Comprehensive Outreach: A New Model to Improve Children's Access to Health Care

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Although the 1990s did not close with the nation's health insurance problems resolved, as some had predicted when the decade began, Congress and then-President Clinton did attempt to solve the problem for millions of children through the State Children's Health Insurance Program (SCHIP), which became law in August 1997.[1] States will be spending more than $20 billion in the span of 5 years to enroll uninsured children into a traditional Medicaid program, a separate state-sponsored insurance program, or a combination of both approaches. As of September 30, 2000, over 3.3 million children have been enrolled in SCHIP (1).

Because SCHIP is such a significant investment of public funds and addresses such an important public policy concern, numerous agencies and organizations are closely monitoring and analyzing states' implementation of the program and federal rulemaking concerning the program.

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1 The State Children's Health Insurance Program was part of the Balanced Budget Act of 1997, Public Law 105–33. It became Title XXI of the Social Security Act.

As implementation continues, much attention is focusing on states' enrollment efforts in particular, and rightfully so. The primary goal for the program is to significantly increase the number of children with insurance, and policymakers are looking closely at how well the states are meeting this objective (2). A less stated but equally important goal for the program is to ensure that once children are covered, they receive the care they need in a timely and appropriate way, that this care is of high quality, and that it helps improve children's health status. These additional goals are being increasingly discussed in the literature.(3,4) An insurance card for SCHIP does little good unless it can buy access to care for children. Yet, while the community-based strategies, administrative mechanisms, and policy decisions concerning enrollment are moving on a very visible and creative track, efforts to make this care attainable are not nearly as prominent or well understood.

MOVING BEYOND ENROLLMENT

Since the enactment of SCHIP, the National Center for Education in Maternal and Child Health has focused attention on effective outreach not only to find and enroll children, but also to ensure their access to services (4-6). Research has shown that, although health insurance improves access to care, more action is needed to remove barriers to services presented by families themselves and by the health care delivery system (7,8). The barriers to care faced by such families are well documented and include issues such as:

- lack of transportation;
- language and cultural barriers;
- clinic hours that conflict with work schedules;
- providers' unwillingness to take Medicaid or other low-income patients;

- concern that the care offered is unresponsive to medical needs or insensitive to cultural concerns; and
- stressful living conditions and situations that make the importance of obtaining health care a low priority unless a problem becomes a dire emergency.

The Medicaid expansions, which began in the late 1980s, made policymakers and program managers more acutely aware of the myriad barriers that stand between families, enrollment in Medicaid, and the preventive and primary care services they need. These experiences are instructive as states roll out their SCHIP programs.[2]

During the years of the Medicaid expansions, some Medicaid programs also looked beyond enrollment and, through partnerships with their state Title V Maternal and Child Health programs, community-based organizations, families, the media and others, instituted additional outreach and enabling strategies to help families obtain the services they needed. Because Title V agencies and a wide variety of community groups traditionally work with and understand low-income populations, their leadership was and continues to be invaluable. Outreach and enabling strategies that have been used in the Medicaid expansions to improve access to care are available to SCHIP programs too. Examples include the following:

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[2] Because Medicaid income eligibility levels vary so dramatically across the country, children eligible for SCHIP in one state would easily be covered by Medicaid in a neighboring state. Thus, much of the research on barriers to both enrollment and to care for the Medicaid population, as well as research on outreach strategies to break down these barriers, can be applied to the target population for SCHIP.(9)

- offering bus tokens or vouchers to help ease transportation problems;
- cautiously implementing and monitoring cost-sharing requirements or not requiring them at all;
- expanding clinic hours to better accommodate working parents' schedules;
- hiring bilingual staff and preparing written materials in different languages;
- hiring care coordinators to follow up with families whose children need or have missed well-child visits;
- establishing home visiting programs that send trained lay or professional workers into neighborhoods and homes to support families in various ways, including teaching them about good health practices and how, when, and where to obtain appropriate care when needed;
- permitting presumptive eligibility so that parents can obtain temporary Medicaid or SCHIP coverage for their children, based on self-reported income and other information, at the location where they receive health care; and
- allowing continuous coverage (continuous eligibility) for up to a year so that children do not lose coverage during that time and also so that they and their families have a better opportunity to take advantage of preventive care benefits and develop a relationship with their health care providers.

