HIGHLIGHTS

of The Colorado Trust's Outreach and Enrollment for Children and Youth Grant Strategy Evaluation

Optimizing Outreach and Application Assistance Services in Community-based Organizations

By Deborah S. Main, PhD, Katherine E. Fedde, MS, Jennifer L. Waltz & Catia Chavez, MPH

INTRODUCTION

Despite widespread national and state efforts to ensure that all low-income children are enrolled in public health insurance, this goal has not yet been fully met. In 2011, estimates indicated that nearly 90,000 uninsured low-income children in Colorado were eligible for public health insurance programs but did not enroll.[1] Recent improvements to expand outreach and simplify enrollment processes are promising, as is the Affordable Care Act's focus on broadening the Medicaid and Children's Health Insurance Program (CHIP) umbrella of eligibility.[2] However, these large-scale changes will place considerable demand on existing enrollment systems and require better ways of reaching and enrolling the eligible but not enrolled (EBNE) population. Involving community-based organizations (CBOs) in the provision of enrollment assistance services is among the most commonly recommended solutions for addressing imminent challenges of eligibility expansion.[3-6] Well run and respected CBOs have a special place in local communities by engendering a sense of familiarity, comfort and trust; by reaching eligible families who would otherwise not seek enrollment, either because they are unaware they are eligible, don't know or understand how public health insurance works, are confused by the application process, or mistrust government programs. CBOs are uniquely poised with direct access to families through a variety of means and can serve as "trusted hands."

A trusted-hand approach to outreach and enrollment assistance combines a trusted community organization that has established relationships with the families it serves, as well as a clear understanding of the families' needs, with a comprehensive approach to enrollment that assists families through the entire lifecycle of a public insurance application – from eligibility assessment to enrollment, renewal and utilization of benefits.[7]

BACKGROUND OF GRANT STRATEGY AND EVALUATION

To help realize its vision of achieving access to health for all Coloradans, The Colorado Trust (The Trust) designed a three-year, $3.3 million grant strategy (2009-2011) to help expand enrollment of children and youth in the Child Health Plan *Plus* (CHP+) and Medicaid public health insurance programs. In 2009, The Trust funded 19 CBOs with established access to children to provide comprehensive outreach and application assistance services in community-based settings throughout the state using outreach workers (OWs). The rationale behind this strategy was to "go where the kids are" and in turn support new outreach and enrollment programs within CBOs that were well positioned in the community to reach and assist EBNE children and youth.

In 2008, The Trust partnered with an external evaluation team from the University of Colorado Denver to conduct a comprehensive, multi-year evaluation (2008-2012) of the Outreach and Enrollment grant strategy. The primary goals of the evaluation were to understand the reach, implementation and effectiveness of outreach and enrollment services delivered by a diverse array of Trust-funded CBOs. As well, the evaluation sought to identify best practices for optimizing the practice of outreach and application assistance services in community-based settings.

A total of 12 of the 19 Trust-funded CBOs participated in this multi-year evaluation (see Table 1). These 12 CBOs represented a range of different types of organizations – variation that allowed the evaluators to study how CBOs with different organizational missions and client populations designed and implemented outreach and application assistance programs to fit their settings. The primary evaluation questions were:

REACH: Which populations do CBOs reach and not reach?

IMPLEMENTATION: What outreach and application assistance strategies are CBOs using?

EFFECTIVENESS: What is the impact of these CBO models and strategies on enrollment, renewal of enrollment and use of benefits?

TABLE 1: EVALUATION SITES

Grantee Name	Colorado Locations	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

METHODOLOGY

Data collection methods included a combination of site visits, interviews with outreach workers and administrators, and client-level quantitative information on those assisted, enrolled, and who used health insurance during and six months beyond the three-year funding period. Costs and sustainability data were also collected in order to understand the financial costs of implementing outreach and enrollment services and the extent to which the 12 CBOs continued offering services after Trust funding concluded.

