

**REPORT TO THE PRESIDENT ON  
SCHOOL-BASED OUTREACH FOR  
CHILDREN'S HEALTH INSURANCE**



Submitted by the  
Secretary of Health and Human Services

July 2000

In Collaboration With

The Secretary of Agriculture  
The Secretary of Education

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**for**  
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HHS LOGO

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## **Executive Summary**

The lack of health insurance for millions of American children remains one of the great challenges facing the nation. In 1997, President Clinton worked with Congress to create the bipartisan State Children's Health Insurance Program (SCHIP), the single largest expansion of children's health insurance in 30 years. Every State and Territory has responded to this opportunity provided by SCHIP to expand health insurance coverage to low-income children. SCHIP builds upon the Medicaid program, which currently provides health coverage to very low-income children. States have broad flexibility to expand Medicaid to cover more low-income children and 23 States have exercised this option, 18 States have a combined Medicaid/SCHIP program and the remaining 15 States have separate State programs. As of September 1999, nearly 2 million children who would otherwise be without health insurance were enrolled in SCHIP and many more have also been enrolled in Medicaid as a result of increased outreach efforts.

Together, SCHIP and Medicaid could cover more uninsured, low-income children. There are still many eligible but unenrolled children whom we need to reach. Barriers to enrollment persist, including parents' lack of knowledge about insurance options, cultural and language barriers, complicated application and enrollment processes and the stigma associated with publicly-funded programs.

Because most of the nation's children can be found in schools (including preschool, Head Start and child care), a natural place for outreach efforts to increase health insurance enrollment is in our schools. On October 12, 1999, the President directed the Secretaries of Health and Human Services (HHS), Education (ED) and Agriculture (USDA) to develop specific recommendations to encourage and integrate Medicaid and SCHIP outreach and enrollment for children in school settings. Over the past several months, a cross-Departmental workgroup gathered information about school-based outreach from national, regional, state and local health and education sources and held a National Summit to find promising outreach practices.

Our findings indicate that school systems and early childhood programs are indeed the critical link in successful outreach for children's health insurance programs in many States. In communities across the country, schools are accepted by parents as a conduit for important and credible information. Many schools already partner with States, community-based organizations or provider groups to conduct outreach. Current school outreach activities vary widely, from providing information for children to take home to directly assisting families with enrollment.

There is widespread recognition; however, that schools face multiple barriers in these efforts. Schools lack the funding, expertise or time it takes to conduct sustained outreach campaigns. Privacy issues make sharing information between programs difficult. It is important to remove these barriers through collaboration and partnerships around child health in order to build on and expand effective outreach campaigns in schools across the country.

There is a shared recognition at all levels that America's children face many compelling educational,

health and developmental challenges that affect their lives and their futures. The fields of education and health must work together to give children the assistance they need to have bright and healthy futures.

At the request of the President, we have prepared a Report which outlines our findings, describing barriers and promising approaches to school-based outreach and makes recommendations to ensure that health insurance outreach for children becomes a customary part of school activity. The Report also provides a Federal action plan for assisting States and schools in this effort. In addition, we are developing “how to” school-based outreach guides for distribution to school districts and schools, providers and community groups. Throughout this Report, we refer to schools in the broader sense to include both schools and early childhood programs.

## **Recommendations for the Federal Government**

Although States have used many creative approaches so far to reach out to uninsured children through Medicaid and SCHIP, challenges to identifying and enrolling eligible children remain substantial. While schools can participate in outreach and enrollment efforts under current law, the following proposals would enhance their ability to increase outreach activities and enroll many more uninsured children. We strongly support the President's fiscal year 2001 budget proposals to accelerate the enrollment of Medicaid and SCHIP eligible children through schools and are pleased with the recent passage of legislation by Congress and signed by the President which will increase the coordination between Medicaid, SCHIP and the National School Lunch Program. Additionally, we recommend the Federal government act on the following recommendations:

- ' **Facilitate coordinated enrollment activities between Medicaid, SCHIP and other public programs with similar eligibility criteria, such as the National School Lunch Program.**
- ' **Provide technical assistance and support to help States, communities, health care providers and schools implement school-based outreach and enrollment activities for Medicaid and SCHIP.**
- ' **Encourage new or additional school-based outreach and enrollment efforts by helping States and schools identify and maximize funding opportunities.**

## **Promising State Practices**

Almost every State enlists the support of schools in its outreach and enrollment strategies for reaching

children. In the most effective examples, State agencies' participation have been integral to successful outreach. The State provides leadership, enacts enabling legislation or promulgates effective regulations and procedures, and makes available the essential resources. Without these elements, school-based enrollment may not be successful or sustainable.

The promising State practices included in this Report are based on models where States exercised their leadership and used their resources to achieve successful school-based outreach and enrollment. Simplification is central to the success of outreach and enrollment strategies. The Administration is doing much to encourage simplification, and most States are making efforts to simplify their enrollment systems further. While simplification is critical to successful enrollment efforts, this section of the Report focuses on school-based recommendations and strategies. States can use these promising practices and those that follow for schools to develop or expand their State-specific strategies and plans of action.

While many of the descriptions of the practices refer solely to schools, these same approaches have also shown promise for early child care/education program settings.

## **Promising Practices for School Districts and Schools**

Because of their unique role in local communities, schools are effective in identifying and educating uninsured families and motivating them to seek health insurance and utilize health services for their children. Families believe school organizations associated with school systems provide credible and reliable information. Several State officials report that schools are one of the primary sources of health insurance information identified by callers to State eligibility centers.

Our research on current outreach activities in schools highlighted a wide array of successful techniques to identify and help enroll uninsured children in children's health insurance programs. In part, the continuum of successful outreach includes: identifying and understanding eligible children and their families; educating individuals about the programs; motivating people to take action; facilitating actions needed to enroll children in the programs; following-up with families and State agencies on the status of applications; and evaluating the outreach strategy. While schools can actively participate in all five steps described in the outreach continuum, many schools have fully participated in identifying, educating and motivating families to enroll their uninsured children.

## **Recommendation for Evaluation**

An important step in implementing the recommendations in this Report is to develop evaluation strategies that the Federal government, States and schools can use to determine the success of their

school-based outreach efforts. Designing an evaluation component during the planning stages of an outreach project forces planners to specify the project's desired outcomes. In SCHIP and Medicaid outreach, the ultimate desired outcome is increased access to comprehensive health care especially primary and preventive health services, through increased enrollment. However, focusing on evaluation encourages planners to strategically identify incremental steps that must be accomplished to obtain the ultimate desired outcome.

In order to promote evaluation of school-based outreach activities, we propose the following recommendation:

- ' **The Federal government should evaluate school-based outreach and enrollment in partnership with States, communities and schools.**

## **Summary**

In summary, schools and early child care/education programs are a promising place to conduct outreach for children's health insurance. Most uninsured children can be found in these settings and most parents look to schools and early childhood programs for information they can trust related to their children. However, schools and early childhood programs face multiple barriers in conducting health insurance outreach, including constraints on time, resources and expertise, as well as privacy issues that limit information sharing. In order to facilitate school-based outreach for children's health insurance, the Federal Government, the States, schools and other partners must join together to break down existing barriers and connect eligible children with the health coverage they need. This Report proposes a set of recommendations that would greatly reduce the existing barriers that keep school-based outreach from becoming an integral part of school business.

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# **REPORT TO THE PRESIDENT ON SCHOOL-BASED OUTREACH FOR CHILDREN'S HEALTH INSURANCE**

On October 12, 1999, the President directed the Secretaries of Health and Human Services (HHS), Education (ED) and Agriculture (USDA) to develop a set of recommendations to integrate outreach efforts to enroll children in Medicaid and the State Children's Health Insurance Program (SCHIP) as a regular part of school business. (See Appendix A, Executive Memorandum). In response to this directive, a cross-Departmental workgroup has gathered information from national, regional, State and local health and education sources. This Report outlines their findings, describes barriers and promising approaches to school-based outreach, gives recommendations to make health insurance outreach for children a customary part of school activity and suggests strategies to evaluate these efforts. The Report also provides a Federal action plan for assisting States and schools in this effort. (See Appendix B, Federal Action Plan).

### **Significance of the Problem of Uninsured Children**

Despite unprecedented economic growth and record low unemployment in recent years, in 1998 there were more than 11 million children under the age of 18 who lacked health insurance coverage in the United States. Children represent approximately 25 percent of all uninsured.<sup>1</sup> Two out of three of these children, or over 7 million, live in families with household incomes below 200 percent of the Federal Poverty Level (FPL).

### **New Opportunities to Provide Health Insurance for Children**

Lack of health insurance for millions of American children remains one of the great challenges facing the nation. In 1997, President Clinton worked with Congress to create the bipartisan State Children's Health Insurance Program (SCHIP), the single largest expansion of children's health insurance in 30

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<sup>1</sup> United States Department of Commerce, [www.census.gov/hhes/hlthins98.html](http://www.census.gov/hhes/hlthins98.html).

years. The 1997 Balanced Budget Act allocates \$24 billion over 5 years to extend health care coverage to millions of uninsured children in working families. SCHIP is a Federal/State partnership that gives States three options for covering uninsured children: designing a new children's health insurance program; expanding its current Medicaid program; or a combination of both strategies. Every State and Territory has responded to the opportunity provided by SCHIP to expand health insurance coverage to low-income children.

SCHIP builds upon the Medicaid program, which currently provides health coverage to most very low-income children. Changes have also transformed the Medicaid program. Prior to 1996, many low-income families were eligible for Medicaid through the Federal cash assistance program Aid to Families with Dependent Children. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced the old cash assistance programs with a new State-run Temporary Assistance for Needy Families (TANF) program and ended the automatic link between eligibility for cash assistance and eligibility for Medicaid. To preserve Medicaid coverage for low-income families with children, the welfare reform law created a new Medicaid eligibility category. Under the new provision, families who would have qualified for Medicaid under a State's old cash assistance program are currently eligible for Medicaid now, regardless of whether or not they currently receive TANF assistance. The law also made available to States \$500 million in enhanced matching funds to support system changes and outreach necessary to address the effects of "delinking" Medicaid from welfare. States were also provided with broad flexibility to expand Medicaid to cover more low-income families as an option. A number of the States have exercised this option.

Together, SCHIP and Medicaid could cover most uninsured children. However, increased outreach efforts are necessary to identify and enroll these eligible children.

### **The Importance of Outreach**

Outreach for children's health insurance is a dynamic process of identifying eligible children and families, and educating and enrolling them in Medicaid or SCHIP. The Federal government has worked in partnership with States to find and enroll eligible children in both SCHIP and Medicaid. In 1999, President Clinton and the National Governors' Association launched the *Insure Kids Now!* campaign which includes a national toll-free number (1-877 KIDS-NOW) and web site [www.insurekidsnow.gov](http://www.insurekidsnow.gov). The *Insure Kids Now!* hotline is a toll-free number that connects callers automatically to their own State agency that conducts enrollment activities for Medicaid and SCHIP. To date, over a quarter of a million calls have been placed through this number. The website has information on eligibility requirements for families and ongoing outreach efforts. Federal efforts continue to support State efforts to inform, identify and enroll children in their SCHIP or Medicaid programs. Many States have implemented aggressive outreach and enrollment campaigns that use

radio, television and print media to inform families about the States' programs, provide a toll-free hotline, outstation eligibility workers in local communities, and involve schools, employers, health care providers, community-based organizations and the business community.