PUTTING THE PIECES TOGETHER FOR POLICYMAKERS

The three features of health policy have traditionally been access, cost, and quality of care. For the past several years, however, the most prominent policy focus has been how to slow

and contain escalating costs. During this era of intense cost containment and the accompanying rapid growth of managed care, improving and assuring quality has become a more critical and visible concern. While access to care is addressed in the cost and quality debates, it is often equated with having access to financial coverage for services, and outreach has been limited to strategies that encourage enrollment in these coverage programs. For instance, the statutory purpose of outreach funds for SCHIP is to inform families of eligible children about SCHIP and assist them in enrolling in the program.

While having insurance certainly does improve access to care, outreach to get children covered is not the same as outreach to ensure that they obtain services. This is especially true for children in low income and working poor families, such as those eligible for Medicaid and SCHIP. Improving access for children must include outreach and enabling strategies to help parents gain access to both coverage *and* care for their children.

From a policymaking perspective, the growth of managed care has the potential to address all 3 aspects of the health policy triad: containing costs, assuring quality, and improving access to care. However, considerable work is still needed on the part of state Medicaid and SCHIP agencies, accreditation organizations, and the managed care plans themselves to make this potential become reality. This is especially the case for children enrolled in managed care, about whom little is known (10). Even though most state programs are enrolling children in some form of managed care, they are only in the early stages of developing performance measurement systems to determine the degree to which children have access to quality care in a timely manner (11). States still have to develop adequate action plans for what steps they will take if managed care organizations do not meet their access to care requirements (12,13).

If ever there was a need for agencies and sectors to cross boundaries, learn from each other, and promote one another's good ideas, it is now. While all SCHIP programs involve some form of collaboration, the key players' collective strength is needed to develop policy, administrative, and programmatic mechanisms that not only can establish effective outreach to find and enroll eligible children, but also can help ensure access to care. As many learned with the Medicaid expansions for children and pregnant women in the late 80s and early 90s, a better program will be crafted when decisionmakers in health care financing, public health, and direct service provision join with families and community groups to develop a long-range vision and action plan for children eligible for SCHIP (14,15).

DESCRIPTION OF COMPREHENSIVE OUTREACH MODEL

We propose that a more comprehensive model of outreach and related enabling strategies is needed to give decisionmakers a visual and practical tool for planning, developing, and evaluating an effective mix of methods to ensure better enrollment and access to care (Figure 1). While the term "outreach" has typically included a range of administrative and community-based mechanisms plus public information efforts to increase enrollment, our definition is broader in terms of the types of strategies we include and the timeframe throughout which outreach occurs.

Similar to other models for tracking SCHIP (16), our comprehensive outreach model is a continuum that includes identifying uninsured eligible children, enrolling and retaining them in the program, increasing their appropriate use of services, redetermining their eligibility, and easing their transition off the program or into another program if and when indicated. Based on the model, we have also developed a checklist (Figure 2) to help identify, track and coordinate the various outreach policies that can be adopted and initiatives that can be

implemented. It is our hope that, when taken together, these tools can be used to improve the effectiveness of each step along a child's journey from being uninsured to coverage, receipt of appropriate care and, ultimately, improved health (17).

Stakeholders in SCHIP can use this model and checklist in many ways:

- to ensure a good combination of outreach efforts that compliment each other and meet the needs of eligible children and their parents from enrollment through service delivery;
- to educate policymakers about how each initiative affects the dual goals of enrolling and ensuring care for children;
- to improve working relations between public agencies or between agencies and communities to create a range of administrative mechanisms and grassroots outreach strategies, such as presumptive eligibility, home visiting, or working with schools to enroll eligible children and provide information about available services; and
- to promote teamwork between agencies that can lead to joint funding of one or more outreach initiatives and joint efforts to evaluate these initiatives.

Benefits of a Comprehensive Outreach Model

Such a comprehensive model of outreach can promote better planning and budgeting. While a state is working to enroll eligible children, it can also be planning for how its enrollment strategies can help these same children gain access to care. For instance:

- a marketing campaign about the availability of SCHIP coverage can also include follow-up messages regarding where, how, and why to bring a child in for a well-child checkup;
- home visitors from community-based organizations who are sent out to recruit eligible children can also be trained to help families appropriately use the health care system,

improve patients' understanding of and compliance with treatment plans, and assist providers' understanding of patients' cultural and health belief systems;

- presumptive eligibility workers in a clinic can talk with parents about the typical schedule of well child exams and immunizations, discuss the best ways to set up an appointment, and give them a list of important phone numbers to have on hand; and
- state contracts with managed care organizations can include requirements that a set of outreach strategies be developed and implemented with data collected on their effectiveness in achieving specified access to care goals.

