programs?
3. Did the outreach activities increase enrollment in the target programs?
4. Did new enrollees remain enrolled 6 months following acceptance into a health insurance program and did they establish a medical home and increase their utilization of care?

Evaluation Methodology

To address these objectives, SPHERE designed a two-pronged approach using a combination of qualitative and quantitative research methods to answer these four research questions. The first part of this approach involved a process/formative analysis to documents program activities and look at what systematic, programmatic, and client specific issues facilitate and impede enrollment. Focus groups and semi-structured interviews were conducted to examine these issues from three distinct perspectives: coalition staff (including Community Health Outreach Workers (CHOWs) and administrative staff), clients who participated in the campaign and applied to one of the programs, and potentially eligible parents who had contact with the outreach campaign but did not apply for any of these public health insurance programs through the coalition.

Initial participation in client focus groups was low. Consequently, participants who agreed to attend focus groups were contacted and interviewed by phone using the same research protocols. Ultimately, we spoke with 28 clients who participated in the campaign (of the estimated 30 we anticipated would attend) and 10 potentially eligible parents (of the estimated 20 we anticipated would attend).

The second part of our approach entails an outcomes analysis that examines enrollment patterns in Healthy Families in San Mateo County and in two comparison counties (San Francisco and Ventura). In addition, the outcomes analysis was to explore quantitative information regarding enrollment outcomes and longevity of enrollment and utilization of services up to six months following program subscription. The outcomes analysis makes use of two distinct data sources: (1) data collected by the outreach campaign about applicants to whom they provided outreach services throughout administration of this project; and, (2) state administrative data provided by the Managed Risk Medical Insurance Board (MRMIB) to monitor enrollment in Healthy Families across California's 58 counties.

There are several limitations to the data that severely impede our ability to answer some questions that initially guide the research. First, we do not have complete follow-up information on the full population of families and children who were initially screened by the outreach campaign and applied to one of the available insurance programs. Of the original 654 families with 1,154 children who are in the screening database, only 415 families and 811 children appear in the 45-day follow-up database, and we do not know about insurance coverage for the 343 children for whom we have no follow-up information (a substantial 30% of those originally screened). Furthermore, only 68 families with 137 children appear in the six-month follow-up database. The absence of families who received six-month follow-up services is no doubt a reflection of the fact that program operations were shut down much earlier than anticipated. However, this lack of information prevents our ability to address two of our fundamental research questions: (1) Did new enrollees remain enrolled six months following acceptance into a health insurance program?; and, (2) Have enrollees found a medical home and did enrollment promote utilization of care? Because there are so few families in the six-month database, we cannot address either question with any confidence.

Summary of Process Findings

Program Implementation

- **The outreach campaign planned and prepared for operations for 6 months, from February through July 1999 and actively conducted outreach activities and application assistance for a total of 9 months, from August 1999 through April 2000.** Due to state-wide changes in the Healthy Families application process and the actual application, the campaign was not fully staffed and able to begin outreach activities until August 1999. Therefore it is important that all enrollment efforts be judged in light of the very brief time period in which the campaign was able to provide assistance.
- **While CHOWs were trained on how to complete applications and work with clients, they received no training on how to conduct outreach activities.** For CHOWs with prior outreach experience, this was not problematic. For CHOWs with little outreach experience, this type of training would have been helpful.
- **The outreach campaign focused on Hispanic enrollment to the exclusion of non-Hispanic populations.** Staff acknowledged that an ethnic match between CHOWs and participants facilitated enrollment. Early on, the program decided to focus on increasing enrollment in the Hispanic community and hired and maintained Hispanic staff accordingly.

Outreach Activities

- **Outreach activities promoted awareness of and enrollment in publicly available insurance options.** Successful outreach activities included presentations at local agencies, schools, churches, and employers. Without community-wide outreach, many families who participated in the program might otherwise not have.
- **The state-funded outreach campaign did not promote enrollment in publicly available insurance programs.** While most clients were exposed to the advertisements sponsored by the state-funded outreach campaign, not one used the information to seek out health coverage.
- **County agencies did not refer potentially eligible clients to the outreach campaign or to Healthy Families in general, and improved outreach and referral at these sites is needed.** Neither staff at county hospitals nor eligibility workers at HSA welfare offices told clients about the availability of Healthy Families or the outreach campaign's assistance for potentially eligible families, even when clients asked for information regarding available health insurance options.

Application Assistance

- **Application assistance of the sort provided by the outreach campaign is essential to promote enrollment in publicly available insurance programs.** Most participants in the outreach campaign said they would not have completed an application without assistance. One on one application assistance is best provided in clients' homes, where

clients feel most comfortable, and by a worker who understands and can address client fears and concerns.

Case Management

- **The outreach campaign provided inadequate case management for families who faced obstacles to enrollment.** Participants whose children were not immediately enrolled in health insurance program required enhanced case management activities to revise and resubmit applications, clarify state correspondence, and in many cases, accompany clients referred to Medi-Cal to welfare offices to ensure enrollment. CHOWs reported (and enrollees concurred) that families who were easily and immediately enrolled in insurance programs to which they applied required no more case management.
- **Although not all families require case management, case management took a back seat to outreach and application assistance because staffing was inadequate for CHOWs to accomplish all required activities.** CHOWs estimate that outreach activities and application assistance took up 85% of their time, leaving little time for case management activities. Outreach staff recommended that an additional 3 staff persons would be required to maintain enrollment goals of 10 applications a week while adequately maintaining case management activities on all active clients.

Promoting Utilization of Care

- **The outreach campaign conducted few formal activities to promote client utilization of care and inform provider choice, however, clients felt that these types of activities may have not been necessary given that clients said they already desired coverage and knew how to use it.** Again, due to a lack of resources, activities to promote utilization of care took a back seat to outreach and application assistance.
- **Provider choice was primarily influenced by participant desire to maintain an existing relationship with a current doctor.** Familiarity with a health plan and proximity to the provider were also significant, albeit lesser factors influencing provider choice. Cost was the least mentioned reason for provider choice.
- **Most participants did not choose HPSM due to lack of familiarity, although negative association with HPSM as welfare also influenced consumer choice.** Participants who named cost as the most important factor in choosing a provider were the only consumers to choose HPSM.

Barriers to Enrollment

- **The public charge issue presented a significant barrier to enrollment for Hispanic and Pacific Islander clients.** However, CHOW provided outreach and application assistance allowed participants to overcome their concerns and apply for coverage.

- **State-defined enrollment procedures presented an equally significant barrier to enrollment, and myriad difficulties with the state-defined application process impede enrollment in available programs.** Clients who were denied coverage or required additional documentation for approval were uniformly sent letters in English, despite the primary language noted on the original application. For clients who were denied in error, the re-application process did not work and clients had to submit an entirely new application. Application forms were unclear and did not provide adequate explanation for how self-employed clients could document income. Last, families with a combination of documented and undocumented children receive confusing correspondence (often in the wrong language) regarding the disposition of their applications.
- **Negative client experiences with Medi-Cal impede application to available programs and follow-through on applications referred to Medi-Cal.** Healthy Families is stigmatized by its association with Medi-Cal. Consequently, clients whose applications are referred to Medi-Cal often do not follow through as a result of prior negative experiences with the Medi-Cal program, including poor treatment by workers, a perceived lack of Spanish speaking workers, and worker non-response to client phone contact. Moreover, state sponsored ads that call Healthy Families ‘Medi-Cal for Kids’ confuse clients as to program distinctions, and therefore present an additional obstacle to enrollment.

Role and Value of Health Insurance

- **Parents value health insurance and actively seek it out.** All parents with whom we spoke who had an employer sponsored dependent care option sought it out and paid costly premiums rather than remain uninsured.
- **In the absence of care, families pay out of pocket for routine and emergency care.** In the absence of insurance coverage, most parents still had an existing relationship with a primary care pediatrician for whom they paid out of pocket. Coverage has allowed these parents to visit these doctors more regularly without the attendant costs.

Non-Custodial Dependent Coverage

- **Mothers do not seek out non-custodial provision of dependent coverage because they do not want to encourage paternal contact.** Most mothers wanted to avoid further paternal involvement in their childrens’ lives. The few mothers who would have liked this type of assistance said that the DAFS was unable to locate the fathers for child support collection, and were therefore skeptical of their ability to garner insurance coverage.

Summary of Outcome Findings

- **San Mateo County’s Healthy Families enrollment grew from 1,170 cases to 2,864 cases – a 145 percent increase – from August 1999 to May 2000.** In contrast, San

Francisco and Ventura counties' Hispanic caseloads grew from 5,635 to 8,579 and 4,384 to 8,468 respectively (a 52 and 93 percent increase) over the same time period.

- **San Mateo County's Hispanic Healthy Families enrollment tripled from August 1999 to May 2000.** Hispanic enrollment in the two comparison counties doubled over the same time period.
- **The outreach campaign primarily served Spanish speaking, two-parent, Hispanic families with 3 or more children.** While parents in these families were more likely to be non-citizens, most children were documented.
- **Most parents had a history of insurance coverage.** Seventy-two percent of parents surveyed had a history of insurance coverage and 65 percent of parents surveyed had a history of Medi-Cal coverage. Forty-one percent of parents had current health coverage.
- **Most children lacked insurance coverage at the time of application.** Only 3 percent of children who applied for coverage had been insured in the past 90 days. Only 7 percent had been covered by no-cost Medi-Cal.
- **Lack of affordability was the principal reason cited to explain lack of child health insurance coverage.** Lack of information was the next most frequently cited reason.
- **Healthy Families was the most common insurance program to which outreach campaign participants applied.** A lesser majority (15%) applied to Medi-Cal. Only 5 percent of families were referred to 1931(b) because so few met the eligibility requirements.
- **At 45-day follow-up, 76 percent of children were insured and the bulk of insured children were covered by Healthy Families.** Twenty-four percent of children who worked with the outreach campaign remained uninsured at 45-day follow-up. Of all children in the 45-day follow-up database, 55 percent were covered by Healthy Families 45-days following initial application. Medi-Cal coverage accounted for 15 percent of insured children 45-days following initial application.
- **Incomplete documentation (47%) and ineligibility (38%) were the two main reasons children were denied coverage.** Sixteen percent of children were denied coverage were in the process of resubmitting an application.

Lessons Learned

Findings from both the process and outcome evaluation components can be used to inform multiple levels of service delivery at the program, county, and state level. This section recommends practices for three levels of stakeholders: agencies that may be implementing

similar initiatives; counties who seek to encourage these initiatives; and, the California Department of Health Services who can use the information to lessen bureaucratic obstacles to enrollment.

Program Specific Recommendations

While San Mateo County's outreach campaign is over, lessons learned from evaluation of the campaign can be used to inform similar outreach efforts in San Mateo County or beyond. Some features of the Coalition's outreach campaign were extraordinarily successful, and merit replication, while others provide insight as to how to improve upon outstanding outreach efforts. This section presents a synthesis of both the successful features of the Coalition's effort that merit replication and ways to improve upon their activities in future efforts either within or outside the county.

- 1. Future outreach efforts should seek to reach diverse ethnic groups.** It should be noted that due to the County's large population of low-income Latino families (37 percent of San Mateo County's Medi-Cal population is Latino), the Outreach Campaign made a conscious effort to target Latino families for services. Consequently, a large percentage of non-Latino families remained un-targeted by the outreach campaign. According to staff and clients, ethnic match between client and worker is important, particularly so for non-English speaking monolingual clients. Therefore, these types of outreach efforts should either use a variety of ethnocentric organizations to spearhead outreach efforts, or ensure that the lead agency hire, train, and provide adequate support to a diverse staff of outreach workers.
- 2. Application assistance helps enroll participants in these types of insurance programs.** Any outreach effort should be able to provide one on one assistance to eligible clients, in clients homes if desired. As outreach efforts gain pace, other methods of application assistance (e.g. in group settings at the workplace) might merit further investigation.
- 3. Outreach efforts should ensure that there is adequate staff time allotted for case management activities.** Twenty-five percent of participants in the outreach campaign were not insured at 45-day follow-up, and based on process findings, these families could have benefitted from increased case management to resolve application difficulties, resubmit applications, or assist clients referred to Medi-Cal with that application process. Based on staff estimates, case management activities require fifty percent time, and future outreach efforts should plan for that allocation.

4. **Informal client worker discourse is adequate to promote utilization of care.** Clients with whom we spoke say they already desire, value, and know how to use health coverage, and in many cases already have a regular doctor. Consequently, formal client presentations regarding how to choose a provider and access care are an unnecessary use of scarce time.
5. **If outreach efforts are to include client follow-up, forms should be streamlined and every effort should be made to track all clients.** Client follow-up and tracking are mechanisms by which outreach efforts can self-assess their own progress. However, tracking forms should gather the most basic information consistently across time periods. Furthermore, long term tracking is the only way to account for project success. Without adequate data collection that tracks a majority of participants from screening and beyond, implementation of a tracking system is not worth the effort.

County-Level Recommendations

County-specific recommendations are again, applicable to both San Mateo County and to other counties seeking to encourage similar outreach initiatives.

1. **Ensure that county agency staff who are already outposted at agencies across the county conduct outreach and make referrals as appropriate.** Information regarding available insurance options (particularly non-welfare administered insurance options such as Healthy Families) should be visibly posted at county hospitals and welfare agencies. Furthermore, staff at these agencies who are already trained about available programs should be more assertive about reaching out to clients and providing anticipatory information about the outreach campaign to all clients who come in for services.
2. **Try to ameliorate negative client perceptions regarding Medi-Cal.** Participants say that negative experiences with Medi-Cal prevent them from applying for Medi-cal when referred. While history cannot be undone, changes that might be currently implemented include increasing the number of Spanish speaking eligibility workers, ensuring that workers return client phone calls in a timely manner, and changing the Medi-Cal hours to accommodate client work schedules.

State-Level Recommendations

By far, most obstacles to enrollment can be transcended by changes made at the state-level regarding application processes. Some of these recommendations are concrete and feasible. Others may be more utopian, but nonetheless represent ways that would ultimately improve uptake of low-cost public health insurance programs for children.

- 1. Redesign the application and ensure that it provides adequate space and instruction to cover all information necessary for the state to fully evaluate a client application.** The current application has unclear guidelines and space for income information. Furthermore, there is no process by which self-employed applicants can adequately document their income and qualify for coverage. Redesigning the application to ameliorate these issues might necessitate fewer incorrect denials and lead to increased enrollment.
- 2. Ensure that communication regarding application disposition is sent in the appropriate language.** Applicants are easily discouraged by a difficult application process. Posting letters in the incorrect language adds yet one more unnecessary obstacle to what is already an anxiety provoking process.
- 3. Send a clear message regarding the public charge issue, clarifying that application to Healthy Families will not have negative consequences for undocumented parents.** While outreach workers were able to surmount participant fears and concerns, in the absence of an effective outreach worker, undocumented clients will not apply for child health coverage and children will remain uninsured.
- 4. Make Healthy Families, Medi-Cal, and other public health programs operate seamlessly.** Clients were confused by the multiplicity of available programs and the difference between the regulations for each. Both clients and staff suggested that this confusion, which presents a formidable obstacle to enrollment in all programs, could be alleviated by making the programs operate seamlessly. Suggested ways to do this include: change the timing of redetermination of either Healthy Families (annually) or, preferably, make Medi-Cal (quarterly), so that they are the same; make Healthy Families available on demand, preferably retroactively for clients who come into health care providers with an emergency.
- 5. Consolidate the Healthy Families and Medi-Cal applications into one.** Applications can then be reviewed for all 94 Medi-Cal programs simultaneously.

SECTION 1. INTRODUCTION

In July 1998, the California Department of Health Services (CDHS) launched Healthy Families, California's version of the federal Child Health Insurance Program (CHIP), offering low-cost health insurance to children in families with net income between 100 and 200% of the poverty level. Since the program's inception, the state has focused a good deal of effort on enrollment, funding an \$89.5 million education and outreach campaign, paying certified community-based organizations a fifty dollar fee per approved application, and taking great pains to de-stigmatize the program by separating it and Medi-Cal. Despite this expensive public information and outreach campaign, uptake of the Healthy Families program in the first year was very low. During this period, Medi-Cal rolls across the state continued a precipitous decline, despite that fact that transitional Medi-Cal became more readily available to families leaving TANF. In response to these issues, California counties began looking for ways to encourage Medi-Cal and Healthy Families enrollment, and San Mateo County in particular sought resources to make these low-cost public health insurance programs more accessible to the county's estimated 8,000 uninsured children.