As a result of these and other outreach efforts, nearly two million children who would otherwise be without health insurance coverage were enrolled in SCHIP during Federal fiscal year 1999. This is twice the number reported for the first full year of the program. The new enrollment figures were released by HHS Secretary Donna Shalala in January 2000 and are based on State-by-State reported data on the number of children who had access to health insurance from October 1, 1998 to September 30, 1999. Of the nearly two million children covered during Federal fiscal year 1999, States reported that more than 1.2 million were in the new State-designed children's health insurance program and almost 700,000 were enrolled in Medicaid expansion plans. These figures represent only those children for whom States received SCHIP funding; many children have also been enrolled in Medicaid as a result of increased outreach efforts. The study of Medicaid enrollment in 21 States, recently reported by the Kaiser Commission on Medicaid and the Uninsured, suggests an upward trend in Medicaid enrollment in 12 States as of June 1999, thus reversing an earlier decline.<sup>2</sup>

Despite these encouraging figures, millions of children are still eligible for Medicaid and SCHIP but are not enrolled. Approximately 3 million low-income uninsured children are eligible for SCHIP and approximately 4 million are potentially eligible for Medicaid but are not enrolled. Barriers to enrollment persist, including parents' lack of knowledge about insurance options; cultural and language barriers; special fears among immigrant families; complicated application and enrollment processes; and the "stigma" associated with so-called welfare programs. Intensified outreach is needed to overcome these barriers.

### **President's Executive Memorandum**

Most uninsured children can be found in schools (or in preschool, Head Start and child care programs) and since most parents consider schools a trusted conduit for important information, schools are a critical link in outreach. Recognizing the important role that schools can play in outreach for health insurance programs, President Clinton, on October 12, 1999, issued an Executive Memorandum directing the Secretaries of Health and Human Services, Agriculture, and Education to recommend specific actions to encourage and integrate health insurance outreach and enrollment for children in

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<sup>2</sup> Smith, Vernon K., Eileen Ellis and Health Management Associates, "*Medicaid Enrollment in 21 States: June 1997 to June 1999*," Prepared by the Kaiser Commission on Medicaid and the Uninsured, April 2000.

school settings.<sup>3</sup> The memorandum asks for short and long-term recommendations on administrative and legislative actions for making school-based outreach to enroll children in SCHIP and Medicaid an integral part of school business. These actions may include:

- Technical assistance and other support to school districts and schools that engage in outreach;
- Suggestions on how to effectively use the school lunch program application process to promote enrollment in health insurance programs;
- Lists of practices that have proven effective, such as integration of outreach and enrollment activities into school events; and
- Model SCHIP and Medicaid policies and plans for school-based outreach.

Finally, the President asked for a summary of key findings from national and regional conferences on school-based outreach and for recommendations on methods to evaluate SCHIP and Medicaid outreach strategies in schools. The President directed the Department of Health and Human Services to serve as coordinating agency in the development of these recommendations and asked the Secretary of Health and Human Services report back to him in six months.

In the interim, the Administration has continued to work through public and private efforts to improve children's health coverage. The President's Budget for Fiscal Year 2001 includes several proposals that would facilitate outreach and enrollment, including extending coverage by creating a new "Family Care" program that would build on SCHIP to extend coverage to uninsured parents of low-income children and expand State options to insure children through age 20. The President also proposed accelerating enrollment of eligible Medicaid and SCHIP children through programs that promote enrollment simplification, expansion of enrollment sites, and information sharing between the school lunch program and Medicaid. In addition, the President proposed giving States the option to insure legal immigrant children and pregnant women in Medicaid and SCHIP regardless of their date of entry into this country.

### **Departmental Response**

To implement the Executive Memorandum, the three Departments established a workgroup with

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<sup>3</sup>Memorandum for the Secretary of Health and Human Services, the Secretary of Education, and the Secretary of Agriculture, Subject: School-Based Health Insurance Outreach for Children; The White House, Office of the Press Secretary, October 12, 1999. See Appendix A.

representatives from HHS's Office of the Secretary, Health Care Financing Administration (HCFA), Health Resources and Services Administration (HRSA), and Administration for Children and Families (ACF); the Department of Agriculture (USDA); and the Department of Education (ED). The Department of Justice (DOJ) and Corporation for National Service (CNS) also participated on the workgroup.

A number of activities were completed in response to the President's Executive Memorandum and form the basis of the recommendations in this Report. These included the following:

- **Regional Meetings**

HHS's HCFA, with HRSA, USDA and ED, sponsored a series of seven regional telephone conference calls between October 26, 1999 and November 1, 1999. More than 1,200 call participants representing 36 States discussed State and local issues surrounding school-based enrollment, identified key concerns, and shared successful approaches to outreach. In addition, ED and USDA worked with HHS to sponsor regional conferences on school-based outreach in New York, Philadelphia and San Francisco. The summary of regional meetings is available at [www.insurekidsnow.gov/childhealth/outreach/interim.pdf](http://www.insurekidsnow.gov/childhealth/outreach/interim.pdf).

- **National Summit on School-Based Outreach**

On November 17-18, 1999, HRSA, with HCFA, ED, USDA, and DOJ hosted a two-day National Summit on School-Based Outreach for Children's Health Insurance Programs in Washington, D.C. The conference was attended by more than 300 individuals representing teams of States' Education and SCHIP/Medicaid agencies and outreach workers, Federal agencies and national advocacy organizations. The National Summit opened with remarks from HHS Secretary Shalala, Education Secretary Riley, Agriculture Secretary Glickman and Attorney General Reno. The Summit featured plenary and breakout sessions to identify successful school-based health insurance outreach and enrollment strategies and to discuss ways in which such school-based strategies could become a routine school practice. The National Summit Proceedings are posted at [www.insurekidsnow.gov/childhealth/outreach/summit.pdf](http://www.insurekidsnow.gov/childhealth/outreach/summit.pdf).

- **Consultation with Professional Organizations**

The Department of Education called two meetings to solicit suggestions and feedback from national health, nutrition and education organizations. On November 18, 1999, at the National Summit, many of these groups came together in a breakout session to discuss some of the current practices and challenges in school-based outreach. On February 24, 2000, ED hosted a follow-up meeting to continue this dialogue. Groups in attendance included the Council of Chief State School Officers, the Council of Great City Schools, the National Center for School Health Nursing, the National School Boards Association, the Association of State and Territorial Health Organizations, American School Counselors Association, the AFL-CIO, American School Food Service Association, the Public Education Network and the National Association of Social Workers.

- **Contract**

HCFA contracted with the Barents Group, LLC and the Academy for Educational Development (AED) to collect and synthesize information on school-based health insurance outreach and enrollment strategies. Sources of information included State and Federal government documents and reports, reports by foundations and nonprofit organizations, articles published in peer-review journals and information from relevant websites, and direct contact with 32 State SCHIP/Medicaid representatives. This information assisted in the preparation of this report and “how to” guides on school-based outreach for school districts, health providers and State Medicaid, SCHIP and education agencies.

These activities built on other current efforts already underway to support school-based outreach, including:

- **Using the free and reduced price school lunch program**

This critical program can provide information to families and help to enroll children in health programs. Many school districts have provided families with information about free and low-cost health insurance at the same time they distributed the free and reduced price school meal application. Also, many districts included a check off box on the school meal application, or a separate form so families could request health insurance information.

On April 30, 1999, USDA issued a comprehensive Prototype Free and Reduced Price

Meal Application for use in schools and day care facilities. The prototype application package included a separate form for households to request information about Medicaid and SCHIP. Additionally, these materials were recently translated into 12 different languages and distributed to State agencies that administer the Federally-assisted feeding programs for children in schools and day care facilities. These forms are also available on the agency's website.<sup>4</sup> USDA encourages the use of the prototype school lunch application forms. The applications were translated into other languages so that households with limited English reading skills can apply for free and reduced price meals and can authorize the sharing of information from their free and reduced price meal application for health insurance purposes.

- **Back-to-School campaigns**

The Department of Education launched a campaign entitled *Insure Kids Now! Through Schools*. On August 9, 1999, ED sent letters to all 15,575 school superintendents around the country inviting them to join a national coalition to encourage schools and communities to work together to identify uninsured children for enrollment into SCHIP and Medicaid. A packet of information accompanied the letter, including an activity sheet describing how schools can target and enroll eligible children, a list of State-specific contacts and a pledge form soliciting schools' commitment to outreach.<sup>5</sup> With the support of the National Association of Elementary School Principals and the National Association of Secondary School Principals, a similar letter went to 27,000 elementary and 42,000 secondary school principals and representatives. As of February 2000, 890 school and school district representatives had returned pledge forms, approximately 60 percent from principals, 20 percent from superintendents and 20 percent from an unspecified source.

HHS, DOJ, ED along with several national nonprofit organizations conducted an *Insure Kids Now! National Back-To-School Campaign* in Fall 1999. From September 22 to October 2, 1999, HHS-funded radio announcements to raise awareness about children's health insurance programs in local communities. Forty-five events in more

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<sup>4</sup>Web address is <http://www.fns.usda.gov/cnd/translations/default.htm>

<sup>5</sup>Schools were asked to pledge to take at least one step to help enroll children in health insurance. Possible steps were: contact the State and/or regional SCHIP/Medicaid outreach coordinator for forms or assistance; distribute information to families about children's health insurance programs; help integrate health insurance enrollment into school activities; help get other organizations involved by having ED contact them about how they could help, or conduct another type of school-based outreach/enrollment activity.

than 25 communities were conducted in partnership with local United Way offices, schools, and community partners, including many of the Robert Wood Johnson Foundation's Covering Kids' grantees.<sup>6</sup>

In November 1999, the Administration for Children and Families (ACF) at HHS mailed packets to encourage Head Start programs to become active in Medicaid and SCHIP outreach. Nationwide, 1,513 grantees received materials for dissemination to all 15,872 Head Start programs. The package included an information memorandum with ideas on how to get involved, a Head Start/Medicaid/SCHIP partnership guide developed jointly with HCFA and a pledge form for programs to commit to new or continued outreach efforts. ACF is acknowledging these pledges with *Insure Kids Now!* Coalition certificates and providing follow-up as appropriate through HHS's Regional Offices.

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<sup>6</sup> Covering Kids, a national health access initiative for low-income uninsured children sponsored by the Robert Wood Johnson Foundation, is providing \$47 million to help increase the number of eligible children who benefit from health insurance coverage programs. The three-year grants support 50 Statewide and 167 local coalitions in conducting outreach initiatives and working towards enrollment simplification and coordination of health coverage programs for low-income children. Many of the Covering Kids grantees and their pilot sites are pursuing targeted school-based outreach initiatives.

