

Evaluation Highlights: Optimizing Outreach and Application Assistance in Community-based Organizations

Grantmakers in Health

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Overall Evaluation Questions:

1. **REACH:** What populations do community-based organizations (CBOs) reach and not reach?
2. **IMPLEMENTATION:** What outreach and enrollment strategies are CBOs using?
3. **EFFECTIVENESS:** What is the impact of these CBO models and strategies on enrollment and use of benefits?



Specific evaluation questions I will cover in today's session:

- What were the most successful (i.e., “exemplary”) community-based organizations?
 - » Successful - defined as those most able to (1) enroll a substantial number of children and youth in public health insurance at low cost-per-client and (2) sustain their assistance services after funding ended.
- What are best practices and recommendations for optimizing the success of outreach and enrollment services in community-based settings?



EVALUATION METHODS

PARTICIPATING COMMUNITY-BASED ORGANIZATIONS

DATA COLLECTION METHODS

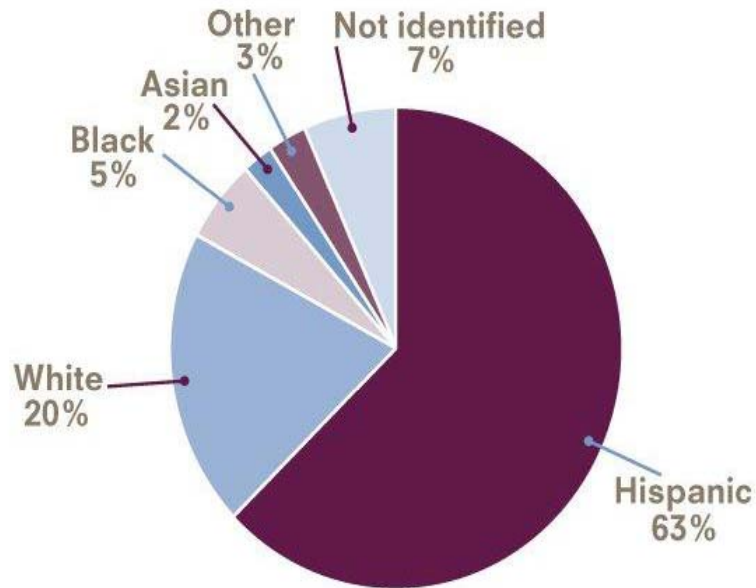
TABLE 1: EVALUATION SITES

Grantee Name	Location	CBO Type or Description
American Diabetes Association	Denver	Application assistance at Mexican Consulate
Boys & Girls Clubs of Metro Denver, Inc.	Denver	Boys & Girls Club
Boys & Girls Clubs of Pueblo County	Pueblo	Boys & Girls Club
Chaffee County Department of Health and Human Services	Salida	Integrated model
Colorado Coalition for the Homeless	Denver	Housing and homeless services
Denver Children's Advocacy Center	Denver	Counseling services
Denver Public Schools	Denver	Schools
Hope Communities	Denver	Housing and homeless services
Inner City Health Center	Denver	Community clinic
La Clínica Tepeyac	Denver	Community clinic
The Gathering Place	Denver	Housing and homeless services
YMCA of the Pikes Peak Region	Colorado Springs	Recreational organization