Conceptualizing outreach along a continuum and implementing strategies with this perspective also can benefit states' evaluations of SCHIP. The model can assist in structuring data collection instruments, interpreting the data, and making programmatic changes based on the findings. Strategies on the checklist can be analyzed and how they interrelate and benefit one another can be determined. More meaningful evaluations can be conducted that track how a combination of outreach strategies affect the successful passage of a child through each step of the model. Surveys of patient/client satisfaction, which are becoming more widely-used evaluation tools, can be especially useful for this type of inquiry. For instance, a recent study based on in-person interviews found that how a person believes he or she will be treated when applying for Medicaid and when seeking health care services significantly affect his or her willingness to enroll. This is in contrast to the widely held notion that people do not sign up for Medicaid due to how they would feel about themselves for being on Medicaid (the "welfare stigma") (18). Satisfaction surveys can identify how well enrollment processes and health care services are being delivered and received by enrolled children and their parents, and corrective measures can be taken where needed.

As part of the federal statutory requirements, states are required to evaluate whether their SCHIP programs achieve the goals of reducing the number of uninsured children and improving children's access to health care (19). In order for states to interpret the outcomes of their programs, they must first understand how well the outreach strategies to enroll and improve access to care were implemented. Evaluation of outreach is fundamentally important to the overall goals of the SCHIP program and many states' evaluations include an examination of outreach to some extent.[3] This comprehensive model and checklist identify points along the continuum at which outreach efforts can be evaluated.

Identifying the Uninsured, Eligible Population

Our comprehensive outreach model begins with identifying the uninsured, eligible population. For instance, the checklist questions include who the children are, where they live, why they are uninsured, and where they typically go for health care. We include this background research effort in our definition of outreach because characteristics of the

[3] As program evaluations for SCHIP are being structured and implemented, the usefulness of existing national and multi-state data sets are being reviewed for their applicability to the SCHIP experience (16, 19-21) and the need for new data collection tools and strategies are being reviewed. One potentially useful tool is the Consumer Assessment of Health Plans (CAHPS) which is a new quality of care tool for measuring patient satisfaction (21). A specific CAHPS for children has been developed and could provide insight into what helps or hinders parents in accessing care for their children, including children with special health care needs and those enrolled in Medicaid managed care systems. These data illustrate the kind of information that is helpful to policymakers and program managers as they implement and monitor the impact of outreach and enabling strategies.

eligible population should affect the choices made about outreach, and they clearly will affect the success of the outreach strategies that are used. Although states vary in the types of data they have at their disposal and in their ability to conduct this type of research, any data they have can be reviewed to help target the strategies. The strategies themselves then can be evaluated and refined over time so that they more accurately target the population in need.

Cultural Competency

Recent decades have seen an increasing influx of immigrants into the United States and a growing awareness of cultural and ethnic concerns among these groups. In addition, the importance of honoring cultural belief systems about health and health care has grown within the health care community as leaders seek to reach and serve different at-risk population groups. To succeed, outreach efforts need to reflect an awareness of, sensitivity to, and competency with different groups' beliefs and concerns. This priority is highlighted throughout our model and checklist.

The importance of cultural competency is particularly evident in the grant programs administered by the federal Maternal and Child Health Bureau (MCHB). For many years, MCHB has emphasized the need for all its grantees to address cultural competency. For instance, an evaluation of the Healthy Tomorrows Partnership for Children Program (HTPCP) found a good deal of innovation and creativity in the approaches used by the HTPCP projects (22). These include a wide variety of staff recruiting and training strategies, the use of culturally appropriate communication methods and marketing techniques, and efforts to tap resources in the community to improve cultural relations and understanding. Thirty-six states and territories have or have had HTPCP projects in one or more of their

communities (22). These and other states can refer to their strategies and expertise when developing and enhancing cultural competency in SCHIP.