## **Section 2: Summary of Findings**

The Interdepartmental Workgroup examined the information gathered from the national and regional conferences, review of current literature, discussions with State Medicaid, SCHIP and education agencies, and meetings with school officials. These findings are summarized below and were used in the development of recommendations put forward in this Report.

The findings indicate that school systems are the critical link in successful outreach for children's health insurance programs in many States. Successful efforts to enroll children in Medicaid and SCHIP are often school-based, because schools are accepted by parents as a conduit for important, reliable information. School outreach activities vary widely, from providing information for children to take home, to direct on-site enrollment assistance. Many schools partner with States, community-based organizations or provider groups to conduct outreach. However, there is widespread recognition that many schools face multiple constraints in these efforts. Schools often lack the funding, expertise or time it takes to conduct sustainable outreach campaigns. State Medicaid and SCHIP agencies can maximize the use of public resources for targeting outreach by jointly partnering and supporting those outreach strategies that schools offer to carry out most efficiently and effectively. To build sustainable campaigns in schools, it is important to reduce these constraints through collaboration and partnerships around child health. Yet at all levels, there is a shared recognition that America's children face many compelling educational, health and developmental challenges that affect their lives and their futures. To help children meet these challenges, the fields of education and health must work together.

### **The Importance of Health Insurance for Children**

Literature reviews indicate clear relationships among health insurance, health outcomes and school performance. Children without health insurance suffer more from asthma, ear infections and vision problems, all treatable conditions that interfere with classroom participation. Uninsured children and adolescents are less likely to visit a doctor for routine and preventive care or to have a usual source of care. Uninsured children are more likely to make doctors' visits in the emergency room. Parents of uninsured children are more likely to postpone health care or to not fill a prescription for their child.<sup>7</sup>

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<sup>7</sup> Perry, Michael, page 3.

Uninsured adolescents, compared to their insured counterparts, were five times as likely to lack a usual source of care, four times as likely to have unmet health needs and twice as likely to go without a physician contact during the course of the year.<sup>8</sup>

Children without health insurance are absent from school more frequently than their peers. Access to health care contributes to a child's academic achievement and success by reducing the number and length of school absences. With 11 million uninsured children, there are too many students whose educational experience is continually interrupted by episodes of preventable illness. In a 1999 survey conducted by the American Academy of Pediatrics, teachers reported that 12 percent of their students, up to 18 percent in urban areas, had health problems that impede their academic performance.<sup>9</sup>

As we strive for high standards in every school and classroom, it is essential that we help families ensure that their children arrive at school ready to learn. Good health is a prerequisite for learning and "unhealthy children are children with impaired learning."<sup>10</sup>

### **The Role of Schools in Reaching Uninsured Children and Families**

Schools are a natural setting to conduct outreach for children's health insurance programs, because schools and early child care/education programs are where most of the uninsured children are. State Medicaid and SCHIP agencies seeking the best return on outreach investments often find that working with schools simplifies targeting audiences (e.g., parents of adolescents, Spanish-speaking families), distributing information, reaching families and enrolling children. Other factors that make schools a logical and successful site for outreach efforts include:

- Promoting the healthy development of children contributes to their academic achievement and success. This supports schools' missions for learning.
- Schools have well-developed systems for information dissemination, and parents expect to learn about programs for their children from schools.

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<sup>8</sup>Newacheck, Paul W., DrPH, Claire D. Brindis, DrPH, Courtney Uhler Cart, MSW, MPH, Kristen Marchi, MPH, Charles E. Irwin and Jr, MD. "Adolescent Health Insurance Coverage: Recent Changes and Access to Care," *Pediatrics* 1999 August; 104(2), pp. 195-202.

<sup>9</sup>American Academy of Pediatrics. *Year 2000 Projection of U.S. Children's Health Status and Program Eligibility*, 1999, [www.aap.org/advocacy/schipef.html](http://www.aap.org/advocacy/schipef.html).

<sup>10</sup>Lavin, AT, Shaprio GR, and Weill KS, "Creating an Agenda for School-Based Health Promotion: A Review of Twenty-five Selected Reports." *Journal of School Health*, 1992; 62(6): 212-228.

- Many schools and Head Start programs already have a school nurse, health coordinator or other health care provider (e.g. staff of a school-based health center, community health care provider, etc.) who connects children and their families with health services. In these settings, there is already a connection between health and school.
- Because schools routinely distribute information, they already know and understand communication problems and other concerns of the families in their community.
- Families trust school officials, school teachers, nurses and other school personnel and the information they impart.
- Many schools already have a strong connection to community networks. These networks can assist schools in conducting outreach.
- Schools are commonly viewed by families as a familiar and comfortable setting within the community.
- Schools have experience in related outreach and education efforts regarding health, such as anti-smoking, anti-drug and improved nutrition campaigns.
- Many schools provide health services to eligible children through school-based health clinics.

### **Motivating School Districts and Schools to Participate**

Schools are primarily held accountable for educational outcomes not health-related measures, so schools' limited resources are naturally focused on the mission of educating students. Many schools recognize that they can play an important role in improving the health and well-being of students as well. To encourage schools to engage in health insurance outreach, it is critical to highlight that healthy children perform better in school. Children with health insurance are less likely to be absent from school and are more prepared for classroom learning. In addition, there is a link between health insurance, healthy children and resources; student absences are lower among insured children, thus boosting schools' Average Daily Attendance (ADA) and available funding for schools.<sup>11</sup> These potential benefits can motivate schools to become involved in health insurance outreach. To achieve the maximum participation, schools need to be able to

count on support from local and State partners so that outreach efforts can be minimally burdensome

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<sup>11</sup> "Healthy Kids, Healthy Schools," Consumers Union, 1999.

and highly effective.

School officials who have engaged in school-based outreach identified other strategies as important, if less quantifiable “motivators.” For example, schools welcome recognition, either in the media or through personal contact from State and local officials (e.g., Governor, Mayor) for their successful outreach efforts. It is important to provide feedback to schools and reward their efforts in highly visible ways. Also, seeing a respected peer such as another superintendent or principal take time to persuade a colleague of the importance of their participation can motivate other school officials. Many schools providing outreach and enrollment assistance to parents saw increased parental involvement in the schools as a positive outcome. Finally, since schools’ time and resources are already limited, providing schools with the additional resources for outreach also serves as a strong motivator.

### **Constraints and Barriers**

Principal barriers to school-based outreach include: inadequate resources and administrative support; difficult enrollment processes; and problems in data sharing. Most schools do not have the funding, staffing and space to make a sustained commitment to outreach. Other schools lack administrative support to engage in outreach, especially if principals view it to be a significant burden. Sharing personally identifiable information from the free and reduced price meal applications or from emergency contact cards requires parental consent, therefore schools may encounter problems in data sharing. Finally, some States have not worked with their schools to address existing barriers and States with lengthy and complicated health insurance enrollment processes undermine outreach.

### **Key Factors in Successful Outreach Programs**

The information gathered about school-based outreach suggests that there are some straightforward “keys to success” that apply in most schools. Successful outreach strategies generally facilitate school-based outreach by providing information, resources and staff; and they simplify the application process (e.g., shorter forms, reducing verification) and make it easier for all types of outreach to succeed. Although most agree that what works in one school district might not necessarily work in another, there are some common elements in successful programs.

For example, many schools cited funding for trained outreach workers and school nurses who assist in enrollment and provide follow-up with parents as critical to their success. In addition, a “dedicated” private space to meet with families about insurance that is outfitted with computers to track applications and enrollments, informational materials, consent forms and applications, and portable copy machines were identified as helpful. A number of school officials noted that having an internal champion who

promotes outreach and encourages colleagues to participate was critical to their success. School officials noted that “piggybacking” on other outreach efforts is helpful, such as through immunization programs and the free or reduced price meals program. Finally, minimizing disruptions by building on already scheduled activities was important. School officials suggested taking advantage of natural opportunities for face-to-face meetings with parents, e.g., providing information during back-to-school night, report card distribution days, PTA meetings and in English as a second language classes for parents. Providing feedback to schools about the enrollment of children from that school will help to motivate schools and their outreach partners to continue their efforts by showing them the positive results for children.

Schools asked that States take measures to simplify the application process. Reducing the length of the application and excessive documentation is critical. A simplified process enables the limited resources of schools and their partners to go much further and make parents’ completion of the enrollment process more likely. States noted that it is helpful to monitor schools’ needs and provide technical assistance, as well as other resources. States that stay in touch with school-based efforts can be ready for a surge in applications as a result of outreach activities.

A description of four promising approaches to school-based outreach are highlighted throughout this Report as “Models that Work.”

### **Sources of Outreach Funding**

The most significant source of program funding for SCHIP and Medicaid outreach are administrative funds provided to States. In SCHIP, States’ administrative spending is limited to 10 percent of their total expenditures; however, there is no such limit in Medicaid. Some States have suggested that it would be helpful to raise the 10 percent cap on the use of SCHIP funds while programs are getting “up and running” and creating public awareness. However, this policy change would require Congressional action. States can also use their allocations of the \$500 million Federal fund available under section 1931 of the Social Security Act, in accordance with guidance issued in the January 6, 2000 letter to State officials and the May 14, 1997 Federal Register notice, or State Maintenance of Effort funds for outreach and training activities for Medicaid and SCHIP. In several States, Federal Medicaid funds are used to match the administrative expenditures incurred by States for the costs of salaries of school nurses who perform outreach activities. Finally, in a number of States, tobacco settlement funds are being considered as a source for outreach funding.

Some States provide additional public funding through either the States’ Department of Education or the Department of Health Services. State funds are accessible to schools in several ways. Several States disseminate funds through mini-grants which support local outreach activities and several of the

grantees are school districts. In a few States, application fees are paid to individuals or organizations under contract with the State for each completed and approved application. These application assistance fees in most States come from SCHIP and Medicaid administrative funds. Other sources of funding available to help schools with outreach include private foundations (e.g., the Robert Wood Johnson Foundation's Covering Kids Initiative and local foundations), businesses and schools districts. The schools themselves provide an in-kind contribution to outreach through staff time, school space, and access to school equipment and supplies.

Partnerships with health care providers can bring additional funds and resources. Children who have insurance are more likely to seek preventive services and have a regular source of primary care. They are less likely to seek more expensive care in hospital emergency rooms and less likely to incur unpaid medical bills.

### **Section 3: Recommendations for Federal Action**

The following are our recommendations to the Federal government for making outreach and enrollment for children's health insurance programs an integral part of school business. This structure for making recommendations acknowledges the key players who can take action to make school-based outreach and enrollment effective - the Federal government, the State Agencies, school districts, schools and early child care/education providers. This information derives from what the Workgroup has learned from States and communities at the National Summit, during the regional conference calls and meetings and through the research conducted. The President also asked for both short and long-term Federal strategies; the Action Plan (Appendix B) provides those details.