In January 1999, the San Mateo County Human Services Agency (HSA) was awarded a planning grant by the Peninsula Community Foundation to design a health care outreach campaign targeting low-income uninsured children in San Mateo County. Immediately following award of this grant, HSA partnered with El Concilio of San Mateo County, a non-profit organization serving the Latino community, to plan a comprehensive outreach campaign to enroll low-income children and families in available public health insurance programs. In March 1999, HSA was awarded an additional grant by the David and Lucille Packard Foundation to support this effort, and later that month, received additional funds from the CDHS Medi-Cal Eligibility Branch to conduct a Medi-Cal outreach program.

In June 1999, HSA formally contracted with El Concilio of San Mateo County to act as the lead agent in the San Mateo County Health Care for All Coalition. The Coalition's mission was to conduct a comprehensive outreach campaign to increase enrollment in three no or low-cost public child health insurance programs: Healthy Families; Medi-Cal; and AB 1931(b), a new Medi-Cal category designed to ensure that families eligible for Medi-Cal under AFDC remain eligible under CalWORKs. Members of the Health Care for All Coalition include HSA, the San

Mateo County Health Services Agency, the Health Plan of San Mateo County, core service agencies, other community-based organizations, schools, Healthy Start sites, and child care agencies across the county.

The Coalition backed its support of this effort by sponsoring an independent evaluation of the campaign's success. The SPHERE Institute was awarded the evaluation contract following a competitive RFP process, and evaluation activities began in January 2000. Evaluation of the outreach campaign has two components:

1. A process/formative analysis that documents program activities and looks at what facilitates and impedes enrollment in low-cost health insurance programs;
2. An impact analysis that examines outcomes regarding Healthy Families enrollment and health care utilization in San Mateo County under the campaign.

1.1 Research Objectives

The San Mateo County Health Care for All Coalition set three specific goals for the first year of program operations: (1) to plan and implement a comprehensive outreach program; (2) to maximize enrollment in Medi-Cal, Healthy Families, and AB 1931(b) for eligible children and their parents; and (3) to ensure that enrolled families remain insured and have established medical homes at six months following enrollment.

Consequently, this evaluation of outreach activities focuses on assessing the Coalition's success in meeting these aims. Specifically, the evaluation of the Coalition's campaign seeks to address four sets of research questions directly related to the campaign's explicit goals:

1. What were the planned outreach activities and how were the activities actually implemented?
2. How do systematic issues and client specific issues such as personal values impact enrollment in public child health insurance programs? How can enrollment procedures and policies be improved to increase uptake of public child health insurance programs?
3. Did the outreach activities increase enrollment in the target programs?
4. Did new enrollees remain enrolled six months following acceptance into a health insurance program? Did they establish a medical home?

1.2 Research Methodology

To answer the research questions, SPHERE designed a two-pronged approach using a combination of qualitative and quantitative research methods. The first part of this approach involves a process/formative analysis that documents program activities and looks at what systematic, programmatic, and client-specific issues facilitate and impede enrollment. Focus groups and semi-structured interviews were conducted to examine these issues from three distinct perspectives: coalition staff, clients who participated in the campaign and applied to one of the programs, and potentially eligible parents who were aware of the outreach campaign but did not avail themselves of the services. The second part of our approach entails an outcomes analysis that examines enrollment patterns in Healthy Families in San Mateo County and in two comparison counties (San Francisco and Ventura). In addition, the outcomes analysis explores quantitative information regarding enrollment outcomes and longevity of enrollment and utilization of services up to six months following program subscription. The outcomes analysis makes use of two distinct data sources: (1) data collected by El Concilio about applicants to whom they provided outreach services throughout administration of this project; and (2) state administrative data provided by the Managed Risk Medical Insurance Board (MRMIB) to monitor enrollment in Healthy Families across California's 58 counties.

It should be noted that because program funding was terminated, the outreach campaign was forced to close operation by May 2000. Consequently, the evaluators were provided with six-month follow-up data for only a small number of families. Therefore, the evaluation could not address questions regarding longevity of enrollment or utilization of services, both of which are exclusively covered in the six-month follow-up of families.

1.3 California's Public Health Insurance System for Children

In order to understand and evaluate the Coalition's outreach campaign, it is important to describe the fundamental administrative differences between the three principal types of public child health insurance programs – Medi-Cal, Healthy Families, and AB 1931(b) – made available to low-income families across the state of California.

The Medi-Cal program is administered by county welfare agencies who assess client eligibility for a variety of public assistance programs including Medi-Cal, TANF, Food Stamps, and General Assistance. Application for Medi-Cal in San Mateo County requires submission of

an application at one of HSA's regional welfare offices. Applications are reviewed by a Medi-Cal Eligibility Worker, and clients are required to attend an appointment at which they provide documentation of earnings, assets, and immigration status/citizenship in order to complete the eligibility determination process. Medi-Cal eligibility, once determined, is redetermined on a quarterly basis by mail with required face-to-face recertification annually. Medi-Cal is available to adults and children.

AB 1931(b) is a newer Medi-Cal category that combines AFDC and CalWORKs eligibility criteria. It was created to ensure that families who were eligible for Medi-Cal under AFDC would continue to be eligible under CalWORKs. Implementation of AB 1931(b) began in January 1999. The program covers families with net incomes up to 100% of the federal poverty level. A family's assets are also counted in determining eligibility. Like Medi-Cal, eligibility determination for AB 1931(b) requires a face-to-face interview with an HSA eligibility worker and is available to adults and children.

In contrast, Healthy Families was designed to be distinct from Medi-Cal and the welfare system. Consequently, the program was initially administered by non-county agencies that were authorized to assist in and submit Healthy Families applications to CDHS, and were paid a fifty dollar fee per approved application. San Mateo County has twenty-seven such authorized administrative agencies, including ten insurance agencies or financial institutions, seven health clinics (including Planned Parenthood offices), six community based organizations, three Healthy Start sites, and one homeless shelter, yet most of these agencies were not actively enrolling clients in Healthy Families. More recently, legislation was passed that condensed the original Healthy Families application from twenty-seven pages to four pages, extended income eligibility to up to 250% of poverty level, and made it possible for applicants to mail in the application directly to the state without going through a state-authorized Healthy Families administrator. These changes make it possible for an application to Healthy Families to be submitted by an authorized administrator or an individual applicant, thus facilitating San Mateo County's outreach campaign. Applicants are notified directly by the state as to the status of their application.

1.4 Outline of Report

This report is organized into six sections. Section 2 describes our process study design in greater detail. Section 3 documents planned and actual program activities conducted during the first year of this campaign. Section 4 presents process study findings and explores how systematic, programmatic, and client-specific issues impacted program uptake. Section 5 presents program outcomes. Last, Section 6 concludes with a summary of our findings and recommendations for future outreach efforts.

SECTION 2. PROCESS STUDY DESIGN

Evaluation of the San Mateo County Health Care for All Coalition Outreach Campaign used qualitative research methods to address two of the four initial research questions: (1) documenting how outreach activities were implemented; and (2) identifying how bureaucratic, programmatic, and client specific issues and values impact enrollment in child health insurance programs. To document planned and actual outreach activities, we conducted interviews and focus groups with the Director of Outreach and MIS specialist, current and former Community Health Outreach Workers (CHOWs), clients who participated in the outreach campaign, and potentially eligible participants who had contact with the outreach campaign but ultimately did not receive application assistance. Qualitative material obtained from focus group participants and interviewees provided the most substantial information to determine which outreach activities were carried out, which activities were the most successful at recruiting applicants, and what systematic and personal issues present obstacles to enrollment in public health insurance programs.

This section describes the process component of the evaluation. Section 2.1 begins with a description of process study participants. Section 2.2 describes our efforts to recruit participants for the focus groups and interviews. Section 2.3 provides an overview of the instruments used to conduct the process component of the evaluation. The chapter ends with an overview of our analysis plans in Section 2.4.

2.1 Process Study Participants

To answer process-oriented research questions, we conducted focus groups and interviews with two groups of outreach coalition staff and two groups of clients. Staff focus groups included: (1) administrative staff, including the Director of Outreach and the MIS specialist who designed the El Concilio database and worked with CHOWs on client follow-up and tracking; and (2) current and former CHOWs. In addition, we conducted focus group interviews with two groups of clients targeted for outreach. For this evaluation, ‘participants’ are defined as parents who participated in the outreach campaign and worked with a CHOW to submit an application to one of the available health insurance programs. ‘Potentially eligible

non-participants' are defined as parents who demonstrated interest in applying for public health insurance for their children through the outreach campaign but ultimately failed to do so.

Outreach Coalition Staff

To document program operations, we conducted interviews with two senior level administrative staff – the Director of Outreach and the MIS specialist – both of whom participated in the design and implementation of the campaign. In addition, we attempted to conduct two focus groups with CHOWs, one with current CHOWs and one with former CHOWs.

Participants

We used El Concilio's client screening database to identify participants to invite to focus groups. The screening database contains the names of all parents who were recruited by the outreach program, worked with a CHOW to submit an application to one of the available health insurance programs, and completed an outreach screening form. Screening forms were completed for every parent in advance of actual application to a particular health insurance program, though it should be emphasized that not every parent who filled out a pre-enrollment screening form ultimately applied for insurance.

At the time we sampled for applicant participation in the focus groups, there was a total of 486 families in the El Concilio screening database. Applicants were categorized by region of residence (South, North, and Central/Coastside) and primary language (English and Spanish). While we originally planned to conduct two focus groups with English-speaking participants and one with Spanish-speaking participants, the data suggested that a vast majority of the 486 participants were Spanish-speaking and that Spanish-speaking participants were concentrated in the South and Coastal regions of the county. Thus, we decided to hold two Spanish focus groups (one in the South and one on the Coast) and one English focus group in a central county location where most English-speaking participants resided. The three focus groups were held in community centers that were well-known to the relevant populations. A random sample of sixty participants was invited to each group.

Potentially Eligible Non-Participants

Focus groups were conducted with parents who demonstrated interest in applying for public health insurance for their children through the outreach campaign but ultimately failed to do so. Because this group was so difficult to identify, El Concilio provided the only mechanism by which we could locate and contact these families. To do so, El Concilio provided a database of potentially eligible non-participants who attended an outreach event at the Ravenswood School District in Fall 1999 and signed a list requesting more information about low-cost health insurance for children. Prior to giving us this list, El Concilio removed the families that ultimately applied for public health insurance through the outreach campaign. Ultimately, 228 families remained on the list and were categorized by language. A random sample of 80 families were selected for invitation to one of two focus groups: one Spanish and one English.

2.2 Focus Group Recruitment

Director and MIS Specialist

A semi-structured interview was conducted with both the Director of Outreach and the MIS specialist one month into the evaluation process. The purpose of this interview was twofold: first, to determine how the planning process began and was developed; and second, to compare planned activities with those actually conducted. The interview addressed issues related to training, supervision, staff outreach activities, and staff perceptions of salient issues related to the barriers to enrollment in public health insurance programs and utilization of medical care.

Community Health Outreach Workers

Focus groups and interviews were conducted with current and former CHOWs delivering the outreach campaign. The focus group with current CHOWs was conducted approximately eight months after start-up of outreach activities. All three CHOWs employed at that time participated. The purpose of this focus group was to determine which outreach activities CHOWs implemented, which activities they would have liked to conduct but could not due to lack of time or support, and which activities were found to be more or less successful. CHOWs also discussed their opinions as to which bureaucratic, programmatic, and client-specific issues prevent potentially eligible parents from applying for public health insurance.

In addition, CHOWs completed a brief self-administered questionnaire polling them as to the percent of time spent on particular activities such as outreach, application assistance, and post-enrollment follow-up and asking them to estimate the ethnic diversity of the clientele with whom they worked. The purpose of this brief survey was to quantify hours spent conducting various activities and to allow us to examine the correlation between CHOW and client ethnicity.

Because three CHOWs were no longer affiliated with the outreach campaign, we attempted to conduct individual interviews with these former staff persons to gain their perspectives on issues related to program activities and barriers to enrollment. Ultimately, we were able to conduct semi-structured interviews with two of the three former CHOWs using the CHOW focus group protocol and an additional set of questions related to their departure from the campaign.

Participants

Maximal focus group attendance is essential to gain the full range of perspectives on the issues at hand. The ideal focus group includes between eight and twelve participants. Because past experience conducting this type of formative oriented research has indicated that ten to fifteen percent of invitees actually attend focus groups to which they are invited, we invited sixty participants to each group. To maximize attendance, we made multiple efforts at contacting invitees and provided a variety of incentives to induce attendance and participation.

Potential focus group participants were initially contacted by mail. Approximately three weeks before the date of the focus group, letters were mailed in the appropriate language explaining the purpose and nature of the focus group and inviting each selected applicant to participate. Invitation letters were printed on El Concilio letterhead, assuming that applicants would be more familiar and comfortable with El Concilio than they would with the SPHERE Institute, and thus more likely to attend. The letter explained that participation in the focus group was completely voluntary, confidential, and anonymous. In addition, free on-site child care, a pizza dinner, and thirty dollars were offered as incentives to participate. We also designated a SPHERE telephone line for inquiries about the focus groups, with a message in Spanish and English describing the project and listing the dates, times, and addresses for all focus groups.

A SPHERE researcher called all invited participants approximately one week following expected receipt of the mailing. We made multiple attempts at phone contact until invitees

actually spoke with a staff person. During this call, staff confirmed receipt of the letter of invitation and reiterated the purpose and nature of the focus group, the fact that participation was entirely confidential and anonymous, the incentives to participation, and the date, time, and location of the relevant group. Staff also made confirmation calls one or two days before each meeting to remind clients of time and location.

Of the English speaking sample, staff spoke with twenty-five participants, eight of whom agreed to attend the focus group. Two actually attended. To compensate for this lack of participation, staff conducted phone interviews with the remaining six who initially indicated they would attend the focus group. Of the Spanish-speaking sample invited to the Southern region focus group, staff spoke with twenty-five invitees, eighteen of whom agreed to attend. Ten participated in the focus group. Of the Spanish-speaking sample residing in the Coastal region, staff spoke with twenty-five applicants, eighteen of whom said they would attend. Ten attended this focus group as well. Ultimately, a total of 28 participants (of an approximate anticipated 30) were interviewed either by the phone or in focus groups.

Potentially Eligible Non-Participants

A total of two focus groups with potentially eligible non-participants were held, one in English and one in Spanish. Because this was a more difficult group to identify and recruit, we invited a total of eighty parents to each of these focus groups. We followed the same invitation process for the non-participants as for participants.

Considerable problems with the contact data provided by El Concilio led to a lack of participation in these focus groups. First, of the eighty English-speakers sampled, thirty-two phone numbers were either disconnected or the parent whom we sought no longer lived at the listed residence. Second, most non-applicants with whom we spoke had not received a letter of invitation, which diminished our legitimacy and likely reduced their desire to participate. Third, the language spoken indicated in the database was not always accurate. Finally, after speaking with some of the English speaking non-participants, staff discovered that most of the names provided in the database were those of the children not parents which caused substantial suspicion and confusion and, again, diminished our legitimacy.

Staff attempted to compensate for these data problems in several ways. Parents were addressed by surname only. Researchers asked to speak to the parents of the listed child.

Despite our efforts, however, recruitment was severely impeded by these obstacles. Ultimately, we contacted only thirteen of the eighty sampled English non-applicants, five promised to attend, and none showed up. Of the Spanish-speaking sample, we contacted twenty-two of the parents sampled, five promised to attend, and one showed up.

To compensate for the low turnout at the non-participant focus groups, staff conducted phone interviews using the same focus group protocol with sampled non-participants who said they would attend the focus group but did not. Ultimately, phone interviews were conducted with all potentially eligible non-participants who initially promised to attend, and five English-speaking non-participants and five Spanish-speaking non-participants were interviewed by phone. In the end, a total of 10 participants (of an approximate anticipated 20) were interviewed.

2.3 Study Instruments

In order to obtain a comprehensive and accurate picture of the activities carried out by the outreach campaign, semi-structured interview and focus group protocols were developed for use with the Outreach Director, CHOWs, participants, and potentially eligible non-participants. Focus groups and interviews were conducted using semi-structured protocols. It should be noted that in all instances, protocols were used to guide the discussions and questions were never asked verbatim.