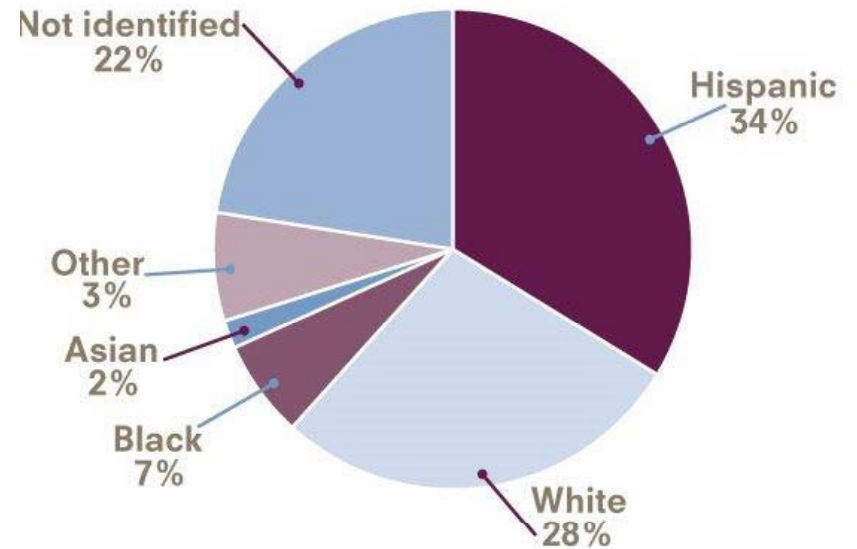


Participating Community Based Organizations

Grantee Client Race/Ethnicity



Colorado 2011 Medicaid/CHP+ Enrollee Race/Ethnicity



Mixed Methods to Identify Most Successful Community-based Organizations

- Client Assistance Data: Outreach workers entered data on their contacts with clients using Client Assistance Tool (CAT) - ***time and effort***.
- Enrollment and Utilization Data: Linked assistance data with state enrollment and utilization data until six months after end of funding - ***enrollment and use of public health insurance***.



Mixed Methods cont.

- Cost Data: Extracted project costs and resources from grantee budget reports and interviews - combined with enrollment/utilization data to derive ***cost-per-client estimates*** required to support outreach and application assistance.
- Sustainability Study: Interviewed grantees six months after grant program ended - ***changes in services and additional funding for services post-grant.***



Mixed Methods cont.

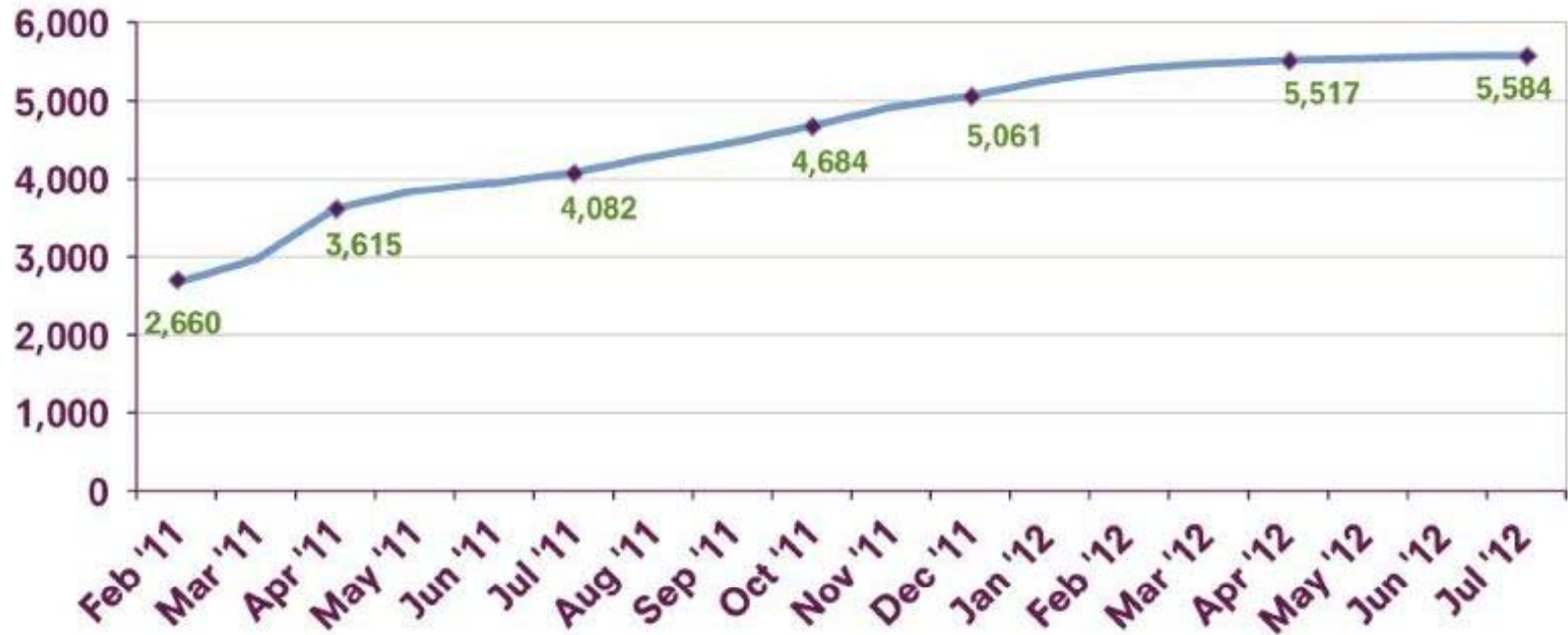
- Identify Most Successful CBOs: Combined cost and sustainability data to ***identify those exemplary CBOs able to enroll substantial # in public health insurance in cost-efficient, sustainable way.***
- In-depth Qualitative Analysis: Used data from site visits, interviews, check-in calls and CBO case summaries to ***identify best practices of more and less successful sites.***