The population of uninsured children eligible for Medicaid and SCHIP is increasing for a variety of reasons. Although States have used many creative approaches to reach out to uninsured children through Medicaid and SCHIP programs, challenges to identify and enroll eligible children remain substantial. While it is possible for schools to participate in outreach and enrollment efforts under current law, these proposals will enhance their ability to do so. In addition to strongly supporting the President's fiscal year 2001 budget proposals to accelerate the enrollment of Medicaid/SCHIP eligible children through schools, we recommend the Federal government act on the following recommendations:

**1. Facilitate outreach and enrollment activities between Medicaid/SCHIP and other public programs with similar eligibility criteria, such as the National School Lunch Program (NSLP).**

The National School Lunch Program (NSLP) is an excellent vehicle to market health insurance and to target outreach efforts to children potentially eligible for SCHIP and Medicaid. About 96 percent of all public and nonprofit private schools participate in the National School Lunch Program. Traditionally, eligibility for free and reduced price meals is based on households' gross income as reported by the household on the free and reduced price meal application. The eligibility limit for free meals is 130 percent of the Federal poverty guidelines and 131 to 185 percent for reduced price meals.

The Federal government should assist in promoting the use of the NSLP through the

following actions:

**1.1 Implement the provisions in the Agricultural Risk Protection Act of 2000 that amend the National School Lunch Act (NSLA) to allow for sharing of children’s free and reduced price school meal eligibility information with Medicaid and SCHIP.**

On June 20, 2000, the President signed the Agriculture Risk Protection Act of 2000. Prior to this legislation, the statute for the lunch program permitted the sharing of information about children eligible for free and reduced price meals without parental consent with some programs. However, school officials could not release individual names to SCHIP or Medicaid agencies without parental consent.

Beginning October 1, 2000, schools can share information about children eligible for free and reduced price meals with Medicaid and SCHIP. Schools must notify parents prior to sharing the information with health insurance programs and must give parents the opportunity to elect not to have their information shared with the Medicaid and SCHIP agencies. Both the State Child Nutrition Agency and the district’s school food service must agree to do this and there must be a written agreement between the school and the State or local agency or agencies administering health insurance programs for children. The three Federal Departments will work together to distribute information on this important legislative change.

**1.2 Use the National School Lunch Program to increase awareness about Medicaid/SCHIP and identify potential enrollees.**

USDA and HHS should annually encourage the distribution of State-developed health insurance information and should provide the State Child Nutrition Agencies with the name of a SCHIP/Medicaid contact person. SCHIP/Medicaid directors and School Districts, including local food service directors, should coordinate to distribute health insurance information or health insurance applications (especially in high-eligibility areas) as part of the schools enrollment process or during the NSLP’s free and reduced price meal application process.

USDA and HCFA should encourage State Child Nutrition Directors and State Medicaid/SCHIP Directors to develop a plan to coordinate the

transfer of school lunch eligibility information to SCHIP/Medicaid for appropriate follow-up. HHS and USDA should develop and share model Memoranda of Understanding to help facilitate this process.

**2. Provide technical assistance and support to help States, communities, health care providers and schools implement school-based outreach and enrollment activities for Medicaid/SCHIP.**

Many options are already available to States and local school districts to work in partnership to increase enrollment and retention in SCHIP and Medicaid. However, these options are not currently utilized to their fullest potential. Therefore, we recommend several actions be undertaken by the three Federal Departments to make schools, States and communities aware of types of school-based outreach and enrollment activities and “how to” carry out these activities and promote their effectiveness. In order for school-based enrollment to work, the application and enrollment process must be simple. To this end, we are also recommending that we continue to work with States to further simplify enrollment and redetermination processes and enlist schools as partners in this endeavor. By facilitating new partnerships, improving forums for information sharing, working with States and other partners and providing other types of technical assistance, HHS, ED and USDA can make an impact on outreach and enrollment activities within the current legislative and regulatory guidelines. The Departments have been working to educate States and other entities about ways to make outreach and enrollment processes more effective within the current guidelines, but these efforts must be expanded.

**2.1 Develop and disseminate “how to” guides for States, school districts, schools and health care providers on conducting school-based outreach and enrollment.**

HHS has contracted with Barents Group LLC and the Academy for Educational Development (AED) to develop three “how to” guides; one targeted to school districts, schools and early child care/early education programs; one to health care providers; and one to SCHIP, Medicaid and State education agencies. By design, the guides will address the roles and interests of each target audience and provide them with the tools to facilitate their participation in school-based outreach and enrollment. HHS, USDA, and ED have been involved in the conceptualization and design of these guides. All three guides will be distributed nationally and will be available on [www.insurekidsnow.gov](http://www.insurekidsnow.gov) in the Summer 2000.

**2.2 Work in partnership with private/public organizations to support up to three regional community-based training centers to prepare school and community staff to participate in outreach activities.**

These centers would provide training materials to support school personnel activities in outreach and organize relevant seminars, workshops and conferences for school and health agency partners interested in beginning or already engaged in joint outreach efforts.

HHS will identify model, school-based outreach locations to serve as regional-level training centers. HHS will work with private and public organizations to secure sustained funding for these regional training centers and to create the training materials. The “how to” guide will be used as a resource.

**2.3 Support passage of an amendment to the Medicaid statute to include all schools engaged in outreach and enrollment activities as “qualified entities” (entities allowed, at the State option, to determine presumptive eligibility under Federal Medicaid statute).**

This proposal is included in the President’s FY 2001 budget. By including all schools as qualified entities to determine presumptive eligibility (State option) and not just those schools who are already Medicaid providers, schools with trained staff will be able to make initial determinations about eligibility in SCHIP and Medicaid and temporarily enroll children pending final approval. Since schools are seen as trusted entities by families, parents may be more inclined to pursue application in a school environment. Should an amendment pass, HHS and ED will work together to gather best practices in instituting presumptive eligibility in schools that are and are not Medicaid providers and disseminate those on the school-based outreach website and listserv.

**2.4 Work with HHS Regional Offices to use current SCHIP monitoring visits to provide technical assistance to States as they continue to work with schools to enroll children. Regional Offices can identify best practices that can be shared with other States.**

HCFA Regional offices have the lead on planning the SCHIP monitoring visits in coordination with HRSA, ACF and the Office of Civil Rights staff. Central

Office staff will work with Regional staff to encourage States during the monitoring visits to support school-based outreach. Regional office staff will gather information on best practices from the visits and make it available to other States and schools through the *www.insurekidsnow.gov* website.

## **2.5 Work with national education organizations, advocacy groups and other education leaders to promote school-based outreach and enrollment.**

The three Departments convened an initial meeting of education, school nutrition and health groups during the National Summit in November 1999. The groups met again in February 2000 to continue to discuss the Departments efforts to promote school-based outreach and enrollment. These stakeholder meetings will continue to be convened by the Department of Education on an ad hoc basis as a venue for promoting school-based outreach and enrollment.

## **2.6 Work with States to encourage the development and evaluation of projects that simplify SCHIP and Medicaid enrollment for children enrolled in other Federal programs.**

Several States and local school districts are interested in developing projects or pilots that would simplify SCHIP and Medicaid enrollment for children already enrolled in the school lunch program, Head Start and subsidized child care. We recommend that the Federal Departments assist interested States in the development and evaluation of these pilots. School Food Service, Head Start, child care and SCHIP/Medicaid officials can work together to improve coordination in planning and implementing these models. They can also ensure that families who give consent to receive health insurance information do receive sufficient follow-up. The Federal government can also identify and share best State practices.

Additionally, HCFA will award approximately five grants of roughly \$80,000 to State Medicaid and SCHIP agencies during a one year project called "Medicaid and SCHIP Eligibility Pilots." The purpose of this project is to identify new and effective ways to simplify the application and enrollment process by piloting innovative efforts on a small scale. State agencies who receive an award will work closely with other stakeholders, including schools, during the project implementation and evaluation. As a result of this grant project, HCFA will provide support to States as they continue to explore

ways of simplifying the application process and encourage States to adopt effective mechanisms to remove one or more steps a family would otherwise have to complete to enroll their eligible children in Medicaid or SCHIP.

**2.7 Create an inter-Departmental electronic mail listserv to facilitate communication, problem solving and exchange of timely information from schools, health agencies and community groups partnering in outreach and enrollment. Share appropriate and timely information related to program implementation, policy development and legislative changes of Federally-funded programs.**

HHS will establish a listserv function to notify interested organizations and individuals of new developments. HHS will use the school-based outreach page on the *www.insurekidsnow.gov* website to post new information. The Departments of Agriculture and Education will take responsibility for providing HHS with timely and relevant information for the site or with relevant links to their websites.

**2.8 Hold regular telephone conferences with electronic mail listserv subscribers from schools, health agencies and community groups to share information about initiating efforts, maintaining efforts, funding sources, promising practices, evaluating efforts and managing barriers. Post summaries or highlights electronically on the *www.insurekidsnow.gov* website.**

HHS, USDA and ED will coordinate scheduling telephone conferences with listserv subscribers as a method for information sharing. Summaries of all conference calls and any other pertinent information will be posted on the *www.insurekidsnow.gov* website. All Departments will be responsible for supplying HHS with information for the webpage and listserv.

**2.9 Provide additional targeted technical assistance to interested States that have not taken advantage of options available under current law for streamlining and simplifying SCHIP and Medicaid enrollment and redetermination processes.**

Several activities are currently underway to reduce barriers which deter enrollment and reenrollment in Medicaid and SCHIP. These activities range

from program practices to caseworker retraining. HCFA is working with States to identify existing barriers, promote promising practices, develop model application language to assist States in reducing the reading/literacy level of applications and identify models of simplified, user-friendly Medicaid and SCHIP beneficiary notices on eligibility actions. In addition, HHS is working with States to develop school-based outreach pilots.

Although not specifically a school-based technical assistance resource, HRSA currently funds and partners with HCFA on the implementation of CompCare, a four-year technical assistance program that makes assistance available to each State over the life of the project. The technical assistance will be tailored to the system improvement needs articulated by each State and designed to support the achievement of State-specific child health outcome objectives including linking eligible children with the SCHIP and Medicaid programs. Streamlining and simplifying enrollment and redetermination processes could be one activity.

Likewise, with the ongoing outreach and enrollment activities and related grassroots experiences provided by the Robert Wood Johnson Foundation's Covering Kids grantees, there are numerous possibilities to work closely with State agencies in further refining and simplifying the enrollment and redetermination processes. Partnerships at all levels enhance the possibilities of continuous improvements for publicly-funded children's health insurance programs.

Other types of technical assistance could include low-cost site visits, meetings or conferences convened specifically around school-based outreach and enrollment. The SCHIP monitoring visits and State evaluations due March 31, 2000 are both ways to identify technical assistance needs and interests of the States and best practices.

**3. Encourage new or additional school-based outreach and enrollment efforts by assisting States and schools to identify and maximize funding opportunities.**

To launch a significant effort such as nationwide school-based outreach and enrollment, States and schools need to work together to identify the sources of funding that are available and how to obtain these funds. This implies private as well as public sources.