Staff interview protocols were designed to cover program planning, hiring and training, supervision and support, outreach activities, utilization of care, and barriers to enrollment. The participant interview protocol covered several topics directly related to our initial research questions: application processes (including exposure to both state-level and project-specific outreach activities), utilization of services, and choosing a provider. Two additional topics – the role and value of health insurance and coverage by non-custodial parents – were also addressed in response to specific requests by the oversight committee. The non-participant interview protocol covered all of the same issues, with a particular focus on three areas of interest: why non-participants chose not to make use of the outreach program given their initial interest in the services provided, whether they ultimately accessed public health insurance, and if not, why not. See Appendix 1 for all four interview protocols developed for use in the study.

2.4 Analysis

Content analysis was used to analyze qualitative data collected through focus groups and interviews. Three SPHERE staff members attended the English focus groups. One staff person facilitated the focus group while the other two took notes, transcribing them immediately following the focus group to ensure that they were comprehensive and accurate. The two note-takers then compared and synthesized notes. One facilitator and one note-taker were present for all Spanish focus groups. Because analysis was to be conducted in English by using English notes and transcripts, these discussions were tape-recorded, transcribed, and translated. Both the notes and the transcripts were reviewed and synthesized by a researcher so that the most complete information from the focus group could be made available. Ultimately, each focus group and affiliated set of interviews yielded a unified transcript for analysis.

After staff completed notes and transcriptions from all Spanish and English focus groups and interviews, content analysis was used to thematically analyze and code the data. Two researchers independently sorted through transcriptions and notes from focus groups and interviews to look for and code themes that naturally emanated from the transcribed information. The researchers then independently categorized these themes to best address the research questions initially guiding the study. Ultimately, the researchers compared thematic categories to assure inter-rater reliability and the most accurate interpretation of qualitative material.

SECTION 3. DOCUMENTING PROGRAM ACTIVITIES

This section documents planned and actual program activities conducted by the San Mateo County Health Care for All Outreach Campaign. Section 3.1 begins by fitting the outreach campaign into a logic model framework, which presents our understanding of the program components, activities, and aims, and goes on to describe how these inform the outcomes, indicators, and data sources we use to subsequently evaluate the campaign. Section 3.1 additionally uses the logic model framework to describe how clients flow through the system. Section 3.2 provides some background on the evolution of the outreach campaign, outlining how the campaign was planned, and providing a detailed time line of program activities. Section 3.3 presents details as to how the program was actually implemented, and covers seven areas: staffing, training, supervision and support, outreach and enrollment activities, case management, promoting utilization of health care, and follow-up activities.

In the course of planning a project as ambitious as this, it is important to recognize that not all planned activities can necessarily be realized once a program is actually operational; mid-course corrections and changes are a necessary component of launching any program. Consequently, throughout this section, we distinguish between what was supposed to occur – planned activities – and activities that actually transpired, and provide some explanation as to why they differ.

3.1 Understanding the Outreach Campaign: A Logic Model Framework

A logic model framework is a common mechanism by which health promotion campaigns such as the Coalition's outreach program are understood and subsequently evaluated. A logic model approach begins by specifying what a program seeks to accomplish, the program components and activities that meet those aims, and the desired programmatic outcomes. Ultimately, a logic model develops and determines feasible indicators to measure these outcomes, and specifies the data sources to be used for measurement purposes. Exhibit 3.1 presents the logic model framework we used to both improve our understanding of the San Mateo County Health Care for All Outreach Campaign, and to further guide the research by providing a systematic analysis of the outcomes we sought to identify.

Exhibit 3.1 Logic Model of San Mateo County Health Care for All Outreach Campaign

PROGRAM COMPONENTS	Outreach	Application assistance	Case management	Promote utilization of care	Follow-up activities
GOAL	Increased applications to available public insurance programs	Increased applications to available public insurance programs	Ensure all applications are complete	Improved utilization of care	Facilitate tracking of client outcomes
ACTIVITIES	<p>1. Conduct community-wide outreach at a variety of locales to inform potentially eligible families about available public options for health insurance.</p> <p>2. Encourage clients to apply for available public health insurance options with assistance of outreach campaign.</p>	<p>1. Make appointments to meet with clients to apply for programs.</p> <p>2. Complete and mail applications to Healthy Families and/or Medi-Cal.</p>	<p>1. Follow-up on client application status.</p> <p>2. Help clients amend incomplete/returned applications.</p>	<p>1. Provide clients with information as to how to choose provider.</p> <p>2. Provide clients with brief training on how to optimally utilize care.</p>	<p>1. Complete 45-day follow-up form.</p> <p>2. Complete six-month follow-up form.</p>
OUTCOMES	Increased screening for available programs	Increased enrollment in available programs	Increased enrollment in available programs	Improved utilization of care	Maintenance of enrollment in insurance programs
INDICATORS	Number of families and children who are screened for application	Number of children who apply for insurance	Number of children who are insured by one of available options	Number of families who say they have a regular health care provider	Percent of originally insured children who remain insured six months later
DATA SOURCES	Coalition screening database	Coalition screening database	Coalition 45-day follow-up database	Coalition 45-day follow-up database	Coalition six-month follow-up database

The logic model presented in Exhibit 3.1 specifies the five program components entailed by the outreach campaign, beginning with outreach and ending with follow-up and tracking activities. It should be noted that once the campaign was fully operational, CHOWs conducted all five activities throughout each of their workdays on an as-needed basis. Furthermore, some activities were conducted concurrently: for instance, a CHOW could conduct case management the same day s/he completed a 45-day follow-up tracking form and provided the family with a brief training on how to choose a provider and utilize care. Nonetheless, to clarify how clients flowed through the system, we have broken activities into these five fundamental tasks.

Outreach activities were conducted to locate potential clients and encourage them to work with the campaign to apply for the available public health insurance programs. Application assistance followed outreach, and began with a call from a client or contact at an outreach meeting. Application assistance consisted of setting up appointments with clients who demonstrated an interest in enrolling in one of the insurance programs and actually meeting these clients to assess their potential eligibility for insurance and complete and submit the application. Case management activities began once the application was submitted. Not all applications were initially approved by the state or county and in many instances, additional information was required of applicants. Consequently, CHOWs were to provide case management activities to determine what types of assistance were additionally required for participants to actually attain health insurance and to provide those services in a timely manner. Once insurance was received, CHOWs were to promote utilization of health care by providing participants with a brief training on how to optimally choose a provider and utilize care. Follow-up and tracking activities were the fifth and final set of duties. CHOWs were to conduct 45-day and six-month follow-up assessments with all campaign participants using forms designed by El Concilio for explicit use by the outreach campaign.

3.2 Program Planning

In April 1998, in anticipation of a Request for Proposals from the CDHS, HSA began planning for a community-wide outreach campaign with a number of San Mateo County's community-based organizations to determine which agency might best take the lead in promoting enrollment for uninsured children and families in no or low-cost public health insurance programs. In December 1998, the unofficially formed Coalition – HSA and El Concilio – applied for a planning grant from the Peninsula Community Foundation, and operational grants

from the CDHS Medi-Cal Eligibility Branch and the David and Lucille Packard Foundation. In January 1999, HSA was awarded \$10,000 from the Peninsula Community Foundation for start-up activities, and using those funds, El Concilio hired a Director of Outreach on February 1, 1999. In March 1999, the Coalition received \$143,374 from DHS and \$178,052 from Packard to fund the first year of program operations.

From February to April 1999, the Director of Outreach was principally involved in designing program activities, defining program goals and measurements, setting up an automated database to be used to track enrollees, and working with an informal oversight committee to set up a system of milestones and deliverables to monitor project progress. Based on previous experience conducting community outreach campaigns, the Director devised a plan for program activities, then forwarded his recommendations to El Concilio's Director for review and suggestions. Amended recommendations were presented to the informal oversight committee for further consideration and review. This process prompted the creation of a formal oversight committee consisting of the Directors of HSA, San Mateo County Health Services Agency, and El Concilio, and a representative from the Health Plan of San Mateo County.

By March 1999, an approved plan for program implementation was in place. The plan provided for the hiring and training of five CHOWs to conduct the actual outreach, monitoring program activities on a quarterly basis, and developing an MIS system to track outreach progress throughout the project's duration. In April 2000, the outreach campaign lost funding and program operations were terminated in early May. Exhibit 3.2 provides a time line of program activities, beginning with the first receipt of funds in January 1999 through the close of program operations some sixteen months later.

Exhibit 3.2 Timeline of Program Activities

Date of Completion	Program Activity
• January 1999	Funding received from Peninsula Community Foundation.
• February 1999	HSA contracts with El Concilio as lead agency for Outreach Campaign.
• February 1999	Johnny Anguiano hired as Director of Outreach.
• March 1999	Funding received from Packard Foundation and CDHS.
• April 1999	Formal Oversight Committee formed.
• August 1999	MIS system developed.
• August 1999	Outreach campaign hires all CHOWs.
• August 1999	CHOWs receive state-level Healthy Families training.
• August 1999	CHOWs receive training for outreach campaign.
• August 1999	CHOWs begin outreach activities .
• December 1999	Outreach campaign contracts with the SPHERE Institute as evaluator.
• April 2000	Program loses DHS and Packard funding, and begins to shut down operations.

3.3 Program Implementation

Program implementation transpired incrementally between February 1999 and April 2000, when the Outreach Coalition was informed of the need to shut down operations. This section details the specific components of program operations, and is structured chronologically to provide an understanding of how and when the project was staffed, how CHOWs were trained, and how CHOWs were supervised and supported throughout the project.

Staffing

In late March 1999, the Director of Outreach prepared and distributed job descriptions for CHOWs to various Coalition member agencies throughout San Mateo County. The Coalition was looking to hire an ethnically diverse group of five staff persons. Preferred requirements for the position included knowledge of San Mateo County’s communities, previous outreach experience, a high school diploma, access to a car, and possession of a valid driver’s license and

car insurance. In addition, the Coalition sought to hire CHOWs with strong organizational skills and attention to detail. CHOWs were expected to work full-time, be available to work during off hours, and preferably live in the neighborhoods in which they were recruiting.

The state scheduled changes to the Healthy Families application in April 1999, and the Director of Outreach decided to be retrained for Healthy Families and Medi-Cal and trained for AB 1931(b) before hiring CHOWs. Thus, the first CHOW was not officially hired until May 14, 1999. The full complement of five CHOWs was on staff by August 1, 1999. It was unclear as to why it took so long to hire CHOWs and begin program implementation.

CHOWs heard about the job in a variety of ways. Two were familiar with El Concilio, having worked as ‘Promotores’ on previous projects; one was informed of the position by his wife who works for El Concilio; and a fourth heard about El Concilio through word of mouth – she cold-called the agency to inquire about the position. One CHOW was recruited into the position by the agency Director, whom he knew from a previous job. The last CHOW applied for the job in response to a job listing.

Of the five original CHOWs, three were Hispanic, one was a Pacific Islander, and one was African-American. Both the Pacific Islander and African-American CHOW were terminated. A sixth CHOW, also Hispanic, was hired early on in the project, but left to work on another El Concilio outreach campaign after several months.

Training

CHOWs received training in four distinct areas: application administration, client application assistance, administration of tracking forms, and health care provider options. CHOWs did not receive training in how to conduct outreach activities or case management activities.

None of the CHOWs had knowledge of the Healthy Families program before hiring. Four had some experience with Medi-Cal (two as former clients, one from information provided to her in medical school, and one from previous health outreach campaigns). The Director of Outreach trained the CHOWs on how to complete Healthy Families and Medi-Cal forms. He was trained by Richard Heath and Associates on April 9, 1999 and is a certified B trainer. He trained CHOWs as to how the various public health insurance programs functioned and how to administer applications for the programs to potential enrollees. CHOWs also attended state-provided training to be Healthy Families Certified Application Assistants (CAAs). Five were

trained as B-level CAAs, meaning they could administer applications. One was trained as an A-level CAA, so in addition to administering applications herself, she can train others to do so as well.

CHOWs were initially told that their responsibilities were to enroll families in Healthy Families or Medi-Cal, or an alternative form of health insurance. CHOWs received no formal training on how to actually conduct outreach, but instead relied on previous experience and self-initiative to contact local agencies, schools, churches, and health clinics. Although they received little guidance as to how to conduct outreach, those who had done this type of work in San Mateo County before seemed to have a good idea of how to begin. The two CHOWs with no previous outreach experience shadowed an experienced worker, and then was critiqued by this worker once they were out on their own. Both felt this was a very effective way to learn outreach techniques.

The CHOWs with whom we spoke felt they had adequate knowledge of how to conduct outreach and administer applications, although they certainly developed more expertise along the way. It should be emphasized that all the CHOWs reported that they really enjoyed doing this type of work and felt good about their efforts, which no doubt contributed to their ability to successfully work with their clientele.

While there was never a formal training on how to actually conduct outreach, CHOWs did receive training on how to provide clients with application assistance. To improve the CHOW's ability to work with potential enrollees, role playing activities were conducted with the Director of Outreach and other staff members pretending to be potential enrollees and mimicking concerns and difficulties these potential enrollees might demonstrate.

In addition, CHOWs were trained on how to administer the three tracking forms – screening, 45-day follow-up and six-month follow-up – to clients over the course of the project. These forms were created by El Concilio to monitor project and CHOW progress over the course of the campaign. To train CHOWs on records maintenance, the Director held roundtables where CHOWs went over every form and field to make sure they understood the types of information they were required to collect. A data entry person entered all information collected on the forms into an ACCESS database, flagged incomplete responses, and informed CHOWs of the missing data which they were directed to collect. The MIS specialist also reviewed 45-day forms for completeness.

Last, CHOWs received training around specific provider options available to clients under the health care programs. Representatives from the providers of each health plan were brought in to talk to CHOWs so they could better inform clients as to their health care options.

Supervision and Support

Although CHOWs had bi-monthly supervisory meetings with the Director of Outreach, they also relied on mutual support and informal meetings with each other and the Director. CHOW performance was monitored by the Director of Outreach through weekly reports. Also, the database provided client information by CHOW, so the Director could regularly communicate with CHOWs and let them know how they were doing. CHOWs were informed of program and procedural changes and updates in weekly meetings, although informal contact occurred on a daily basis. Each day, they were responsible for checking their boxes for regular media and government updates. The Director maintained regular contact with CDHS and provided the CHOWs with up-to-date information on programs. The Director also monitored CHOW progress by looking at the ACCESS database that records, by CHOW, the number of screenings, number of assisted enrollments, and number of 45-day follow ups completed.

CHOWs were supported in a variety of ways. They were each given cellular phones in the fifth month of the project so they could more easily maintain contact with the office. They had full use of office phones and computers. Upon hiring, all CHOWs were also provided with a chart of all available health plans so they could quickly evaluate which plan a client might be eligible for or which might best suit a particular client's needs.

It should be noted that the two non-Hispanic CHOWs who were terminated did not report the same level of support as the current and former Hispanic CHOWs with whom we spoke. The non-Hispanic CHOWs were responsible for recruiting participants who primarily resided in the East Palo Alto/Menlo Park area of the county. As a consequence, they had less informal contact with Hispanic CHOWs who were more centrally located and who seemed to spend more time in El Concilio's office. Furthermore, both non-Hispanic CHOWs sensed that the outreach campaign was much more focused on reaching Latino populations and felt marginalized by this focus. For instance, one of the two CHOWs reported an order to refer English-speaking Hispanic clients to a Latino CHOW, despite the fact that the CHOW did not find working with these families to be problematic. Ultimately, both non-Hispanic CHOWs were terminated in November and were told that their termination was due to cessation of funding. One of the two

believed this explanation while the other feels termination was due to a desire to hire more Hispanic CHOWs. Neither believed that their work was sub-standard.

3.4 CHOW Activities

As described in the logic model framework presented at this section's outset, CHOWs were responsible for performing five major activities: (1) outreach; (2) application assistance; (3) case management; (4) promote utilization of care; and, (5) follow-up and tracking. This section describes CHOW roles and responsibilities for each of these five particular activities.

Outreach Activities

CHOWs conducted outreach in a variety of ways. Some CHOWs set up their own presentations to make at schools, churches, and community-based organizations; some tabled at health and other fairs, health clinics, and schools; some put flyers at local community-based organizations; some got clinics to provide them with lists of uninsured patients to call. One CHOW went to local grocery stores and approached customers. Another gave presentations at a Half Moon Bay employer who provides employee but not dependent coverage. Word of mouth helped the recruitment effort, and often clients would either refer friends or even bring them to appointments. Although the CHOWs helped each other with recruitment and would gladly assist all over the county, they tried to divide the county into three zones: North, South, and Central/Coastside.

