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ABSTRACT

The State Children's Health Insurance Program (SCHIP) in 1997 signaled a major increase in time, energy, creativity, and money devoted to enrolling eligible children in health insurance programs. Child advocates and others have focused on developing outreach and enrollment strategies to bring the benefits of these new SCHIP programs to children and their families. Noting that knowing whether these strategies are working is as urgent as the strategies themselves, this issue brief discusses the role of participatory evaluation in keeping a clear focus on the purpose of the project and its learning objects in order to develop a program which can be evaluated for effectiveness, not only at the project's completion, but while the project is underway. Every project component--planning the activities, identifying the participants, developing the training, deciding on the data to be collected, and designing the tracking forms--needs to be measured against these questions: Why are we doing this project? and What do we want to know when the project is over? An interview with Pat Redmond, the health director at the Philadelphia Citizens for Children and Youth, is presented to illustrate how participatory evaluation leads to a project that can be evaluated for effectiveness. (KB)

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Planning the Beginning with the End in Mind: Evaluating Outreach and Enrollment Strategies, A Case Study

An Interview with Pat Redmond, Health Director, Philadelphia Citizens for Children and Youth, a NACA Member Organization

By Margaret Schmid, Child Health Project Director, NACA

The establishment of the state children's health insurance program (SCHIP) as part of the Balanced Budget Act of 1997 (BBA), signaled a major increase in time, energy, creativity, and money devoted to enrolling eligible children in health insurance programs. Child advocates and others energetically tackled the challenge of crafting state-level SCHIP programs and undertaking the outreach and enrollment needed to bring the benefits of these new SCHIP programs to children and their parents.

The State Children's Health Insurance Program (SCHIP) was established as a part of the Balanced Budget Act of 1997 (BBA). Immediately following passage of the law, child advocates began working to shape state SCHIP program designs which would benefit the maximum number of children. They advocated generous eligibility levels and comprehensive benefits. The BBA required that, prior to enrollment in a state SCHIP program,[1] a child be screened for eligibility in Medicaid and, if Medicaid-eligible, be enrolled in Medicaid rather than SCHIP. As a result, SCHIP outreach and enrollment efforts have become SCHIP/Medicaid outreach and enrollment programs instead of programs devoted to SCHIP alone, building on existing Medicaid outreach work where such programs existed, and stimulating broad new efforts elsewhere.

Child advocates have become heavily involved in outreach and enrollment work. In eleven states, child advocacy organizations serve as the lead grantee in the Robert Wood Johnson-funded *CoveringKids* initiative. Numerous other state-, city-, and community-based child advocacy organizations are included in outreach and enrollment, either as *CoveringKids* pilot sites, committee members, or partnering organizations, or through other outreach and enrollment work. Many child advocates have adopted the label "child health insurance outreach and enrollment" for SCHIP/Medicaid outreach and enrollment campaigns to emphasize their goal of gaining health care coverage for all children, regardless of the specific type of health care program entailed.

Other entities have been active in outreach and enrollment as well. States have undertaken a wide range of activities,[2] including promotional materials, radio and television promotion, toll-free hotlines, web sites, outstationing of eligibility workers, and more. In some states, SCHIP and Medicaid have been given a single name and use common marketing materials, including a single application form for both.

Some states have established partnerships or advisory committees including advocates, parents, providers, and community-based organizations.

The federal government has likewise been active. Under the slogan "Insure Kids Now," it sponsored a public education campaign including a national 1-800 number to increase public awareness of the new SCHIP programs.[3] Several federal agencies, including the Department of Health and Human Services, the Department of Education, the Department of Agriculture, and the Department of Justice have collaborated on highly visible joint projects related to SCHIP, and a variety of other federal agencies have undertaken some activity designed to increase enrollment in SCHIP. The federal government identified incorporation of outreach and enrollment activities in schools across the country as a priority activity, and sponsored an "Education Summit" to further this initiative.