**3.1 Encourage State Medicaid agencies to utilize the special \$500 million fund set aside for Medicaid outreach following welfare reform to fund school-based outreach and enrollment activities, in accordance with Federal guidance.**

The January 6, 2000, HCFA letter to State officials and the May 14, 1997 Federal Register Notice<sup>12</sup> provide guidance to States on using this fund for Medicaid and SCHIP outreach. HCFA will continue to work with the State Medicaid agencies to identify remaining funds set aside for Medicaid outreach and assist States in using these resources to support school-based outreach activities.

**3.2 Develop guidance letters, workshops and other forms of technical assistance detailing options available under current law for States to receive Federal match for reimbursing schools and other entities that are conducting outreach and enrollment activities. Guidance on how school districts and schools can contract with State Medicaid/SCHIP agencies to get reimbursed for their outreach and enrollment work should be a priority. Include guidance and sample Memoranda of Understanding to assist State Child Nutrition Directors, food service personnel, school district personnel and others whose commitment to carrying out outreach activities is contingent on reimbursement for the costs associated with these efforts.**

In addition to the letter to State officials and the Federal Register notice already providing guidance on the continued availability of the \$500 million special fund, HCFA is currently in the process of reviewing public comments on its Draft School-Based Administrative Claiming Guide<sup>13</sup>. This Guide will provide information for schools, State Medicaid Agencies, HCFA staff and other interested parties on the existing requirements for claiming Federal funds under the Medicaid program for the costs of administrative activities, such as Medicaid outreach, that are performed in the school setting.

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<sup>12</sup>Letters posted on:

[www.hcfa.gov/medicaid/wrd11600.htm](http://www.hcfa.gov/medicaid/wrd11600.htm)

<http://www.hcfa.gov/medicaid/wrd1514.htm#A3>

<sup>13</sup>The guide is available on: [www.hcfa.gov/medicaid/schools/machmpg.htm](http://www.hcfa.gov/medicaid/schools/machmpg.htm).

**3.3 Develop a model Memorandum of Understanding (MOU) that can be used by Medicaid/SCHIP agencies in collaborating with State Education Agencies, Federally-funded grantees, foundation grantees and school districts for conducting and funding outreach and enrollment activities.**

HCFA Central Office will draft and disseminate a model MOU to help States better collaborate with State Education Agencies. As States implement Memoranda of Understanding with other agencies and entities that assist in school-based outreach, it is important that they include local outreach workers in the execution of school-based enrollment. Including local eligibility workers is important to successfully streamline, simplify and coordinate a system for child health insurance coverage. Their involvement provides schools with resources to carry through with outreach to the point of enrollment.

**3.4 Facilitate partnerships between public and private entities to identify new and innovative funding streams to pay for school-based outreach and enrollment.**

HHS and ED will continue to meet with foundations and private organizations to learn about funding options for States. The Departments will meet with national organizations that represent integrated health systems, hospitals, and managed care organizations to identify potential areas of interest in promoting and funding school-based outreach and enrollment activities consistent with federal policies. All findings will be disseminated via the list serv and the [www.insurekidsnow.gov](http://www.insurekidsnow.gov) website.

## Spotlight: Models That Work

### Partnership between Schools and a Health System in Virginia

Inova Health System, a large not-for-profit health care organization in Northern Virginia, works in partnership with Fairfax County public schools and community-based organizations (CBOs) to conduct outreach and enrollment in elementary schools. The goals of the partnership are to:

- identify children who do not have a medical home or health insurance coverage;
- refer/enroll all eligible uninsured children in Medicaid, the *Children's Medical Security Insurance Plan* (CMSIP, which is Virginia's SCHIP), or other health care programs;
- provide follow-up with families; and
- monitor and report on outcomes.

The partnership was initiated in 1993 by the health system's Board of Trustees' task force on community health. A community needs assessment identified children's preventive health and children's access to health care services as two of the most pressing child health concerns in Fairfax County. The impetus for this effort was and is the health system's commitment to provide quality care and to improve the health of the diverse communities they serve. Inova strives to increase the number of previously underserved children receiving primary care and preventive services to ultimately optimize the value of each dollar spent on caring for the underserved. Schools also benefit because their students receive health insurance coverage, obtain health care services and are ultimately healthier students.

After two years of planning and collecting baseline data, the health system created a program, Partnership for Healthier Kids (PHK), with local community organizations including Fairfax County Public Schools and Northern Virginia Family Service. The school district has participated as a "partner" since PHK's inception, actively providing input every step of the way. One Fairfax County superintendent<sup>14</sup> embraced the health system's initiative and identified a school and its enthusiastic principal, a person well respected by other principals in the district, to pilot the outreach program. From the outset, the superintendent made school participation in the program voluntary. To encourage school participation, she described the shared benefits of the program for schools, providers and families. This superintendent was the catalyst in linking the health system to the schools.

Once the school decides to participate in the program, the PHK staff host introductory workshops and individual school training sessions to two or three school representatives (usually the principal, secretary, assistant principal, public health nurse, parent liaison or guidance counselor). PHK educates them on the importance of school-based outreach and works with the staff to develop a school specific outreach plan. PHK staff provide a procedural manual, consent forms, letters and educational materials—flyers, posters, newsletter articles, tent cards- to schools to distribute and display around the school.

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<sup>14</sup> Fairfax County Schools are divided into three areas, each of which has a superintendent.

Most materials are translated into the five most common languages in the county. PHK and the schools take the following steps to identify and help uninsured children:

- Designated school staff identify potential eligible children through a review of the emergency contact forms that are completed by parents. Forms lacking information on insurance or a doctor are earmarked as potential referrals to PHK.
- The school principal motivates families to respond by sending a personal letter to each family who has missing information on the emergency contact sheet. Information on obtaining free or low cost health insurance through the PHK, a parental consent form and a self-addressed, business reply envelope that parents can use to return the form to the schools are also included in this packet.
- As parents or guardians return consent forms, the PHK outreach coordinator collects, reviews, logs data and forwards forms to PHK case workers. Professional case workers, contracted by Inova from Northern Virginia Family Service, then complete telephone and/or personal interviews with families, conduct a needs assessment, prepare a CMSIP/Medicaid application and help compile the required documentation. Ineligible children are referred to a local, public primary care provider.
- The PHK case workers follow-up with the Fairfax County Department of Family Services on the status of applications. Family follow-up sessions are conducted with referred/enrolled families four times over a 12-month period to ensure that the new insurance and medical provider meet their health care needs.
- Results of the outreach activities are reported and shared with the schools.

Inova has hired an external organization to evaluate the partnership program. The first year evaluation summary reported that, "The partnership between a major health system and local school system, coupled with methods of case finding and referral, make this one of the most innovative projects in the country." Partnership for Healthier Kids has developed effective methods of conducting individualized, school-based outreach without violating the privacy rights of students or unduly burdening school administration.

## **Section 4: Promising Practices**

### **Innovative Outreach Approaches for States and Schools**

The following is a series of promising practices for States and schools for making outreach and enrollment for children's health insurance programs an integral part of school business. This structure for highlighting promising practices acknowledges the key players who can take action to make school-based outreach and enrollment effective - the Federal government, the State Agencies, school districts, schools and early child care/education providers. This information derives from what was learned from States and communities at the National Summit, during regional conference calls and meetings, and through research. The promising practices for States and schools represent successes across the country. This section is divided into two parts: Promising State Practices and Promising School Practices.

#### **Part 1: Promising State Practices**

Almost every State enlists the support of schools in their outreach and enrollment strategies for reaching children. Various State models have produced successes. In the most effective examples, the State agencies themselves have been integral to successful outreach. The State provides leadership, enacts enabling legislation or promulgates regulations and procedures and makes available the essential resources. Without these elements, school-based enrollment may not be as successful or sustainable.

The promising State practices that follow are based on models where States exercised their leadership and used their resources to achieve successful school-based outreach and enrollment. Simplification is central to the success of outreach and enrollment strategies. The Administration is doing much to encourage simplification, and most States are making efforts to simplify their enrollment systems further. While simplification is critical to successful enrollment efforts, this section focuses on school-based recommendations and strategies. States can use these promising practices and those that follow for schools to develop or expand their State-specific strategies and plans of action. While many of the descriptions of the practices refer solely to schools, these same approaches have also shown promise for early child care/education program settings.

***Promising State Practice #1: Make schools and early child care/education programs a priority for conducting outreach and enrolling eligible children.***

Most uninsured children are in schools and early child care/education programs. Many school aged children (age 5-18) have only recently become eligible for public health insurance programs. Children of working families with incomes above the poverty level may also be newly eligible. Moreover, as States expand eligibility to higher income groups and older children, the schools are where these children are most easily located and informed about potential eligibility.

States that have used school settings for outreach report the effectiveness of this approach. Their experiences have ranged from surges in applications following school information distribution drives to phone callers indicating that schools were the prime source of information on the health insurance programs.

While evaluation of school-based outreach is not yet complete, school-based outreach is a logical and practical solution to finding the parents of most of the uninsured children. Thus, it should be a major emphasis for outreach funding.

***Promising State Practice #2: Involve school officials and officials administering the school nutrition programs at all levels in planning and carrying out school-based outreach activities.***

When States forge partnerships with schools, they gain entrée into the communities where they need to focus their outreach efforts. Schools understand the target audience on a deeper level because of their knowledge of and ties to the community. States that use the expertise of school officials expand their reach and access to the target community and increase their credibility with the community. By working with school health and nutrition officials, States build upon existing, trusted relationships and programs.

***Strategy 1: Develop a plan to coordinate sharing of school lunch information through the National School Lunch Program's free and reduced price school meal application process.***

The National School Lunch Program is an excellent vehicle to educate households about the availability of health insurance for children and to target potentially eligible children for Medicaid/SCHIP enrollment. The lunch program operates in about 96 percent of all public and nonprofit private schools and serves free and reduced price

meals to children from households at or below 185 percent of

poverty. Many of these children are uninsured and would be eligible for Medicaid or SCHIP.

At the beginning of the school year, most schools are required to distribute a letter and an application to all households notifying them of the availability of free and reduced price school meals. Many schools have included information about health insurance, a contact person or phone number for more information, along with the school meal application materials. This is an effective way to educate all families in the school, regardless of their income, about the health insurance options for low-income households.

USDA had issued several model free and reduced price school meal applications that were used by schools to target households for health insurance who were applying for free and reduced price meals. Depending on the model, parents could either consent to have their names and addresses shared with Medicaid/SCHIP officials to get more information about health insurance or they could consent to share all their free and reduced price school meal eligibility information with Medicaid/SCHIP officials to determine their eligibility for free or low-cost health insurance.

Beginning October 1, 2000, because of new legislation enacted June 20, 2000, schools can share free and reduced price eligibility information with Medicaid and SCHIP unless the parent/guardian tells the school that they do not want their information shared. The school must notify parents prior to sharing the information with health insurance programs and must give parents the opportunity to elect not to share their information. Both the State Child Nutrition Agency and the district's school food service must agree to do this and there must be a written agreement between the school and the Medicaid/SCHIP agencies prior to the transfer of eligibility information.