Application Assistance

All application assistance began with a call from a client or contact at an outreach meeting. CHOWs got client numbers in one of two ways: clients left a name and number at an event or clients called the Coalition. During this first phone contact, the CHOW questioned the client about his/her economic status to determine if s/he was eligible for any programs. If a client was potentially eligible, the CHOW met with the client at a mutually agreed upon location.

CHOWs emphasized that it was important to reach out to clients instead of waiting for them to call. Because so many clients were employed, CHOWs needed to make these calls on weekends or evenings. Likewise, appointments were set up at the client's convenience. CHOWs learned to make reminder calls to clients before appointments, and to call no-shows immediately since most would usually respond to this phone call and eventually make and keep another

appointment. Some clients wanted to work only with a female CHOW, a request that was accommodated. Community-based organizations were cooperative about letting CHOWs meet clients on site, as were school districts.

Enrollment goals for the project as defined in the original plan were 1200 Medi-Cal and 1600 Healthy Families enrollees. These goals were based on a 1998 UCLA study by Richard Brown, estimating that there were 8,000 uninsured children in San Mateo County. Enrollment goals were communicated to CHOWs some time after the first two months of program implementation. Although enrollment goals were about 10 applications per week, CHOWs emphasized that the numbers actually enrolled vary greatly over time. For instance, December was a particularly difficult time to recruit, whereas during other months they had more applicants than they could handle.

Case Management Activities

Case management entailed following up with clients on the status of their applications. In some cases, families received notification from the requisite aid program that the application was complete and approved, in which case little case management was required. In many instances, however, the application outcome was nebulous for a variety of potential reasons: the client was denied Healthy Families benefits (either correctly or not); the family was referred to Medi-Cal for one or more children; or, the family received a request for more information to complete the application. In these circumstances, extensive case management was required and the CHOW would need to work with the family towards obtaining the appropriate insurance coverage. It should be noted that a number of participants with whom we spoke in focus groups received little in the way of case management.

Promoting Utilization of Care

Once clients were enrolled, CHOWs were to conduct an orientation explaining how to use the plan, pay premiums and co-payments, pick a doctor, and make regular health care visits. The orientation was to take an average of a half an hour, although some clients needed much more explanation than others. This orientation was usually conducted at the 45-day follow-up, although CHOWs often had to see clients more than once, especially when children in a family were enrolled in multiple programs. A number of clients called CHOWs beyond the follow-up period to ask questions about how to use insurance, switch carriers, or change doctors. In some

cases, CHOWs had to call doctors to set up appointments, although they tried to encourage clients to learn by doing. It should be noted that in many cases, participants we met in focus groups reported no such orientation, either formal or informal.

Follow-up Activities

Follow-up activities beyond case management entailed conducting a 45-day and six-month follow-up contact – either by phone or in person – to complete the affiliated tracking forms with each parent who worked with the campaign to complete an application to one of the available health insurance programs. The purpose of the 45-day follow-up was linked with the case management process in that it assessed the insurance status of each applicant child. The purpose of the six-month follow-up contact was to assess ongoing insurance coverage for these children as well as utilization of care.

It should be emphasized that when the 45-day follow-up took place, it did not necessarily occur at 45 days, but usually when the client called the CHOW with the information sent to them by Healthy Families or Medi-Cal. If the CHOW did not hear from the client within 45 days, they were supposed to contact the client. Otherwise, CHOWs encouraged clients to call them as soon as they heard about the status of their application. Again, this follow-up contact did not always occur, and 45-day follow-up information was not gathered for approximately one third of clients.

SECTION 4. PROCESS FINDINGS

The following chapter discusses qualitative findings collected from focus groups and interviews with outreach coalition administrative staff, CHOWs, participants, and potentially eligible non-participants. Findings are structured around seven areas that emerged from qualitative data. Because information regarding each of these areas was yielded from interviews with the four aforementioned independent groups, this section presents a synthesis of perspectives. When possible, we used these multiple perspectives to triangulate participant reports and opinions, and note differences and nuances in opinions where applicable.

This chapter is loosely structured around activities described in the logic model, and moves on to answer research questions related to program effectiveness. Section 4.1 begins with a discussion about outreach activities and recruitment. Section 4.2 describes the application process, namely, what assistance participants received from CHOWs, and what assistance they would have liked to receive. Section 4.3 describes participant and CHOW assessments of the case management process. Section 4.4 outlines factors that influence choice of health care provider and utilization of health care services. Section 4.5 moves on to address research questions regarding bureaucratic, programmatic, and client-specific obstacles to enrollment in public health insurance programs. Section 4.6 discusses the role and value of health insurance for children. Finally, Section 4.7 describes barriers to health care coverage by non-custodial parents.

4.1 Outreach Activities and Recruitment

CHOWs outreach activities to recruit children into the available public health insurance programs are described in Section 3. This section provides participant and CHOW assessments as to the relative effectiveness of particular outreach activities, and describes participant exposure to and assessment of the state-funded outreach and education campaign.

Based on focus group interviews with participants, outreach presentations were the most effective means of successfully recruiting the parents of eligible children to apply for public health insurance. Most participants were recruited through CHOW presentations at schools, workplaces, and community-based organizations. Recruitment by friends and family was also common. Often, the referring friend or family member was a recent participant or even a member of the outreach campaign staff. A few participants were not recruited at all, but instead

sought out affordable health insurance for their children. These parents made telephone calls to community-based organizations, who then referred them to El Concilio.

Formal outreach activities were not conducted at HSA welfare offices or at public or private hospitals. Despite the fact that HSA workers were outposted at San Mateo's one public hospital, participants and potentially eligible non-participants with whom we spoke did not have contact with outposted workers and were therefore not referred to the outreach campaign. Both participants and potentially eligible non-participants noted that they would have benefitted from these types of outreach and referral, as many had gone to both welfare offices and hospitals looking for coverage.

While CHOWs felt that all their outreach activities had some measure of success, most CHOWs felt that presentations at schools, work sites, community centers, and churches were most effective in initially drawing clients. One CHOW reported the most success at clinics and doctors offices. In describing the outreach process, CHOWs suggested that working with clients required an enormous amount of patience. Clients don't always understand what it means to be documented or undocumented. They don't always honor appointments. They have a lot of distrust about the system and are easily discouraged. To overcome these barriers, CHOWs had to be empathetic and persistent.

Almost all participants reported that they had seen state-funded public service announcements for Healthy Families on television. Nearly half had heard public service announcements on the radio, mostly on Spanish language AM stations. A few saw fliers and billboards in locations throughout the Bay Area. Only a handful reported not having seen or heard any advertisements about Healthy Families. It should be noted, however, that state-funded advertisements prompted no participant to apply for Healthy Families as the announcements did not provide enough information to fully explain what Healthy Families. In fact, some only noticed advertisements after they had applied for Healthy Families with the help of an outreach worker.

4.2 Application Processes

The vast majority of participants were extremely satisfied with the assistance they received in completing an application for health insurance. Few reported difficulty with the application process and by and large, participants agreed that CHOWs were extraordinarily

friendly and helpful. In contrast, potentially eligible non-participants received no contact from the outreach campaign, which entirely explains their lack of participation.

Participants most commonly received CHOW assistance with completion of health insurance application forms. A large number of participants reported that CHOWs literally filled out applications for them to ensure that all responses were complete and everything was in order. This form of assistance was essential, as some participants were intimidated by the forms and would not have completed them without assistance. Even those participants who understood the paperwork noted that others, especially immigrants, might have a very difficult time completing an application on their own. CHOWs answered questions about coverage and enrollment, usually at the time of application. Some participants mentioned that CHOWs helped them find a doctor in their plan by reviewing the book listing the available providers, often targeting doctors that spoke the appropriate language. Along those lines, some participants received telephone calls from their CHOW confirming whether they were enrolled and ascertaining if they needed further assistance with their application. Of these participants, some received help from CHOWs in resubmitting omitted or lost information or correcting other problems with the original application.

Home visits were the most appreciated and successful component of the outreach campaign. Given the time constraints and transportation limitations faced by many low-income parents, both participants and CHOWs reported that home visits made the application process much easier. In fact, many participants were very clear that in the absence of a home visit, they would not have attempted the application process. Though most participants had seen public service announcements about Healthy Families, parents were clearly in need of much more information about the available health insurance programs before they would consider applying. Many said that they saw the commercials but never thought about calling for more information. Contact with an outreach worker enabled them to receive all the information they needed to apply.

CHOWs also succeeded in alleviating parents' doubts and concerns about the application process. For example, one applicant was reluctant to apply for Healthy Families because she viewed it as public assistance. A CHOW convinced her that because she was a taxpayer and would be paying a monthly fee, she had a right to coverage. Now her children are insured and she is comfortable using her coverage to obtain health care. Another applicant noted that she trusted the CHOW because she was also a mother who had used Healthy Families. Also, CHOWs

clarified that citizen children of undocumented parents could qualify for public health insurance, a point of confusion for many potential participants. While CHOWs did not make any guarantees about the public charge issue, their explanation of eligibility rules made many undocumented participants feel more comfortable enrolling their documented children in the program.

For potentially eligible non-participants, lack of CHOW contact was the sole reason for failure to participate in the outreach campaign. With the exception of one parent, no non-participant received a call from an outreach worker, and the one candidate who reportedly received a call said that the outreach worker did not show up for their scheduled home visit. Nearly all non-participants said that they would have applied with the assistance of an outreach worker had it been offered. Instead, non-participants with an employer sponsored dependent care option pay for dependent coverage through an employer, and the remainder remain uninsured.

Non-participants provided three reasons for either paying for expensive employer-sponsored dependent coverage or remaining uninsured despite the availability of public child health insurance programs. First, non-participants did not know enough about the programs to apply. Many reported that they would have applied if the available programs had been explained to them. Second, some non-participants avoided public health insurance programs because they viewed them as a form of welfare. Some Hispanic and Samoan non-applicants were afraid to apply lest they become a public charge. Others simply did not want to receive any form of welfare, preferring to pay out of pocket or remain uninsured. (It should be noted that upon learning from SPHERE researchers that Healthy Families requires monthly insurance premiums, the stigma associated with the program was reduced, and many said they will now consider applying.) Finally, many non-applicants assumed they would not qualify for public health insurance. In most cases, these non-applicants were undocumented; in a few, families assumed that they earned too much to qualify. Overall, reasons for non-application were not dissimilar to those provided by participants. Had these families received CHOW contact, they very well may have applied.

Despite lack of CHOW contact, a few non-participants applied for Healthy Families or Medi-Cal on their own. One applicant successfully enrolled her children in Healthy Families after receiving an application from a clinic. She reported that the application process was easy, and was grateful that she no longer had to visit the welfare office to qualify, as she had when enrolled in Medi-Cal. Another parent applied for Medi-Cal three times, and each time failed to

qualify. Her children are undocumented, and she knew that was a factor in her failure to qualify. However, she seemed to be confused about the eligibility requirements, and could have benefitted from explanation and proper referral from an outreach worker.

All non-participants noted that they would not have turned away the assistance of an outreach worker. Most non-applicants reported that an explanation of the programs would have been sufficient to enable them to apply; they did not think that assistance with the application would be necessary. Points of clarification that would have helped include: distinctions between Healthy Families and Medi-Cal, coverage for documented children of undocumented parents, income requirements, and reduced cost of care compared to employer-based options. However, it is clear that some applicants needed assistance filling out the application and providing other documentation.

4.3 Case Management

While satisfaction with application assistance was almost uniformly high, case management was one area in which participants could have benefitted from further assistance. The most pressing need among participants was more follow-up calls or visits to address any omissions from or problems with the pending application. It seems that follow-up calls were not frequently made to participants. For those who immediately qualified for insurance coverage, follow-up was not an issue, but for those with problems with their application or for those who did not qualify, a follow-up call could have helped them to correct mistakes or find alternative sources of health insurance coverage. For example, one mother applied for Healthy Families for her daughter, and although she received a call telling her that she was enrolled, she never received a Medi-Cal or Healthy Families card and could not access insurance coverage. She did not receive a follow-up call from her CHOW that could have alleviated the confusion, and upon calling her CHOW for assistance was instead referred to the welfare office. Another applicant was notified by the state that she had omitted information in her application, but her CHOW did not return her calls to address and rectify the problem.

It should be noted that because of demands on their time to do outreach and application assistance, CHOWs felt ill-equipped to do as much case management with participants as they would have liked. In fact, both CHOWs and administrative staff estimated that an average household required no less than three contacts per completed and approved application and that

an additional three staff persons would be required to adequately accomplish these essential duties.

4.4 Promoting Utilization of Care

One assumption that guided program activities was that providing children with health coverage is not enough if parents do not use coverage to access preventive and routine care. Consequently, a principal goal of the outreach campaign was to promote participant utilization of care and ensure that clients found a permanent medical home. To that end, we investigated activities intended to encourage appropriate provider choice and utilization of care, and the relative necessity and effectiveness of these activities.

Provider choice was influenced by several equally important factors. First was maintaining a relationship with a current provider. By far, the most common reason participants gave for choosing a particular provider is that their current doctor was covered by that plan. Likewise, past use of a health plan also influenced choice of provider. Parents who had previously used a particular plan through an employer often remained with that provider under Healthy Families. Proximity to care was another significant reason given for selecting a particular provider, especially for participants in the coastal area and those without cars. Cost was rarely given as the reason for choosing a provider. (In fact, those who named cost as their reason for choosing a provider were the only ones to choose the Health Plan of San Mateo (HPSM).) Most participants did not choose HPSM due to lack of familiarity. Most participants who had heard of HPSM thought it was Medi-Cal, and negative associations with Medi-Cal influenced their choice of another plan. Likewise, several participants who had heard of HPSM said that it “sounded like welfare” (perhaps because it was the only available Medi-Cal plan) and suggested that the name alone might deter people from choosing it.

No participants reported invitation to a formal presentation promoting utilization of health services by their CHOW or anyone from the outreach campaign. However, findings suggest that such a presentation may not have been necessary for most participants. Nearly all participants accessed medical care under health insurance coverage and none with whom we spoke required persuasion to understand the need for coverage. Most participants said that they did not require more information about obtaining health care for their children. Furthermore, though no applicant attended a formal class concerning utilization of care, almost all participants said that their CHOW explained how to use their coverage to access care at the time of

application. These participants seemed content with this explanation and most were able to use medical services without problems. Outreach campaign staff also noted that participants were knowledgeable about the use of health services, and therefore used their limited time and resources to focus on more pressing needs such as outreach and enrollment assistance.

Most participants reported that they took their children to the doctor for preventive care before enrolling in Healthy Families. However, most of these participants were insured by employer-based coverage or Medi-Cal prior to enrollment in Healthy Families. A few said that they only take their children to the doctor when they are sick. Consequently, most participants say that the frequency in which they take their children to the doctor has not changed now that they are enrolled in Healthy Families. Again, this may be because most participants had a history of prior health care coverage and were already using health services regardless of current coverage status. Only a few participants reported that they use health care much more now than before enrollment. For example, one participant now obtains preventive care for her son's asthma and prescription medication for his eczema, whereas before she could only afford emergency care and over-the-counter medicine.

Most non-participants with whom we spoke pay for employer-based health insurance coverage for their children. Those who are insured have regular doctors for their children, and most visit this doctor for preventive care, though a significant number visit the doctor only in emergencies. The uninsured non-participants did not have regular doctors for their children, and most only visited the doctor in emergencies. It should be noted that all uninsured non-participants reported that they would take their children to a doctor for checkups and other preventive care if they were insured.

Some participants would have liked more assistance in selecting a provider or a primary care physician. One mother complained that she was not given enough time or information to make an educated decision about which provider to choose. Another mother selected a provider and then realized that the hospital covered by that provider was far from her home. While most clients understood the differences between health plans and had good reasons for choosing their providers, a few could have benefitted from an explanation of their differences and features. Again, CHOWs and administrative staff admitted that due to staffing limitations, activities to educate participants about health care options were given lesser priority to basic outreach and enrollment efforts.

CHOWs concurred that clients who enrolled in Healthy Families are indeed utilizing preventive and other types of health care more readily and regularly than they did before, and that they are very thankful for the insurance coverage. Before, clients were getting health care when they had emergencies, and paying large bills to cover those emergencies. Because many of the children they enroll have pre-existing conditions for which they need attention but were over the Medi-Cal threshold, Healthy Families is an essential mechanism to provide these children with adequate care.