For a complete description of the evaluation methods, please see the full evaluation report at www.coloradotrust.org.

EVALUATION FINDINGS

The following summary of findings is organized by the three focus areas of the evaluation: Reach, Implementation and Effectiveness.

REACH: Which populations do CBOs reach and not reach?

The 12 CBOs assisted a total of 6,242 clients from 3,202 households with public health insurance outreach and enrollment-related efforts over the course of the grant period (between January 2009 and December 2011). These clients were 63% Hispanic, 20% white, 5% black, 2% Asian and 3% multi-race/other (see Figure 1).

Notably, outreach workers from the 12 CBOs reached a much higher percentage of clients who identified as Hispanic when comparing these data to summary data on the race and ethnicity of the overall Colorado Medicaid/CHP+ enrollee population (for 2011) and for Denver County (see Figures 2 and 3).

These same patterns of difference hold for the primary language spoken in the household: 50% of clients assisted by grantees spoke Spanish as their primary language, compared to state and Denver County percentages of 16% and 29%, respectively. That grantees reached clients from a significantly higher percentage of Spanish-speaking households demonstrates the value of CBO assistance providers who target non-native English speakers, as this population comprises a large part of those EBNE who might not otherwise be reached.[8]

IMPLEMENTATION: What outreach and application assistance strategies are CBOs using?

The diversity of the 12 grantees' settings, missions and populations they serve resulted in using wide-ranging approaches to outreach and application assistance. However, there were a few common strategies used by sites to reach, assist and help enroll children and families in public health insurance.

- **IN-REACH** – The large majority of grantees – nine of 12 – focused more of their time and energy on "in-reach" (i.e., working within their own organizations to identify EBNE children). For example, drop-in and recreational sites added questions to intake forms or member surveys to ask about health insurance and whether they want to be contacted. Also, one site added application assistance services to their existing menu of public assistance resources and information they offer at the Mexican Consulate.

