THE SOUTHERN INSTITUTE
on Children and Families

Report on

Communication and Marketing Strategies Meeting

August 6, 1998
Atlanta, Georgia

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Southern Institute on Children and Families
Communication and Marketing Strategies Meeting

August 6, 1998

Opening Remarks:

Sarah Shuptrine, President
Southern Institute on Children and Families and
Director, National Program Office for Covering Kids

We are very pleased to have gotten so many movers and shakers on this issue in the same room in the middle of the summer. We hope that we have created a networking opportunity for you, as well as an information sharing and learning opportunity for us.

The Southern Institute is a public policy organization working on behalf of disadvantaged children in 17 southern states and the District of Columbia. We recently completed site visits to the southern states to meet with Medicaid and welfare officials, child advocacy groups and, in some instances, business groups, to address the issue of improving access to benefits for low-income families with children. In February 1998, we published a report based on our findings from the site visits, titled *Southern Regional Initiative to Improve Access to Benefits for Low Income Families With Children.* Hard copies of this report are available from the Southern Institute, and it also is available over our Southern Institute and Covering Kids web sites at www.kidsouth.org and www.coveringkids.org, respectively.

Late last year, The Robert Wood Johnson Foundation launched the Covering Kids program, which is the national initiative to help children gain health coverage. The program has three primary goals:

- to identify and enroll children,
- to simplify the eligibility and enrollment processes, and
- to coordinate across health coverage programs.

We were astounded and delighted to receive 45 applications from 44 states and the District of Columbia and are in the midst now of conducting Covering Kids site visits. The Foundation is looking to see what we might do beyond these states.

While many of us share information on a regular basis, many may not be aware of what others are doing. This meeting is a great opportunity for all of us to learn about what everybody is doing with regard to increasing enrollment in child health coverage programs.

The subject here today is communications and marketing – strategies that work and those that don't work. We'll be looking very closely at the state organizations that are present today. These are the folks who have been at the forefront, and we hope to learn from them.

I'm really interested in some of the terms that get thrown around that we really don't fully understand. The word "stigma," for example. Nobody really understands what stigma means. We won't know how to address it unless we know what causes it. As we explore these issues, it is very important to differentiate whether they are communications issues or process issues — you know, where people have been turned off so much about how they are treated when they try to apply for these programs — or whether they comprise a combination of both, or even something else.

We also need to look at the issue of how we can motivate people to enroll when their children are not sick. What can we do to give well children the advantage of health coverage?

Also, we need to develop ideas or thoughts about the Hispanic population. The data show that Hispanics should be a target population for outreach. There are plenty of indications that the information requested during the eligibility process, particularly Social Security Numbers, may be causing some of the problem. We need to know what the *real* problems are so that we can get at some of the real solutions.

In addition, the Southern Institute has found from its research that many families really believe they must be on welfare in order for their children to get Medicaid.

We have a lot of challenges ahead of us. There's no question about that. Knowing what has worked and what regional or national efforts have helped the states enroll children will be useful. And if there is some regional and national initiative that isn't needed and is actually in your way, we are very interested to know about that as well.

Families, of course, are our most important source of information. The Southern Institute has done a lot of work in trying to communicate with families, but we feel there is real value in bringing together the professionals who work in this area. Again, we are extremely pleased we were able to get so many top-notch folks together.

Below are highlights from the morning's presenters, followed by questions and answers, where applicable. The second half of this report contains dialogue from the afternoon's brainstorming session.

State Presentations:

Joe Quinn, Communications Director
Arkansas Department of Human Services

What works? Money. Advertising. Thinking out of the box.

It is absolutely essential to identify funding first. Traditional avenues of communication are dead. Conventional (free) PSAs don't work anymore. Money works. Spend it with professional advertising agencies. Purchase broadcast time. ARKids has negotiated a 2-for-1 deal with TV stations on purchasing spots. We call it leveraging (where you buy time, you also get time). We don't spend any money on newspaper or print advertisements. We focus on television.

When the governor of Arkansas was poised to sign a health care bill at a special event held at a day care center, he spontaneously borrowed a crayon from one of the youngsters and used it to sign the document. Thus, a logo was born. We printed our toll-free information number on red crayons and began handing them out. People loved it. From that day forward, the crayon became the centerpiece of our campaign.

It is important to have an "action step" for every campaign. Give people a way to act. The ARKids action step was the toll-free phone number.

Leverage with TV stations and other media. Negotiate deals such as one free spot for every comparable spot purchased in a time period. In evaluating our progress, we can take parts of the state, look at what TV and radio time we are buying and overlap down to the zip

code to see how we're enrolling. Now more than ever before we are tracking the bang we're getting for our dollar.

You should integrate your messages with programmatic decisions from the get-go. Choose words and language for your messages that people can understand. Make materials colorful, glossy and attractive. People don't know what a "waiver" is. Frame the discussion so that people are able to understand. Put issues in context for the mainstream population. For example, in 1980 most employers paid the full cost of health care coverage for their employees. This is no longer the case. A family making $19,000 with four children may opt not to take insurance offered down at the factory because their share of the premiums is unaffordable

Build non-traditional partnerships with entities like fast food restaurants, pharmacies and schools. For a media event we held at our state capitol, McDonald's provided 300 Happy Meals for schoolchildren who were on hand for the event as part of a pre-negotiated field trip. McDonald's later volunteered to distribute and provide ARKids posters and brochures at its local restaurants. This promotion did not cost us one cent. All it required was a little non-traditional thinking. To review:

- Identify funding at an early stage.
- Integrate programmatic decisions with the message.
- Move forward.

Those kinds of things have worked for us.

Our average cost per month per enrollee is $36. That is far below what we had expected. We're also seeing recipients using dental and eye and preventive services. That means that if we spend $36 per month, we'll get a healthier, thriving kid down the road and save millions of tax dollars over the lifetime of the child. It is essential to lay out the cost-saving benefits of the program. Never assume that the public knows what you know.

We call it our holistic approach: prenatal program, immunization program, ARKids program. Paint the total package from conception to three years old. If you do the total package, you are in much better shape for the future.

Our Medicaid ConnectCare Program is how we link Medicaid recipients with the primary care physician. The Kennedy School of Government at Harvard University last year received 16,050 applications for innovation in government awards, and we won with ConnectCare. It's a wonderful outreach program to link the Medicaid recipient with a primary care physician. If we can take that Medicaid recipient out of the emergency room, we are saving Arkansas millions of dollars. The more we take out of the ER, the more we save.

If we can mix ARKids and ConnectCare, which we are starting to do more than ever, we can steer people into ConnectCare as we enroll them in ARKids.

The ARKids bill was signed on March 1, 1997. We worked all summer, beginning with issuing an RFP to bring in an ad agency. We rolled out radio and TV spots on September 1, 1997, and started accepting applications the same day. From September 1, 1997, through August 5, 1998, we enrolled 27,500 kids with far less money than some states. All together, we spent about $1 million (with the Medicaid match and creative leveraging).

Mr. Quinn then showed TV spots on videotape.

We couldn't do this campaign without the support of our governor. We strongly recommend you seek out support from your governor.

Q&A

Q — What other groups (besides McDonald's) did you involve in the campaign at the grassroots level? Also, you focus a great deal on TV. Would you recommend radio to complement TV ads?

A — We have used Arkansas Advocates, a children's advocacy group. They have a grant to go to school guidance counselors and factory personnel. I think school guidance counselors are a huge untapped resource. Pharmacies are good, too. We have our poster in all pharmacies now. We would like to it displayed in all school guidance offices. Those are groups we are looking to partner with. You also need good associations with TV stations. This has been a project the TV stations like. It is important to tap into what they like.

Regarding radio, yes, I would recommend radio spots. They have value but should be used with extreme care. It can be difficult not to perpetuate racial stereotypes on the radio.

Q — We have all discussed the importance of changing the name of a program so that it isn't called Medicaid. When you market a new program and the families actually pick up the phone and make that call, what happens when they find out that what they're really going to get is Medicaid? Won't they be upset?