Simplifying the Eligibility Determination and Enrollment Processes

Many state Medicaid agencies have teamed up with Title V agencies, community health centers, community-based organizations, and others to develop simplified application forms and processes for Medicaid and now for SCHIP. Several such strategies are noted in our checklist. These include devising shortened application forms, allowing them to be mailed in or faxed in, and posting them on web sites. Also, every state has involved schools and health care providers in more targeted outreach efforts; most have toll-free hotlines and advertising campaigns (2). While some states have written their application forms and other materials at appropriate reading levels, many have not but should. Additionally, translating forms and materials into the languages of eligible families and children is commonly done in some locations, but must be universally done. In fact, the Department of Health and Human Services issued policy guidance in late summer 2000 for all health and human service providers to ensure that persons with limited English skills can effectively access health and social services, including SCHIP (23).

Outstationing eligibility workers in health care sites frequented by the target population can also be an effective technique to both increase enrollment and improve the use of services (24). Presumptive eligibility has been shown to be effective in enrolling children (25) and brings the application and enrollment processes out of the welfare office and into the community to facilities where eligible children and families come for health care. With presumptive eligibility, a child can obtain immediate, temporary coverage and receive needed

care while the formal application is processed. It is another good example of an outreach strategy that can improve both enrollment and access to care.

Cost Sharing. Yes? No? How Much? Cost sharing can be an enabling strategy that affects enrollment and access to care, depending on the type and amount of cost sharing a state chooses to impose and how and when it decides to collect the amount owed. Most states that have established non-Medicaid SCHIP programs have instituted some form of cost sharing (13). This policy decision has a major impact on program design and is made more difficult by conflicting research findings on what levels and types of cost sharing are appropriate (26). Because cost sharing can affect both enrollment and service utilization rates, care must be taken to monitor the effects of whatever types of cost sharing are imposed. States should be prepared to make adjustments as needed along the way.

Retention and Continuity of Coverage

Ensuring continuous eligibility or continuity of coverage for a guaranteed period of time regardless of fluctuations in family income has been shown to be effective in retaining children in Medicaid and is being used by SCHIP programs in 18 states (2). How often a program requires family members to have their eligibility redetermined varies, but it can be as often as every few months. If a family's circumstances have changed during that time, then the eligible members can lose their coverage and may or may not reapply at a future date, even if their circumstances worsen. Some states have simplified forms and mechanisms for the eligibility redetermination process that families must go through to maintain their children's coverage over time.

Continuity of coverage is permitted for up to a year and eliminates the barrier to care, at least for this long, that is presented by cycling on and off a coverage program due to fluctuations in family income. It is especially important in helping a covered child obtain preventive well-child care and immunizations that are needed only on a periodic basis. It also gives a family time to develop a relationship with a primary care provider, which in turn offers the child a medical home. For a child enrolled in managed care, this gives parents time to learn how to negotiate the system, the child is in the program long enough to receive appropriate health care services, the managed care organization has an incentive to be sure the child gets in for well-child checkups and stays as healthy as possible, and the state's investment in finding and enrolling the child is protected.

Utilization of Services: Turning Coverage into Care

Once enrollment is secured, traditional outreach usually ends. Typically, state Medicaid agencies and the federal Health Care Financing Administration concern themselves with enrolling individuals, covering certain benefits, signing providers up to participate, and paying the bills that come in. However, beginning with the Medicaid expansions for children and pregnant women, many state Medicaid agencies teamed up with Title V agencies and others to identify and implement strategies to help Medicaid cards buy the care that was needed. Now with SCHIP, the opportunity is available again, and a more comprehensive model for outreach and related strategies can help ensure that such collaborations and cross-fertilization of ideas continue and flourish.

