COVERING
KIDS AND
FAMILIES
EVALUATION

Reaching out to
Enroll Children in
Public Health
Insurance: The
CKF Grantees and
their Experiences

Embry Howell
Brigette Courtot

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INTRODUCTION

In 1997 the U.S. Congress created the State Child Health Insurance Program (SCHIP), following several years of expansions of the Medicaid program for children (Mann, Rowland and Garfield 2003, Rosenbaum and Sonosky 2001). The combination of these actions created an entirely new situation in which the large majority of low-income children were entitled to health insurance, either through their parents’ employer or one of these two public programs. The number of children enrolled in public programs grew steadily between 1999 and 2004 (Figure 1). In spite of this growth, many children remain uninsured (Dubay and Kenney 2004).

![Figure 1](image)

**Figure 1**
Trends in Public Health Insurance - Number of Children Ever Enrolled 1999-2002

Note: Medicaid enrollment data for the years 2003 and 2004 are unavailable.

At the time SCHIP was implemented, policymakers were aware of the problem of lack of participation by eligible children in public programs. In 1996, following the Medicaid expansions for children, about 50 percent of income-eligible children were enrolled in Medicaid and about a quarter were enrolled in private insurance, but 22
percent of potentially eligible children remained uninsured (Selden, Banthin, and Cohen 1998). The authors of the SCHIP legislation, recognizing the need to improve rates of children’s coverage, provided funding for outreach in order to encourage participation in both public health insurance programs. This emphasis on outreach for child public health insurance programs contrasts with Medicaid’s traditional focus on enrolling children whose parents came to central sites to apply for benefits.¹

SCHIP outreach funding is large, but declining. Figure 2 shows SCHIP outreach expenditures for the 12 states that reported this measure to CMS in their annual reports for FY 2001, 2002, and 2003. (Other states’ reports were incomplete for one or more years in this period.) Total SCHIP outreach expenditures for these 12 states declined from $43 million to $15 million (although four of the states increased SCHIP outreach expenditures). The decline was greatest in two large states, California and Texas, which together accounted for about half of the decrease across the 12 states.

¹ “Outreach” is defined in the American Heritage dictionary as “The act or process of reaching out” and further “A systematic attempt to provide services beyond conventional limits.”
Several qualitative studies have described the large variety of outreach programs sponsored by SCHIP funds (Wooldridge, Hill, Harrington, et al. 2003; Cohen Ross and Hill 2003), as well as the process of slow retrenchment in SCHIP-funded outreach after the initial intensive focus on it (Cohen Ross and Cox 2004; Hill, Courtot, and Sullivan 2005). Although SCHIP-funded outreach varies from place to place, the SCHIP outreach programs have taken two major forms: (1) broad media outreach and (2) targeted community-based outreach using in-person contacts through, for example, partnerships with community-based organizations.

In spite of good qualitative knowledge of the types of SCHIP outreach programs that have been implemented, and the recognition that outreach is important to improve the rate of health insurance coverage, there have been few quantitative studies that document which outreach methods are effective. One comprehensive literature review uncovered little quantitative evidence concerning the effect of outreach on public
program enrollment (Remler and Glied 2003). In another study in California, Aizer (2003a) found no relationship between the number of community-based application assistants (who in California are paid through SCHIP outreach funding) in a zip code and the number of new Medicaid enrollees from that zip code. However, she found different effects for children with language barriers. Both Hispanic and Asian parents were more likely to enroll their child if they lived near a bilingual application assistant or were exposed to advertisements in their language (Aizer 2003b).

Recognizing that the additional funding provided through the SCHIP program was unlikely to solve the problem of uninsurance in children, the Robert Wood Johnson Foundation (RWJF) provided substantial additional outreach funding through, first, the Covering Kids (CK) program and then, beginning in 2002, the Covering Kids and Families (CKF) program. Covering Kids and Families is a four-year, $55 million initiative to increase the number of children and families with health care insurance coverage, operating through 45 statewide grantees (and the District of Columbia) that sponsor over 140 local community projects (Covering Kids and Families 2005). These grantees and projects use three strategies to promote enrollment: outreach; simplification of the enrollment and renewal processes; and coordination between health care coverage programs.