A — We don't have a fancy name for Medicaid. It's Arkansas Medicaid, and I am proud of it. It just won national recognition with ConnectCare. It is receiving rave reviews for ARKids First. The word "stigma" came up in the introduction today. Stigma to us is breaking down that "I don't want to walk into the county office." That's a double-edged sword to me. I am proud of what goes on in our county offices. What can we do to make people want to approach the county office, to make them feel decent about it? Maybe we are looking at that backwards.

You could conceivably find out about ARKids, apply for it, enroll and take your kid to the doctor and never know Arkansas Medicaid was funding it. But that's true of a lot of things. I don't think people would have a problem finding out that Medicaid was funding ARKids. We put a clause in our program criteria that you had to have been without insurance for your kids for a full year to enroll. We had a huge worry that if we did not build in that safeguard, people would walk into the factory, drop their health plan and come to us the next day. We had to protect ourselves from that.

Q — What's the total number of folks you're covering?

A — Our initial estimates were that we had 125,000 kids in the state without insurance. Our initial target for enrollment was 55,000. And we're on track to probably hit 33,000 or 34,000 the first year.

Q — What are some of the hallmarks of your ConnectCare outreach effort that might be different from what you're doing starting up ARKids?

A — ARKids applicants now must designate three physicians they would like to see. Then we assign a primary care physician. There have been minor problems because those who have not been in the system don't know any doctors. There is confusion, and applicants are requesting guidance. We're working on it.

In conclusion, let me say that it is possible for you to get the money. We're Arkansas. We're the little guy. And we found $500,000 ($1 million with the federal match). I *can* be done.

Jana Key, Director of Research
Florida Healthy Kids

(Editor's Note: Since this meeting, Ms. Key has accepted a new position as Program Director with PeachCare for Kids in Atlanta, Georgia)

There have been a lot of changes, even for people who are familiar with Healthy Kids. Our legislature recently created Florida KidCare, which really solved a lot of our problems with outreach. Three programs address different age groups: MediKids is for ages 0-5; Healthy Kids for ages 5-19; CMS Network for ages 0-19 with special health care needs.

Healthy Kids right now is accepting every application for every program. We like to call it one-stop shopping for the families. They don't have to figure out which program to apply for. There is one toll-free phone number. People call in, and we mail them one application. We figure out where they go. Simple.

We're applying every disregard possible. If people are Medicaid eligible, they are enrolled in Medicaid. If not, they are referred into other programs under Florida KidCare, which is co-located with Medicaid staff.

Our primary avenue for outreach is schools. It is possible to reach an estimated 69 percent of uninsured children through the schools. Every child receives a flyer with our toll free number. In counties with a health plan in place, those children are receiving an application along with the flyer. Everyone else is getting a flyer only.

We also use radio and television ads, billboards, restaurant trayliners. While our numbers initially showed that we didn't get a lot of outreach from the McDonald's trayliners, they didn't cost us anything either. If it doesn't cost anything but you find just one family, then it works. Organizations like McDonald's are there to help, and they are willing to do it.

We conducted surveys of families enrolled in Healthy Kids. Overwhelmingly, they heard about the program through the schools. We found cultural differences also. Hispanics hear (and trust) information from family and friends more than non-Hispanics. But schools still are our number one referral source.

We can't talk about outreach without talking about enrollment. If everybody in the world knows about your program but they don't know how to get in, you haven't done them any favors. We must reduce the barriers. Florida's application is:

- one page,
- can be mailed in,
- does not require a face-to-face interview , and
- allows self-attestation on income (with random audits).

We send the message to families: "We trust you."

We have used the school lunch program as an income indicator since day one. Parents are asked to *volunteer* the information that their child is in the school lunch program, which is different from just taking the information from the school lunch application and sharing it without permission. This is an important distinction. The information may be verified "for research only," and it is completely confidential.

Eligibility determination is the sole responsibility of the Medicaid agency. Parental involvement is limited to corrections or incomplete information.

Make sure your toll-free phone lines can handle the volume, especially after major outreach messages are released. Try to anticipate volume. For example, there is a program called "Unavision," which is a Spanish news station. They did this huge, great, wonderful five-minute report on Healthy Kids. Our phone volume on our Spanish queue tripled in one day. This was great outreach, but we were not prepared for the response. Our phones just fried!

Q&A

Q — What did you find about the Medicaid stigma?

A — We did a phone survey in which we found that people have lots of issues with Medicaid. Some don't like coming down to the office. It was humiliating to them. It's an educational issue. Our messages now say "There's a new enrollment process. It's easy to get. It's great to get." We are trying to get people to look at Medicaid in a new way instead of the old way. We are calling this a new program.

Becky Shoaf, Project Director
Right from the Start Medicaid
Division of Family and Children Services
Georgia Department of Human Resources

(Editor's Note: Since this meeting, Ms. Shoaf has left Right from the Start Medicaid but continues to serve as a consultant to the agency.)

In Georgia, we thought we had the best program that had ever been invented, the best thing since sliced bread. We thought it absolutely would sell itself. All we had to do was tell people about Right from the Start Medicaid, and we were convinced they would beat our doors down. Here's what happened.

We took 195 outreach workers five years ago and put them in the communities working non-traditional hours. We told them to go the extra mile to help families.

What we learned is that many families don't apply because they are healthy right now. Some are not aware of potential eligibility and believe that working families never get a break. The welfare stigma is alive and well. It is a bad thing. There is a perception of laziness. Applicants don't want to be seen in a welfare office. People also cite poor service in welfare office and that they are not always treated with respect there.

Here's what worked for us with outreach:

- Be available during non-traditional hours to accommodate working people.
- Offer customer friendly sites. Meet families where they want to meet (take applications at McDonald's, for example).
- Appear separate from welfare system. We use the name RSM often.
- Treat families well. Pay attention to traditional customer service protocols.
- Use health care providers to get the word out. Families generally trust providers.

Always include in your message that this program is something for *working* families. It is not a handout program. This will help families succeed.

It is important to have a simplified application process. It has to be quick. It has to be easy. And you must reduce verification standards. It is possible to accept self-declaration and not have major problems with quality control.

Continually reinforce the message that your organization's goal is healthy kids. It is a worthy thing. Use the message that your organization is interested in preventative health care and is getting nothing from promoting the program. If your organization is really concerned about families, show it!

Families say they want to be comfortable with the process. Walk them through it. Tell them what to do next. Hold their hand and treat them with respect. Be sincere. Offer to come to their house if they can't get in to see you. We can't emphasize enough the need for an easy application.

If there is anything you can do in your state, convince people of the need for continuous eligibility. Tell applicants to report anything that changes but don't call them up every month and to verify their income. It just won't work. Confidentiality is very important.

This is what we learned:

- Relationships with community agencies are invaluable. You cannot hire enough people to broadcast your message.
- Staff development and retention is a big need. Spending money on this will always pay off. Make sure that you listen to the workers; they are the experts.
- Having few or no resources sometimes pays off. Outreach workers get involved with community groups and task forces. They develop positive relationships. Later, when they need something from community, they are welcomed in.
- Technology is important. Paper processing is crazy. Everyone should be able to access the system, sign up, determine eligibility and go. That should be the end of it. We need interactive ability. If Kroger can tell me exactly what I bought as soon as I walk out the door, why can't my workers tell people the same thing about something as important as their child getting to the doctor next week?
- We need professional-quality literature. It must be simple and supplied in abundance.

These are effective ways to share news:

- Utilize all media, broadcast and print.
- Use local programming. People love small-town local talk shows.

- Hire people who live in and are active in the community.
- Educate all health care providers and staff. Point of service is the very first opportunity you will get to serve some families. Don't miss this opportunity.
- Involve the faith community and other volunteers such as senior adults.
- Involve 1-800 services, but be very careful that you select someone who can deliver your message intact.

We would like to share information through schools and are hoping to get to that point in Georgia. Direct mail, using up-to-date information, also can be valuable.

