



Evaluation of the Health Care for All Coalition Community Outreach Program

Executive Summary

June, 2000

Anne Moses
Jennifer Gera
Akiba Scroggins

Submitted to:

County of San Mateo
Human Services Agency
400 Harbor Boulevard
Belmont, CA 94002

Submitted by:

The SPHERE Institute
1415 Rollins Road
Suite 204
Burlingame, CA 94010

Director:

Maureen Borland

Project Director:

Anne Moses

Project Officer:

Ursula Bischoff

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.