The CK program coincided with the initial SCHIP outreach efforts, and the CKF program began its activities around the time that states were beginning to pull back from intensive SCHIP outreach. Thus CKF outreach funding has helped to fill a growing outreach funding gap.
METHODS

About the same time that it began CKF, the RWJF funded an evaluation of the program. Mathematica Policy Research is conducting the evaluation in partnership with the Urban Institute and Health Management Associates. The evaluation uses a variety of data collection approaches, which include site visits, telephone interviews, grantee quarterly reports, surveys, and enrollment files. This report is one of a series of special reports or analyses that have been produced throughout the evaluation. Through it, we provide new data describing CKF outreach programs, and we synthesize findings from other evaluation reports.

Much of the information in this report derives from a web-based quarterly reporting system developed for the evaluation (Howell and Beuttgens 2003). We provide data for seven quarters, beginning in first quarter, 2003 and ending in third quarter, 2004. During 2002, not all grants had been awarded and grantee reporting was phasing in. Following the third quarter, 2004, grantees began reporting in six-month intervals, so the data are not comparable. In addition, ten grants end in December 2005, so grantees and local projects may have begun phasing down outreach to an unknown degree. Thus, the data presented here are for the “mature” CKF program, during 2003 and most of 2004, after all programs were fully implemented and before they began phasing down. Reporting system data are self-reported by the grantees and their local projects, so measures such as the number of sites, events, attendees, or applications assisted were estimated by them. See Appendix A for more detail on the quarterly reporting system and how the data have been used for this report.
To provide a better-rounded picture of CKF outreach, we also include qualitative information from the on-line system (from the open-ended narrative report sections), site visits, telephone interviews, and a meeting of grantee staff where they discussed outreach. The site visits were conducted in 10 states from March through June 2003.2 Each visit included trips to the state capital (the location of the state grantee) and to two local project sites (usually one urban and one rural). Respondents included state grantee and local project staff, coalition members, Medicaid and SCHIP officials, Department of Social Service officials, health care providers, child health advocates, and health plan representatives. CKF state project directors and 2 local coordinators in 36 states were interviewed by telephone in November and December 2003 (accounting for all but the 10 states that were selected for site visits). Interviewers asked both state and local staff about their outreach approaches, why they chose to focus their efforts on outreach, and outcomes from the outreach they conducted.

FINDINGS

State grantees selected their local projects as “laboratories” or pilot sites, where different outreach approaches could be tested. Both state grantees and their local projects consistently reported heavy involvement in a wide variety of outreach activities. Indeed, 59 percent of state projects and 77 percent of local projects reported in telephone interviews that outreach activities consumed a majority of their resources (Paxton, Wooldridge, and Stockdale 2005). Projects reported that they concentrate their efforts on outreach, because they perceived this to be the best way to achieve “quick, perceptible

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2 The states were: Arkansas, California, Colorado, Illinois, Massachusetts, Minnesota, New Mexico, New York, Texas, and Virginia.
results” (Hoag et al. 2005). In the following sections, we first describe the approaches that grantees and their local projects have taken to outreach, from broad media outreach to more intensive in-person outreach. Then we describe in more detail targeted outreach approaches, such as school outreach, that grantees have used to reach special audiences. Finally we present the limited evidence that is currently available on the effectiveness of these approaches.

Media Outreach

Using media for outreach is a way to reach a large audience and create broad awareness, and CKF grantees and their local projects have employed a variety of media approaches. They reported using media to inform the broad public, as well as specialized audiences such as specific ethnic groups, about the availability of health insurance and how to get more information or apply for coverage.

While CKF grantees did not use a large percentage of their budgets for media campaigns (only 12 percent of funds are spent on media by state grantees and 6 percent by local projects— Paxton, Wooldridge, and Stockdale 2005), they described creative approaches that maximized their resources. Table 1 lists the types of media outreach that CKF projects conducted. As shown, 91 percent of state grantees and 68 percent of local projects reported some media activity in the third quarter of 2004.