Q&A

Q — How do you find and hire quality outreach workers?

A — We often get kids fresh out of college. They feel they can change the world. These folks believe they have the answer and can make a difference in the lives of families. They are creative and energetic. We will go anywhere. We will talk to you any time. We will take an application from our car trunk. We give these workers a whole lot of training. If there's anything we can get for free or almost free, we ask for it.

Q — Are these workers monitoring enrollment and identifying any conflicts with providers and recipients?

A — We are not at this point. With CHIP, we may be asking applicants to select providers in their county, so we'll begin building information from there.

Q — How are you addressing the challenges of outreach workers in remote areas that don't have shopping malls and widely accessible public places?

A — You've got to find something that will fit with your community. Some communities close up shop at 5 o'clock, so you can forget traditional outreach. You might go out when the state highway patrol is checking to see if people are wearing their seatbelts. Outreach workers need to seize opportunities and talk to people and pass out literature wherever they are.

Q — Are your caseworkers just doing CHIP or the full package?

A — Not the full package. Just Right from the Start Medicaid. Basically, they are eligibility workers who offer Medicaid. However, they will walk families through the PeachCare process.

Keith Johnson, Director of Operations
TennCare Bureau
Tennessee Department of Health

TennCare is working very hard to be the best program it can be. On January 1, 1994, TennCare overnight converted 800,000 Medicaid recipients to managed care. The state retained a marketing firm to help prepare videos, TV and radio spots. A large TennCare Information Line was established to help people with questions, and local health departments conducted major enrollment drives in their communities. They were the key

players in conducting outreach for this new program. That first year, our outreach methods were so good, we enrolled an additional 400,000 uninsured and uninsurables.

TennCare services are offered through managed care organizations (MCOs) and behavioral health organizations (BHOs) under contract with the state. Enrollees have a choice of MCOs (and their corresponding BHO partner plan) from those available in their geographic area. Effective January 1, 1997, all services are delivered within a strict gatekeeper system requiring primary care providers to manage enrollees' health care. It took some time to get used to a managed care environment.

After the first year, we were reaching our cap and had to close enrollment to the uninsured population. TennCare remained open to the Medicaid population and also to uninsurables (those who could not get insurance). Effective April 1, 1997, the governor announced open enrollment to uninsured children.

The cost for coverage under TennCare is determined by income. TennCare covers children in families up to 200 percent of poverty. The program accepts mail-in applications. Benefits education is conducted at the time of enrollment. There is no charge for preventive services, and we need to educate people about the need for insurance *before* they get sick.

We use flyers, posters, brochures and videos in health offices. Television stations agreed to run our video free for three months. We also made presentations to universities and neighborhood associations.

Local health departments contacted families who had applied for coverage for uninsured children after the Uninsured category was closed in December 1994 and told them about the new opportunity to enroll their children.

Mr. Johnson then showed a videotape on TennCare.

Q&A

Q— Are you using civic organizations such as the Lions Club for outreach?

A — Yes

Q — How might you target the middle class and the poor equally?

A — Probably through churches.

Q — Assuming we reach these targeted enrollment numbers, have states addressed the capacity issue? Will there be enough physicians to accommodate the number of people enrolled, and can those physicians afford to care for this Medicaid population?

A — This is a very complicated issue. Let's revisit it when we go into the brainstorming sessions this afternoon.

National and Regional Presentations:

Joan Henneberry, Maternal and Child Health Program Director
National Governors Association

The governors believe that children eligible for Medicaid benefits should receive those benefits. Accordingly, states have implemented strategies designed to increase participation in the Medicaid program, including dropping the assets test, adopting presumptive eligibility, shortening application forms, expediting eligibility determinations, allowing application by mail, guaranteeing 12 months of coverage per eligibility period and providing continuous eligibility for newborns. In addition, states have developed outreach campaigns designed to promote Medicaid enrollment while educating the public about the importance of prenatal and primary health care services.

Good information about the uninsured will help states develop more targeted and effective outreach strategies. Although some Medicaid-eligible unenrolled children are not covered by any program, others receive private sector insurance, often through noncustodial parents. Outreach efforts should accommodate this connection to the employer-based insurance market.

Any strategies the federal government considers to reach families of these Medicaid-eligible children must be developed in conjunction with the states. One of the simplest, least expensive and easiest-to-replicate strategies is a toll-free hotline. Many states operate a toll-free hotline providing information or referrals. In some states, families can even apply for and immediately enroll in programs over the telephone.

By January 1999, the National Governors' Association will launch a national toll-free telephone number and campaign, "Insure Kids Now." The initiative is designed to help governors and states identify and enroll millions of children in the new state Children's Health Insurance Programs. Bell Atlantic, telecommunications firm, has made a generous contribution that should cover transfer costs and long-distance charges for the first year. Long-term funding in the FY 2000 budget will be requested so that there will not be any telephone-related charges to the states. The number will be 1-877-KIDS-NOW (1-877-543-7669).

We think this is an exciting opportunity to assist states in their efforts to enroll millions of children eligible for new programs or Medicaid. The hotline will connect families nationwide to the appropriate toll-free number in their own state by an electronic transfer inaudible to the caller. America's Promise has been working with NGA and others on this initiative and has focused on marketing the toll-free number. AT&T will provide monthly reports on the number of calls made to the national number and to which states those calls were routed.

The NGA is aware of concerns about states being ready for the increased call volume that the national hotline will generate. No doubt, states need to be prepared to accept these calls from parents of potentially eligible children and to direct them to the appropriate resources. Preparation includes assuring adequate staffing of state-run telephone assistance, streamlining enrollment and application procedures, and training staff who answer phones and accept applications.

We try to keep governors focused on women and children's services. It is important to learn from social marketing campaigns, taking aspects that work with commercial products

and consumers, and applying them to our messages. The NGA has lots of information on its web site at www.nga.org.

Michelle Mickey, Health Policy Analyst
American Public Human Services Association

The APHSA is developing an Online Information Clearinghouse featuring:

- An online library of outreach and informational materials from state CHIP and Medicaid programs.
- Text and visual images.
- Portable Document Files (PDF) that can be downloaded and printed.
- A search feature by state, type, media and keywords (still under development).

The internet address for the clearinghouse will be http://medicaid.aphsa.org. Materials available online will include brochures, flyers, program descriptions, posters, application forms, quality assurance reports and unique distribution methods. All material will be scanned and left up on the site until APHSA receives updated information from states.

Please send any comments or suggestions to:

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Todd Askew, Healthy Start Coordinator
America's Promise

When America's Promise conducted focus groups on health coverage, the words "free" or "low cost" got the greatest response from participants.

Plans are under way, in conjunction with the National Governors' Association and others, to establish a national toll-free hot line with links to programs in all states. The toll-free number will be 1-877-KIDSNOW (1-877-543-7669).

So far, an estimated 30 states are technically ready to go, but there is concern about whether complete infrastructure is in place. The White House has been very involved in the development of the toll-free hotline.

(Debate on the efficacy, timing and infrastructure of a national toll-free number was deferred until afternoon brainstorming.)

America's Promise has published a book of corporate pledges in support of health coverage education and awareness.

Donna Cohen Ross, Director of Outreach
Center for Budget and Policy Priorities

Through our *Start Healthy, Stay Healthy* outreach campaign, established in 1994, the Center on Budget and Policy Priorities (CBPP) is promoting the availability of free and low-cost health insurance for children. Our approach is to focus on a broad, unified message — rather than one that promotes one program over another or confronts families with the task of figuring out whether their child is eligible for Medicaid or a CHIP-funded separate program. Our posters and flyers carry the theme: "Free and Low-Cost Health Insurance: Is Your Child Missing Out?" These materials have a space on them for community groups to convey a local message, such as a number families can call for more information or a place they can go to get help with an application.

We have been encouraging states that have established non-Medicaid child health insurance programs to design coordinated, seamless enrollment systems. This makes a unified outreach message more feasible — and we think it can help reduce some of the stigma families may associate with public benefit programs.