Another way to use the free and reduced price application process is to send Medicaid/SCHIP information or a Medicaid/SCHIP application with the notification of approval or denial of household's eligibility for free and reduced price meals. Regardless of the method used, Medicaid/SCHIP agencies and Child Nutrition agencies should develop a plan for the transfer of information and follow-up with households that have expressed interest in health insurance.

While some suggest linking school lunch and health insurance applications, the program eligibility requirements are sufficiently different to pose some potential risks and problems for the National School Lunch Program. Apart from different household and income definitions, the school lunch program differs by not requiring children's Social

Security numbers or citizenship status - requirements considered especially sensitive for children of immigrant families. Because requiring this additional information on the school lunch application could indeed deter participation in the school lunch program, States and school districts should pursue linking strategies that minimize this risk - such as requesting citizenship status or Social Security numbers through an alternative method.

The Center on Budget and Policy Priorities recently prepared a report for the Covering Kids project <sup>15</sup> on promising strategies for using the school lunch program for outreach and enrollment. A survey of State practices is currently underway.

Whatever the approach, it is important for Medicaid/SCHIP and Child Nutrition State and local agencies to work together to design appropriate and cost-effective procedures for distributing insurance information to households using the free and reduced price application process or for sharing school lunch eligibility information to Medicaid/SCHIP. Presumptive eligibility for health insurance using eligibility for free and reduced price school meals is also an option to consider.

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## **Spotlight: Models That Work**

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<sup>15</sup> “Fostering a Close Connections: Report to Covering Kids on Options for conducting Child Health Insurance Outreach Enrollment Through the National School Lunch Program,” prepared for Covering Kids by Donna Cohen Ross of the Center for Budget and Policy Priorities; [www.coveringkids.org/outr-DCRossFostConn1-2K.html](http://www.coveringkids.org/outr-DCRossFostConn1-2K.html)

### **Certified Application Assistants Working in San Diego School Districts**

Pilot school districts in San Diego County are participating in an outreach program that uses certified application assistants (CAAs) in schools to enroll children in State health insurance programs. The CAA program provides grant funding to support trained CAAs who work full time at participating schools for a specific time period. CAAs follow-up on filed applications or with families who have been identified by the school as eligible for State health insurance programs. For example, a CAA assigned to Chollas Elementary School will spend about eight weeks at the school, following up to see if families who send in applications are enrolled in the health insurance program and if they have signed up with a provider. The State of California requires completion of an eight-hour CAA training program and pays them \$50 for each successful application. The State provides entity numbers to schools and districts for billing purposes.

School nurses are critical links in this program. The school nurse, a trusted individual from the school, works with the certified application assistant and provides feedback from parents. For example, the school nurse may tell the CAA which families have not yet received word on their insurance program applications. The CAA is considered a school district employee (though funded by outside agency funding) and as such is allowed access to home telephone numbers of those students who may not have health insurance.

Once students are enrolled, the school nurse serves as a “focal point” between children/parents, the insurance program and the providers. Parents feel that having a school nurse to assume this role helps to reduce barriers and provides optimal case management. When the CAA leaves to do follow-up at another participating school, parents from the Chollas Elementary School are given a central number at the district that they can use to locate the CAA. Parents also have the name and phone number of the school nurse to assist in follow-up.

The Chollas Elementary School’s principal believes that parents are motivated to participate in these programs by the low premiums and through “word of mouth” referrals. The school motivates children to return completed application forms by using incentives, such as certificates for snacks.

**Promising State Practice #3: Provide technical assistance and ongoing support to school districts, schools and early child care/education programs for outreach and enrollment.**

School districts and schools can be more effective given the right combination of technical assistance and adequate funding. While schools may not be experts in all aspects of outreach due to program complexity and time considerations, there are many strategies initiated by States to support school-based outreach. The strategies below have been used by States to support schools.

**Strategy 1: Establish a single point of contact at the State or local level for school personnel to call to obtain information about their State’s programs (e.g., eligibility criteria, brochures, flyers) and the status of applications that have been submitted.**

State and school partnerships work best when there is a single point of contact to answer questions, provide information and arrange for staff visits, when appropriate. Schools also need a single point of contact to follow-up on the status of applications when the school is providing enrollment assistance.

**Strategy 2: Provide schools with culturally appropriate materials and applications.**

Schools prefer materials that are sensitive to the cultural backgrounds of their students and are consistent with their education role. States have developed marketing materials in multiple languages and designed the message consistent with the school’s mission. States have partnered with schools and community groups to understand the socioeconomic, demographic, cultural, linguistic and social characteristics of the community.

Schools with large immigrant populations also need information on the issue of “public charge” for their student population. Immigrant parents are reluctant to sign up their eligible children for any public program because of fear that this will have a negative impact on their own immigration status. States can take advantage of existing materials that have been collected at the Federal level.

**Strategy 3: Train superintendents, principals, teachers, school nurses, school-based health center providers, counselors, child nutrition directors and other school personnel on the State’s insurance programs and how schools can assist in the effort.**

Schools identified the need for training on how to give presentations, motivate parents and track applications and enrollments. They want to know more about cultural relevance and be able to tailor outreach approaches to their own situations. They want to know how to answer frequently asked questions about State programs.

It is also important to stress the benefits to schools in conducting outreach. Increased attendance, fewer days lost due to illness and healthier children who learn better are substantial incentives for schools to become involved. Unexpected benefits included increased involvement of parents in the schools and improved community relationships. Using school colleagues to deliver these messages increased the credibility of the message.

Some States found it productive to initially target their efforts on school districts with the highest rates of uninsured children. If school district level information is not readily available, the State can also use proxy measures such as targeting schools with the highest rates of children eligible for free or reduced meals.

***Promising State Practice #4: Provide feedback to schools on the impact of their efforts in identifying and enrolling uninsured children.***

Schools maintain their enthusiasm for outreach activities when they see the results of their activities. Schools that are advised on the results of their efforts are more interested in continuing their effort. Even feedback on unsuccessful outreach attempts is valuable, so schools will know that their approach needs to be changed.

Recognition of the leadership and achievements of schools who do an outstanding job in outreach deserves public acclaim.

***Promising State Practice #5: Maximize schools’ ability to conduct outreach and enrollment by funding such activities, providing staff resources or identifying other funding sources.***

In general, schools lack the necessary resources to take on a significant new workload involving health insurance outreach. States have used a variety of methods to dedicate

funding to school-based outreach. Some reimburse schools directly for conducting outreach, fund community-based organizations to conduct outreach in schools or hire dedicated state staff to work in the schools. States have used the three strategies outlined below.

**Strategy 1: Assist school districts by developing partnerships with community-based organizations to provide application assistance in schools. Use mini-grants or offer application assistance fees to community-based organizations to provide enrollment assistance in schools.**

Partnerships between States, community-based organizations and schools have been very successful. Community organizations have credibility with families and are also trusted. States have funded these groups to work with schools to handle the major workload of school-based outreach.

Informing schools of the existence of these community organizations or community providers and how they can utilize them to help enroll their students are helpful practices important to schools and the overall outreach effort.

States have employed a variety of financial models to support school-based outreach. Some have provided mini-grants to community organizations while others have paid schools or community organizations on the basis of successfully completed applications. In order to sustain outreach, it is important for the State to provide an ongoing source of funding tied to performance.

**Strategy 2: Outstation State or local outreach employees in schools and early child care/education centers. Arrange for training of school volunteers to provide assistance.**

Schools are a familiar setting for parents and they are more comfortable going to a school than a public assistance office to enroll. Some States have funded dedicated outreach workers for schools and child care/education centers. Likewise, they have provided in-service training and materials. Schools assume responsibility for publicizing the days, times and locations that workers will be available so parents can plan to come to the school or community setting.

**Strategy 3: Target dollars from the fund established to conduct Medicaid outreach following welfare reform to school-based outreach and enrollment.**

Some States have paid for school-based Medicaid outreach activities from the fund established to conduct Medicaid outreach after the delinking of Medicaid and TANF. Permissible activities are addressed in the January 6, 2000 letter to State health officials and the May 14, 1997 Federal Register notice.<sup>16</sup>

## Spotlight: Models That Work

### Partnership Between the State of Illinois, Chicago Public Schools and KidCare Application Agents to Identify and Enroll Uninsured Children

Since October 1998, the State of Illinois and the Chicago Public Schools (CPS) have been partners in the development and implementation of school-based outreach activities to enroll uninsured children into *KidCare*, Illinois' SCHIP. The CPS partnership uses mapping databases to geo-code demographic variables that highlight geographic concentrations of CPS students appearing to be eligible for *KidCare* based on their eligibility for free and reduced price meals under the National School Lunch Program (NSLP). They then target those schools with an amended NSLP application to include a consent section for families to sign to release information to the Illinois Department of Public Aid and certified *KidCare* Application Agents (KCAA) to follow-up with them about applying for *KidCare*. A separate flyer accompanying the NSLP application explains the consent box.

One of the major activities has been Report Card Pick-Up Days in November 1998, April 1999 and November 1999 where families could get information on *KidCare* and application assistance. Report Card Pick-Up Days were targeted because the CPS system requires parents to physically enter the school and personally attend a teacher/parent conference to pick up their child's report card. A diverse array of outreach activities advertised the Report Card Pick-Up Days.<sup>17</sup> At the school-level, each school principal designated an individual to be a resident *KidCare* expert and coordinator, as well as to assist families in completing a *KidCare* application. CPS personnel, with the Illinois Department of Public Aid, conducted a massive training session of approximately 2,000 volunteers for the November 1998 Report Card Pick-Up Day. The training has been refined over time to reflect lessons learned and to provide more advanced and accurate enrollment information to volunteers in the schools. The Illinois Department of Public Aid provided a \$850,000 grant to CPS to cover the costs associated with the first two Report Card Pick-Up Days.

The State and CPS also worked together to implement a number of administrative simplification activities that included CPS opening six regional centers in April 1999 where families can walk in to obtain information and assistance; shortening the *KidCare* application in April 1999; implementing a mail-in application option; implementing 12-month continuous financial eligibility for Medicaid children to match the 12-month

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<sup>16</sup><http://www.hcfa.gov/medicaid/wrd11600.htm>  
<http://www.hcfa.gov/medicaid/wrd1514.htm#A3>

<sup>17</sup>The outreach activities include: reproducing and mailing *KidCare* applications to targeted families' homes; creating flyers and information sheets about *KidCare*; using an automatic calling system to remind parents of the Report Card Pick-Up Days and the availability of enrollment assistance; advertising the outreach effort on ethnic radio stations, in newspapers, and at press conferences.

continuous eligibility already available through *KidCare*; implementing a toll-free *KidCare* hotline and certifying entities as KidCare Application Agents (KCAAs). Entities eligible to become KCAAs include Federally Qualified Health Centers, Rural Health Centers, hospitals and community-based organizations among others. Each entity undergoes training and signs an agreement with the Illinois Department of Public Aid and is paid \$50 for a successful application. In addition, the Illinois Department of Public Aid has assigned a central contact person to each KCAA to resolve any outstanding *KidCare* application issues.