Both state and local projects drew heavily on the media materials they received from GMMB, the media contractor that RWJF hired to provide technical assistance. Grantees and local projects spoke very positively of the assistance they received from GMMB in their media outreach. One site visit respondent commented, “The materials we receive from the CKF program are wonderful,” and another, “The Covering the
Uninsured Week activities make sense, because we are able to use national CKF materials and capitalize on the publicity surrounding the larger, national event.” CKF projects have, through this technical assistance, become more “media savvy” over time, as the number of media mentions of CKF has grown for television, radio, and print media (data not shown).

A large majority of state grantees reported using newsletters, listserves, or mailings (or some combination of these) to reach specific constituencies. For example, they may have included their coalition and other community partners in their listserv, or may have used a targeted mailing to reach all parents of a particular type (for example, parents of school children). These approaches were more commonly reported by state grantees (82 percent) than local projects (34 percent).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Types of Media Outreach</th>
<th>Covering Kids and Families State Grantees and Local Projects</th>
<th>Third Quarter, 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Media Activity</td>
<td>State Grantees 91%</td>
<td>Local Projects 68%</td>
<td></td>
</tr>
<tr>
<td>Any Newsletters, Listserves, Mailings</td>
<td>82%</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>Any Earned Media¹</td>
<td>58%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Any Media Mention</td>
<td>51%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Any Public Service Announcements</td>
<td>29%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Any Paid Advertising</td>
<td>29%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Number of Grantees Reporting</td>
<td>45</td>
<td>142</td>
<td></td>
</tr>
</tbody>
</table>

*Note: 1. “Earned Media” refers to instances where grantees or projects sent press releases, Op-ed pieces, or letters to the editor.
Source: Covering Kids and Families Web-Based Reporting System, 2004.*

Grantees and local projects also frequently employed “earned media” (press releases, op-ed pieces, or letters sent to the editor). This approach resulted in frequent media mentions. For example, 51 percent of state grantees and 43 percent of local projects were mentioned in the media (either television, radio, or print) in the third
quarter of 2004. In addition, 29 percent of state grantees and 27 percent of local projects used public service announcements (which they did not have to pay for) frequently, as well as paid advertisements (more often on radio or in print than on television).

CKF grantees often used another inexpensive media approach - posters that they displayed and brochures that they passed out to families. These materials can be used both for broad outreach and for more targeted outreach when combined with in-person contact. During site visits, grantees told us that it was essential to give people they met written materials to take home. Often the state grantee assisted the local project by developing materials that could be further refined for a local audience. The brochures and posters frequently contained the telephone number for a central “hot line,” or some other place to call for more information.

Figure 3 illustrates that media outreach was more frequent during certain times of the year, particularly for local projects. The seasonal pattern is more obvious for school-specific media activities such as school mailings, which were concentrated in the third quarter, as illustrated in Figure 4. The seasonality in CKF-sponsored media activity is
largely explained by the media support that projects received during both “Covering the Uninsured Week” in the spring and (especially) “Back to School” in the late summer and early fall. The RWJF provided intensive technical assistance to CKF grantees at these times of the year.

Table 1 and Figure 3 also show that state grantees were more likely to use media outreach than local projects, and the differences in the media activities that each undertook different types of media activities. A much higher proportion of state grantees than local projects used newsletters, listserves, or mailings. On the other hand, more local projects used school mailings, which required the cooperation of local school districts and schools (Figure 4). The data from the reporting system indicating that state projects were more involved in media outreach than local projects was confirmed in telephone interviews. While about a third of state projects mentioned media outreach as their most time-consuming activity, very few local projects did so.
It is not surprising that, in general, state projects were more involved in media outreach than local projects. State projects had a statewide audience for their outreach, and this large audience was easier to reach with media. In addition, different types of organizations were implementing state and local projects. Half of the state projects were advocacy organizations, and thus had more experience with media and reaching broad audiences, while a majority of local projects were community based organizations (Paxton, Wooldridge, and Stockdale 2005), had daily in-person contact with families, and thus were more oriented to in-person outreach. Also, the budgets of state projects were larger than local projects, providing them with more resources for media efforts.