FIGURE 1. GRANTEE CLIENT RACE/ETHNICITY

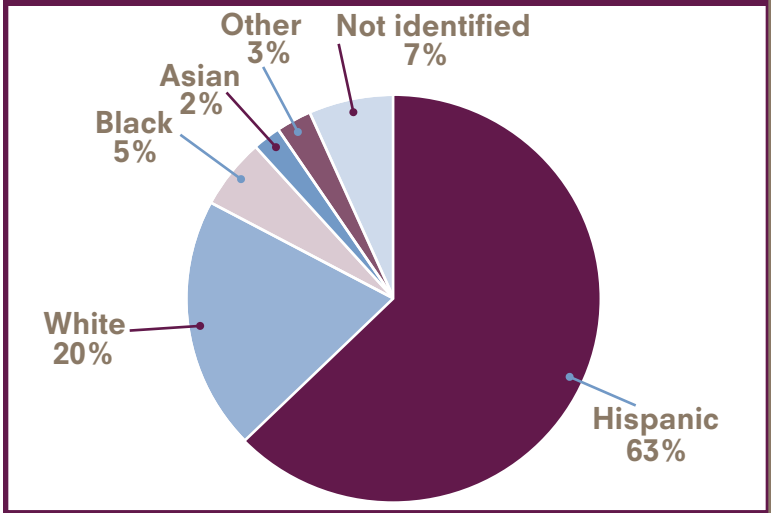


FIGURE 2. COLORADO 2011 MEDICAID/CHP+ ENROLLEE RACE/ETHNICITY

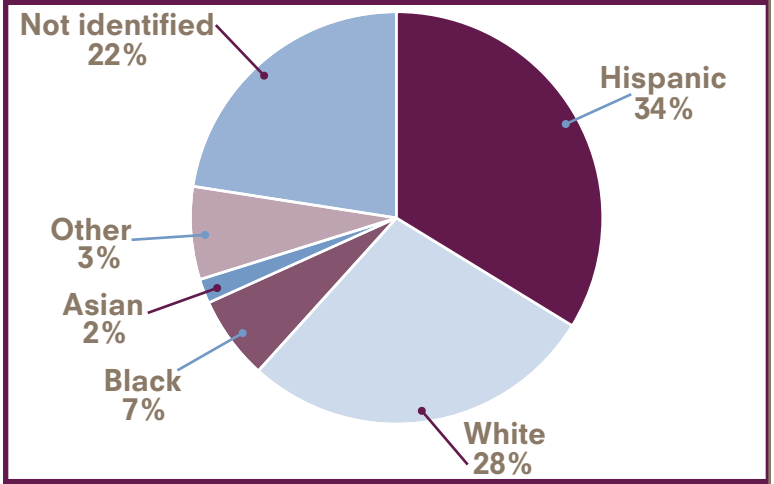
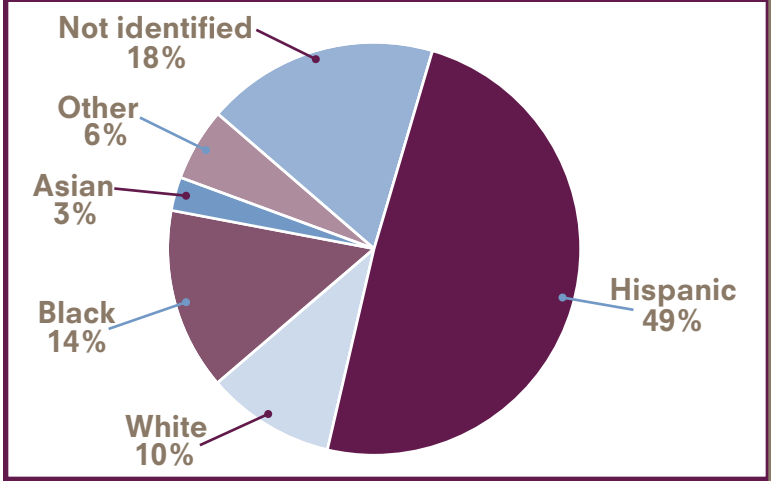


FIGURE 3. DENVER COUNTY 2011 MEDICAID/CHP+ ENROLLEE RACE/ETHNICITY



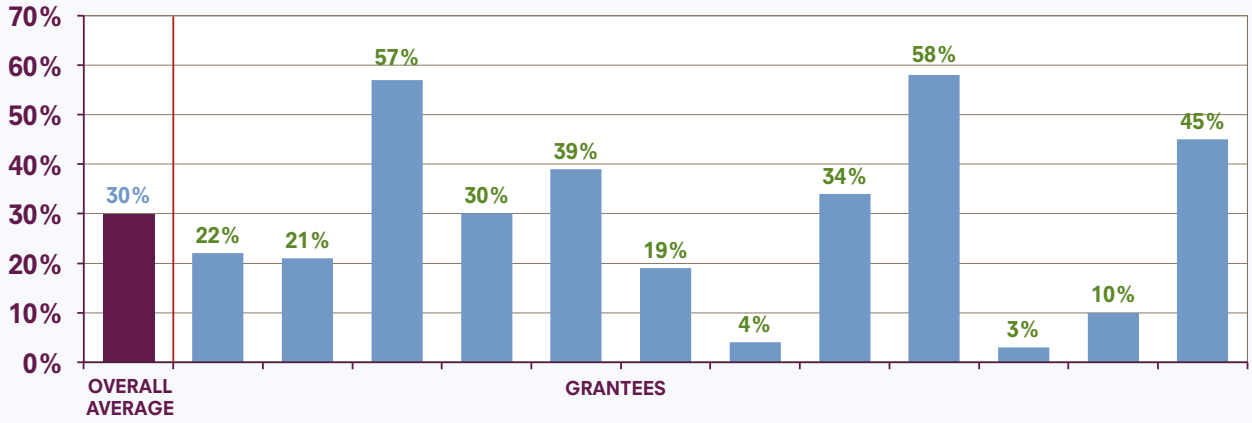
- **FINANCIAL INCENTIVES/REIMBURSEMENT FOR CLIENTS** – About half of the CBOs used some of their grant funds to cover costs for obtaining missing client identity documents (e.g., birth certificates). Another CBO used grant funds to offer clients a $50 incentive to complete an application or cover document costs.
- **COLLABORATION/PARTNERSHIPS WITH OTHER CBOS** – Many sites focused primarily on in-reach strategies established linkages with other CBOs to which they could refer their clients for services. For example, one site provided extensive support (e.g., training, technical assistance, policy updates) to several community-based partners to assist clients with applications. Another site was able to successfully leverage an existing partnership with a CBO that served a similar population so that together they were able to offer a wider range of coordinated services to their clients.