A vast majority of participants reported no barriers to accessing health care since they have been enrolled in Healthy Families. The one major complaint offered by participants concerned the scarcity of dentists. Participants reported having a difficult time finding dentists who will accept Healthy Families.

4.5 Obstacles to Enrollment

A number of barriers presented significant impediments to enrollment in available public child health programs. The following section categorizes these barriers into three groups: (1) bureaucratic barriers are impediments posed by the state eligibility and application process; (2) programmatic barriers are limitations posed by the outreach campaign; and, (3) client-specific barriers are defined as more personal fears and concerns that impede the application and enrollment process.

Bureaucratic Barriers

Fear of becoming a public charge was one of the most significant bureaucratic obstacles to enrollment, especially within Latino and Samoan communities. On the screening form, in response to a question from the Coalition asking about client barriers to enrollment, nearly 40% indicated that public charge issue caused them concern. Focus group participants verified these sentiments, and a number of participants reported that they had chosen not to apply for public health insurance programs in the past, lest it compromise their immigration status. While CHOWs were extremely effective in easing participant fears, common consensus was that the public charge issue remains a significant impediment to enrollment in these types of programs for Latino families. Participants suggested that more outreach be done to ease parents' fears on this issue.

Findings from the interview with the Director of Outreach and CHOW focus groups confirm the significance of the public charge issue. Because they were not literate, many participants were not well informed of state policy. In addition, staff stressed that this is a population that might not accurately assess their risks, and generally wants to remain invisible to government. Fear of becoming a public charge is not restricted to the undocumented; documented parents who are not subject to the public charge issue are also fearful. To deal with this issue, CHOWs were trained to provide as much information as possible to interested clients. However, because of the uncertainty of the political climate, they were trained not to make any assurances to clients. Though CHOWs did not make any assurances concerning immigration status, providing potential applicants with more information about eligibility eased their concerns and enabled them to apply.

State-defined enrollment procedures also represented a significant barrier to enrollment. Clients who were altogether rejected by Healthy Families received a very confusing letter – always in English – stating, “You do not qualify for Healthy Families. You *may* qualify for Medi-Cal.” This letter, which could not be read by Spanish-speaking clients, made clients feel discouraged and ashamed. Often clients threw the letter out and did not contact their worker. Furthermore, CHOWs discovered that many of these Healthy Families rejections were mistaken, yet the re-application process did not function, and clients never heard back from Healthy Families as to the status of their re-submission. Ultimately, CHOWs determined that this formal case review process was a waste of time, and that it was better to start the whole application process again rather than resubmitting.

CHOWs also found that the Healthy Families application forms, particularly the sections regarding income, were very unclear. To compensate, they learned to provide a great deal of detail regarding the frequency with which clients get paid. They say that Healthy Families made a lot of mistakes in processing these applications, rejected applicants for Healthy Families, and then incorrectly forwarded the applications to Medi-Cal. Again, because the case review process was so flawed, the CHOWs had to start the whole application process over again.

Clients who worked as house cleaners or were self-employed never had adequate documentation of income, and were therefore always rejected from Healthy Families for “incomplete income documentation.” CHOWs felt there needed to be some mechanism by which these families could qualify for coverage. Likewise, clients in the process of acquiring

documentation, even those with a permanent alien resident care were rejected. Children with a valid work permit were rejected as well.

Some participants received conflicting information as to which programs their children were enrolled in. Often, participants would receive notification that some of their children were covered and some were not qualified for coverage. This happened often to immigrant families in which the undocumented children were denied coverage. CHOWs report that participants were often confused about what it meant to be documented or undocumented, and thus did not understand why their children qualified for different kinds of coverage. Participants seemed to understand why these children were denied, but felt it was unfair. A few parents asserted that they deserve to obtain coverage for every child they can afford to cover, because they are paying for coverage under Healthy Families.

Programmatic Issues

Programmatic issues also impeded enrollment in public child insurance programs. Case management, which all staff agreed was integral to the enrollment process, took an enormous amount of time and outreach program staff needed to decide whether the priority was enrollment or follow-up and case management. For instance, once clients were enrolled, CHOWs would get calls from clients about child health issues or whether a particular circumstance merited a doctor visit. CHOWs had little time to assist clients beyond enrollment and, due to time restrictions, could not handle these types of issues.

Estimation of CHOW time spent on particular types of activities indicates that CHOWs did indeed have little time to conduct adequate case management. Most CHOWs worked a 40-hour week, and maintained flexible hours to accommodate client needs. CHOWs reported spending an average of twenty-five percent of their time on outreach, another twenty-five percent setting up appointments, and thirty-five percent actually providing application assistance. The remaining fifteen percent – only six hours per week – was left for case management and follow-up. Consequently, planned activities to promote utilization of care or follow-up on client application were often neglected.

Client-Specific Issues

Negative experiences with Medi-Cal presented the most significant client-specific barrier to enrollment in public health insurance programs. Most clients knew about Medi-Cal prior to

contact with a CHOW, but had little desire to apply for Medi-Cal for a variety of reasons. In many cases, clients who had been to Medi-Cal reported poor treatment by eligibility workers, and clients who had no prior contact had heard such rumors. Language issues were a problem, and in many cases eligibility workers were not bi-lingual and clients were unable to have questions answered adequately. Participants complained that Medi-Cal office hours were inconvenient for clients who worked. Many felt that the application process was too intrusive. Also, participants disliked visiting a welfare office quarterly to maintain their health insurance benefits.

Parents with prior negative Medi-Cal experiences did not necessarily understand the programmatic distinctions and were therefore more likely to avoid Healthy Families. Participants reported more confidence in Healthy Families once CHOWs explained the difference. However, participants reported that they would not have pursued Medi-Cal had they been referred there by Healthy Families. In fact, the few participants we met who had been referred to Medi-Cal had not pursued their Medi-Cal application for the aforementioned reasons.

Associations between Medi-Cal and Healthy Families impeded applications to other available insurance programs for a variety of reasons. Participants felt stigmatized by participation in Medi-Cal and one CHOW noted that calling Healthy Families ‘Medi-Cal for kids’ actually scared some clients away. In contrast with other studies, a number of participants with whom we spoke felt that accepting Medi-Cal (which they perceived as welfare) was stigmatizing. Consequently, paying a nominal fee for insurance coverage through Healthy Families bypassed the stigma associated with Medi-Cal as welfare, and participants reflected that this added to a sense of entitlement regarding Healthy Families. For instance, one participant, after describing her difficulties with Medi-Cal, noted that doctors must treat Healthy Families recipients well because they pay for it.

4.6 Role and Value of Health Insurance

Healthy Families works on the assumption that health insurance is a desired commodity. Given that Medi-Cal is available to many low-income families on an as-needed basis, participants were polled as to their perception of the role and value of health insurance under either set of circumstances. Focus groups findings indicated that almost every applicant valued health insurance enormously. Nearly all participants had previous experience with health insurance programs, either through employer-based programs or through Medi-Cal. In many

cases, parents so valued health insurance for their children that those with employer options paid an average of \$100 per child per month for employer-sponsored dependent care.

Participants cited the high cost of obtaining emergency care as the primary reason for valuing health care coverage. Many participants reported paying out of pocket for expensive emergency care when they were uninsured. With health insurance, participants felt assured that they could afford any services that their children might need. These parents felt more comfortable paying for coverage per month than risking an exorbitant bill for emergency services.

Somewhat fewer participants noted that they appreciated health insurance for the improved quality of care that is available. Participants recounted long waits in the emergency room and poor treatment by doctors and health care workers when they were uninsured. Participants also noted the difficulty of finding a doctor or dentist who would accept Medi-Cal. With health insurance, participants said that they received more reliable, prompt, and comprehensive care.

Some participants also stated that health insurance is necessary if a child is to receive preventive care that will keep him or her from getting sick. Most participants reported that they currently take their children to the doctor for checkups, dental visits, and other preventive care. A few participants reported that they took their children to the doctor for checkups even when they did not have health insurance. However, few participants cited preventive care as the primary benefit of having health insurance.

In the absence of insurance, most participants said that they would pay out of pocket for emergency care for their children when necessary, and in fact, many participants had done so in the past. In contrast, very few participants said that they would pay for preventive care out of pocket in the absence of health insurance. Several uninsured Mexican-American participants received care from Mexico instead. One mother took her daughter to Mexico for doctor visits. Another mother said that she gets prescription medication when in Mexico, where it is cheaper and more readily available.

Like participants, most potentially eligible non-participants valued child health insurance enormously. Families illustrated this by paying out of pocket for expensive dependent coverage through an employer, maintaining consistent health insurance coverage for their children, and applying several times to obtain health insurance despite confusion about the application process. However, a few uninsured non-participants were concerned about the cost of coverage. For

example, one parent was concerned that health insurance premiums would cost more than emergency health care for his children should they become sick.

CHOWs felt that prior to enrollment in Healthy Families or Medi-Cal, clients were not adequately using health care, although they emphasize that the reason for this lack of utilization was not due to an absence of value. Rather, families were mistrustful of the system, often faced language barriers in accessing care, and had a lot of uncertainty about where to go. Most health care utilization was to maintain immunization currency, since this is required for school enrollment. Beyond immunization, more pressing health issues were handled on an as needed basis, by bringing children to emergency rooms and paying for these services for months afterwards.

4.7 Coverage by Non-Custodial Parents

The majority of Latino participants with whom we spoke lived with the father of their children, however, almost all of the non-Latino participants did not. While a few single parents had either obtained insurance coverage for their children through the non-custodial parent or were in the process of doing so, most of these single parents were simply disinterested in obtaining such coverage. Most said that they would rather pay out of pocket for health insurance than take the chance of involving the non-custodial parent in their lives. Often, these non-custodial parents were not involved in their children's lives, and mothers feared that pursuit of health coverage would cause fathers to seek more active visitation or other types of involvement. Some mothers reported that non-custodial parents worked under the table and therefore lacked insurance coverage. According to one interviewee, the father of her children claimed to work under the table deliberately so that child support and health insurance for the child could not be deducted from his paycheck. In addition, most single parents doubted the effectiveness of pursuing non-custodial health coverage given the county's lack of success in collecting child support.

SECTION 5. PROGRAM OUTCOMES

The original goal of the outcomes analysis was to answer the remaining research questions: (1) Do outreach activities increase enrollment in the target programs?; (2) Do enrollees remain enrolled six months following acceptance into such programs?; (3) Have enrollees found a medical home and did enrollment promote utilization of care? To do this, we designed a study that makes use of two administrative data sources to track enrollment in the publicly funded child health insurance programs available to low-income families and children in San Mateo County: data provided by MRMIB regarding Healthy Families enrollment in San Mateo and two comparison counties; and, data provided by the outreach campaign which was to track participants from initial screening and application through a 6-month follow-up period. However, we were provided with six-month follow-up information for only 10 percent of the original participant families. Consequently, we are unable to address the latter two questions.

This section begins with a description of the approach we used to assess program outcomes, including study design, data sources, variables, and data limitations. The section goes on to present findings to answer the only research question we can given the available data: Do outreach activities increase enrollment in the target programs?

5.1 Method

Study Design

Evaluation of the San Mateo County Health Care for All Outreach Campaign was designed to examine program impacts by tracking enrollment patterns in Healthy Families, Medi-Cal, and 1931(b). To track enrollment, the evaluation uses administrative data from the outreach database, designed explicitly for use in this project, and from the Managed Risk Medical Insurance Board (MRMIB), which collects data to track Healthy Families enrollment in all of California's 58 counties. Data extracted from the outreach database were used to identify the families and children who were initially screened for potential enrollment in one of the available health insurance programs and to follow these families over time. Because MRMIB data were provided to us in an aggregate form, we did not plan to link the two data sets. However, we do use MRMIB data to establish and compare county-wide trends in enrollment in Healthy Families.

It should be noted that it is difficult to attribute outcomes to program operations in these types of settings. Therefore, while we can make inferences regarding trends in Healthy Families

enrollment throughout the study period, we cannot infer the extent to which the outreach campaign actually *caused* changes in Healthy Families enrollment.

Data Sources

We relied on two primary data sources to address questions regarding program impacts. First, we received data from the Managed Risk Medical Insurance Board (MRMIB), which administers the Healthy Families program across the state of California. MRMIB provided us with aggregate data regarding Healthy Families enrollment from the program's inception, in July 1998 through May 2000, when the outreach campaign came to an end. In addition to providing us with data for Healthy Families enrollment in San Mateo County, MRMIB gave us corresponding data for San Francisco and Ventura counties. These counties were chosen as potential comparison counties for several reasons: Ventura is the county most often likened to San Mateo in terms of demographic and economic characteristics; San Francisco is adjacent to San Mateo County and therefore shares certain regional characteristics; neither county had launched an outreach campaign during the same time period in which San Mateo was operating its outreach campaign. (San Francisco began a planning process for an outreach campaign in January 2000.)

The second data source available for analysis consisted of the information provided by the outreach campaign from three sets of tracking forms: an initial screening form that was administered to all families who applied for one of the available public insurance programs with assistance from an outreach worker; a 45-day follow-up form that was to be administered to these same families approximately 45 days after the initial screening; and, a six-month follow-up form that was to be administered to these same families approximately six months following the initial screening. However, as noted above, not all families and children were included in the 45-day follow-up and only about 10 percent of the families and children have information from the six-month follow-up form in the database. These missing data limit the usefulness of the follow-up data.

Variable Definitions

We relied on data from MRMIB and the outreach campaign to examine whether outreach activities increased enrollment in Healthy Families. Outreach data was used to establish baseline characteristics of and insurance rates for children and families who participated in the outreach campaign. MRMIB provided us with monthly aggregate counts of Healthy Families enrollment data for the three counties from July 1998, when Healthy Families began, through May 2000, when the outreach campaign ended. For each county, MRMIB provided these monthly counts by client ethnicity, allowing us to use the information to make more accurate comparisons with enrollment patterns in San Mateo County. It should be noted that MRMIB collects all data by child not case.

A number of variables were constructed from information collected in the screening form and included in the outreach database. Exhibit 5.1 list the variables we developed to describe baseline characteristics of families who participated in the outreach campaign.

Exhibit 5.1 Variables Taken From Screening Data	
Child-level variables	Case-level variables
Demographic characteristics <ul style="list-style-type: none"> • Gender • Ethnicity • Age • Citizenship status 	Demographic characteristics <ul style="list-style-type: none"> • Number of children in family • Family status • Parental citizenship/immigration status • Primary language • History of parental insurance coverage • History of child insurance coverage for any child in family • Reasons for parental non-coverage • Reasons for past application for child coverage

From the 45-day follow-up form, we constructed variables to determine what percentage of children who originally applied for insurance actually received it, and why those who did not receive coverage were denied. Exhibit 5.2 presents these variables, differentiating between child- and case-level indicators.

Exhibit 5.2 Variables Taken From 45-day Follow-up Data	
Child-level variables	Case-level variables

<ul style="list-style-type: none"> • Number of children enrolled in each type of insurance program 	<ul style="list-style-type: none"> • Application disposition • Reasons for denial from program
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Data Limitations

Before any discussion of findings, there are several limitations to the data that severely impede our ability to answer some questions that initially guided the research. First, we do not have complete follow-up information on the full population of families and children who were initially screened by the outreach campaign and applied to one of the available insurance programs. Of the original 654 families with 1,154 children who are in the screening database, only 415 families and 811 children appear in the 45-day follow-up database, and only 68 families with 137 children appear in the six-month follow-up database. The absence of families who received six-month follow-up services is no doubt a reflection of the fact that program operations were shut down much earlier than anticipated. However, this lack of information severely limits our ability to address two of our fundamental research questions: (1) Did new enrollees remain enrolled six months following acceptance into a health insurance program?; and, (2) Have enrollees found a medical home and did enrollment promote utilization of care? Because there are so few families in the six-month database, we cannot address either question with any confidence.

Furthermore, initial information collected at all three points in time is sometimes case-specific and sometimes child-specific, thereby making it impossible to directly compare percentages across intervals. Last, questions that attempt to track insurance coverage or service use over time are inconsistent in wording and often in concept. Therefore these types of information, as noted in the findings, are also not comparable across time periods.