The first step is for states to simplify and streamline their Medicaid application and enrollment systems. To do this, states can:

- Shorten and simplify the Medicaid application.
- Eliminate the assets test.
- Allow applicants to submit their completed applications through the mail.
- Expand the use of Medicaid "outstations."
- Adopt the new Medicaid "presumptive eligibility" option.
- Adopt the new Medicaid 12-month continuous eligibility option.
- Make income eligibility rules consistent across age groups.
- Coordinate a separate state child health insurance program with the existing Medicaid program.
- Target Medicaid administrative funds for outreach and enrollment activities. Contract with community-based groups to conduct Medicaid outreach and enrollment activities.

These strategies not only make enrollment easier, they provide community groups with powerful outreach tools that can help them make the application process more accessible — especially for working families — and enable them to provide direct application assistance. The Center has Medicaid and child health insurance applications from every state, and we have been sharing them with state agencies and advocacy groups that want to help in making their own state's application easier and more consumer-friendly. We also have been providing direct technical assistance to states on streamlining specific aspects of their application and enrollment systems.

We need to remember that no matter how simple we make the application system, there will always be families who need help navigating the system — and they need help from someone they know and trust. People-to-people approaches establish trust.

There is tremendous opportunity to link families with health insurance at the same time they are seeking help with other benefits. Child care is a good example. The early childhood community has begun to build health insurance into its routine activities — when families sign up for subsidies, when Head Start programs conduct home visits or when Child Care

Food Program sponsors provide training for family child care providers. Early childhood programs that require families to fill out application forms may be asking questions similar to those on a child health insurance application form. Through our work, we have seen how coordinating these sign-up activities can greatly reduce the burden on families.

Genny McKenzie, Assistant Director
Southern Institute on Children and Families

A study conducted by the Southern Institute, in cooperation with the North Carolina Department of Human Resources and the Tennessee Department of Human Services, identified serious misconceptions about the availability of benefits.

One of the most compelling findings was that families on welfare and families receiving Transitional Medicaid, as well as community organizations who work to help them, lacked information or were misinformed about the availability of health coverage and other benefits.

As part of the study, the Southern Institute conducted personal interviews with randomly selected recipients of Aid to Families with Dependent Children (AFDC) and Transitional Medicaid benefits. Specific questions sought to determine the degree to which recipients understood how benefits changed when they left welfare for work.

More than three-quarters of the study group provided incorrect responses regarding the availability of Medicaid benefits for families leaving welfare and children's Medicaid. Almost half provided incorrect responses regarding the impact their new earnings would have on child care benefits.

Based on these findings, we recommended that state social services divisions develop user-friendly materials to effectively communicate available benefits.

With the knowledge gained from 27 focus group sessions, we developed brochures in Georgia and North Carolina:

- The *Leaving Welfare for Work* brochure is for families who are on welfare to let them know about benefits that are available to them when they leave welfare and go to work.
- The *Benefits for Working Families* brochure is targeted toward families that have no connection to the welfare system. It is designed to let them know that there are benefits available for them, and they do not have to be on the welfare system to receive the benefits.
- The *Facts for Employers* brochure is specifically geared to low-wage employers to inform them about benefits for which their employees might be eligible.

All brochures discuss the Medicaid program and children, the EITC, child care assistance and Food Stamps. One has a section on child support enforcement, and another has a section on employer incentives.

The focus groups served two purposes. The first was to get feedback on the brochures and what we could do to improve them. An example of what we learned from families was that they wanted figures related in monthly income rather than annual income. The second purpose was to inform these families because many of them did not know about the benefits discussed in the brochures. Participants took a pretest before reviewing the

brochures and then a post-test to ascertain what they had learned and understood after reading the brochures.

Pretest Results:

- 55 percent did not understand that if parents get off welfare because of work, their children would be able to get Medicaid.
- 59 percent did not know about the availability of Transitional Medicaid for up to one year.
- 41 percent did not know that a paycheck plus EITC money is much greater than a welfare check.
- 39 percent did not understand that if parents get off welfare because of work, they can get help with child care expenses for up to one year.

Post-Test Results:

- The number of correct EITC answers improved from 41 percent to 86 percent.
- The number of correct Medicaid answers improved from 38 percent to 81 percent.
- The number of correct child care answers improved from 76 percent to 93 percent.

Ideally, the Southern Institute would like to see a caseworker sit down with the families and go over the brochure. It takes only a few minutes. However, because that is not always realistic, the brochure needs to be as simple and readable as possible.

Florida, Georgia, North Carolina and Tennessee were using the brochures before the project. The Robert Wood Johnson Foundation has provided funding to the Southern Institute to replicate the brochures in 13 others states in the southern region and the District of Columbia. The following eight states have replicated the brochure for statewide use, bringing the total to 12 states:

- Arkansas
- Delaware
- Kentucky
- Maryland
- Mississippi
- Missouri
- South Carolina
- Virginia

Hopefully by the end of the year, the rest of the states and the District of Columbia will be using the brochures. The Southern Institute also has developed videos that go along with the brochures. The videos use the same cute characters that were received favorably during the focus groups. All states using the brochures will get multiple copies of the video, which refers to the brochures. We encourage states to use both. There is a Spanish version of the two consumer videos, and, in the next couple of months, we will have these two brochures translated into Spanish.

Group Brainstorming
Key Points

Following are the key points raised during the afternoon's brainstorming dialogue.

1. Identify target audiences and generate simple messages with clear purpose. Keeping it simple is key.

Sometimes organizations with very limited budgets try to produce a single, all-purpose video or brochure that can address a number of very different purposes and audiences. For the most part, this approach is ineffective. Have a clear purpose. Don't hold the expectation that every PSA, every brochure, every engagement with your target audience is addressing all of the messages and all of the issues. Often the tenet "less is more" applies with regard to health coverage outreach. Be sure to keep messages simple, offer an action step and try to include the words "working families" if possible.

2. Recognize that TV or radio spots and other publicity are only single elements in an overall marketing/communications strategy.

It is important to reinforce key messages through a number of different mechanisms and messengers. It is OK that some things are going to be very simple and, in a sense, partial in communicating what you want to communicate as long as it really is part of an overarching communications and marketing strategy.

3. Be aware that in a rapidly changing, overly competitive media environment, traditional, or free, Public Service Announcements (PSAs) are a thing of the past.

In developing your media messages, identify adequate funding to purchase broadcast air time if you want your message to be heard.

4. If your resources are limited, look to other organizations to fill the gap. Seek out lessons learned and best practices.

Many states do not have a full-time communications staff person. One of the best ways to overcome this is to link with outside experts or organizations that have experience to share. Are there regional or national strategies and materials that can be replicated? Are there models out there? Find out and take advantage of what is already out there. Many organizations are dealing with limited resources, and it is to everybody's benefit not to duplicate efforts. It is useful to know that others are doing. The states want this.

5. Develop a compelling public message that child health insurance is needed.

One distinction between health care and health insurance is that health care is there, regardless. Anybody can go to the emergency room whether they're insured or not. But recent studies have shown that a lack of health insurance still is a major barrier to receiving care, especially preventive care. This is what we should focus on.

6. Use information from focus groups with care. Consider the merits and drawbacks of various types of research.

It is important to distinguish what is learned from focus groups and what is learned from quantitative market research. No one message will address all the sensitivities. Quantitative market research could provide insights that you can't get from focus groups. It is difficult to extrapolate from local focus groups for wider audiences.

7. Be sensitive to state government concerns about money. Establish positive relationships with policy people.

Remember the state legislature controls the budgets in most states. So it isn't just the executive branch you have to work with. Make sure you're talking to the right people and make sure it's a lot of different policy people. The challenge is to orchestrate outreach without spending unnecessary resources.

8. Share information about your activities and successes in brief doses. Partner with organizations that are in a position to help relay your message.