Media outreach and other forms of outreach were often intertwined. An outreach event (for example, a well-advertised health fair) may have attracted media attention. This happened particularly during the Back-to-School period when events and other efforts to “earn” media attention were planned together. During the 2003 site visits, project representatives spoke of the challenge of keeping such events “fresh” and interesting, so that media would be attracted to them.

In-Person Outreach

In-person outreach is a way to provide specific information about health insurance for children to smaller groups or individuals. During our site visits, one respondent said, “In-person outreach activities are very labor-intensive, but in-person contact is absolutely necessary to make sure people are comfortable and can navigate the system.”

All state grantees and local projects used in-person outreach regularly, and it was the primary activity of most local projects. CKF grantees and their local projects used the following four types of in-person outreach:
1. **Presentations and Training Sessions**: These were used for professional audiences, parent groups, employers, or other community groups to provide them with the information they needed to encourage families to enroll their children.

2. **Outreach Events**: A variety of events (such as health fairs) that were either sponsored by CKF grantees or by other organizations, with CKF participation.

3. **Fixed Outreach/Enrollment Sites**: CKF projects may have supported outreach or enrollment sites staffed by other organizations, by providing information and materials. Projects may have also placed CKF staff at selected sites (for example, schools, clinics, or social service agencies) where they provided information on health insurance and (often) filled out applications with families.

4. **One-on-One Outreach**: In this most intensive form of outreach, CKF grantees worked with families individually at various community locations.

Table 2 illustrates that all CKF grantees and local projects used in-person outreach. The most common form was outreach events (100 percent of state grantees and local projects), followed by outreach at fixed outreach or enrollment sites (80 percent and 70 percent respectively); presentations and training sessions (76 percent/40 percent); and one-on-one outreach (24 percent/46 percent).
### Table 2
Types of In-Person Outreach
Covering Kids and Families State Grantees and Local Projects
Third Quarter, 2004

<table>
<thead>
<tr>
<th></th>
<th>State Grantees</th>
<th>Local Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentations or Training Sessions</td>
<td>76%</td>
<td>40%</td>
</tr>
<tr>
<td>Outreach Events</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Fixed Outreach/Enrollment Site</td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>One-on-One Outreach</td>
<td>24%</td>
<td>46%</td>
</tr>
<tr>
<td>Number of Grantees/Projects Reporting</td>
<td>45</td>
<td>142</td>
</tr>
</tbody>
</table>


Presentations and Training Sessions. CKF staff viewed themselves as a key source of training for community partners about public health insurance eligibility and enrollment (Wooldridge et al. 2003b). To accomplish this goal, CKF grantees and local projects conducted a large number of presentations or training sessions for various audiences, even while acknowledging that presentations and training sessions are time-consuming (they include planning, preparation of materials, and the sessions themselves).

In the third quarter of 2004 alone, CKF grantees and projects sponsored 1,165 of these presentations and training sessions, which were attended by 23,529 individuals. Since events often “train the trainers,” their ultimate reach was much larger. For example, one CKF state grantee staff member spoke of traveling around the state to meet with all local public health departments. The issues she spoke with them about included “how the problem of uninsurance affects them directly, the specific actions they could take to help enroll children, and how to get involved in a local coalition.”
Figure 5 shows the places where CKF presentations and training sessions were offered. About one-third were at community-based organizations, and nearly a quarter were at school or child care provider sites. The rest were offered at a wide variety of other sites including health care providers (20 percent), businesses (11 percent), government agencies (10 percent), and other places.