Overall, nearly all interactions with new clients (95%) involved assisting with a new application, 4% for redetermination/reenrollment, and 1% on an existing application. The high number of new clients seeking application assistance within these 12 CBOs is not surprising given that this was the first foray for most into the realm of application assistance; however, it does indicate how they spent their time when they first met clients: completing and submitting applications.

Notably, all 12 CBOs placed less of an emphasis on assisting clients during the post-application submission period. Among all clients/households, only 30% received some type of assistance after submitting their applications. Figure 4 illustrates the considerable variability among grantees in assistance they provided to clients post-submission (from 3% to 58%). This finding suggests that most CBOs, while well-positioned to assist EBNE clients during the outreach/in-reach and application phases, may be less suited to provide post-application assistance, especially as it relates to facilitating utilization of health care services.

Figure 4

Percent of Households Receiving Post-submission Assistance



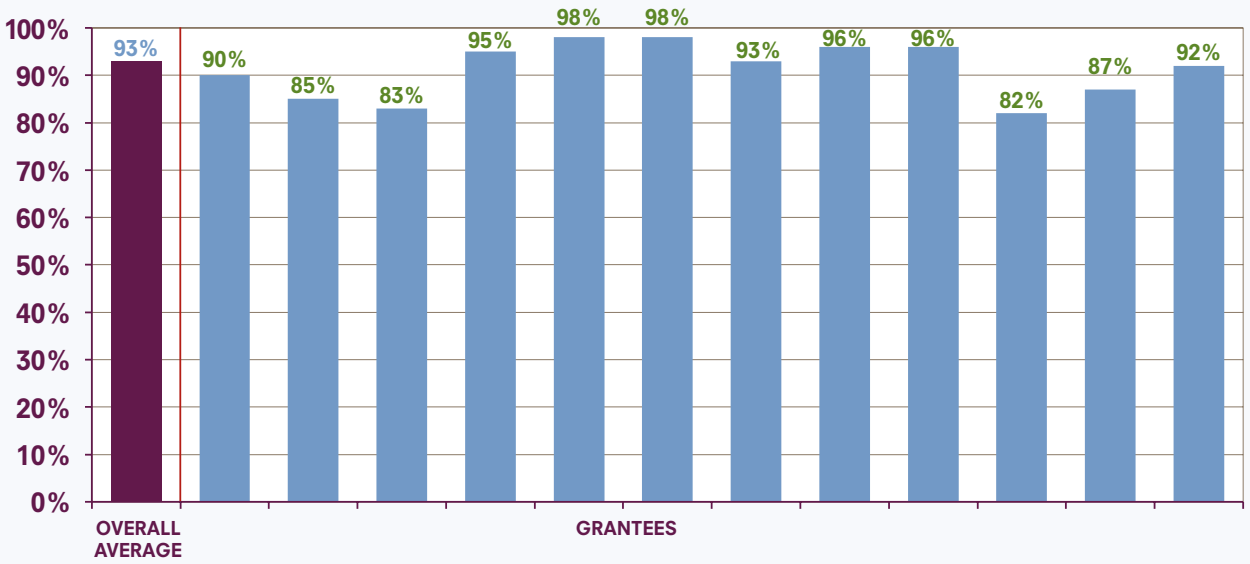
EFFECTIVENESS: What is the impact of these CBO models and strategies on enrollment, renewal of enrollment and use of benefits?