Not only do people not have the time to read all the great reports and communications or to look at one other's websites, they don't have the time even to send information to those people who are trying to collect everything and distribute it to everybody. To save everyone precious time, it is essential to identify what national marketing and communications strategies, materials and outreach aids are helpful to state and local efforts. Figure out the best way to reach all the people who could benefit from your message and establish two-way communications so that you have a way not only of letting everyone know what is available but to receive feedback about how you could make things even then more useful.

9. Do not begin any outreach strategy, such as the national toll-free phone number, until you have a workable process and infrastructure in place to support it.

It is important that communication efforts be tied both to outreach and real programmatic capacity. One of the worst things that can happen is to have a great success in terms of raising awareness and getting people calling a toll-free number. But for those people who have taken that very important step of calling, there should be clear communication on about what their next steps should be. If this does not occur, and they don't know how to take any more steps, you have lost them. Don't jump ahead of yourself. If you publicize a program that is not ready, and people are told they must wait for the service, your outreach has been completely ineffective.

10. Understand that the stigma issue is very real and complex. Consider this in developing your outreach messages.

Stigma is not just a perception. It really exists in a two-tier health care system. There are people with private insurance, and there are people with public insurance. The recipients of the insurance see it as different. Nobody's thinks that Medicaid is as good as an employer-subsidized Blue Cross Blue Shield indemnity plan. Providers see it as two-tier. Recipients see it as two-tier. And the public generally sees it as two-tier. Therefore, it would be worthwhile to frame messages in a way that doesn't stigmatize free care. We must start thinking about the Medicaid stigma in a more thoughtful way and put an end to the mindset that, if you change the name of a program, that will take care of it. We must educate people about the real value of what they're getting.

Edited Dialogue Excerpts

Following are edited excerpts from the afternoon session. A full list of meeting participants appears in the appendix to this report.

Deborah Clark, Director of Cause Marketing
GMMB & Associates, Inc.

Having a clear target audience is absolutely essential. Be clear about the *purpose* of the communication. Sometimes folks with very limited budgets try to produce a single video that can address a number of very different purposes and audiences. For example, a video to train outreach workers is very different from one to help families become more confident about the application process.

It also is important to make sure the communication efforts are integrally tied not only to outreach activities but also to real programmatic capacity, like changes underway to simplify the application and enrollment process. For those people who have taken that very important step of calling a toll-free number, there should be clear messages about what their next steps should be. If families don't know how to take any more steps, or if the states aren't really prepared to implement a user-friendly system of enrollment and then utilization of health services, it will be much harder to get families to contact government programs again.

Part of what we're dealing with is the need to have an overarching communications and marketing strategy that supports specific outreach efforts. TV spots are only one possible element of the overall marketing/communications strategy. I understand the frustration of ascertaining how we can fit in all the different things that families need to know. You don't have to. In fact, an all-purpose message that sort of tells everybody to do everything will not work. It's also important to reinforce the key messages through a lot of different mechanisms and messengers. It's OK that some communications are going to be very simple and, in a sense, as long as it really is part of an overarching communications and marketing strategy that distinguishes messages for different audiences based on what we are trying to get them to do (action steps).

Stephanie Nelson, National Director
American Hospital Association

The American Hospital Association, in partnership with WJLA-TV (an ABC affiliate in the District of Columbia region), the March of Dimes and the Health Care Financing Administration broadcast ads on children's coverage that ran in the District of Columbia, Virginia and Maryland for about six weeks. WJLA produced the ads for free, but the other partners paid for air time. It was challenging for a couple of reasons. We are dealing with three different Medicaid and CHIP programs. We also are trying to show a partnership and use it as a model that can potentially be used by other regions. We tried to think of everything. We thought about words. When we got our script, we thought it was on track. But someone else read it and thought people won't understand what the word "coverage" means. It's really overwhelming. How can you motivate people to enroll healthy children in a 30-second spot? There's a lot of interesting dynamics to it. Everybody with a stake in this had to be able to respond when the telephone rang. Our action step was to get people to call an information hotline.

It is important to point out that WJLA approached us when they heard about this effort and offered to produce the ads free. We ran more than 200 spots. It was a big buy, and it was

not heavily discounted. But it has proven invaluable because WJLA has some corporate relationships through other advertising and resources that we don't have. So they brought to the table a lot of local players already that they work with.

Jana Key, Former Director of Research
Florida Healthy Kids
Current Program Director
PeachCare for Kids

We have looked at television marketing. We have different programs in different counties. Same program, but some for different ages, different rates, etc. So we tried to do a TV ad that speaks to all of the different programs, but it got too complicated.

Our TV message is, "Are you uninsured? Call this number. Go to your school. Get an application. Fill it out and return it." That was the message. If you're uninsured, get the application and fill it out.

Joe Quinn, Communications Director
Arkansas Department of Human Services

Our governor has a newsletter. He has a Saturday radio address. I'll call his communications guy and say let's do something in the governor's newsletter about ARKids. If you have a strong governor's office with a good communications staff, use them.

Joan Henneberry, Maternal and Child Health Program Director
National Governors Association

Most of the states probably do not have a full-time communications person. If the agency does, they spend a lot of their time just putting out fires. It is important to be to be realistic about what kind of marketing talent and expertise the state has access to. That may be one of the best ways you can help them is by helping them hook up expertise or outside organizations that can fill the gap.

Lil Gibbons, Director
Children's Health Initiative Outreach
Health Care Financing Administration

That raises a question: Do we have a regional strategy? A national strategy? Do we have models out there? The Southern Institute is working with multiple states to replicate brochures. The Health Care Financing Administration is trying to develop some background material for about six states right now to give them some of the things they need to get on TV and radio. The states want this. But how many different ways can you say it?

Christa Grim, Media Associate
Children's Defense Fund

Say you're someone like Children's Defense Fund and you're looking for ways to supplement strategies states are doing. Through our network, we have enormous influence, enormous capability, people and resources. CDF has been a leader in the religious affairs network. We reach 50,000 congregations. Our communications challenge is determining what role CDF will play and, more than that, how we can be helpful. CDF and advocacy organizations like it have a national perspective and broader-based role to play, and the

message gets weaker when you do that. So what we're trying to do is develop some communications tools that aren't so weak that they're not useful for anybody, but at the same time are really utilizing the resources that we have.

My question is to Todd Askew. You have mentioned this booklet that you have that lists all the people or organizations you're working with who have approached you and said we want to help get the word out on CHIP. How do we coordinate these efforts so we're not all duplicating? Some areas are uncovered totally. CDF certainly has the resources in various specific areas, such as child care. We have an incredible child care network that we are really hoping to tap into, but if it's already being done, what use is it to duplicate the efforts of others? Our communications challenge is helping supplement what states are already doing.

One thing we have talked about is doing a media kit where we'll target 10 states and communicate what messages work. America's Promise found one message that worked was "free or low-cost health insurance." One thing we found when we tested our message with focus groups is that people don't like the word "insurance." A lot of people don't know, don't understand or don't care. Or they just tune you out when you say insurance.

Todd Askew, Healthy Start Coordinator
America's Promise

One distinction we are trying to make is between health care and health insurance because health care is there. Anybody can go to the emergency room. When you break a leg, you don't lay at home wishing you had health insurance. You take your kids to the emergency room whether they're insured or not. The recent studies I think that have shown access to health insurance is a major barrier to whether or not they're getting care, I think is what we want to focus on. We can say you first get the health insurance and then you get the health care.

Christa Grim

What we found was that "coverage" was a more universal word. At least for our audiences, it resonated better. Actually, we shot ourselves in the foot though. In developing a set of public education materials around trying to get CHIP passed, we used the words "health insurance" because we lost our policy wonk battle. They wouldn't let us take that word (insurance) out. It's interesting to me, but specific word choice makes a difference.

When we were talking about trying to get a health insurance bill passed, we wanted to find out what kinds of communications strategies would ensure that people were aware. We wanted to develop public outcries that child health insurance reform is needed. So it was centered on health insurance reform, not enrollment. It was very different.

Sarah Shuptrine, President
Southern Institute on Children and Families and
National Program Office Director, Covering Kids

In our focus groups, we used the word "coverage," and that communicated much better where "insurance" wouldn't have done it.