Enabling Strategies to Remove Barriers to Care. If a state program is knowledgeable about its target population for SCHIP coverage, numerous strategies are at the state's disposal for improving the likelihood that enrolled children will receive timely and appropriate care:

- Clinic hours can be extended to accommodate parents who work at times other than the day shift or 9 to 5.
- Bus tokens or vouchers can be given to parents to help them get their children to clinic visits.
- Orientation programs can be offered or required to inform newly enrolled children and families about procedures of their managed care plan, what is appropriate use of the emergency room, when to call the doctor or nurse and what to say about a child's illness, and what other matters may affect access to care.
- Reminder cards can be sent or phone calls made to parents for well child visits or immunizations that are coming due.
- Television or radio ads can be placed at key times during the day to remind parents to take their children in for preventive well-child checkups and immunizations.
- Home visiting programs that use trained professionals or lay workers can be established in targeted neighborhoods to help families better understand what their health needs may be, how to make and keep appointments, how to maintain good health, and how to become self-sufficient in making those decisions and reaching those goals.
- Cultural competency among service providers, office receptionists, and others can be enhanced through using educational programs; hiring bilingual staff members; and preparing patient educational materials in appropriate languages, at appropriate reading levels, or in video formats. These steps can encourage parents to take care of their health and that of their children, to make and keep appointments for their children, to ask questions when needed, and to follow the instructions they are given.
- Hotlines can be established to take calls from parents who are looking for a primary health care provider for their children or have other questions.

- Adequate provider participation in SCHIP can be assessed and steps taken to assure service availability for children. The same providers who accept Medicaid can be recruited to accept SCHIP and visa versa. This can help children stay with the same provider over time, even if their source of coverage changes. This is a serious problem in many areas of virtually all states, especially in rural communities and inner city neighborhoods.

Eligibility Redetermination and Transition

When a child's eligibility is redetermined, he may or may not be found still eligible. It is crucial that SCHIP programs help ensure that the child continues to have coverage and access to care by instructing eligibility workers or other front line workers to inform parents of their options, such as traditional Medicaid, another locally-based or statewide insurance program for lower income families, or possibly health insurance through a parent's employer. By considering this phase of children's coverage status up front, states can institute processes to ensure that children do not fall through the gaps between programs and coverage options and lose their eligibility as well as access to care.

Assuring a child continues to have coverage either through Medicaid, SCHIP, or another source for which he is eligible is an acute problem in most states. This is particularly the case since the 1996 welfare reform law. As families move from welfare to work, states have seen their Medicaid enrollment numbers decrease, despite the implementation of SCHIP, with more than half of these individuals becoming uninsured (27). For instance, many families are automatically dropped from Medicaid when they lose their TANF benefits whether they are still eligible for Medicaid or not. Families often do not know, and are not

being told, that they and/or their children could still be eligible for Medicaid (or SCHIP or another coverage program) even though they are no longer eligible for TANF (9).

CONCLUSION

The State Children's Health Insurance Program offers the nation a tremendous opportunity to improve children's health. While the primary goal of SCHIP is to increase the number of children with health insurance, SCHIP also can be a catalyst to break down barriers to care once and for all. For such additional goals to be met, decisionmakers at all levels need a long-range vision of what they can do -- together -- to successfully take uninsured children through the enrollment process, retain children's enrollment over time, and remove barriers so that children gain access to appropriate care. The only way to reach that goal is for SCHIP, Medicaid, Title V, and other state agencies along with families, schools, community-based organizations and others to understand this comprehensive view and commit themselves to a range of well-developed, effective initiatives. Leadership and a well-articulated vision of what can be accomplished are also necessary ingredients to bring and keep these stakeholders at the table.

We have developed a comprehensive, continuum model of outreach and a checklist of strategies that work to help a family enroll their child or children, retain that enrollment, and gain access to appropriate and timely care. Strategies can be implemented to improve the likelihood of success at each step in the outreach process. As SCHIP is evaluated and refined in the states, finding ways to ensure that the SCHIP card will actually buy appropriate services will become more obvious and important. These tools can help states

present a comprehensive vision of outreach and enabling strategies, such as we have described here, which in turn can help decisionmakers as they work toward achieving enrollment and access to service goals for children and their families.

References

1. Health Care Financing Administration. *State Children's Health Insurance Program (SCHIP): Aggregate enrollment statistics for the 50 states and the District of Columbia for Federal Fiscal Year (FFY) 2000.* www.hcfa.gov/init/fy2000.pdf. Accessed April 7, 2001.

2. National Governors' Association and National Conference of State Legislatures. *The 1998 State Children's Health Insurance Program annual report.* Arlington, VA: National Center for Education in Maternal and Child Health, 1999.

3. Shi L, Oliver TR, Huang V. The Children's Health Insurance Program: Expanding the framework to evaluate state goals and performance. *The Milbank Quarterly.* 2000; 78(3):403-446.