5.2 Findings

This section presents two sets of findings. First, we examine whether outreach activities increase enrollment in Healthy Families. To do so, we use data provided by the outreach campaign to establish demographic characteristics of the outreach participants and receipt of insurance coverage at 45-day follow-up. MRMIB data are then used to further examine county-wide trends in Healthy Families enrollment for San Mateo, San Francisco, and Ventura counties.

Participant Characteristics

We use two data sources to address whether outreach activities increased enrollment in the target programs. First, outreach data allows us to examine characteristics of children and families served by the campaign, including client demographics, history of insurance coverage, application disposition, and insurance receipt at 45-day follow-up. Second, MRMIB data provides county-level caseload information by month and by ethnicity. Using these data, we look at total overall caseload trends and trends for Hispanic enrollees in San Mateo, San Francisco, and Ventura counties from June 1998, when Healthy Families began, through April 2000, when San Mateo County's outreach campaign came to an end.

The outreach screening database provides information regarding a total of 654 families with 1,154 children who worked with a CHOW to complete an application to one of the available public health insurance programs. Exhibit 5.3 provides a breakdown of child-level demographic characteristics, including gender, age, ethnicity, and citizenship prior to submitting an application to one of the available public health insurance programs. Exhibit 5.3 shows that while gender and age were relatively evenly distributed, the bulk of the 1,154 children who worked with the outreach campaign to apply for health coverage were citizens of Hispanic origin.

Exhibit 5.4 examines case-level demographic characteristics of the 654 families who completed a pre-enrollment screening form. Most families who participated in the outreach campaign were married with two or more children. Only 27 percent of parents who participated in the outreach program were actually U.S. citizens, although 78 percent met the immigration requirements for application to Medi-Cal. Sixty-four percent of families spoke Spanish as their primary language, although given that 90 percent of children were Hispanic, it is likely that a large percent of the families for whom primary language was missing spoke Spanish as well.

Exhibit 5.3 Child-level Demographic Characteristics	
Demographic Characteristics	Percent of children
Gender <ul style="list-style-type: none"> • Male • Female 	49 51
Age <ul style="list-style-type: none"> • 0-5 • 6-11 • 12-18 	38 40 22
Ethnicity <ul style="list-style-type: none"> • Hispanic • White • African-American • Asian/Pacific Islander • Other 	90 1 3 4 2
Citizenship status <ul style="list-style-type: none"> • Citizen • Non-citizen 	88 12

Exhibit 5.4 Case-level Demographic Characteristics	
Demographic characteristics	Percent of families
Number of children in family <ul style="list-style-type: none"> • 1 • 2 • 3 or more 	29 37 34
Family status <ul style="list-style-type: none"> • Single-parent • Two-parent 	17 83
Parent citizenship/immigration status <ul style="list-style-type: none"> • Citizen • Satisfactory immigration status 	27 78
Primary language <ul style="list-style-type: none"> • Spanish • English • Asian/Pacific Islander • Missing 	64 10 2 24

Exhibit 5.5 examines history of insurance coverage for parents who participated in the outreach campaign as well as their children. The exhibit additionally looks at reasons for parental non-coverage and reasons parents had not applied for child coverage prior to participation in the outreach campaign. While the bulk of parent participants had been covered by health insurance at one time or another, only 41 percent of parents had health coverage for themselves at the time they applied for their children. Sixty-five percent of families had been covered by Medi-Cal at some point, but only 21 percent had Medi-Cal experience in the past 15 months.

Exhibit 5.5 History of Insurance Coverage	
History of coverage	Percent
Parental insurance coverage	
• Ever covered	72
• Current coverage	41
• Medi-Cal past 15 months	21
• Medi-Cal ever	65
• Employer coverage ever	45
• Ever covered dental	37
• Ever covered vision	30
Reasons for parental non-coverage	
• Unaffordable	75
• Not provided by employer	10
• Unemployed	7
• No information	3
• Recent immigrant	1
• Not needed	1
• Terminated by provider	1
• Other	2
Child insurance coverage	
• Covered in past 90 days	3
• Current coverage by no-cost Medi-Cal	7
Reasons for previous non-application	
• Unaffordable	77
• Lack of information	11
• Previously insured	5
• Not needed	2
• Not Medi-Cal eligible	2
• Recent immigrant	1
• Unemployed	1
• Not provided by employer	1

Most parents explained lack of current coverage financially. Three-fourths of parents felt coverage for themselves was unaffordable. Likewise, they had not applied for child coverage because they perceived that it too was unaffordable. The database provided scant information regarding history of child insurance coverage, however information provided suggests that only three percent of children served by the outreach campaign had insurance coverage in the past 90 days, and only seven percent of these children were currently covered by no-cost Medi-Cal.

Child health coverage was monitored for families at three points in time: at screening, 45 days following application to a health insurance program, and again, six months following the initial application. Unfortunately, the number of cases for whom we have follow-up data decreased from each time period to the next. Exhibit 5.6 presents information regarding the number of families and children for whom information was collected at each point in time, and indicates that while 654 families with 1,154 children actually participated in the outreach campaign, only 63 percent of those families and 70 percent of children initially served were tracked 45 days later, and only 10 percent of the families and children who appear in the screening database are tracked six months later. While subsequent exhibits look at enrollment outcomes and utilization of services, it is important to note that long-term findings represent a much smaller proportion of the population than were initially served. Because we have 45-day follow-up information on 70 percent of the children initially served, we report coverage data on these families and children. However, we present no findings for the 10 percent of children and families who appear in the six-month follow-up database as the numbers are too small and we have no way of knowing how representative these families are of the original number served.

Exhibit 5.6 Number of Families and Children at Each Time Period			
	Screening	45-Day Follow-Up	6-Month Follow-Up
Number of families in database	654	415	68
Number of children in database	1,154	811	137

Based on eligibility information provided by the client at the pre-enrollment screening appointment, CHOWs submitted child applications to the state for one of six available programs.

Exhibit 5.7 examines enrollment outcomes for the families and children tracked at each interval, beginning with this initial referral.

Again, it is important to note some data discrepancies. First, rates of non-specific insurance coverage are inconsistently reported over time. That is, at screening the percentage of uninsured children reflects the number of children uninsured in the 90 days prior to completing a screening. In contrast, 45-day follow-up information determines insurance coverage at that point in time. Second, ‘Cases applied to...’ at screening refers to case-level information about the 654 *families* served by the outreach campaign, while ‘Children received...’ at 45-day follow-up is *child* specific.

Last and perhaps most important, it should be emphasized that percentages of uninsured children or children receiving one of the available insurance packages 45 days following initial application are calculated based on the 811 children in that database. We do not know about insurance coverage for the 343 children who were in the screening database but for whom we have no 45-day follow-up information. Because those 343 children represent a substantial portion (30 percent) of the original children who applied for coverage, the outreach campaign might have been significantly more or less successful than we can document in this report.

Exhibit 5.7 Application Disposition at Screening and Insurance Receipt at 45-day Follow-up			
Screening	Percent	45-Day Follow-Up	Percent
Insured children	3	Insured children	76
Cases applied to...		Children received...	
• 1931(b)	5	• 1931(b)	1
• Healthy Families	71	• Healthy Families	76
• Medi-Cal	15	• Medi-Cal	21
• WELL	7	• WELL	2
• Other	2	• Other	0

With those caveats, Exhibit 5.7 shows that the percentage of insured children grows from three percent at screening to 76 percent at 45-day follow-up. By far, the bulk of families applied for Healthy Families, with a significantly smaller fraction applying for Medi-Cal and other programs. At 45-day follow-up, 76 percent of insured children were enrolled in Healthy Families and 21 percent of insured children were enrolled in Medi-Cal.

Exhibit 5.7 presents *percentages* of insured children at each time period. Because analysis of MRMIB data will examine Healthy Families enrollment *numbers* over time, it is equally important to look at the associated numbers of children who applied for and received health coverage so we can compare this number with the number of Healthy Families enrollments documented by MRMIB over the same time period. Unfortunately, because the six-month follow-up data is scant, we can only rely on 45-day follow-up information to assess how many children were enrolled in public insurance programs as a consequence of participation in the outreach campaign, and of those insured, how many were insured by Healthy Families. Exhibit 5.8 translates percentages in Exhibit 5.7 into actual numbers, and shows that of the 1,154 children originally served by the outreach campaign, the outreach database indicates that 591 were actually covered at 45-day follow-up. Of these 591, 450 were insured by Healthy Families.

Exhibit 5.8 Number of Insured Children at 45-day Follow-up			
Screening	Number	45-Day Follow-Up	Number
Insured children	35	Insured children	591
Cases applied to...		Children received...	
• 1931(b)	33	• 1931(b)	5
• Healthy Families	464	• Healthy Families	450
• Medi-Cal	98	• Medi-Cal	125
• WELL	46	• WELL	10
• Other	13	• Other	1

At 45-day follow-up, CHOWs also polled the 113 parents of children who were denied coverage as to why their applications had been rejected. Exhibit 5.9 shows that the majority of these families were denied coverage for one of two reasons: either they provided incomplete documentation on their application or the children were found ineligible. Process findings presented earlier in this report suggest that these denials may be mistaken. Consequently, of families who were denied coverage, 16 percent were in the process of re-submitting an application.

Exhibit 5.9 Reasons for Denial of Coverage	
Reason denied coverage	Percent
• Incomplete documentation	47
• Ineligible	38
• Client rescinded application	12
• Missed payment	2
• Unknown	1

Exhibits 5.10 through 5.13 use MRMIB data to examine overall trends in Healthy Families enrollment in San Mateo and the two comparison counties. Exhibit 5.10 shows the overall Healthy Families caseload trends for each of the three counties. Examination of the specific time period between August 1999 and May 2000, when the outreach campaign was fully operational, shows that San Mateo's caseload grew from 1,170 cases in August 1999 to 2,864 cases in May 2000. In contrast, San Francisco and Ventura counties' total caseloads grew from 5,635 to 8,579 and 4,384 to 8,468, respectively, over the same time period. As San Mateo County has a much smaller general population than both San Francisco and Ventura counties, one would expect the total caseload growth to be much smaller than in the other two counties.

Exhibit 5.10 Cumulative Healthy Families Caseload by County, June 1998 - May 2000

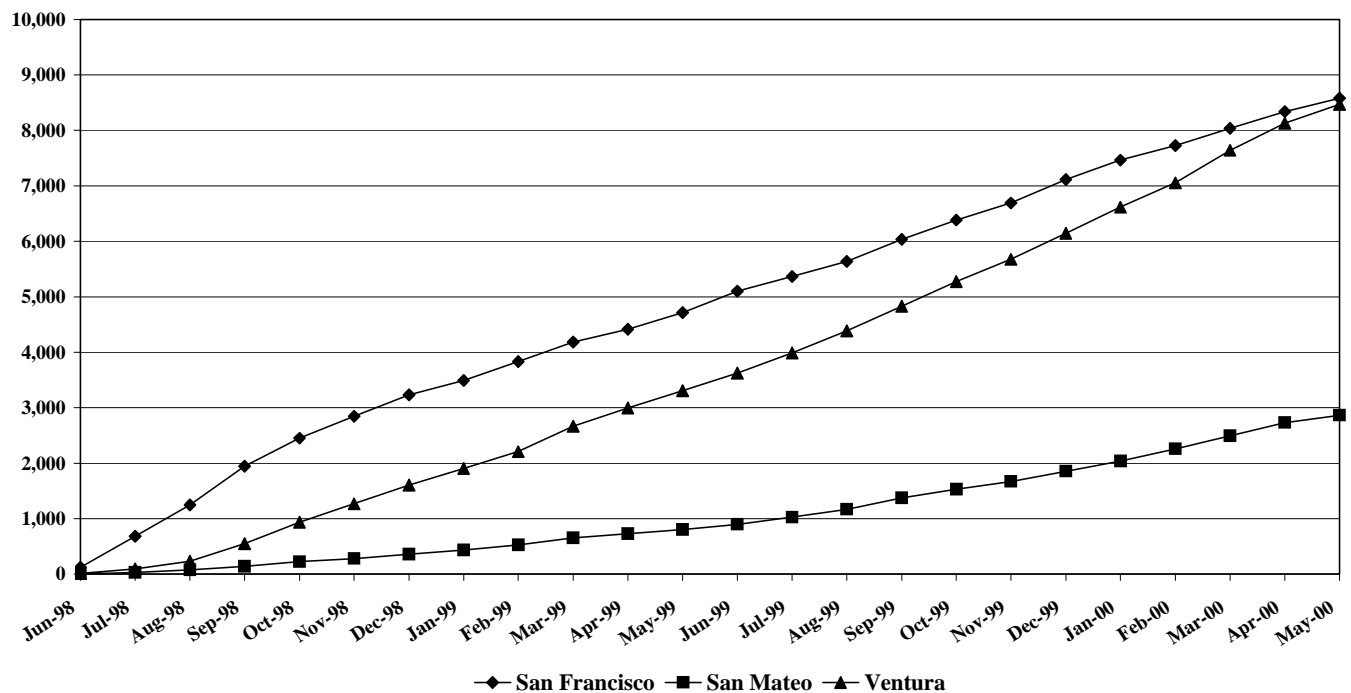
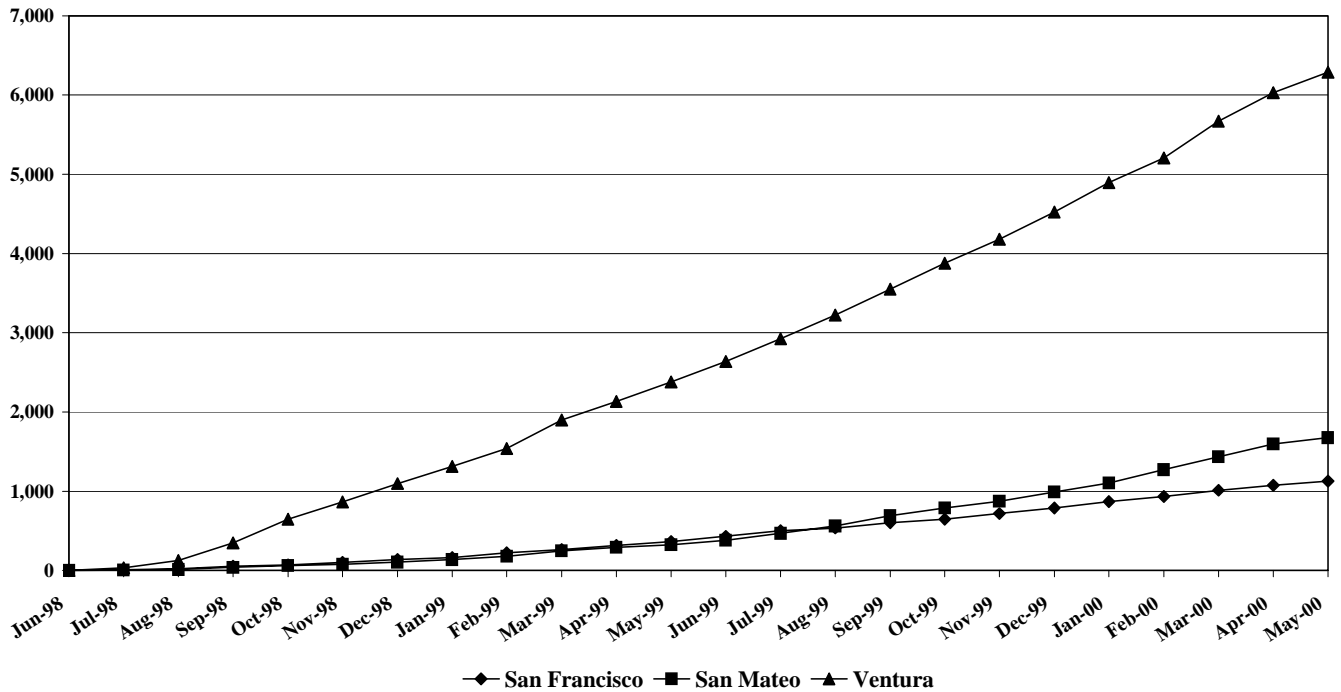


Exhibit 5.11 Cumulative Hispanic Healthy Families Caseload by County, June 1998 - May 2000