The experience gained during the Report Card Pick-Up Day events has resulted in the implementation of a pilot project where CPS, with the Illinois Department of Public Aid, is partnering with a selected group of fourteen “corporate” KCAAs, representing over 100 sites in Chicago.<sup>18</sup> The KCAAs are targeting approximately 61,000 children whose parents signed the release waiver on the amended NSLP application at the beginning of the 1999/2000 school year. In January 2000, CPS contacted the selected group of KCAAs to invite them to join the pilot project whereby the KCAA partners “adopt” schools to conduct intensive outreach and follow-up. Each adopted school’s listing of targeted students includes the student’s name, parent/guardian’s name, address and phone number. In February 2000, CPS sent a letter to each principal of an adopted school indicating the community-based agent that will be working to contact families of targeted students in their school. CPS also sent a letter to parents indicating which community-based agent would contact them. KCAAs began contacting families in March 2000. Each participating KCAA will receive information about those individuals contacted under this pilot who are successfully enrolled into *KidCare* and, for those not enrolled, the reasons why. Illinois uses State general funds and Federal Medicaid matching funds for the grant to the CPS and for the payments to KCAAs.

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<sup>18</sup> Each of the selected KCAAs has a 70 to 80 percent acceptance of applications into *KidCare*.

## **Part 2: Promising Practices for School Districts, Schools and Early Child Care/Education Centers**

Research on current outreach activities in schools highlighted a wide array of successful techniques to identify and enroll children in the State's health insurance programs. The following activities comprise a continuum of successful outreach: identifying and understanding who are the potentially eligible children and their families; educating individuals about the program; motivating people to take action; facilitating actions needed to enroll in the programs; following-up with families and with State agencies on the status of applications and evaluating the effect of the outreach strategy. Schools are uniquely positioned to undertake several of these outreach activities.

Because of their unique role in the community, schools are effective in identifying and educating uninsured families and motivating them to seek health insurance for their children. Families trust information provided by the school or under the aegis of the school. Several State agencies report that schools are one of the primary sources of referral identified by callers to State eligibility centers.

There are many promising strategies for schools which are based on actual school activities. Schools have clearly taken into account their unique environments in implementing these strategies.

***Promising School Practice #1: Distribute information on the availability of children's health insurance programs.***

When schools provide information on the availability of health insurance, parents are more likely to read it, believe it and act on it. Additionally, messages that are repeated multiple times and conveyed in multiple ways are most likely to be heard. Sending a flyer home once is not as effective as a multifaceted approach which could include distributing a flyer, publishing a newsletter article and talking directly with parents through school nurses. Schools are well positioned to participate in the following types of outreach activities:

**Strategy #1: Send health insurance information along with other information that parents are likely to read (e.g., brochures sent home at the start of the school year; flyers attached to report cards; printed information about the program on school lunch menus; information from the school nurse, school-based health center and/or school health service providers; items in school newsletters).**

Use of existing school structures and processes for conveying helpful information minimizes the burden on schools and maximizes the likelihood that parents will read the material. Distributing information at the start of the school year is effective as parents are more attentive at this time of year and are more likely to read the information provided. Similarly, when information is attached to documents of importance during the year, such as report cards or messages from the school nurse on health concerns, parents are more likely to notice and read them. It is more effective when the information refers families to a state, community or school contact for follow-up.

**Strategy #2: Distribute information at well-attended school events (e.g., back-to-school night, report card pick-up day, sports events and enrollment for services of a school-based health center). School staff, State or county outreach workers or community volunteers should be available to talk with parents about health insurance coverage at these events.**

Building upon existing programs and events minimizes disruptions while providing opportunities for face-to-face meetings with parents. Because school and family schedules are hectic, it is important to take advantage of existing events to distribute information and have community volunteers or state or county staff available to answer questions or assist with applications.

**Strategy #3: Send a letter to families from the principal or other key school official about the school's support for the children's health insurance programs and the importance of enrolling children.**

The principal of a school or the superintendent of the school district is a recognized leader in the community. School nurses and other school health care providers are also trusted, key school officials. Various schools have sent personal letters from such officials to the uninsured families to stress the importance of health insurance, healthy children and learning and the availability of health insurance. The support of the school leadership for these efforts can be critical to a family's interest in the program.

**Strategy #4: Distribute materials in languages other than English if children come from families in which English is not the primary language.**

Schools know their student population and their families. They know which families need foreign language materials, and if so, in what languages. Most States have produced materials in a least Spanish and many have produced materials in multiple languages. Community groups and USDA have also produced materials in multiple languages and appropriate reading level for the community.

**Strategy #5: Distribute applications, in addition to general brochures or flyers, if most of the children who attend the school are likely to be eligible (e.g., in Title I, ESEA schools with a high percentage of children eligible for free or reduced price meals, Provision 2 or 3 schools under the National School Lunch Program, or Head Start centers). Include information with applications on where they can get assistance in completing the application.**

Children who are in Title I, ESEA schools or Provision 2 or 3 schools will usually qualify for one of the children's health insurance programs because their family income levels are low. Schools that have high proportions of these students found it cost effective to send out applications to all students, rather than try to identify individuals who might be eligible.

**Strategy #6: Designate someone on the school staff, a parent volunteer or a community volunteer for parents to contact if they have questions.**

Parents may be more comfortable initially contacting someone who they trust at the school for more information, e.g., the school nurse, school-based health center staff, teachers of English as a second language or community or parent volunteers. This trusted person could assist the family in obtaining information or assistance.

**Strategy #7: Ask staff to take advantage of teachable moments to educate families about the importance of health insurance and its availability.**

When a sick child is picked up from the school nurse or other school health care provider or when a child is screened and a referral for a health problem is sent home, the parent is focused on the health of that child and the need for medical care. Information on the importance of health insurance to a child's health and

academic performance and the availability of free or low-cost health insurance is more likely to be read and favorably received during such times.

**Promising School Practice #2: Identify specific children who may be eligible and provide, or arrange for, targeted assistance to their families.**

Schools have a number of readily available methods to identify uninsured children potentially eligible for enrollment in the State's child health insurance program. This enables a school or its partners to target resources on those most likely to be eligible.

**Strategy #1: Ask a question about health insurance status on school forms that parents are required to complete annually for each child. Follow-up with the family if the child does not have insurance or insurance information is missing.**

Many schools ask questions annually about health insurance on an emergency contact form. A number of schools have used this approach as an easy method to identify uninsured children. If the schools have the resources, they follow up by letter from a school official or by calling families who did not have insurance or where insurance information is missing. In cases where resources are limited, the schools obtained consent from the parents and provided the names of uninsured children to outreach workers or eligibility workers for follow-up. These workers agreed to contact the families and provide them with information and assistance.

**Strategy #2: Ask parents about health insurance status and discuss the availability of insurance and offer information on application assistance on relevant occasions.**

Schools can request information on health insurance as a standard part of school registration, registration for early child care/education, enrollment for services of a school-based health clinic, follow-up to health screenings or sports registration. Occasions where parents are present provide a great opportunity for providing in-person information.

**Strategy #3: Use school-based health centers and other health personnel to educate all students and identify uninsured students as they seek services.**

School health personnel often have a significant role in school-based outreach efforts. School nurses and school-based health center staff can be the connection between children/parents, the insurance program and health care providers. Some school clinics are qualified providers for Medicaid and SCHIP services and help enroll children in the appropriate insurance program.

***Promising School Practice #3: Partner with local community-based organizations, health care providers and businesses for staffing or financial assistance in conducting outreach and enrollment, especially for application assistance.***

While most agree that schools are ideal partners to build long, lasting mechanisms for sustaining outreach to uninsured children, there are limits to what they can do without additional resources or technical assistance. In addition to using State support, schools have successfully partnered with community groups, health care providers and AmeriCorps volunteers to follow-up with families. After schools have obtained permission of the uninsured families, community groups and health care providers have contacted families by phone or in person and assisted them in completing applications and following through on the application processing. Many community groups have been actively engaged in trying to enroll children in health insurance programs and would welcome the opportunity to work directly with schools. Local businesses have provided schools with prizes or in-kind contributions, such as printing or copying material, for these outreach efforts.

***Promising School Practice #4: Take advantage of the State Medicaid/SCHIP agencies' point of contact for up-to-date materials, information on funding opportunities, training and promising practices for conducting school-based outreach and enrollment.***

Some States have a State-wide model for outreach, while others have delegated the responsibility to county or local level. States have been providing mini-grants or other funding to grass roots organizations to conduct outreach. Some States are providing payments to organizations for successful applicants while other States cover the administrative cost of outreach (e.g., supplying postage paid envelopes and flyers).

There may be opportunities for local schools to obtain funding to conduct outreach activities. If schools want to use their own materials, State or local officials can ensure that they are up to date as programs are expanding in scope. Some States have also provided opportunities for training on their State's health insurance program as well as outreach techniques. School health officials can acquire valuable information on the programs, as well as generic skills in communicating with their community.

## Spotlight: Models That Work

### A State Legislative Approach to School-Based Outreach

In the late 1980s, State officials in Florida identified school-based enrollment for health insurance as one way to reduce the high number of uninsured children in the State. This recognition led State leaders to launch an ambitious experiment called the "Healthy Kids Corporation Act" in 1990<sup>19</sup> to implement a comprehensive health insurance program for uninsured children using school-based strategies. In this approach, "school systems would be used as the mechanism for creating large risk pools of people to cover participants the way large businesses did. Coverage could be offered to families with children enrolled in school and benefits would be designed specifically for them."<sup>20</sup> Schools would also be used for outreach, distribution of applications and marketing of the Healthy Kids program. With the creation of SCHIP, Florida built upon the experience of the Healthy Kids program and expanded the number of programs it offers to families with uninsured children. *KidCare* was the name assigned to the array of programs available to families of which Healthy Kids is a major component.

Florida's 10 years of experience with school-based outreach have shown that the most effective strategy is getting an application into the hands of everyone identified as not having insurance.<sup>21</sup> Florida supplements its strategy with activities to raise awareness and educate families about its programs, including multi-media marketing, involving community-based organizations and providers in regional outreach projects, the use of a toll-free hotline and information dissemination.

The State has played a significant role in initiating and endorsing the school-based outreach initiative. However, Florida recognizes that the power to effectively implement strategies in the schools is located at the district level among school boards. In Florida, schools' willingness to participate and to conduct outreach is extremely important. The State works with schools to ensure that they are actively engaged in outreach and to help ensure that outreach becomes an integral part of their day-to-day business. By August 1999, 94,344 students in 41 of Florida's 62 counties received health insurance coverage through the Healthy Kids Program.<sup>22</sup> During the 1995-96 school year, hospitals in Healthy Kids communities reported a 30 percent decrease in pediatric charity work and a 70 percent decrease in pediatric emergency department visits.<sup>23</sup> Findings from surveys conducted by the

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<sup>19</sup>Healthy Kids Annual Report, February 2000.

<sup>20</sup> Ibid.