Foundations and other national and local groups with an interest in promoting child health have stepped up to the plate with funding to support a variety of programs. Notable among these is the Robert Wood Johnson Foundation's $47 million dollar, three-year *CoveringKids* initiative[4] noted above, with funded programs up and running in 49 of the 50 states as well as the District of Columbia. This initiative supports outreach and enrollment programs for both SCHIP and Medicaid, with strong emphasis on the goals of simplification of application and enrollment and of coordination with existing benefits coverage programs. Other national and local entities ranging from corporations to charitable nonprofit organizations are likewise involved, through public education efforts designed to increase awareness, through direct support of outreach and enrollment, or through a host of other activities.

Evaluating the Impact of Outreach and Enrollment Activities

What are the results of all these activities? When the SCHIP program was established, proponents spoke of achieving SCHIP enrollments of well over four million children. A survey of states to determine SCHIP enrollment as of a set date, June 30, 1999, showed that, on that date, 1,979,450 children were enrolled in SCHIP programs.[5] The most current report, based on data submitted to HCFA by the states for federal fiscal year 1999 (10/1/98-9/30/99), indicates that 1,979,450 children were enrolled in SCHIP programs at some point during the year,[6] indicating that enrollment progress is being made. At the same time, reports of falling enrollments in Medicaid programs around the country, most related at least in part to improper or inadequate state approaches to maintenance of Medicaid enrollment when families leave TANF, have given rise to great concerns in the child advocacy community.[7] Given the importance of increasing child health insurance coverage and the significant resources now engaged in efforts to do so, the question of how to assess outreach and enrollment programs to identify what works and what doesn't is an obvious and significant one.

Participatory evaluation proposes that assessment of effectiveness can be achieved as a project is underway – if project planning is done with the end in mind, if ongoing data collection is designed to provide information needed to assess effectiveness, and if evaluation activities are structured into the project design.

The question of how to accomplish such assessment is not only important, but complex and difficult as well. Outreach and enrollment efforts occur on many levels – local, state, and national. They take many forms – targeted community presentations at churches, schools, and community centers; outstationing of outreach and eligibility workers in schools and child care centers; training of community leaders to lead local outreach programs; outreach in community health centers and hospitals; use of paid application assistance or facilitated enrollment; public service announcements; campaigns publicizing SCHIP names and 1-800 numbers. It is difficult to disentangle the impact of one form of outreach from that of others. It is not possible to say with precision whether the first, third, or seventh contact which a parent has with information about the local SCHIP program is the contact which prompts that parent to initiate the application process, or what role national media or awareness efforts play in the mix. Further, because there are significant cultural differences among some of the groups with large proportions of children without health care coverage, it is

highly likely that methods which are effective with some groups are less so with others.

Nonetheless, given the importance of identifying strategies that work and the significant quantities of resources involved, the challenge of evaluation must be addressed. Further, child advocates and others who are actively engaged in outreach and enrollment efforts do not want to defer evaluation of effectiveness until programs are over, as more traditional, formal models of evaluation would suggest. Rather, child advocates seek timely information on strategies which work so they can use their resources to best effect, both in their own outreach and enrollment efforts, and in administrative and legislative advocacy efforts in support of successful strategies.

Participatory evaluation proposes that assessment of effectiveness can be achieved as a project is underway – if project planning is done with the end in mind, if ongoing data collection is designed to provide information needed to assess effectiveness, and if evaluation activities are structured into the project design. This Issue Brief presents an interview with Pat Redmond, Health Director at NACA member organization Philadelphia Citizens for Children and Youth (PCCY). PCCY's design of their Medicaid/CHIP enrollment fund project is a useful example of how "planning the beginning with the end in mind" leads to a project which can be evaluated for effectiveness. PCCY is a pilot site for Pennsylvania's *CoveringKids* initiative, managed by lead grantee Pennsylvania Partnerships for Children, also a NACA member organization. The enrollment fund is a *CoveringKids* project, which began in 1999.

NACA: What is the enrollment fund strategy all about?