Lil Gibbons

It is difficult to extrapolate from focus groups for a wider audience. Focus groups really are not a representative sample to any extent to make some conclusions. I want to illustrate that

by this flyer that was done by the White House that we need to give out regarding "affordable health care." Some people define "affordable" quite differently from others. And yet, the term was focus group tested, we were told. What we're talking about now is how to relay a simple message. Instead of people going back to their own corners and designing and redesigning and so forth, I'll hear about things that the expertise already out front can pull together.

Joan Henneberry

I don't think it's our job at the national level to define those things for the states and for the community. I think our job is to look where we know there are lessons learned, best practices, and get that information out and hook up the states and communities with the expertise and resources. All this work at the national level won't cause any harm, and hopefully it will be helpful to get more information. But I still say true outreach is going to happen neighbor to neighbor, person to person, in the street, in the communities, because we already know from kids who have been eligible for Medicaid and not enrolled something about why they didn't come in and what those barriers were. Those are the kinds of relationships that need to happen so that families will see why it is important to get their kids coverage or insurance, or whatever words we use, before they get sick and that's why it's especially important that they have it when they are sick.

All of us at the national level, while we think we're being helpful by developing press kits or flyers — whatever — is that just making it more complicated?

Joe Quinn

Let's take the resources at the Children's Defense Fund, for example. Any time you're putting into a press kit, I think, is wasted. What you need to be doing is working your sources at *The Washington Post* or *The New York Times* and playing those sources to try to get national media coverage. Press kits are sort of an outdated thing.

Christa Grim

The press kit is just one little piece of an overall communications strategy. It's one tool that can be effective in one or two states. Perhaps we could be useful on a broad level — not just organizations like CDF but other organizations — where we do have the grassroots support and we can go neighbor to neighbor, church to church. That's what we're trying to figure out. What are the best tools to help people do that? Are we to be developing brochures for the "end user," or is it our job to develop a brochure to inform our child care provider to then, in turn, talk to their child care folks? We're struggling with that. Where can organizations like CDF partner with one another so that we are not duplicating efforts?

Donna Cohen Ross, Director of Outreach
Center for Budget and Policy Priorities

I think outreach does happen at the community level. But having worked at the community level for many years, I know that very often I did rely on resources I got from states and national groups to help me figure out what I had to do. It was my job to localize the message.

Regarding the national toll-free number, we have been saying that state toll-free numbers will be plugged in when they are "ready to go." We need to define what we mean by "ready to go." Our staff took the list of state toll-free numbers and we called each of them. We found tremendous variation in what happens when a caller is connected. For example, there

were a small handful of states in which the caller can be helped to complete an application over the phone. That's service. But there were some states that referred callers to other numbers and others for which the person who answered the phone was unable to help a caller with children's health insurance at all. That is not service. I am afraid a national campaign promoting a single number will be wonderful in some communities and a real disaster in others. This is a serious problem. There should be criteria set to determine what "ready to go" means. The state toll-free numbers should have to provide some specified level of service in order for a national toll-free number to be viable. If we are not ready nationally, then we shouldn't go forward, or we should plug in only those states that have met the criteria.

Joe Quinn

What happens to callers when they do call the national number?

Sarah Shuptrine

They get routed. They don't know they're being bounced. So if a consumer from Arkansas called the 1-877 number, they would be routed to where Arkansas has told the national number to send them.

Donna Cohen Ross

I want to know what happens when I get to Arkansas or what happens when I get to Connecticut or what happens when I get to some other state? Sometimes I will get my child insured (or covered). In some states, I will get another number or I will be told that they don't know what I'm talking about.

Sarah Shuptrine

I think what Donna (Cohen Ross) is saying is that the readiness standard has to be tough.

Joan Henneberry

I have to add the caveat that every state is not going to do it exactly the way we think is the gold standard.

Sarah Shuptrine

It sounds like the train has left the station, but we can use this as an opportunity to get the word out. However, we need to do everything we can to ensure that the caller has a positive rather than a negative experience.

Stephanie Nelson

The American Hospital Association does quite a bit of focus group research. Consistently, the number one symbol for health care that the community trusts is the nurse. That is really the only provider that resonates in a good way. I am worried about the states that have shown some real reluctance when they are approached by our hospitals that want to help. There is not 100 percent, across-the-board willingness by every state to get out in the community.

Sarah Shuptrine

Stephanie (Nelson) says she's got hospitals that want to help, and they're running into state governments that say — and I've heard it, too, from the lower ranks in state government — that we still don't have enough money to cover everyone who is going to be eligible under these programs and that we don't want to do that.

Joan Henneberry

Remember the state legislature controls the budgets in most of the states. So it isn't just the executive branch you have to work with. All I can say is make sure you're talking to the right people and make sure it's a lot of different people. It could be that your best friend is going to be in the public health department or it's going to be the Medicaid director or it's going to be the governor's policy chief. It could be a variety of different people, and I just would say don't give up. This program isn't even a year old. Let's not give up on anything yet.

Lil Gibbons

This program cannot be made a success by the state alone. The state agencies, as such, cannot do it alone. I think the issue at hand right now is how we orchestrate outreach without spending unnecessary resources. These kinds of forums are extraordinarily important to find out if the expertise is growing. It seems now with all this expertise that we have that we have we really have the opportunity of a lifetime to talk about how we will orchestrate this — public, private — in a way to help states be successful to the extent that they want to be successful.

Paul Tarini, Communications Officer
The Robert Wood Johnson Foundation

I don't want to let us off the hook, but at the same time I don't want us to spend the afternoon twisting our stomachs into knots. There's no way that we're going to get nice, clean categories for organizations to assist with outreach. Optimally, CDF will have a critical mass over here, but there's going to be overlap, and people expect that. I don't think we're going to be able to figure that out for awhile. It makes a difference in materials and messages. We don't question who our "end user" is. But I think it makes sense to deal with your strength, and your strength is your numbers. What's the role they can play in their states. What do they need to play that role most effectively?

Becky Shoaf, Project Director
Right from the Start Medicaid
Georgia Department of Human Resources

Anybody can say "This is what happens if you don't have coverage and your child gets sick but it's not a life-threatening illness." Anybody can demonstrate that, and that's a message than can be used.

Joe Quinn

What we also need to be saying is that we're paying for it anyway. Want to manage out tax money better? The taxpayer is paying for the uninsured broken leg in the emergency room anyway. Fiscal conservatism can be a selling point.

Sarah Shuptrine

Well, is it a good idea to try to do something to coordinate nationally or not?

Unita Blackwell

I get a feeling we have come up with some good ideas about child coverage and this agency and that agency and so forth, but there seems to be a climate of mistrust on the community level. Is this a trend that we can break? As far as conservatives versus liberals, we have to figure out how to communicate with one another and get the job done. We have to break in and zero in on the children.

Sarah Shuptrine

What do you all think we need to talk about? It seems to me that people here, and others who aren't here, could communicate with an entity that can keep us all aware of what other groups are doing. Would you want to receive this kind of communication?

Deborah Clark

We have to apply the same principles that we were talking about earlier. Who is the target audience? What are the messages? What is the purpose of the communication to this overarching discussion that we're now having? I love national networking, coordinating, communicating. The "I Am Your Child" campaign, for anybody who knows it, is one of the most holistic, let's-tap-into-every-single-sector campaign of its kind. However, I can tell you from experience that, not only do people not have the time to *read* all the great reports and communications or to go look at each other's websites, they don't have the time to write up and send in information to those people who are trying to collect everything and send it out to everybody. So I really believe that what needs to happen is that we have to say for what purpose, with whom, done by whom are we going to coordinate what? What do we need to be communicating about?

What national marketing and communications strategies, materials and outreach aids are helpful to state and local efforts? That's to me what we ought to be talking about. What Todd (Askew) was getting at is that you have national level partners who only can actually come into this problem-solving effort if there's a national scope to what you're asking them to do. Todd was referring to companies whose market and outreach and communication mechanisms are national. How to tap what they have to offer is by thinking nationally about what we need.