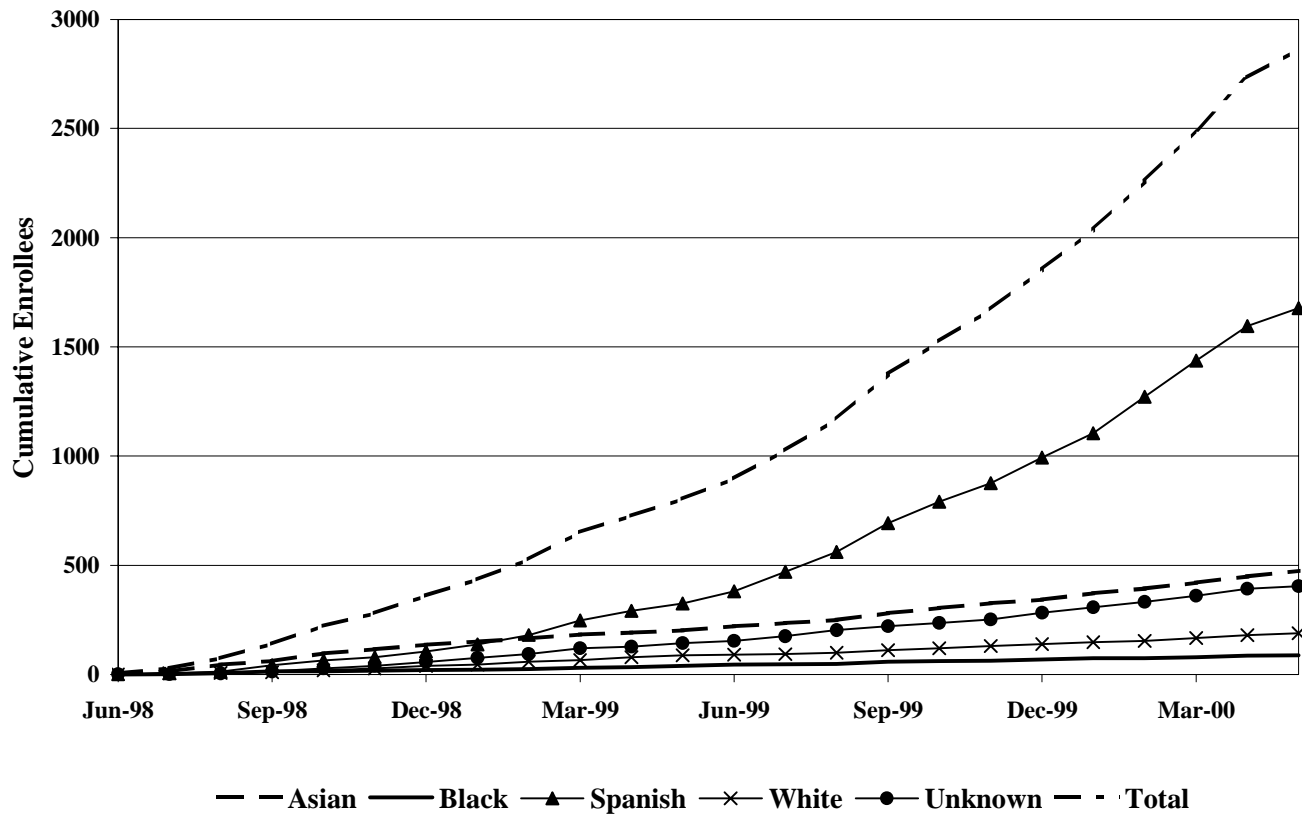


However, San Mateo County’s total Healthy Families caseload has grown by 145 percent since August 1999, while San Francisco and Ventura counties’ caseloads have grown by 52 and 93 percent, respectively.

Based on outreach data, we know that the Coalition almost exclusively worked to recruit Hispanic families. Therefore we also looked at county-wide Healthy Families caseload trends for Hispanic enrollees over the same time period. Exhibit 5.11 shows that from August 1999 through May 2000, San Mateo County’s Hispanic Healthy Families caseload almost triples, growing from 561 cases in August 1999 to 1,677 cases in May 2000. At the same time, San Francisco and Ventura’s Hispanic caseloads double, growing from 535 to 1,126, and 3,223 to 6,287 respectively. Taken together, these findings suggest that while Healthy Families enrollment does increase in the absence of an outreach campaign, San Mateo County’s outreach campaign may explain the extra boost in the number of children – in particular Hispanic children – who enrolled in Healthy Families.

Exhibit 5.12 looks more closely at Healthy Families enrollment in San Mateo County for all ethnic groups and shows that overall growth in San Mateo County’s Healthy Families caseload during the study period is driven by the increasing number of Hispanic enrollees. While

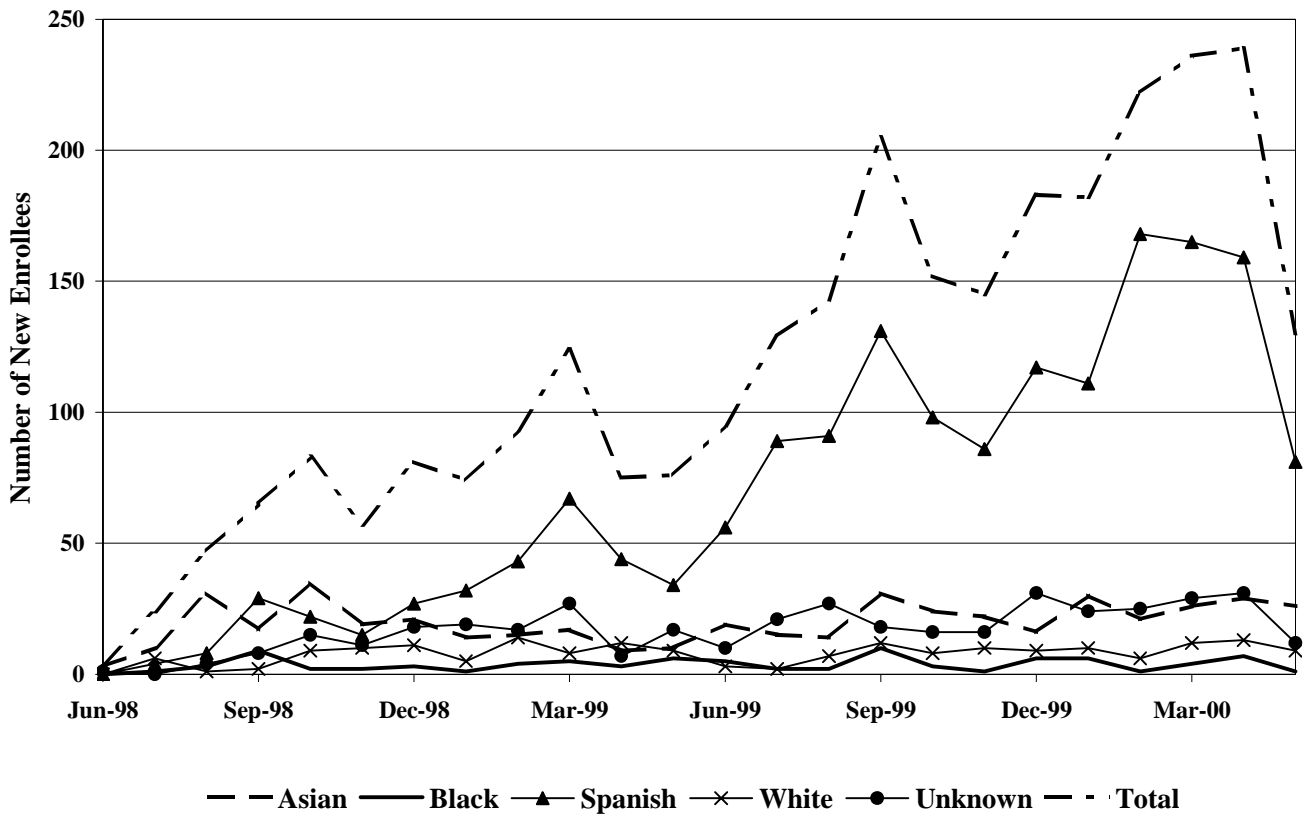
Exhibit 5.12 Cumulative San Mateo Healthy Families Enrollees by Ethnicity



Healthy Families enrollment does climb for all ethnic groups throughout the study period, it increases more steadily for Hispanic children than for Asian, White, and Black children. Furthermore, while enrollment for non-Hispanic children doubles throughout the study period, Hispanic enrollment nearly triples.

Last, Exhibit 5.13 shows the number of San Mateo new Healthy Families enrollees by ethnicity from June 1998 through May 2000. The number of new non-Hispanic enrollees remains relatively stable throughout the entire period. In contrast, the number of new Hispanic enrollees climbs over time, mounting its greatest increases from May 1999 through May 2000. While not all of these increases can be explained by the outreach campaign, some of the vicissitudes in Hispanic enrollment that occur between August 1999 and May 2000 can. In particular, additional Hispanic CHOWs were hired in January 2000, which likely explains the jump in monthly Hispanic enrollments that occurs around that time.

Exhibit 5.13 Number of New San Mateo Healthy Families Enrollees by Ethnicity



SECTION 6. CONCLUSIONS AND LESSONS LEARNED

This report presents findings regarding evaluation of San Mateo County's Health Care for All Outreach Campaign. This concluding chapter briefly summarizes these findings, and then presents recommendations for three relevant stakeholders: agencies that may be implementing similar initiatives; counties who seek to encourage these initiatives; and, CDHS who can use the information to lessen bureaucratic obstacles to enrollment.

6.1 Summary of Key Process Findings

The summary of process findings presented in this section is organized around the same logic model framework that defines our initial understanding of how the program operated. We begin with a summary of findings related to program implementation, then move onto outreach activities, application assistance, case management, activities to promote utilization of care, follow-up and tracking activities, barriers to enrollment, and coverage by non-custodial parents.

Summary of Process Findings

Program Implementation

- **The outreach campaign planned and prepared for operations for 6 months, from February through July 1999 and actively conducted outreach activities and application assistance for a total of 9 months, from August 1999 through April 2000.** Due to state-wide changes in the Healthy Families application process and the actual application, the campaign was not fully staffed and able to begin outreach activities until August 1999. Therefore it is important that all enrollment efforts be judged in light of the very brief time period in which the campaign was able to provide assistance.
- **While CHOWs were trained on how to complete applications and work with clients, they received no training on how to conduct outreach activities.** For CHOWs with prior outreach experience, this was not problematic. For CHOWs with little outreach experience, this type of training would have been helpful.
- **The outreach campaign focused on Hispanic enrollment to the exclusion of non-Hispanic populations.** Staff acknowledged that an ethnic match between CHOWs and participants facilitated enrollment. Early on, the program decided to focus on increasing enrollment in the Hispanic community and hired and maintained Hispanic staff accordingly.

Outreach Activities

- **Outreach activities promoted awareness of and enrollment in publicly available insurance options.** Successful outreach activities included presentations at local agencies, schools, churches, and employers. Without community-wide outreach, many families who participated in the program might otherwise not have.
- **The state-funded outreach campaign did not promote enrollment in publicly available insurance programs.** While most clients were exposed to the advertisements sponsored by the state-funded outreach campaign, not one used the information to seek out health coverage.
- **County agencies did not refer potentially eligible clients to the outreach campaign or to Healthy Families in general, and improved outreach and referral at these sites is needed.** Neither staff at county hospitals nor eligibility workers at HSA welfare offices told clients about the availability of Healthy Families or the outreach campaign's assistance for potentially eligible families, even when clients asked for information regarding available health insurance options.

Application Assistance

- **Application assistance of the sort provided by the outreach campaign is essential to promote enrollment in publicly available insurance programs.** Most participants in the outreach campaign said they would not have completed an application without assistance. One on one application assistance is best provided in clients' homes, where clients feel most comfortable, and by a worker who understands and can address client fears and concerns.

Case Management

- **The outreach campaign provided inadequate case management for families who faced obstacles to enrollment.** Participants whose children were not immediately enrolled in health insurance program required enhanced case management activities to revise and resubmit applications, clarify state correspondence, and in many cases, accompany clients referred to Medi-Cal to welfare offices to ensure enrollment. CHOWs reported (and enrollees concurred) that families who were easily and immediately enrolled in insurance programs to which they applied required no more case management.
- **Although not all families require case management, case management took a back seat to outreach and application assistance because staffing was inadequate for CHOWs to accomplish all required activities.** CHOWs estimate that outreach activities and application assistance took up 85% of their time, leaving little time for case management activities. Outreach staff recommended that an additional 3 staff persons would be required to maintain enrollment goals of 10 applications a week while adequately maintaining case management activities on all active clients.

Promoting Utilization of Care

- **The outreach campaign conducted few formal activities to promote client utilization of care and inform provider choice, however, clients felt that these types of activities may have not been necessary given that clients said they already desired coverage and knew how to use it.** Again, due to a lack of resources, activities to promote utilization of care took a back seat to outreach and application assistance.
- **Provider choice was primarily influenced by participant desire to maintain an existing relationship with a current doctor.** Familiarity with a health plan and proximity to the provider were also significant, albeit lesser factors influencing provider choice. Cost was the least mentioned reason for provider choice.
- **Most participants did not choose HPSM due to lack of familiarity, although negative association with HPSM as welfare also influenced consumer choice.** Participants who named cost as the most important factor in choosing a provider were the only consumers to choose HPSM.

Barriers to Enrollment

- **The public charge issue presented a significant barrier to enrollment for Hispanic and Pacific Islander clients.** However, CHOW provided outreach and application assistance allowed participants to overcome their concerns and apply for coverage.
- **State-defined enrollment procedures presented an equally significant barrier to enrollment, and myriad difficulties with the state-defined application process impede enrollment in available programs.** Clients who were denied coverage or required additional documentation for approval were uniformly sent letters in English, despite the primary language noted on the original application. For clients who were denied in error, the re-application process did not work and clients had to submit an entirely new application. Application forms were unclear and did not provide adequate explanation for how self-employed clients could document income. Last, families with a combination of documented and undocumented children receive confusing correspondence (often in the wrong language) regarding the disposition of their applications.
- **Negative client experiences with Medi-Cal impede application to available programs and follow-through on applications referred to Medi-Cal.** Healthy Families is stigmatized by its association with Medi-Cal. Consequently, clients whose applications are referred to Medi-Cal often do not follow through as a result of prior negative experiences with the Medi-Cal program, including poor treatment by workers, a perceived lack of Spanish speaking workers, and worker non-response to client phone contact. Moreover, state sponsored ads that call Healthy Families 'Medi-Cal for Kids' confuse clients as to program distinctions, and therefore present an additional obstacle to enrollment.

Role and Value of Health Insurance

- **Parents value health insurance and actively seek it out.** All parents with whom we spoke who had an employer sponsored dependent care option sought it out and paid costly premiums rather than remain uninsured.
- **In the absence of care, families pay out of pocket for routine and emergency care.** In the absence of insurance coverage, most parents still had an existing relationship with a primary care pediatrician for whom they paid out of pocket. Coverage has allowed these parents to visit these doctors more regularly without the attendant costs.

Non-Custodial Dependent Coverage

- **Mothers do not seek out non-custodial provision of dependent coverage because they do not want to encourage paternal contact.** Most mothers wanted to avoid further paternal involvement in their childrens' lives. The few mothers who would have liked this type of assistance said that the DAFS was unable to locate the fathers for child support collection, and were therefore skeptical of their ability to garner insurance coverage.

6.2 Summary of Outcome Findings

- **San Mateo County's Healthy Families enrollment grew from 1,170 cases to 2,864 cases – a 145 percent increase – from August 1999 to May 2000.** In contrast, San Francisco and Ventura counties' Hispanic caseloads grew from 5,635 to 8,579 and 4,384 to 8,468 respectively (a 52 and 93 percent increase) over the same time period.
- **San Mateo County's Hispanic Healthy Families enrollment tripled from August 1999 to May 2000.** Hispanic enrollment in the two comparison counties doubled over the same time period.
- **The outreach campaign primarily served Spanish speaking, two-parent, Hispanic families with 3 or more children.** While parents in these families were more likely to be non-citizens, most children were documented.
- **Most parents had a history of insurance coverage.** Seventy-two percent of parents surveyed had a history of insurance coverage and 65 percent of parents surveyed had a history of Medi-Cal coverage. Forty-one percent of parents had current health coverage.
- **Most children lacked insurance coverage at the time of application.** Only 3 percent of children who applied for coverage had been insured in the past 90 days. Only 7 percent had been covered by no-cost Medi-Cal.
- **Lack of affordability was the principal reason cited to explain lack of child health insurance coverage.** Lack of information was the next most frequently cited reason.