Redmond: Let's start with some context. As in other places, there are many uninsured children in Philadelphia and the surrounding counties in the region. But awareness of Medicaid and CHIP is probably higher than in some parts of the country, for at least two reasons. One, there is a high child poverty rate in Philadelphia, and so Medicaid has been critically important for many years. At one point, almost 60 percent of children in the city were enrolled in Medicaid, although this number has fallen since welfare reform. A second reason is that Pennsylvania has had a CHIP program since 1992 – our state's program was one of the models for the national SCHIP program. The state, state-contracted insurance companies, and community groups have been promoting CHIP for many years.

PCCY plays a key role on this issue: we brought together a Greater Philadelphia Child Health Insurance Coalition on child health issues many years ago, developed user-friendly outreach materials and enrollment tools, and trained neighborhood groups and health care providers on the ins and outs of enrolling children. We've also taken an active role in advocating for systems that work well for families, and have been gratified to see real improvements take place in Pennsylvania. But there's still a lot of work to be done.

"There is a lot of interest in children's health insurance in this region, but many agencies that express interest have not been able to get involved in hands-on enrollment work. We were interested in learning whether a stipend to offset some costs and provide an incentive for this additional work might prompt some groups to get more involved."

– Pat Redmond, PCCY

The *CoveringKids* project offered us the opportunity to try something new – to experiment with a model that might work to engage organizations that care about children's health, but haven't been able to put real time and resources into enrolling kids. We and our coalition partners decided that an enrollment fund might work in this region.

NACA: What do you mean by "enrollment fund"? Where did you get the idea?

Redmond: We got the idea from California and other states with finders fees, application assistance, or similar programs – there are a variety of names. What they have in common is that they try to encourage outreach and enrollment work by paying a set fee for submission of completed SCHIP and Medicaid applications to individuals or groups who have helped parent organizations to complete those applications.

NACA: Why did you choose this idea over others?

Redmond: There is a lot of interest in children's health insurance in this region, but many agencies that express interest have not been able to get involved in hands-on enrollment work. We were interested in learning whether a stipend to offset some costs and provide an incentive for this additional work might prompt some groups to get more involved. We

designed the enrollment fund to test two closely-related concepts: one, whether community groups can and will integrate enrollment work into their ongoing operations without the support of dedicated staff, and two, whether system barriers would interfere either with the groups' willingness to do this work or with their success in enrolling children. These were, in effect, our outreach strategy research questions and all of our planning was done with these underlying questions in mind.

NACA: Can you be more concrete?

Redmond: Sure. Since we knew what we wanted to learn, we also knew that we had to identify the specific pieces of information we'd need to have to get those answers, and then build in a way to gather it. This meant we had to consider what the participating organizations would do, what information and resources they would have to have, and how we would provide that to them – that is, we had to begin developing our training and monitoring strategies right up front.

NACA: Let's talk about information – what information did you decide you'd need in order to find out whether the enrollment fund strategy was working?

Redmond: Simple things, really. We needed to know how many applications were being submitted as a result of the fund, and how many were being approved. We also needed to know what problems agencies were experiencing, and have a mechanism for identifying whether they were agency problems or problems caused by the larger system.

In consultation with an advisory committee, we selected ten agencies with a total of 31 sites. We offered two in-depth training sessions with the participating agencies. We established a reporting and tracking process to give us the information we needed to monitor applications and identify potential problems. Participating agencies keep copies of all applications and supporting documentation, which they submit directly – note that in Pennsylvania, the insurance companies process CHIP applications, while the state handles Medicaid. Every few months, the agencies send PCCY what we call a tracking form, which contains demographics and other key information on each application they have turned in. We use the tracking forms to monitor the numbers generated by each participating agency. This information also determines the enrollment fund reimbursements for each agency.

We also use the tracking forms to select a random sample of the applications, and to identify how many were accepted into CHIP or Medicaid, respectively. We are fortunate in that we were able to get the assistance of a professional evaluator who agreed to select the random sample and track the results, pro bono. We're in the process right now of getting our first reports back, where we'll learn how many of the applications that were submitted were approved, rejected, or are pending.

NACA: Are you counting completed, submitted, or approved applications?

Redmond: Our advisory committee decided early on that each organization would complete an application tracking form, and that the form would track not application forms given out, but each application that was completed and submitted. That early decision reflected our emphasis on achieving actual enrollment, not simply broad distribution of the enrollment forms.