![Figure 5](image)

Figure 5
Presentations and Training Sessions by Type of Site
Covering Kids and Families State Grantees and Local Projects
Third Quarter, 2004

<table>
<thead>
<tr>
<th>Type of Site</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider</td>
<td>20%</td>
</tr>
<tr>
<td>Business</td>
<td>11%</td>
</tr>
<tr>
<td>Government</td>
<td>10%</td>
</tr>
<tr>
<td>Community-Based Organization</td>
<td>31%</td>
</tr>
<tr>
<td>School or Child Care Provider</td>
<td>22%</td>
</tr>
</tbody>
</table>

Number of Presentations and Training Sessions: 1,165


**Outreach Events.** Outreach at community events was by far the most common form of CKF outreach. Every state grantee and local project reported at least one outreach event every quarter. Their most common activities at outreach events were passing out brochures and providing information to families about health insurance.

Hosting CKF events, or participating in them, requires planning, co-ordination with other organizations participating in the event, and effective advertising of the event.
Outreach events took on a wide variety of forms. The following list of event titles illustrates this variety:

- Hispanic Day at the Zoo (California local project)
- St. Joseph Hospital Children's Christmas Party (Rhode Island local project)
- New Year, New You! (Hawaii state grantee)
- Doc'toberfest (Indiana local project)
- Adventure Read Family Day (Alabama state grantee)
- Helpful Tools for Teen Parents (Nebraska local project)

The number of these outreach events - either sponsored by CKF grantees/projects or at which they participate - was very large (Figure 6). For example, in one quarter alone (third quarter, 2003) 139 local projects reported over 1,800 outreach events in which they participated (an average of over 12 per project). State grantees reported participating in fewer outreach events: between 100 and 200 events each quarter, or an average of 2 to 3 events per state grantee per quarter. Outreach events followed the seasonal pattern mentioned above for media outreach, with peaks in the Back-to-School period (quarter 3), especially at the local level (Figure 6).
Government locations were the most common place to hold events; over a third of all events reported were held at a government agency (often social service agencies or WIC sites, see Figure 7). Events were also held at health care providers, schools and child care provider sites, businesses, and a wide range of other places such as faith-based sites, city parks, museums, fairgrounds, and festivals.
**Fixed Outreach and Enrollment Sites.** Most CKF grantees and local projects had one or more fixed outreach/enrollment sites, with which they either coordinated closely (for example, by providing training and materials) or supplied with paid staff that provided outreach (for example passing out materials and making referrals) and/or application assistance to families and children. As Table 2 showed, a large proportion of both state grantees (80 percent) and local projects (70 percent) reported sponsoring an outreach/enrollment site of one type or the other. However, most of these sites were staffed by individuals who are not funded through the CKF grant. Only 1 percent of outreach/enrollment sites affiliated with the state grantees were actually staffed by the grantees, and only 19 percent of local project sites were CKF-staffed (data not shown). Thus, the CKF program had limited involvement in financing staff that provided application assistance at fixed sites.

Figure 8 shows that these CKF-sponsored or CKF-affiliated enrollment sites were at a variety of types of locations. By far, the largest proportion of CKF fixed sites were either co-located with community-based organizations (40 percent) or schools/child care providers (37 percent).
**Figure 8**  
Location of Fixed Outreach and Enrollment Sites  
Covering Kids and Families State Grantees and Local Projects  
Third Quarter, 2004

- Community-Based Organization 40%  
- School or Child Care Provider 37%  
- Health Care Provider 7%  
- Government 9%  
- Other 4%  
- Business 3%

Number of Sites: 5,800


**One-on-One Outreach.** Site visit respondents mentioned that the staff of public agencies often did not have the time or the skills to develop trust with vulnerable groups, and that one-on-one contact with a trusted individual was often necessary to enroll parents or their children in public health insurance. The approaches CKF grantees took were very diverse, and for this reason it is difficult to develop a statistical profile of them. However, two examples are: (1) promatora programs using lay outreach workers that were sponsored by some local projects with monolingual Hispanic target populations, and (2) “street outreach” to find adolescents where they congregate.
Targeted Outreach

To augment the media and one-on-one outreach discussed above, CKF projects reached out to special populations through specialized media and in-person outreach. These approaches were especially useful for targeting ethnic groups, immigrants, rural residents, and working families. Almost all CKF grantees targeted outreach to one or more of these special populations. In a meeting of CKF project representatives in mid-2003, several commented that, in general, targeting outreach to specific, hard-to-reach groups was the most cost-effective way to conduct outreach (Wooldridge et al. 2003b).