4. Carpenter MB, Kavanagh LD. *Outreach to children: Moving from enrollment to ensuring access.* Arlington, VA: National Center for Education in Maternal and Child Health, 1999.

5. Summer L, Carpenter MB, Kavanagh LD. *Successful outreach strategies: Ten programs that link children to health services.* Arlington, VA: National Center for Education in Maternal and Child Health, 1999.

6. MCH program interchange: *Focus on outreach.* Arlington, VA: National Center for Education in Maternal and Child Health, 1999.

7. Short PF, Lefkowitz DC. Encouraging preventive services for low-income children: The effect of expanding Medicaid. *Med Care* 1992; 30:776-780.

8. US General Accounting Office. *Prenatal care: Medicaid recipients and uninsured women receive insufficient care.* GAO-HRD-87-137. Washington, DC: US General Accounting Office, 1987.

9. Summer L, Parrott S, Mann C. *Millions of uninsured and underinsured children are eligible for Medicaid.* Washington, DC: Center on Budget and Policy Priorities, April 1997.

10. Bergman DA, Homer CJ. Managed care and the quality of children's health services. *The Future of Children: Children and Managed Care* Los Altos, CA: The David and Lucile Packard Foundation. 1998. 8(2): 60-75.

11. Crooks GM, Meyer JA, Bagby NS. *Quality health care for children in SCHIP: A guide for state legislators.* Washington, DC: New Directions for Policy, 1999.

12. Meyer JA, Bagby NS. *Beyond enrollment: Are SCHIP plans linking children to quality health care?* Washington, DC: New Directions for Policy, 1998.

13. Edmunds M, Teitelbaum, M, Gleason, C. *All over the map: A progress report on the State Children's Health Insurance Program (CHIP).* Washington, DC: Children's Defense Fund, 2000.

14. Hill IT, Bennett T. *Enhancing the scope of prenatal services.* Washington, DC: National Governors' Association, 1990.

15. Margolis PA. The rest of the access-to-care puzzle: Addressing structural and personal barriers to health care for socially disadvantaged children. *Arch Ped Adolesc Med* 1995; 149:541-545.

16. Halfon N, Inkelas M, DuPlessis, Newacheck PW. Challenges in securing access to care for children. *Health Affairs.* 1999; 18(2): 48-63.

17. Flanders G and Gonzalez R. CHIP: Outreach and enrollment. In occasional series: *The State Children's Health Insurance Program: Insuring More Kids -- Options for Lawmakers*. 1999. Denver, CO: National Conference of State Legislatures.

18. Stuber JP, Maloy KA, Rosenbaum S, Jones KC. *Beyond stigma: What barriers actually affect the decisions of low-income families to enroll in Medicaid?* Washington, DC: The George Washington University Medical Center, School of Public Health and Health Services, 2000.

19. *Evaluating CHIP -- A "how to' for states* and *state and federal health data sources: an inventory for CHIP evaluators.* 1998. Portland, ME: National Academy for State Health Policy.

20. *Framework and user's guide for state evaluation of the Children's Health Insurance Program.* 1999. Portland, ME: National Academy for State Health Policy.

21. Crooks GM, Meyer JA., Bagby NS. Quality health care for children: A guide for state legislators. 1999. Washington, DC: New Directions for Policy.

22. Eisen N, Evans J, Kavanagh L, Athey J, Schwab J. *The Healthy Tomorrows Partnership for Children Program in review: Analysis and findings of a descriptive survey*. 1999. Arlington, VA: National Center for Education in Maternal and Child Health.

23. Department of Health and Human Services. *HHS provides written guidance for health and human services providers to ensure language assistance for persons with limited English skills*. Press release. www.hhs.gov/ocr. Accessed August 30, 2000.

24. US General Accounting Office. *Prenatal care: Early success in enrolling women made eligible by Medicaid expansions.* Washington, DC: US General Accounting Office, 1991.

25. Rosenbach ML, Irvin C, Coulam RF. Access for low-income children: Is health insurance enough? *Pediatrics*. 1999; 103: 1167-1174.

26. Gauthier AK, Schrodel SP. *Expanding children's coverage: Lessons from state initiatives in health care reform.* Washington, DC: Alpha Center, 1997.