Overall, enrollment rates suggest that the CBOs demonstrated effective practices. Among all individual clients assisted, 93% were successfully enrolled in Medicaid or CHP+. Figure 5 on page 5 illustrates the range of enrollment rates across all 12 CBOs.

Among the 12 CBOs, out of the 6,242 clients assisted, a total of 5,584 clients were enrolled in public health insurance. The overall distribution was 77% Medicaid, 23% CHP+. A comparison of these findings to similar data from the state (Medicaid: 88%, CHP+: 12%) and Denver county (Medicaid: 91%, CHP+: 9%) reveal that clients served by CBOs participating in this evaluation were more likely to be

Figure 5

Enrollment Rate



enrolled in CHP+, an indication of the different target populations reached by these CBOs. The number of clients enrolled also varied considerably from one CBO to the next, ranging from a low of 29 to a high of 1,100.

With respect to utilization of insurance benefits, 87% of Medicaid beneficiaries used their benefits at least once between January 1, 2009 and July 1, 2012. (Note: This only pertains to EPSDT (Early Periodic Screening, Diagnosis and Treatment), dental, physician, inpatient hospital and outpatient hospital visits, and does not include HMO visits – which are not tracked by the Medicaid Management Information System, the database that tracks utilization of health services, among other data points; these limitations need to be taken into account in understanding this indicator.)

COSTS ANALYSIS

In addition to tracking enrollment and utilization rates, the evaluation calculated a cost-per-client enrolled figure based on Trust-only funding. Findings show that the cost-per-client enrolled varied considerably across the 12 CBOs, with three CBOs clearly standing out due to their extraordinarily high cost-per-client enrolled, ranging from $1,162 to $7,862. These numbers are in stark contrast to the lowest cost-per-client CBOs, with the lowest two at $117 and $119-per-client enrolled and two others coming in just below $300-per-client enrolled ($244, $294). Estimates of cost-per-client enrolled of these four "top" CBOs compare favorably to the estimate of $280-per-client enrolled reported in a 2004 cost analysis study of outreach and enrollment in managed care organizations in New York City.[9]

Interestingly, time spent with clients, and the type of client populations these CBOs served, seemed to have no relationship to their costs ranking. Two of the top four ranked CBOs, in terms of lower costs, spent significantly more time with clients, and all served client populations previously described in the literature as hard to reach (e.g., homeless, Latino, many primarily Spanish speaking). In contrast, the lowest-ranked three CBOs did not spend more time with clients; their high costs were due to their failure to assist or enroll many clients in public health insurance.

SUSTAINABILITY OF PROGRAMS

An important organizational indicator of the success of The Trust funding is whether CBOs continue to offer enrollment assistance services after funding ends. Based on qualitative interviews conducted six months after Trust funding ended, the evaluation found that eight of 12 continued to provide outreach and enrollment services in some capacity. The four CBOs not continuing services all had the highest cost-per-client enrolled estimates.

BEST PRACTICES OF OUTREACH AND APPLICATION ASSISTANCE SERVICES

Taken together, the findings reinforce the strong potential of CBOs in reaching and enrolling children and families in public health insurance. However, it was clear that CBOs in the evaluation were not equally able to provide outreach and enrollment services in an efficient and sustainable way. Those CBOs considered "exemplary" in the evaluation (as defined by low cost-per-child enrolled and sustaining services six months after funding) shared several elements:

- **APPROPRIATE PLANNING AND START-UP TIME**
  Especially because CBOs were new to public health insurance assistance, the successful CBOs built in ample planning time (approximately two to three months) and pre-implementation activities, such as hiring and training outreach workers.
- **ORGANIZATIONAL FIT AND INTEGRATION**
  Successful CBOs planned and implemented outreach and enrollment services that closely aligned and supported their organizational mission. These new services were viewed as an essential part of the organization and were integrated into existing organizational structures and processes to enhance efficiency and sustainability.
- **A FOCUS ON IN-REACH STRATEGIES**
  Successful CBOs focused primarily on in-reach strategies targeting their own client populations. This not only allowed them to work with clients with whom they had developed close relationships (within a setting that was familiar), but to deliver these services more efficiently, particularly for those sites already working with low-income populations with sufficient numbers of EBNE.