For example, media activities were targeted to Hispanic audiences using Spanish-language media. Media were also useful for reaching rural audiences, who were not as practical to reach through in-person outreach. Some of the targeted approaches that have been tested include outreach in school, provider, employer, and faith-based settings.

School Outreach. CKF projects found that schools are a useful place to communicate with parents. Grantee representatives repeatedly told us “Schools are a natural place to do our work because that’s where the kids are.” In addition, “Schools have a vested interest in enrolling kids in health insurance, because there is a link between enrollment and success in school.” School outreach was especially important in rural areas where families were dispersed. CKF projects increased school outreach during the Back-to-School period, receiving encouragement and assistance at that time of the year through RWJF’s Back-to-School campaign.

School outreach required extensive co-ordination with school officials. Each school district had different levels of approval needed for such activities. Projects

3 Targeted outreach is described more fully in two other CKF reports (Howell and Courtot, 2004; Stockdale, Howell, and Hill 2004).
reported that one way to gain support was to convince superintendents and principals that health and school performance were linked. CKF projects had varied experiences obtaining this type of cooperation, and were most likely to succeed in this if there was a “health care champion” present at the appropriate level in the district or school (Stockdale, Howell, and Hill 2004).

When such leadership was present, some CKF projects adopted a more intensive form of school-based outreach that included application assistance. This involved contacting parents of children without health insurance, and assisting them to enroll (either directly or through a referral to assistance). Grantees contacted parents in several different ways: (1) by sending a survey home to them, asking them to indicate whether their child had insurance, (2) reviewing school health forms for similar information, and (3) reviewing and modifying school lunch applications to ask whether the child was enrolled in health insurance.

Even the most common and “lightest” school-based activity - the distribution of information to parents through their children, including flyers and brochures sent home in a child’s backpack - was time-consuming. In addition to the development of appropriate materials, it involved the negotiation with schools in order to obtain permission to distribute materials, and the logistics of distributing materials to principals and teachers. More intensive school outreach was even more time-consuming and met with variable success in different locations. The first challenge was getting parents to respond to requests for information on their child’s insurance status. One project reported a very high response rate (75 percent) to a backpack survey, but for others it has been much lower. Parents had few incentives to return the forms. While teachers could be enlisted
to improve return rates, their main priority was the child’s learning and not health care. Some projects had better luck working with school nurses, who typically reviewed forms and contacted families with uninsured children. However, not all schools had nurses, and most were busy and unable to take on this responsibility. Other projects hired staff or developed a pool of volunteers to identify children and contact families. One problem with this approach concerned confidentiality of school information. State or district rules could prevent those who were not employees of the school system from obtaining access to confidential information. Some projects were able to overcome this barrier and some were not.

*Provider Outreach.* Provider outreach was another common form of CKF outreach. When asked why they adopted this form of outreach, one project reported “We target people where they access care and at a point in time when they are most likely to see the need for and apply for coverage.” Another project reported, “We saw a gap, because people were being turned away by providers because they did not have insurance, rather than being referred to us to help them get coverage.”

As with school outreach, provider outreach ranged in intensity. The least intensive approaches involved posting materials in doctors’ offices and clinics, and providing office staff with brochures to pass out to patients. The more intensive form of provider outreach involved either a process for referring uninsured children to the CKF project so that they could provide application assistance, or stationing someone in the provider’s office to provide such assistance.