27. *Losing health insurance: The unintended consequences of welfare reform.* Washington, DC: Families USA Foundation, 1999.

COMPREHENSIVE OUTREACH

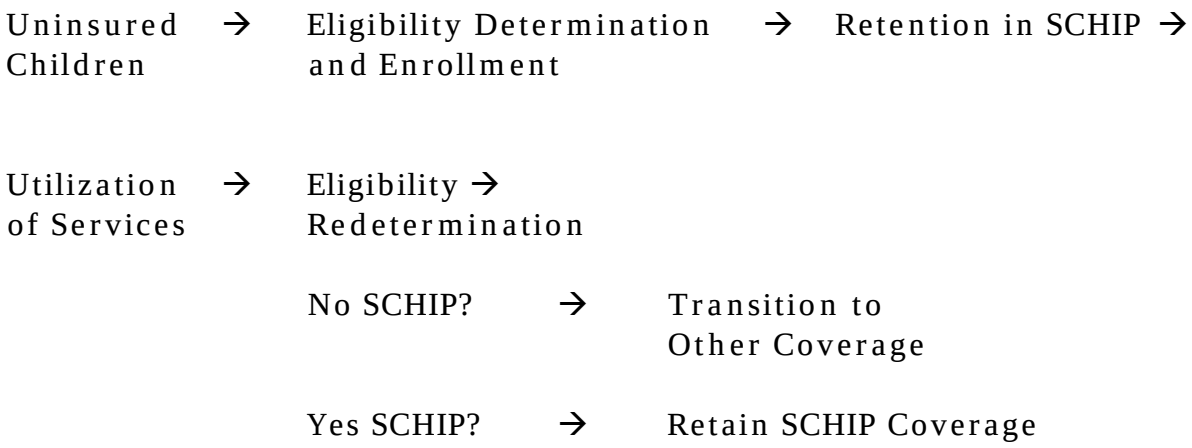

Figure 1

Checklist of Outreach and Enabling Strategies to Improve Children's Enrollment and Access to Care in the State Children's Health Insurance Program (SCHIP)

Identifying the Uninsured, Eligible Population

- Who are the uninsured children in our state?
- What racial/ethnic/cultural groups are represented?
- Where do they live?
- Why are they uninsured?
- What proportions are at what income levels?
- Where do they typically obtain primary health care?

Eligibility Determination and Enrollment Processes

- Simplify application processes by shortening forms, allowing forms to be mailed in, faxed in, or e-mailed in.
- Identify community organizations and groups to collaborate with, including schools, churches, synagogues, community service groups (e.g., Kiwanis and Lions clubs), Boy and Girl Scout troops, local business groups.
- Establish and coordinate toll-free hotlines.
- Develop targeted advertising campaigns.
- Prepare culturally competent and sensitive program materials and messages in languages understood by target populations. Ensure that reading level is appropriate for target groups.
- Outstation eligibility workers in community health centers and other health care sites frequented by the target population.
- Implement presumptive eligibility in health care sites frequented by the target population.
- Implement cost sharing cautiously and carefully and monitor closely.

Retention and Continuity of Coverage in SCHIP

- Simplify eligibility redetermination forms and processes.
- Train eligibility workers about importance of cultural competence and sensitivity in assisting families.
- Implement continuous coverage for children and pregnant women for one year.

Utilization of Services: Turning Coverage into Care

- Extend clinic hours.

- Offer bus tokens and vouchers.
- Require managed care programs to provide orientation programs for newly enrolled families.
- Have participating providers send out reminder cards when well child visits and immunizations are due.
- Establish and link hotlines.
- Place television and radio ads at key times to remind parents to take children to well child visits.
- Establish home visiting programs to help families enroll and appropriately seek and use services.
- Educate providers and office staff on cultural competency issues.
- Work with providers to hire bilingual staff, prepare patient educational materials in appropriate languages, written at appropriate reading levels or in video formats.
- Involve families and key community groups in program planning, implementation, and evaluation efforts.

Eligibility Redetermination and Transitioning from SCHIP to Other Programs

- Simplify forms and processes.
- Identify alternative programs and sources of care in addition to Medicaid for children transitioning off SCHIP.
- Train eligibility workers to understand the importance of referring children to other sources of coverage and care.
- Implement continuous coverage for children and pregnant women for one year.

Figure 2