RECOMMENDATIONS AND CONCLUSION

As community organizations have the potential to play a larger role in expanding outreach and enrollment services, especially under the Affordable Care Act, there are several important recommendations for both practitioners and public and private funders to consider.

FOR PUBLIC AND PRIVATE FUNDERS:

1. **Increase support for community-based organizations to have an expanded role in the Affordable Care Act.** As health care reform implementation unfolds, communities will be a primary locus of activity. In turn, CBOs can play a major role in supporting the varied needs of newly eligible populations, specifically as it relates to outreach, education, enrollment and patient navigation.
2. **Identify the appropriate role that community-based organizations can play within the continuum of public health insurance outreach, enrollment and benefit utilization.** This report's findings suggest that not all CBOs are well positioned to provide outreach and application assistance services effectively and efficiently. Public and private funders should identify the appropriate role that CBOs, especially those that are new to public health insurance outreach and enrollment, can play and then provide the corresponding training and support. For example, CBOs, while effective at identifying and enrolling EBNE children may be ill-suited to connect them with health care services.
3. **Provide capacity building support to community-based organizations.** Ongoing education, training and support are essential in a CBOs ability to implement an effective outreach and enrollment service. Key areas of support to consider include education on changes in screening and enrollment policies, best practice approaches to collaborating with county agencies and other CBOs, cultural and language competency, better access to information technology and electronic data tracking systems.

FOR COMMUNITY-BASED ORGANIZATIONS:

1. **Ensure organizational "fit."** Organizational "tailoring" of outreach and application assistance services is essential to ensuring that services "fit" well within the CBO. This "fit" should complement the mission of the organization, the client populations they serve, and populations in the community they can potentially reach. Specifically, CBOs may want to conduct a comprehensive needs assessment, carefully considering whether the organization has ready access to "target populations" that include sufficient numbers of EBNE.

2. **Ensure appropriate planning and start-up time.** CBOs new to providing application assistance services need time to hire and train outreach workers, plan these new services and identify relevant community partners. The vast majority of CBOs in the evaluation averaged two to three months before their services were up and running.
3. **At the outset, focus more on in-reach not outreach strategies.** External outreach activities should be strategically planned and monitored to ensure that these efforts do not detract from the core work of the organization and the clients it serves. Similar to findings of a previous study,[10] many CBOs found that outreach was not an effective method for enrolling new clients; some saw its value more for making connections with other CBOs, raising visibility and marketing the organization more generally.
4. **Focus on application assistance.** Despite well-intentioned efforts to facilitate the use of health care services, CBOs, in large part did not fulfill this function. However, CBOs succeeded when focused largely on application assistance (i.e., getting EBNE children enrolled in public health insurance).

As these recommendations suggest, maximizing the unique role that CBOs can play in identifying and assisting EBNE populations requires interventions at multiple levels. Accordingly, it would behoove funders – be they public or private – to pay attention to the broader health care reform implementation environment that outreach and enrollment services operate in and the tangible organizational supports needed to facilitate a successful outreach and enrollment program. Likewise, it is important for CBOs to pay attention to the organizational conditions and strategies that foster an effective and sustainable outreach and enrollment program. Taken together, addressing these parallel opportunities can help optimize the role of CBOs as trusted, local institutions to support access to health.

ENDNOTES

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1600 SHERMAN STREET
DENVER, CO 80203-1604
WWW.COLORADOTRUST.ORG

PHONE 303-837-1200
TOLL FREE 888-847-9140
FAX 303-839-9034