Such “outstationing” of enrollment assistance in high volume sites has become increasingly common around the country, with the cost of the enrollment assistor being
covered by either the health care provider or a social services agency (Wooldridge et al. 2003a; Howell et al. 2005a). The CKF project—as discussed above—was often not directly involved, but rather provided information, training (through presentations), and materials. In some cases the effort was initiated by the CKF project, but the provider assumed the cost of the effort after seeing its cost-effectiveness.

*Outreach at Businesses or Faith-Based Sites.* While CKF projects experimented with a variety of ways to target outreach to special populations, projects found some forms of outreach to be more challenging to implement. While both employer and faith-based outreach were important to some local projects, in general, neither businesses nor faith-based sites were used as a major place for CKF outreach due to logistical difficulties and a perception by projects that they were less productive in terms of increasing enrollment.

Coordinating with businesses was viewed by some projects as a good way to identify uninsured, working poor parents, which is a group that was hard to reach since they are not connected to other public programs. Projects reported that outreach at businesses was useful at times for distributing information, but not for actual enrollment, because of the stigma of applying for public benefits in such locations. In addition, employer outreach carried the concern of “crowd out” whereby employers might encourage employees to sign up for public coverage rather than employer coverage. For example, in one instance Wal Mart distributed CKF-provided information on public coverage to its employees. For this reason, projects attempted to target either employers who did not offer dependent coverage or whose employees lost coverage due to plant closings or layoffs.
Work with faith communities was also used by some projects as an approach to overcoming stigma and trust barriers to enrollment, especially with minority groups. Faith-based outreach often involved enlisting clergy to discuss the availability of health insurance and the places to apply with parishioners, or a more intensive version where enrollment assistance was provided at the church, synagogue, or mosque. We heard that intensive faith-based outreach was often challenging to sustain because of turnover in volunteers. Also, the stigma of applying for a public program could deter congregation members from applying in a parish hall, for example.

**CKF Outreach Effectiveness**

Since CKF local projects did not begin their grants with the knowledge of what the most effective forms of outreach would be in their local communities, they experimented with many different types outreach, in a variety of settings. While the relative effectiveness of alternative CKF outreach approaches is perhaps the most important question for the CKF evaluation, it is also the most difficult to answer. To date, most of the evidence we have comes from anecdotal reports from the projects themselves about what they perceive to be effective forms of outreach. Indeed, projects reported frustration at not being able to directly document the effectiveness of their outreach efforts, and many requested technical assistance on how to do so (Courtot 2004). Sometimes they told us that they were “sure” their activities were effective, but had little hard data to show such results. On the other hand, many reported that some types of outreach (for example, school and provider outreach) were more successful than others (for example, outreach targeted to businesses or churches).
State grantees and local projects reported the following six characteristics to be the most important characteristics of effective CKF outreach (Hoag et al. 2005):

- Conducted by a “trusted” organization in the community
- Well targeted to special populations
- Easily accessible and convenient for clients
- Well coordinated with other organizations offering outreach
- Capitalizing on a “teachable moment” (for example, in provider sites when parents are most motivated about their children’s health)
- Having state grantee and state government co-ordination and support

For grantees and local projects that provided direct application assistance (either at outreach events, fixed sites, or one-on-one) the CKF on-line reporting system requests the estimated number of applications for which the state grantee or local project provided direct assistance. As shown in Figure 9, this was a large number of applications per quarter (about 25,000). (Applications at sites that do not have CKF-funded staff were not included.) While these were a small part of the total number of Medicaid/SCHIP applications each year, they provide a clear measure of substantial activity for those states and local projects doing this form of outreach.
Additional evidence of outreach effectiveness is just emerging from case studies of the effect of local CKF activities on enrollment trends in their target areas in selected states, conducted as part of this evaluation. The case studies examine differences in trends in new child enrollees in Medicaid and SCHIP in those areas of the state with a CKF local project, and compare the trend to that in other parts of the state without a CKF local project (adjusting for demographic factors).

The first four case studies (Arkansas, California, New Jersey, and Virginia) do not provide evidence that CKF-sponsored activities affect enrollment in public health insurance programs for children in their target areas (Howell et al. 2005b; Trenholm, Lavin, and Wooldridge 2005; Sullivan, Hill, and Trenholm 2006; Walls, et al.)