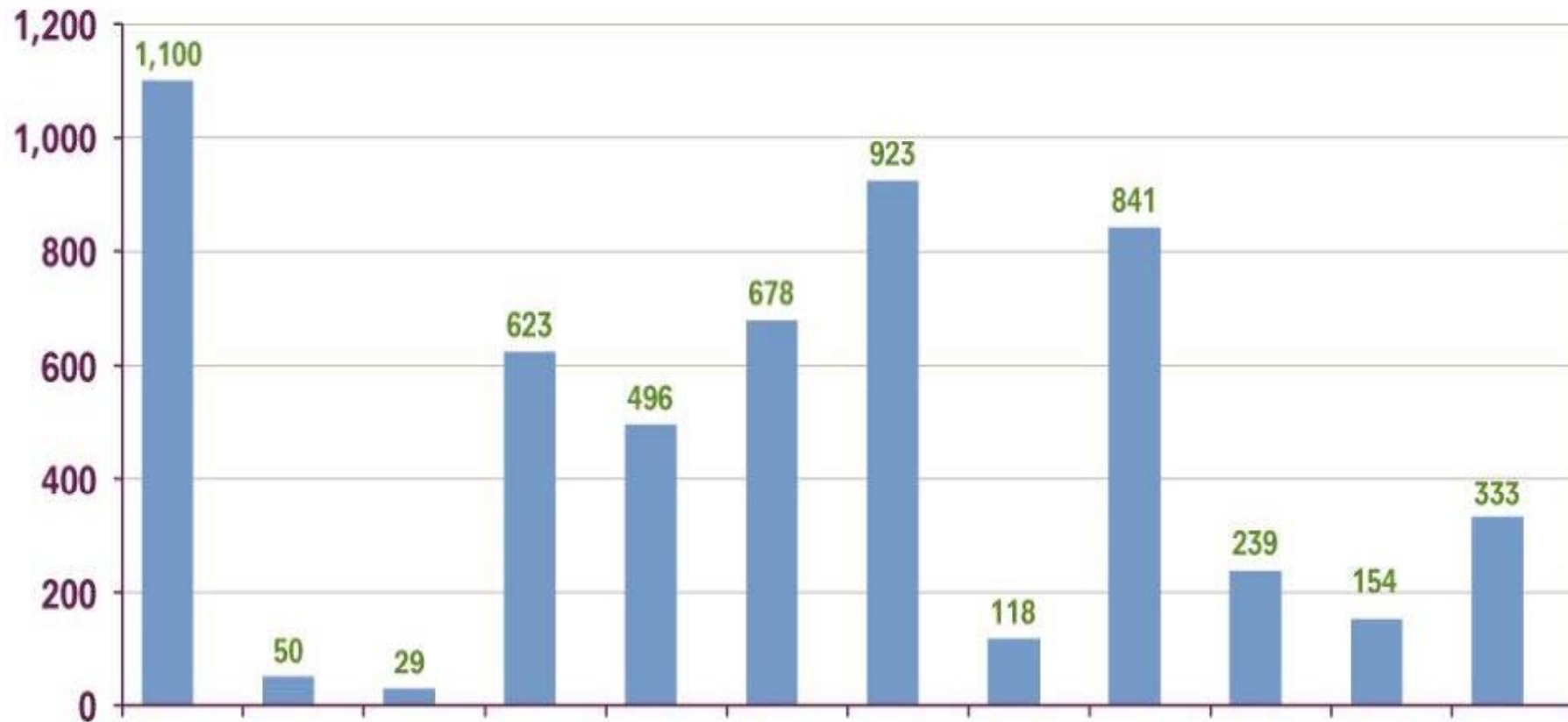
EVALUATION FINDINGS

EXEMPLARY COMMUNITY-BASED ORGANIZATIONS
AND BEST PRACTICES

Number of Clients Enrolled in Medicaid or CHP+ (Post-assistance)



Number of Clients Enrolled in Medicaid/CHP+ thru July 2012 (Post-assistance)