We know from the experiences of the "I Am Your Child" campaign, we can't pit tapping the national infrastructure against going in through the grass roots. We were able, by building partnerships with 154 national organizations, to actually get local members of those organizations to take our messages about early childhood development directly into the ongoing work they were already doing with families. We have been able to disseminate materials that community-based programs are saying are useful to them in their ongoing work and to elicit from them a kind of involvement that their local agencies were not able to elicit — not because they haven't been trying, but, in a lot of cases, they just don't have the resources and expertise to sustain coalitions and partnerships. Through the National Head Start Association, we were able to facilitate that every single Head Start program in the country now has "I Am Your Child" materials. Through the American Library Association, we were able to place these same core materials in more than 9,000 libraries across the country. Through a partnership with Blockbuster Video nationally, all

Blockbuster outlets in the US and Canada offer the same "I Am Your Child" video to families as a free rental. That's enough said about that.

I think we have to talk about what you want to happen nationwide and relate that to very practical marketing and organizing strategies. I'm honestly interested in the experiences the Southern Institute has had in taking materials and localizing them. Does this work?

Sarah Shuptrine

The original idea was to try and help the southern states. There was a total mix of some states that were way ahead, some that were way behind and some that were somewhere in between. What we're hearing is that some states would say "This is too expensive; I can't do it. I can't get any money out of my legislature or my governor." We perceived a need there on the part of some states for this kind of national effort. Going back to the point that a national effort won't do any harm, I think that's still a test. We have to make sure that the national effort is helpful and doesn't do harm.

Deborah Clark

You can't say that unless absolutely everybody needs and wants what we have to offer, it isn't worth doing it. And you can't expect that everyone will need and use it exactly the same way. So that's why you have to go back and figure out exactly which needs are the ones you are trying to address. There has to be a critical mass of widespread, tangible activity and interest across the country that makes it worth it to invest resources at the national level. That investment then becomes the catalyst to amplify and unite the scattered local and state efforts. There being a national *something* is sometimes the catalyst to states finally getting people to move. It can also be the leverage point for states to form partnerships with companies and media that they couldn't have formed before because they lacked a national strategy and, therefore, the basis to tap the national infrastructure and resources of the media and corporate America.

You need to figure out the way to reach all the potential people who could benefit from what you're trying to do, assuming you've done a good analysis that there is a critical mass out there that warrants the kind of investment you want to make, and you let those people who could benefit from having those things know what you can provide that will be truly useful to them. Then you have to establish two-way communications so that you have a way not only of letting everyone know what is available but to be informed about how you can provide resources, technical assistance and materials that will be ever more useful.

Jana Key

Can you do outreach before you have a process? One county (in Florida) distributed 180,000 applications without telling us (the state agency) about an open enrollment. The reality was that the coverage would not be available in that particular county for six months. Do you know how angry callers were when they were told it would be six months before they could get anything? There are people who do not call until they need the help. They're not calling because they want health care six months from now or three months from now. That's too far away. They want it right then.

We did a small pilot study because the Department of Health in Florida runs a hotline. So we asked people for one week when they called to get an application, do you have an immediate health care need? If so, we'll refer you to someone. The number one response was, will I get my application processed quicker if I say yes? So if you run this toll-free line and advertise and the person who picks up the phone is told that they will have to wait

a while, you just lost that person. Your outreach has been completely ineffective. You can't jump ahead of yourself. You want to have a little buildup maybe the week before the program comes out, but you really have to coordinate this on the national level and a state-by-state basis because you really want to know what happens. You want to know when they pick up the phone to call, there's going to be something to come out of it because that's the biggest step. That first step is very important.

Deborah Clark

From the national level, the expectations for what the hotline should be is entirely different from at the state level. Where it gets tricky is that you are connecting people directly with their state, but it has to be defined. What is the purpose of them talking with that person in the state. A philosophical perspective about how to make progress in real life is really important here. Many of the different things you've been discussing will not be happening by the gold standard. Instead of asking, "Is this state's program up to the gold standard?" ask, "What steps could be taken to genuinely make the program more family friendly and effective as a vehicle to link families with health care services for their kids?" Constantly, all of us, whether we're working national, state, local or in some little neighborhood, must distinguish how our efforts fit with our objectives and how we can then be accountable to the different people that we're communicating with.

Sarah Shuptrine

I think we've gotten out of this some idea of what it would take to deal with it on a national level as far as capacity within the states. We'd want to develop something that some states would want and not push it on the others. The other key is the messages. We're probably going to be doing some of this with Covering Kids as far as how to make sure that the messages are going to be communicated effectively to families. So that's another piece of this. The other is what other organizations are doing. I really think it is valuable for us to know what they're doing. How can we best do that? We need to think about that. Covering Kids, I think, is probably going to be a national resource for this whole mission of trying to get kids insured. We are willing to play that role, but we need to know mechanism for that. The communications piece is incredibly important for organizations. It is important at so many different levels. What's the best way to do that?

Joan Henneberry

Let me make sure I understand what you're asking. If you (the Southern Institute and Covering Kids) became sort of the national focal point, this resource center for outreach and enrollment and all that, are you asking how we could keep you informed if we're doing anything that might support or parallel those efforts?

Sarah Shuptrine

Not just us, but everyone — *through* us. To have some aggregate information on our website that is available for folks who are too busy to read everything or go to everybody's linkage. An update of what folks are doing, some kind of baseline information about what NGA is doing, what APHSA is doing, what CDF is doing. We can all key into that.

It isn't rocket science to try to develop something basic that you go national without anything about eligibility levels or anything like that. It's just motivational. But that toll-free number that's attached to it has to be workable for the family, not just technically, but it has to mean something. They have to get some help from it.

Todd Askew

The folks that can make this happen need to be motivated and educated as to the value of it because the materials that all the groups around here produce, they are great, but for some reason the phones aren't ringing off the hook.

Sarah Shuptrine

Is this something we should put in writing?

Christa Grim

I'm thinking a meeting and follow-up with written materials.

Donna Cohen Ross

I would prefer paper and then, maybe every six months, meet and talk about main issues like we did here. Just focus on some things that are really important as we move forward. Right now we're very focused on the national toll-free number because that's something that's coming down the pike very soon. Maybe in six months it will be something else.

Sarah Shuptrine

Would each of you be willing to give us, to start something out in writing, a page or two about what you're doing? Can you do that?

Deborah Clark

I would just like to suggest that it not be more than a page. You even give us the template electronically, and it's simple. It could have the contact person and the date and the organization, and we just put bullets so that people can get an idea of what's being worked on. If they want more, they can get it.

Sarah Shuptrine

Maybe six months from now we'll call together another meeting of people to just talk about what they are doing in terms of updates based on that basic information. We should just do it along the lines of the three Covering Kids goals.

Deborah Clark

Keep it as concrete and simple and succinct as possible. Otherwise, you're going to be burdened with way too much.

Becky Shoaf

At the national level, just remember one thing. Some of us were born and raised in environment s where you have to turn in your old ink pen to get a new one. We just need to bear in mind that there are folks trying to do the job without the things they need.

Sarah Shuptrine

This is where we could tie in with what America's Promise has pulled together — a directory of corporate sponsors that are looking for things to do. These connections can

take place, hopefully, through this mechanism or some other mechanism and we can get some help where it is needed.

Deborah Clark

It has been an incredible challenge for the staff of America's Promise to actually follow through on the commitments that were made by those companies. They have so many things on their plate that, unless you can make it really easy for them to do what you want them to do, they're not doing it.

Covering Kids has been set up with three very clear purposes. You've thought this through. You know what you want to do for sure with all the grantees. How will you be able to best accomplish those national objectives through your support of the grantees? You're not saying it's either all national or it's all local. You're trying to bring that together. It's a very practical question. What can you be doing to create a more favorable environment for local and state efforts? What do you need from national organizations like those sitting around this table?