There are several possible explanations for the lack of evidence of CKF local activities’ effects on enrollment in these states. For example, in these four states, other, non-CKF agencies often had substantial outreach activity. In fact, with CKF funding, states were often able to target dwindling SCHIP outreach funds to non-CKF local areas. Such factors make it difficult to assess CKF effects on enrollment. In addition, these early case studies use enrollment information only through 2002 and 2003 (the first years of CKF). These case studies will be extended in 2006 to look at additional years of data and more states.

SUMMARY AND CONCLUSIONS

The CKF grantees employed a wide range of diverse approaches to identify and enroll children in public health insurance programs, and CKF has filled an outreach gap left in many states by declining SCHIP outreach funding. CKF outreach has been sustained throughout the life of the program, and the mix of CKF outreach approaches has been consistent over time, though there have been seasonal variations in outreach intensity. CKF programs—both state grantees and local projects—employed both media and in-person outreach. Because of the breadth of their reach, state grantees were more likely to use media approaches. In turn, local projects more often used the more intensive outreach approach of in-person outreach. The most frequent outreach efforts occurred in the spring (around Cover the Uninsured Week) and in the fall (around the Back to School period). School outreach was the most popular targeted outreach approach for CKF grantees and projects, although there was great variety in targeted approaches.
We cannot draw definitive conclusions about the effect that these CKF outreach activities have had on enrollment growth. Findings to date from the enrollment data analysis, conducted as part of the case studies, have identified some isolated examples of effective outreach efforts, usually when outreach was combined with application assistance (see, for example, Howell et al. 2005). However, they have not shown widespread or consistent evidence that the local CKF projects studied so far have been any more successful than regions that do not receive CKF support.

Qualitative findings from interviews provide a somewhat more positive perspective on outreach, particularly certain types of media efforts when combined with targeted outreach such as school outreach or outreach to ethnic groups. Fortunately, the diversity of CKF programs offers an ideal laboratory to further investigate the success of these various outreach approaches. As additional case studies covering the full period of the CKF grant are completed, we will be better able to assess more fully the effectiveness of CKF-funded outreach and to identify potential models for extending coverage to uninsured children.
REFERENCES


The Robert Wood Johnson Foundation (RWJF) and its collaborating partners—the National Program Office, GMMB (the communications contractor), and the evaluation contractor—each require periodic reports from CKF grantees and their local projects (which are sub-grantees in selected areas of the state). In order to reduce the reporting burden for grantees, the reporting system was jointly developed to serve the needs of all organizations. Grantees must complete one report every three months, and reporting cycles depend on the grant award date. Throughout the report, we discuss reporting system data in terms of the calendar-year quarter in which the reporting period ended. For example, the first quarter of 2003 data are from all grantee reports ending in January (these cover activities from November 2002 – January 2003), February (covering activities from December 2002 – February 2003) and March (covering activities from January 2003 – March 2003). The majority of grantees (62 percent) report in quarters as follows: January-March, April-June, July-September, and October-December. A smaller number of grantees report with quarters covering—for example for their first quarter—November - January (10 percent) or December - February (28 percent).

When we encountered extreme outliers in the data reported by grantees (for example over a thousand outreach events in a quarter), we attempted to confirm the unusually high or low number with the grantee or project that had reported it; if we could not confirm that the number was accurate, we excluded the outlier from the analysis.

The quarterly reports contain both quantitative and qualitative information on a variety of types of outreach activities including, for example, media activities, outreach events, outreach sites, and the number of applications assisted through CKF-sponsored outreach activities. For this report, we analyzed data from all reports for 2003 and the first three quarters of 2004. We included quarters during which most or all CKF grantees had complete reports. Thus, we eliminated 2002 data because many grantees had not begun reporting in that year, and reporting periods ending after September, 2004 (that is the third quarter of 2004). After that date, reports were submitted on a semiannual basis, and thus quarterly data were no longer available.