- **Healthy Families was the most common insurance program to which outreach campaign participants applied.** A lesser majority (15%) applied to Medi-Cal. Only 5 percent of families were referred to 1931(b) because so few met the eligibility requirements.
- **At 45-day follow-up, 76 percent of children were insured and the bulk of insured children were covered by Healthy Families.** Twenty-four percent of children who worked with the outreach campaign remained uninsured at 45-day follow-up. Of all children in the 45-day follow-up database, 55 percent were covered by Healthy Families 45-days following initial application. Medi-Cal coverage accounted for 15 percent of insured children 45-days following initial application.
- **Incomplete documentation (47%) and ineligibility (38%) were the two main reasons children were denied coverage.** Sixteen percent of children were denied coverage were in the process of resubmitting an application.

6.3 Lessons Learned

Findings from both the process and outcome evaluation components can be used to inform multiple levels of service delivery at the program, county, and state level. This section recommends practices for three levels of stakeholders: agencies that may be implementing similar initiatives; counties who seek to encourage these initiatives; and, the California Department of Health Services who can use the information to lessen bureaucratic obstacles to enrollment.

Program Specific Recommendations

While San Mateo County's outreach campaign is over, lessons learned from evaluation of the campaign can be used to inform similar outreach efforts in San Mateo County or beyond. Some features of the Coalition's outreach campaign were extraordinarily successful, and merit replication, while others provide insight as to how to improve upon outstanding outreach efforts. This section presents a synthesis of both the successful features of the Coalition's effort that merit replication and ways to improve upon their activities in future efforts either within or outside the county.

1. **Future outreach efforts should seek to reach diverse ethnic groups.** It should be noted that due to the County's large population of low-income Latino families (37 percent

of San Mateo County's Medi-Cal population is Latino), the Outreach Campaign made a conscious effort to target Latino families for services. Consequently, a large percentage of non-Latino families remained un-targeted by the outreach campaign. According to staff and clients, ethnic match between client and worker is important, particularly so for non-English speaking monolingual clients. Therefore, these types of outreach efforts should either use a variety of ethnocentric organizations to spearhead outreach efforts, or ensure that the lead agency hire, train, and provide adequate support to a diverse staff of outreach workers.

2. **Application assistance helps enroll participants in these types of insurance programs.** Any outreach effort should be able to provide one on one assistance to eligible clients, in clients homes if desired. As outreach efforts gain pace, other methods of application assistance (e.g. in group settings at the workplace) might merit further investigation.
3. **Outreach efforts should ensure that there is adequate staff time allotted for case management activities.** Twenty-five percent of participants in the outreach campaign were not insured at 45-day follow-up, and based on process findings, these families could have benefitted from increased case management to resolve application difficulties, resubmit applications, or assist clients referred to Medi-Cal with that application process. Based on staff estimates, case management activities require fifty percent time, and future outreach efforts should plan for that allocation.
4. **Informal client worker discourse is adequate to promote utilization of care.** Clients with whom we spoke say they already desire, value, and know how to use health coverage, and in many cases already have a regular doctor. Consequently, formal client presentations regarding how to choose a provider and access care are an unnecessary use of scarce time.
5. **If outreach efforts are to include client follow-up, forms should be streamlined and every effort should be made to track all clients.** Client follow-up and tracking are mechanisms by which outreach efforts can self-assess their own progress. However, tracking forms should gather the most basic information consistently across time periods. Furthermore, long term tracking is the only way to account for project success. Without adequate data collection that tracks a majority of participants from screening and beyond, implementation of a tracking system is not worth the effort.

County-Level Recommendations

County-specific recommendations are again, applicable to both San Mateo County and to other counties seeking to encourage similar outreach initiatives.

- 1. Ensure that county agency staff who are already outposted at agencies across the county conduct outreach and make referrals as appropriate.** Information regarding available insurance options (particularly non-welfare administered insurance options such as Healthy Families) should be visibly posted at county hospitals and welfare agencies. Furthermore, staff at these agencies who are already trained about available programs should be more assertive about reaching out to clients and providing anticipatory information about the outreach campaign to all clients who come in for services.
- 2. Try to ameliorate negative client perceptions regarding Medi-Cal.** Participants say that negative experiences with Medi-Cal prevent them from applying for Medi-cal when referred. While history cannot be undone, changes that might be currently implemented include increasing the number of Spanish speaking eligibility workers, ensuring that workers return client phone calls in a timely manner, and changing the Medi-Cal hours to accommodate client work schedules.

State-Level Recommendations

By far, most obstacles to enrollment can be transcended by changes made at the state-level regarding application processes. Some of these recommendations are concrete and feasible. Others may be more utopian, but nonetheless represent ways that would ultimately improve uptake of low-cost public health insurance programs for children.

- 1. Redesign the application and ensure that it provides adequate space and instruction to cover all information necessary for the state to fully evaluate a client application.** The current application has unclear guidelines and space for income information. Furthermore, there is no process by which self-employed applicants can adequately document their income and qualify for coverage. Redesigning the application to ameliorate these issues might necessitate fewer incorrect denials and lead to increased enrollment.
- 2. Ensure that communication regarding application disposition is sent in the appropriate language.** Applicants are easily discouraged by a difficult application process. Posting letters in the incorrect language adds yet one more unnecessary obstacle to what is already an anxiety provoking process.
- 3. Send a clear message regarding the public charge issue, clarifying that application to Healthy Families will not have negative consequences for undocumented parents.** While outreach workers were able to surmount participant fears and concerns, in the absence of an effective outreach worker, undocumented clients will not apply for child health coverage and children will remain uninsured.
- 4. Make Healthy Families, Medi-Cal, and other public health programs operate seamlessly.** Clients were confused by the multiplicity of available programs and the difference between the regulations for each. Both clients and staff suggested that this

confusion, which presents a formidable obstacle to enrollment in all programs, could be alleviated by making the programs operate seamlessly. Suggested ways to do this include: change the timing of redetermination of either Healthy Families (annually) or, preferably, make Medi-Cal (quarterly), so that they are the same; make Healthy Families available on demand, preferably retroactively for clients who come into health care providers with an emergency.

5. **Consolidate the Healthy Families and Medi-Cal applications into one.** Applications can then be reviewed for all 94 Medi-Cal programs simultaneously.

APPENDIX

Evaluation of the Health Care for All Coalition Community Outreach Program

Interview Protocol: Director of Outreach

Planning

- When did the Coalition apply for DHS and Packard grants? When did the Coalition receive them? How much did the Coalition receive?
- What was the subsequent planning and program design process?
- When were you hired? What were your responsibilities? What was your role in the planning process?
- Who was primarily responsible for designing program activities?
- How were decisions made?
- Were informal or formal advisory structures instituted? If so, what was the role of these structures?

Staffing

- How were CHOWs recruited and hired? What qualities and experience were required?
- What kind of time commitment do you require of CHOWs? Do they work regular hours? Do they work off hours?
- How many CHOWs were hired? When were you fully staffed?
- Who does the Coalition staff other than CHOWs? What are their roles?

Training and supervision

- How is staff trained to perform outreach activities?
- How are CHOWs trained to administer the Healthy Families/Medi-Cal applications? Is training updated to reflect changes in application procedures and program rules?
- How are CHOWs trained to administer intake and 45-day and 6- month follow-up forms and maintain records?
- How are CHOWs supervised? How is their progress monitored?
- How are CHOWs supported? What resources are available to them?

Outreach Activities

- How is the outreach program implemented?
- Can you describe the process by which a typical family might be enrolled in Healthy Families or Medi-Cal?
- What activities do CHOWs perform?
- Is there a goal as to how much time should be allotted to each activity? How do CHOWs determine their allocation of time?
- Is there an ideal client/CHOW ratio? How was this determined?
- Does the program have enrollment goals? How were they determined?
- Do CHOWs have enrollment goals? How were they determined?
- How is client data entered into the MIS system? When is data entered?

Systematic Issues

- In your experience, what barriers impede clients from enrolling in Healthy Families, Medi-Cal, and AB1931?
 - S length of application
 - S public charge issue
 - S enrollment procedures
 - S other programmatic/systematic issues
- How has the outreach program sought to overcome these barriers? For instance, how do CHOWs go about overcoming client fears about the public charge issue?
- What kinds of programmatic/systematic changes at both the state and local level would you recommend to maximize enrollment?

Utilization of care

1. Have you found that clients use health care prior to enrolling in the program? If so, for what purposes? If not, why not?
2. What are client barriers to regular health care utilization?
3. How does the outreach program attempt to impact utilization of health care services? What do CHOWs do to encourage regular health care utilization?

Focus Group Protocol: Community Health Outreach Workers (CHOWs)

Section 1: Current and former CHOWs

Duties and responsibilities

- Prior to working with the Coalition, how much did you know about Medi-Cal, Healthy Families, and AB1931?
- Prior to this campaign, had you done outreach?
- How did you hear about this outreach program and this position?
- Initially, what were you told would be your responsibilities?
- Did these responsibilities change over the course of the project? If so, how?
- Do you feel that you are unable to fully perform any of your duties due to lack of time?

Training and support

- How were you trained to perform outreach activities?
- What methods of training were most helpful? Which were least helpful?
- How were you trained to complete applications?
- What methods of training were most helpful? Which were least helpful?
- How was your training updated as changes were made to the Medi-Cal, Healthy Families, and/ or AB1931 programs?
- Was there an informal or formal structure for soliciting advice about and making suggestions for outreach activities?
- How were you trained to administer screening and 45-day and 6-month followup forms?

Outreach activities and performance

- How is the outreach program implemented?
- Initially, what were planned health education activities?
- Initially, what were planned outreach activities?

- What were subsequent changes to outreach activities? Were any discontinued? If so, why? Were new activities implemented?
- Did you feel that you had a voice in the planning and decision-making process?
- In what forums, did you conduct outreach activities?
- What forums yielded the most clients?
- In your experience, which outreach activities were most successful – yielded the most clients?
- In your experience, which outreach activities were least successful – yielded the least clients?
- Does the campaign have enrollment goals? How and when were you informed of them?
- Initially, how many clients were you expected to enroll per week? Was this expectation reasonable?
- After implementation of the outreach activities, did the enrollment goals ever change? If so, why?
- How was your performance monitored?
- Has the campaign been successful? Are clients enrolling in health programs and utilizing care?
- Have you started administering 45-day followup forms? If so, have you found that client attitudes about health care coverage and utilization have changed?

Client issues

- In your experience, did clients know about the Medi-Cal, Healthy Families, and AB1931?
- Did they know that they were potentially eligible for these programs?
- In your experience, prior to enrollment, were clients availing themselves of health care? If so, what kinds of services were they using? If so, how was the care being financed?
- How did you make efforts to recruit non-Hispanic clients? How successful were you?
- Were some outreach activities more successful for recruiting certain demographic groups?
- Were some outreach activities less successful for recruiting certain demographic groups?

Systemic and programmatic issues

- In your experience, what barriers impede clients from enrolling in Healthy Families, Medi-Cal, and AB1931?
 - S length of application
 - S public charge issue
 - S enrollment procedures
 - S other programmatic/systematic issues
- How have you sought to overcome these barriers?
- What kinds of programmatic/systematic changes at both the state and local level would you recommend to maximize enrollment in public health programs?

Section 2: Former CHOWs

- Were you expected to target a particular demographic group or neighborhood? If so, in what ways were outreach activities tailored to this group?
- Why did you leave the campaign?
- How were enrollment goals explained to you and did you meet them?
- Did you feel that the enrollment goals were reasonable? If not, why?
- Did outreach activities target all groups? If yes, how so? If no, how not?
- What kinds of changes to the outreach campaign would you suggest to increase enrollment of non-Hispanic clients?

Focus Group Protocol: Participants

Application processes

- How did you hear about the health insurance program for which you ultimately applied?
- Did you hear any public service announcements, radio ads, television ads? Did you go to any meetings?
- How were you recruited into the outreach program? How did you make contact with your outreach worker?
- Had any of you tried to complete a Medi-Cal/HF application prior to receiving assistance from your outreach worker?
- What about the application process was easy?
- What made it difficult to apply?
- Would you have applied for the program without the assistance of an outreach worker? **Why or why not? Must get at fears, concerns.**
- How did your worker help you through the application process?
- What other kinds of assistance would you have like to have had?
- If you could redesign how the application process worked, how would you design it?
 - All applications through county welfare office?
 - All applications through one non-county office?
 - Separate programs or just one?
- Have you ever been on TANF or AFDC? Did your county worker ever tell you about this program?

Utilization of health services

- Did you attend a meeting explaining your health benefits, encouraging you to use health care services, or helping you to find a doctor?
- Now that you have coverage, how often do you go to a doctor?
- Do your children currently have a regular doctor?
- For what do you usually see this doctor? (Prevention, immunization, check-ups, acute care needs)

- Prior to enrolling in this program, did your children have a regular doctor? How often did they see that doctor?
- Has enrolling in the program changed the frequency with which you take your children to the doctor?
- Did your worker do or say anything that influenced a change in this frequency?

Value of health insurance

- How important do you think it is to have health insurance?
- If you could afford to go to a doctor any time you wanted – but maybe not the same doctor every time – would you feel health insurance is necessary?
- Do you feel that it is important to see a doctor regularly for check-ups and preventive care?
- Do you feel that it's important to establish a relationship with one doctor who sees your kids each time?
- What would you do if your child had a health care emergency and you didn't have health insurance?

Choosing a provider

- When you enrolled, how did you choose your provider?
- Do you remember what your choices were? (Cue list)
- Had you heard of any of these providers before? If so, how?
- Which do you think was more important in choosing your provider: cost, familiarity, or reputation?
- Did you know about the Health Plan of San Mateo? Given that the Health Plan of San Mateo is the least expensive provider, why do you think that so few families choose it?

Coverage by non-custodial fathers

- How many of you don't live with your children's father?
- Does he have employer-based insurance?

- Have you ever tried to get him to provide insurance coverage for your kids? If so, what happened? If not, why not?
- What do you think the county can do, if anything, to help mothers get insurance coverage for their kids from non-custodial dads?

Focus Group Protocol: Potentially Eligible Non-Participants

Application processes

- Have you heard about the HF/Medi-cal for kids health insurance programs offered by the state?
- Did you hear any public service announcements, radio ads, television ads? Did you go to any meetings?
- Were you recruited into the outreach program? Did an outreach worker attempt to make contact with any of you to help you enroll in the program?
- Did any of you try to complete a Medi-Cal/HF application? With or without assistance from an outreach worker?
 - What about the application process was easy?
 - What made it difficult to apply?
 - What was the outcome of the application?
- We got your name from a list indicating that you signed up for information about child insurance? Why didn't you ultimately apply for the insurance program?
 - application process too difficult?
 - public charge issue?
 - thought would be ineligible?
 - bad experience with other public insurance programs? (If so, describe)
 - too much red tape/not worth trouble?
 - other reasons?
- Were you called by an outreach worker? If yes, why did you reject their assistance? At what point did you reject their assistance? (i.e.: was a meeting set up or did the worker get told no over the phone)
- Would you have applied for the program with the assistance of an outreach worker?
- What kinds of assistance would you have like to have had to help you through the application process?
- If you could redesign how the application process worked, how would you design it?
 - All applications through county welfare office?
 - Separate programs or just one?
- Were any of you on TANF before now? Did you know about this program through your TANF/Medi-Cal worker?

Utilization of services

- Do you currently have health insurance for your kids?
- Do you have a regular doctor for your children?
- When do you usually see this doctor? (Prevention, immunization, check-ups, acute care needs)
- Do you think that getting health insurance would make you change the amount you take your children to the doctor?

Value of health insurance

- How important do you think it is to have health insurance?
- If you could afford to go to a doctor any time you wanted – but maybe not the same doctor every time – would you feel it was necessary to have a health insurance card?
- Do you see a doctor regularly for check ups for your kids? For preventive type care? Do you think it matters?
- Do you have a relationship with one doctor who sees your kids each time? If you could have a consistent doctor, would you, or does it matter?
- What would you do if your child had a health care emergency and you didn't have health insurance?

Coverage by non-custodial parents

- How many of you don't live with your childrens' father?
- Do you know if he has insurance through his work?
- Have you tried to get insurance coverage for your kids from him? If so, what happened? If not, why not?
- What do you think prevents moms from trying to get child insurance coverage from non-custodial dads?
- What do you think the county can do, if anything, to help moms get insurance coverage for their kids from non-custodial dads?