Sarah Shuptrine

What I've asked for is two pages. We'll come up with a format, and we'll send you the format. That's what we're going to need based on those goals, which is what everybody wants to do. We're all trying to do the same thing. We'll do that and start it out there. As we move along, each of the states has coalitions that are state and local. They are learning from pilots that are feeding back to the state and vice versa. It's a very good focal point in every state for what we're learning and what we can share.

Joan Henneberry

The primary reason should be that this is useful when you get ready to work with the grantees. For example, we have a grant to provide technical assistance to the states. If the Southern Institute knows that the NGA has money to pay for on-site, state-based technical assistance and comes across something at the state level that is outside of the scope of the Covering Kids grant but that the state clearly needs some help with, then the Southern Institute can refer them to the NGA.

Sarah Shuptrine

We've got something tangible. There's been a lot of sharing of information and a lot of concern expressed about the 1-800 number with regard to readiness issues, so we'll be talking about that some more. Any closing ideas?

Donna Cohen Ross

I think it's a good idea to bring together information in the format that you suggested — just a short synopsis keeping everybody up to date. I think it would be good for us to all be as specific as possible so that when we say we provide technical assistance we describe exactly what kinds of help that we provide so that it is real specific. I think coming together to meet periodically is a good idea as well. This would be a very good opportunity to sit around the table with people you sometimes talk with on the phone.

Sarah Shuptrine

We'll do that in about six months.

Let's talk about the stigma thing for a little while. What have you all learned about the stigma issue that you can tell us and we can learn something from? My concern is that it is something that's out there, but we don't really know what it is. Don't you feel we need to have more information on this?

Todd Askew

It's not a perception. It's really there because we have a two-tier health care system. There's people with private insurance, and there's people with public insurance, and the recipients of the insurance see it as different. Nobody's thinks that Medicaid is as good as having your employer buy you a Blue Cross Blue Shield indemnity plan. The providers see it as two-tier. The recipients see it as two-tier. And the public I think sees it as two-tier because, I mean, it *is*.

Sarah Shuptrine

Does it go back to the reimbursement thing?

Todd Askew

With providers, it does.

Joan Henneberry

I wonder about the bigger context of our general resistance as consumers to finding insurance that we don't think we need. We all hate the fact that we have to spend a lot of money every year on car insurance, and how often do you ever use it? Seriously, I don't think we really understand that the challenge is to convey in our messages to the general public why we need to have health insurance.

Deborah Clark

I think we really have to distinguish what you learn from focus groups versus what you learn from quantitative market research. Maybe one thing your project could consider is commissioning some market research, quantitative surveys, so we can know the right questions to ask, not just of the target population but really of the American people and get a handle on some of these questions in terms of how people understand this, what kind of values are attached to all these different entities, and I don't mean the acronyms for all the state programs, I mean in a way regular people look at it. Really do some research on it because I am very uncomfortable when people refer to focus groups as the way to learn how to communicate the overarching messages because it's *not*.

No one thing is going to address all the sensitivities. That's why I'm saying you have to recognize what you can get out of quantitative research versus focus groups versus just the one-on-one situation that isn't at all organized. Do I think this kind of market research would give us insights that we do not have and we're not going to get from either focus groups? Yes. Definitely.

Jana Key

Getting back to the pure stigma issue, one of the groups that is always overlooked in this research are the actual Medicaid workers and policy people. One of the things that we found from our Medicaid service was that people didn't want a program that's free. And

we're talking to Medicaid people who are working on the CHIP program. There's a lot of hand-holding mentality from the Medicaid policy people where you are transitioning from that type of mode to taking care of themselves. They need to transfer them to the health insurance market as well because if they get a credit card and don't pay, they get canceled. If they get car insurance and they don't pay, they get canceled. But yet with health care, there's the mentality of a lot of Medicaid people that we'll hold their hands as long as possible. That contributes to the stigma, the fact that they're treated differently than their counterparts are in the private insurance world.

Donna Cohen Ross

I have heard other people say, not always in relation to Medicaid but other programs as well, that people don't want something that's free. They want to pay for it. And I sort of understand that way of thinking to a certain extent, but I've also seen studies that have shown that when premiums were introduced or went up, people dropped off. So there's a sort of disconnect with "I want to pay for it" and "I can't pay for it."

Jana Key

We did a study like that and took it bit further. We would give it away, because we were a Medicaid waiver demonstration program, gave it away for free for some people. It went up to $50 per month. And we had a lot of people drop out in the free category. What we found out, though, was that of the people who were enrolled in the free category, 80 percent of them never accessed services. So don't pay $50 a month for these children who aren't going to the doctor anyway. Let's give it to them free. They didn't invest anything in getting health insurance, but they're not investing anything in going to the doctor. Is that really health care coverage? They're doing the same things. They're going to the emergency room for limited care, if at all.

Donna Cohen Ross

In our discussion of stigma, I think it would be worthwhile to figure out if there is some way to frame the discussion in a way that doesn't stigmatize free care. I think we all have a big hand in perpetuating the stigma.

Sarah Shuptrine

We talked about this in the 1994 report that we did, the fact that families want to be able to pay based on their ability to pay. Medicaid is saying it's all or nothing because you can't have an effective buy-in without getting a waiver. Again, I'm trying to get down to the real causes. Is it that they want to be in the private insurance market or would they be satisfied in the public insurance market?

Joan Henneberry

Because we put so much stake in our culture in having a job and supporting yourself, there's no question that people think they're supposed to be working towards employer-sponsored insurance

Sarah Shuptrine

But taking that to the next step, there is a way for the Medicaid program to work through the employers.

Joan Henneberry

Absolutely, although rules and regulations make it operationally almost impossible. That's probably where we're doing most of our work now is trying to help states figure it out. The policy that they're trying to promote is to use the CHIP program as the bridge. It's very tied into the welfare-to-work initiatives and self-sufficiency initiatives. That's not everybody. There certainly are people out there whose goal is not to get everyone employer-based health insurance. For the most part, I think, in terms of the governors, they would be the most popular governor in the world if everybody in their state had jobs that were good enough to have employer-based insurance. They'd be governor for life if they could accomplish that.

Deborah Clark

That's another benefit to having this type of market research. You would be able to use the results of the survey to go to employers and policymakers and be able to persuade them to do some things differently than they now are doing.

Joan Henneberry

Jana (Key) raised something that I definitely think we don't know about. When you even give it away and there's no premium, what's going on with 80 percent of the people who don't access services?

Jana Key

People don't want to be treated differently, and as long as you have one system that treats them completely differently and a policy that perpetuates that and caseworkers that perpetuate that, you're going to feel different. Nobody wants to feel different.

Donna Cohen Ross

That's something that's changeable.

Joan Henneberry

There may not be the political will to change it. The reality is that in some states, there is a very deliberate reason why they want one program.

Donna Cohen Ross

Like the question that Stephanie (Nelson) was asking before, in some states there is not the political will to enroll children. I think that's true.

Sarah Shuptrine

One thing we can all do is to start causing people to think about stigma in a more thoughtful way and put an end to thinking that, if you change the name of a program, that is going to take care of it. We just need to be more thoughtful about it. There's a lot that can be done and we can begin to get to that quantitative type of research and other kinds of research. I think that would be very helpful.

Todd Askew

It might just be a stigma, period, and you have to educate people about the value of what they're getting. I don't think you can ever totally overcome the stigma problem, but you have to make it easier for families personally to overcome the stigma problem.

Jana Key

While I was at a meeting in Florida, in talking about outreach, someone said, "Why don't we market Medicaid as a quality program?" And all the Medicaid people dropped their jaws. It never occurred to them to market themselves as quality.

Sarah Shuptrine

Thank you so much for hanging in here. We'll call you back together about six months from now.

(adjourn)

Report on Communication and Marketing Strategies Meeting

APPENDIX

Southern Institute on Children and Families
Meeting on Child Health Coverage Communication and Marketing Strategies

Atlanta Airport Hilton and Towers • Atlanta, GA
August 6, 1998

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