It also became clear quite quickly that documentation of approval of applications would be tough. Finding out what happens after applications are completed and submitted is time-consuming and resource intensive. We considered tracking approved applications and paying the $25 enrollment fund fee only for those. But we needed to keep the needs of the participating organizations in mind as well as our own resources and priorities. We decided that tying payments to approved applications alone would have made the work more risky and less attractive to the participating organizations. As just noted, we are tracking acceptance for a sample of applications because we also need to know whether we're achieving the ultimate goal of the program – enrolling kids in CHIP or Medicaid.

> "We will use the data on approval rates to help identify and address possible problems. If the approval rate of applications submitted by a given agency falls below 80%, we will review the cases and discuss the situation with the agency. This is one way in which we've built ongoing evaluation and opportunities for course corrections into our work."
>
> – *Pat Redmond, PCCY*

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NACA: How will you use the evaluator's work?

Redmond: That gets to the specific objective of the enrollment fund project – to see if community groups can integrate enrollment work into their ongoing operations successfully. We will use the data on approval rates to help identify and address possible problems. If the approval rate of applications submitted by a given agency falls below 80%, we will review the cases and discuss the situation with the agency. This is one way in which we've built ongoing evaluation and opportunities for course corrections into our work. There may be issues with that organization; if so, we will address them. But there may be systemic issues related to how the applications are processed, issues indicating that some advocacy with the state is needed. If the rates are low for just one organization, it is likely that the issue lies with the organization. But if approval rates are low for many organizations, it is likely to be a state system issue. Of course, we also need to monitor our work to make sure applications are submitted for families who are screened and are likely to be eligible.

NACA: Let's get back to the project start-up process. How did you identify the participating groups?

Redmond: Our Greater Philadelphia Child Health Insurance Coalition mailing list provided our starting point. Because we wanted to get started quickly, we decided to use only the coalition's existing mailing list of organizations to gauge interest. Twenty-two were interested. With the assistance of our advisory committee, we selected 10 organizations for participation. Organizations had filled out a simple form for us, telling us what groups they expected to target and how the Enrollment Fund would work in their agency. Let me mention that we could have selected all 22, and maybe recruited more. And we would gladly have done this, but needed to limit the number for administrative reasons. We selected agencies which would provide the project with geographic and demographic diversity, as well as agencies where enrollment work seemed especially urgent. The participating groups include a YWCA, a community center, Catholic Social Services, a consortium of nurse-managed health centers, and a mobile health van, among others.

NACA: How did you prepare the agencies for the enrollment fund work?

Redmond: We provided two sets of intensive training for the participating organizations. In general, each organization had identified one or more staff per site who were likely to be doing the outreach/enrollment work, and these were the staff who participated in the trainings. The first training described Pennsylvania's CHIP and Medicaid programs, how they are structured, how they interact, and what kinds of questions and information needs the staff were likely to encounter. The second was a hands-on training, with forms, paper, and pencil. The staff practiced enrolling, using a variety of case studies. They were trained in completing both the CHIP and the Medicaid application forms. Since Pennsylvania still uses two forms, and since the CHIP application is one page and the Medicaid application form is six pages long, there were lots of questions. We focused on the particulars of how to complete and send in both forms, with particular attention to the demanding matter of income documentation.

NACA: You're tracking both the volume of applications submitted and whether a sample of them have been accepted. Are you using any other gauge of how well the process is working for the participating organizations?

Redmond: We built in several ways of evaluating whether things are going well and where more resources or program changes may be needed. Early on, we offered additional training to organizations when questions and comments indicated a need. About two months into the work, we did a set of phone interviews with the organizations. These interviews uncovered some real enthusiasm and some frustrations as well. It seems to take three to four contacts with a family to complete an application, and the amount of the enrollment fund fee - we're paying $25 - is not equal to the work they are contributing. On the other hand, as non profits, their motivation is to help. Interestingly, initial results seem to indicate that those organizations new to the issue were among the most energized with the highest numbers of applications turned in. The question of how long the enthusiasm can be sustained is a good one, one which is at the heart of the enrollment fund project. We are having an advisory committee meeting soon in which we will look at how the process is working, how/if it should be modified, and how to help those organizations that are struggling.