<sup>21</sup> Florida uses a direct application mailing to parents whose child(ren) was identified by a modified emergency contact card as not having health insurance. Florida's dial-up computer system has the ability to dial homes and give a pre-recorded message.

<sup>22</sup> Coordinated School Health Programs: Health Services: Developing Funding Strategies, CCHI. [www.cchi.org/cgi-bin/cchi/doc.asp?ID+3729](http://www.cchi.org/cgi-bin/cchi/doc.asp?ID+3729).

<sup>23</sup> Shenkman E., et al. The School Enrollment-Based Health Insurance Program: Socioeconomic Factors in Enrollees' Use of Health Services. *American Journal of Public Health*, December 1996: Vol. 86: 1791-93.

Institute for Child Health Policy indicated that schools were the primary way new enrollees learned about *KidCare*. The percentage of families reporting that they heard about it from the schools ranged from 50-59 percent, depending on the racial and ethnic group.<sup>24</sup>

## Section 5: Evaluating School-Based Outreach

An important step to implementing the recommendations in this Report is developing evaluation strategies that the Federal government, States and schools can use to determine the success of their school-based outreach efforts. Designing an evaluation component during the planning stages of an outreach project forces planners to specify the project's desired outcomes. In SCHIP and Medicaid outreach, the ultimate desired outcome is increased access to health care through increased enrollment. However, focusing on evaluation encourages planners to strategically identify incremental steps that must be accomplished to obtain the ultimate desired outcome.

Evaluations of outreach interventions require a combination of advanced planning, methodological expertise, data collection instruments, data bases, personnel to collect and compile information and computer tracking systems to bring disparate pieces of information together. These elements can be expensive and may compete with the outreach activities themselves for scarce resources.

It is important to note that the SCHIP statute required States to submit to the Department of Health and Human Services a State evaluation of their State Children's Health Insurance Program by March 31, 2000. However, since all States implemented their programs at different times over the past two to three years, some may not have sufficient information to produce a comprehensive evaluation at this time.

### Types of Evaluation

The Department of Health and Human Services' National Institutes of Health provide valuable insight to evaluating outreach in their Making Health Communication Programs Work: A Planner's Guide.<sup>25</sup> Two types of evaluation that are particularly pertinent to school-based outreach are process and outcome evaluation. Process evaluation examines the procedures and tasks involved in implementing outreach activities. For school-based outreach, process evaluation measures might

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<sup>24</sup> Shenkman, E., H. Steingraber, and C. Bono. Op. Cit.

<sup>25</sup> National Institutes of Health, Making Health Communication Programs Work: A Planner's Guide, NIH Publication No. 92-1493, April 1992.

track how many applications were distributed through schools or how many parents checked a box on a school lunch application. Outcome evaluation is used to obtain descriptive data on a project and to document short-term results. These results might

include knowledge or attitude changes; expressed intentions of the target audience; or intermediate behavior changes.

### **Completed Evaluations of Outreach to Increase Enrollment**

The Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) and Office of the Assistant Secretary for Planning and Evaluation (OASPE) recently commissioned a review of the literature on outreach interventions intended to increase enrollment in public health insurance programs. The researches report that few rigorous evaluations of outreach interventions have been completed.<sup>26</sup> They found nine evaluations that met the criteria for inclusion in their review. Four of these examined the impact of simplified application procedures on Medicaid enrollment, two examined approaches for increasing awareness of public health insurance programs, one focused on the effect of positioning Medicaid as "private-type" insurance, and two utilized case management and beneficiary advocacy to increase enrollment. Case management and advocacy programs encompass a range of outreach steps and a large number of activities. These evaluations were focused on the "intervention package," not the specific interventions.

While none of these completed evaluations focused specifically on school-based outreach strategies, school-based outreach evaluation could share similar evaluation measures, including: awareness of the SCHIP/Medicaid program; source of knowledge about the SCHIP/Medicaid program; reason enrollees report for joining the program; number of potentially eligible people contacted either one-on-one or in a group setting; number of inquiries based on public information activities; number of people referred; number of people who applied; number of people who enrolled by race/ethnicity.

### **On-going Evaluations of Outreach to Increase Enrollment**

Even though most of the outreach evaluations currently underway are not focused solely on activities linked to schools, the interventions may be useful in designing school-based outreach evaluation. This section highlights a few on-going outreach evaluations that are particularly relevant to school-based outreach. These evaluations are organized by the name of the program, author of the

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<sup>26</sup> Barents Group, Final Report on "Outreach for Public Insurance, prepared for the Agency for Healthcare Research and Quality, February 2000.

evaluation, intervention focus, and outcomes to be measured.<sup>27</sup>

**Evaluation of the First Things First Initiative:** University of California, Berkeley School of Public Health, Center for Health Management Studies, in collaboration with the Institute for Health Policy Studies, University of California at San Francisco; contact Thomas G. Rundall, U.C. Berkeley School of Public Health. Study focuses on the efforts of ten community coalitions to reduce Medicaid barriers.

- **Process evaluation measures in ten sites include:**
  - < Number of potential applicants contacted by the project.
  - < Number of applications completed and submitted to Medi-Cal.
  - < Number of applicants contacted who were found to be eligible.
  - < Number of applicants denied and reasons for denials (including referral to other programs).
  - < Number of Medi-Cal recipients disenrolled and reasons for disenrollment.
- **Outcome evaluation measures:**
  - < Monthly enrollments of children in Medi-Cal in ten communities from 4/1/96-9/30/99.
  - < Number of applicants in ten communities contacted who were enrolled for the first time.
  - < Number of re-enrollments facilitated by the program.

**Evaluation of the Seek-Find-Enroll Initiative:** Jack Wheeler, School of Public Health, University of Michigan, and Gary Freed, Division of Pediatrics, University of Michigan Medical Center. The focus is on 14 community coalitions targeting diverse populations using a variety of outreach methods. Some school- and church-based activities will be included. Measures include:

- Enrollment rates in *MiChild* and *Healthy Kids*.
- Enrollments in *MiChild* and *Healthy Kids* from the community coalitions.
- Process measures: Number of individuals contacted, number of flyers distributed, number of presentations given, number of clients provided with application assistance, number of completed applications, among others.

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<sup>27</sup> Barents Group, Final Report on "Outreach for Public Insurance," prepared for the Agency for Healthcare Research and Quality, February 2000.

**Evaluation of Four Pilot Projects to Increase SCHIP and Medicaid Enrollment in Pennsylvania Under the Children’s Health Coverage Campaign:** Consumer Health Coalition (Pennsylvania’s Partnership for Children); contact Ann Bacharach. Focus is on assessing three different coalition-building approaches: a fee-per-application approach, an approach relying on volunteers, and an approach using a “community health worker.” Schools are among the best possible sites for meeting with families. Measures include:

- SCHIP and Medicaid enrollments tied to each approach/project site.
- Barriers to enrollment.
- Problems with the enrollment process.

**Evaluation of the Health-Insurance Access Through Schools:** “HATS” Project: School Health and Community Pediatrics Division, University of California-San Diego; contact Dr. Howard Taras. The focus is on assessing the use of schools for reaching children eligible for SCHIP and Medicaid and developing a “formula” that can be replicated in other school districts. Measures include:

- Number of hours of outreach work and number of visits or calls by outreach workers required to complete an application.
- Proportion of parents who begin, but do not complete the application process, and reasons for non-completion.
- Number of applications completed.
- Number of children enrolled in Medicaid or SCHIP.

### **Ongoing Evaluations of Outreach to Increase Access to Care**

Two ongoing school-based outreach evaluations are looking explicitly at the effects of enrollment on access to and utilization of services. Steven Horam of Community Health Resource Center is evaluating the Inova Health System’s Partnership for Healthier Kids in Northern Virginia. During the 1998-99 school year, 5,000 emergency medical information cards were audited, 820 families were contacted and 487 children were referred to a “medical home.” The evaluation of 1999-2000 school year activities is underway and will include an expansion from ten to an estimated 50 schools. Eventually, the evaluators would like to be able to determine, by using a survey, the number of primary care, prevention

and emergency room services used by newly insured and referred families.<sup>28</sup>

Dr. Howard Taras' evaluation of the Health-Insurance Access Through Schools (HATS) Project will go even further. In addition to measuring change in enrollment and change in access to health services, Dr. Taras intends to evaluate pre- and post-enrollment school absenteeism rates and school performance of the newly insured children.

### **Evaluation Recommendations**

Given the importance of evaluation to informed decision making, evaluation should be a key component of the Federal, State and school-level recommendations found earlier in this report. In instances where outcome evaluation measures are not feasible due to financial resources or other confounding factors, outreach planners should at least integrate process evaluation measures as part of specific outreach strategies.

In order to promote evaluation of school-based outreach activities, we propose the following recommendations:

#### **4. The Federal government should evaluate school-based outreach and enrollment in partnership with States, communities and schools.**

- 4.1 Create and disseminate tools for States and schools to use to evaluate the impact and effectiveness of their outreach efforts.
- 4.2 Establish clear and simple performance measures and reporting guidelines for States to share their evaluation results with the Federal government and other States.
- 4.3 Create and implement a tool for evaluating the impact of Federal initiatives to increase Medicaid/SCHIP enrollments through school-based outreach efforts.
- 4.4 Gather and make available information on the results of outreach evaluation efforts.

In addition, we strongly encourage that HHS, in conjunction with ED, USDA, State and school

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<sup>28</sup> Szilagyi, Peter and colleagues (2000) studied the Child Health Plus program (CHPlus) which became the model for SCHIP in New York State. Their objective was to examine changes in access to care, utilization of services and quality of care for children after they enrolled in CHPlus. They found statistically significant increases in access to a medical home and a usual source of preventive care after enrollment. However, there was not a significant difference in emergency department services associated with enrolling in CHPlus.

partners, support studies to examine the link between health insurance and educational performance. Many schools already recognize the important role they can play in linking children with health insurance. However, schools also recognize that they are primarily held accountable for educational outcomes, not health-related measures. For sustainability of school-based outreach and enrollment, it is important to demonstrate the link between health insurance, healthy children and educational performance.

While there are a number of challenges to designing evaluation tools for school-based outreach, the benefits far outweigh the costs. The outreach and enrollment landscape is an evolving one with multiple activities frequently directed at the same family. This confounds and complicates efforts to understand which outreach strategies are more effective. However, evaluation is the key to spending outreach dollars as wisely as possible. By choosing the most effective outreach strategies based on informed decision making, scarce resources can be maximized and more of America's children can be served.

## **Summary**

In summary, schools are the promising place to conduct outreach for children's health insurance. Evidence, both from States and local communities, supports the impact that schools can have in reaching millions of uninsured children. However, at the present time, and despite the extraordinary outreach effort involving thousands of schools throughout the nation, barriers often prevent schools from building a sustainable outreach program. This Report puts forth a set of recommendations that address the resources needed to make outreach to uninsured children an integral part of school business. It calls for a partnership between the public and private sectors, and close collaboration among the health, education and nutrition agencies at the Federal, State and local levels.