Cost-Per-Client Enrolled Metric

- A metric to compare diverse community-based organizations (i.e., different funding amounts, anticipated client enrollment numbers, types of clients).
- Cost-per-client enrolled varied considerably across 12 community-based organizations.
- Cost-per-client of four “top” CBOs and overall estimates compare favorably to the \$280-per-client estimate reported in 2004 cost analysis of outreach and enrollment services in managed care organizations in New York.*
- (Fairbrother et al. Health Affairs, 2004)



TABLE 3: AVERAGE COST-PER-CLIENT BY GRANTEE

Rank Order	Funding Amount	Cost-per-Client Assisted (Minus Start-up)	Cost-per-Client Enrolled (Minus Start-up)	Cost-per-Client Utilizing Medicaid (Minus Start-up)
1	\$98,000	\$103 / \$92	\$117 / \$104	\$123 / \$109
2	\$125,000	\$102 / \$92	\$119 / \$107	\$130 / \$117
3	\$225,300	\$220 / \$220	\$244 / \$244	\$281 / \$281
4	\$145,977	\$274 / \$259	\$294 / \$278	\$341 / \$322
5	\$225,300	\$318 / \$291	\$332 / \$305	\$362 / \$332
6	\$216,588	\$331 / \$321	\$348 / \$337	\$378 / \$367
7	\$75,300	\$390 / \$347	\$489 / \$435	\$559 / \$497
8	\$130,300	\$439 / \$305	\$545 / \$379	\$611 / \$425
9	\$221,257	\$611 / \$577	\$664 / \$627	\$803 / \$758
10	\$137,127	\$1,031* / \$956	\$1,162* / \$1,077	\$1,428* / \$1,324
11	\$179,661	\$2,764* / \$2,668	\$3,593* / \$3,468	\$3,696* / \$3,567
12	\$228,000	\$6,333* / \$5,630	\$7,862* / \$6,989	\$9,434* / \$8,386
Average		\$325 / \$299	\$363 / \$334	\$403 / \$371
Average without Outliers		\$263 / \$242	\$293 / \$270	\$326 / \$300

* Outlier CBOs



Sustainability Six Months Post Funding

- A total of 8 community-based organizations continued their outreach and enrollment services, sometimes in a different form.
- The 4 that discontinued these services had the highest cost-per-client enrolled estimates.



Best Practices of Exemplary CBOs

- For exemplary CBOs, outreach and enrollment services addressed an important organizational need, and improved their ability to accomplish their core mission (and meet the needs of clients and other community partners).
- Most successful CBOs had a clear understanding of their clients and client needs BEFORE funding and sought funds to address important client need: health insurance.



Best Practices of Exemplary CBOs

- Exemplary CBOs spent less time trying to find clients who were EBNE; often able to help enroll clients who walked through the door.
- More in-reach, less outreach. Although all CBOs spent majority of time reaching and assisting clients from within their organizations, the four exemplary sites reached clients within their organizations efficiently and systematically.



Best Practices of Exemplary CBOs

- The most successful organizations were able to reach and enroll client populations traditionally defined as hard-to-reach and enroll: Hispanic/Latino, Spanish-speaking, African-American and homeless.
- Although each had their own approach and style for working with clients, they all seemed to have a consistent presence in the community and a trusted status with their clients.



Recommendations for Funders

- Increase support for community-based organizations to have a key role in Affordable Care Act.
 - » CBOs can play important role in supporting varied needs of newly eligible populations – the more “points of entry” a community can provide to enroll newly eligible, the more likely children and families will have access to health insurance.
- Identify the appropriate role for CBOs within the continuum of public health insurance outreach, enrollment and benefit utilization.
 - » Not all CBOs are well positioned to provide these services efficiently and effectively.



Recommendations for Community-Based Organizations

- Make sure that outreach and enrollment services “fit” the organization – complement mission, clients served, and populations served in community.
 - » Needs assessment may help determine whether organization has ready access to “target populations” that include sufficient # of EBNE
- Ensure appropriate planning and start up time.
 - » Need time to hire and train outreach workers, plan new services and identify community partners. Integration is important early on.



Recommendations for Community-Based Organizations

- At the outset, focus more on in-reach not outreach strategies.
 - » External outreach should be strategically planned and monitored so it does not detract from core mission of organization and clients it serves.
- Focus on application assistance.
 - » Despite well-intentioned efforts to facilitate use of health care services, CBOs, in large part, did not fulfill this function. However, they succeeded when focusing largely on getting EBNE children enrolled in public health insurance.