NACA: Do you have any data on numbers of completed applications to date?

Redmond: In our first three months, 187 applications were submitted, and 20 were still being processed within the organizations. Additionally, a mobile health van lost all of its completed applications when it was caught in a flood during Hurricane Floyd, so this number is low. We had anticipated 800 applications over a year, so this shows that we're on track.

NACA: What's next?

Redmond: In the short run, more data, more program refinements, and more evaluation. If the enrollment fund concept succeeds as we have defined success, we plan on continuing it for the three-year duration of the *CoveringKids* initiative, at which point funding will cease. We need another several months worth of data on results before we will know. Once the program is solidly launched, participating organizations will turn applications in to PCCY only once every six months. We are pleased that organizations that applied but were not chosen as direct participants are still involved through help with outreach.

NACA thanks PCCY and Pat Redmond for sharing information on this carefully planned and well-thought out outreach and enrollment strategy. It shows that "Planning the Beginning with the End in Mind" – that is, keeping a clear focus on the purpose of the project and what you want to learn at the time the project is first designed – can create a program which can be evaluated for effectiveness, not just at the end, but while the project is underway. Every project component - planning the activities, identifying the participants, developing the training, deciding on the data to be collected, and designing the tracking forms, or more - needs to be measured against these questions: why are we doing this project, and what do we want to know when the project is over. PCCY has developed a project design which not only meets this standard, but which will give them the opportunity for course corrections early in the project. The need for effective outreach and enrollment strategies is urgent. The need to know whether the strategies we attempt are working is equally urgent for child advocates to help identify and promote strategies that work. The PCCY example shows that it can be done.

1. In a reflection of the extent of state control over the SCHIP program, the names of such programs vary widely, sometimes even county by county. For purposes of this Issue Brief, however, except when discussing Pennsylvania's SCHIP program, entitled Child Health Insurance Program or CHIP, all programs will be referred to by the generic term "SCHIP."
2. For examples, see *1998 State Children's Health Insurance Program Annual Report*, published jointly by the National Conference of State Legislatures and the National Governors' Association; *The Children's Health Insurance Program - States' Application and Enrollment Processes: An Early Report from the Front Lines*, Office of Inspector General, Department of Health and Human Services, OEI-05-98-00310, May 1999; *Children's Health Insurance Program - State Implementation Approaches Are Evolving*, General Accounting Office, GAO-HEHS-99-65, May 1999; or "CHIP Outreach and Enrollment: A View from the States," American Public Human Services Association, September 1999.
3. See www.insurekidsnow.gov for the web-based component of this campaign.
4. See www.CoveringKids.org for an overview of the Robert Wood Johnson Foundation-funded CoveringKids initiative, its grantees and programs in the states, and for links with additional information about the program and its objectives.
5. *Enrollment Increases in State CHIP Programs: December 1998 to June 1999*, Vernon K. Smith, Health Management Associates, for The Kaiser Commission on Medicaid and the Uninsured, July 30, 1999.
6. *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 through September 30, 1999* based on reports from 35 states and projections for others. Note that these two sets of data measure different things – the first measures enrollment as of a given date, as defined by state receipt of Title XXI matching funds; the second measures total unduplicated enrollment over the period of the federal fiscal year. The total enrollment over the fiscal year is higher than would be a report of total enrollment as of, for example, the final day of the federal fiscal year.
7. See *Losing Health Insurance: The Unintended Consequences of Welfare Reform*, Families USA, May 1999; *The Medicaid Maze: Coverage Expands, But Enrollment Problems Persist*, Marilyn Ellwood, Mathematica Policy Research, Inc., for The Kaiser Commission on Medicaid and the Uninsured, September 1999; *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary*, General Accounting Office, GAO/HEHS-99-163, September 1999; *Missed Opportunities: Declining Medicaid Enrollment Undermines the Nation's Progress in Insuring Low-Income Children*, Center on Budget and Policy Priorities, October 1999.

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