Monitoring and Evaluation of Outreach Strategies for Low-Income Children and Their Families

Prepared By

Elizabeth Shenkman, PhD

Donna Hope Wegener, MA

Heather Steingraber, MA

Institute for Child Health Policy
Division of Health Services Research

October 1999

About Covering Kids

Covering Kids is a national health access initiative for low-income, uninsured children. The program was made possible by a $47 million grant from The Robert Wood Johnson Foundation of Princeton, New Jersey, and is designed to help states and local communities increase the number of eligible children who benefit from health insurance coverage programs by: designing and conducting outreach programs that identify and enroll eligible children into Medicaid and other coverage programs; simplifying the enrollment processes; and coordinating existing coverage programs for low-income children. *Covering Kids* receives direction and technical support from the Southern Institute on Children and Families, located in Columbia, South Carolina.

The views expressed in this report are those of the authors, and no official endorsement by The Robert Wood Johnson Foundation is intended or should be inferred.

MONITORING AND EVALUATION OF OUTREACH STRATEGIES FOR LOW-INCOME CHILDREN AND THEIR FAMILIES

INTRODUCTION

In the 1980's Congress passed legislation to expand Medicaid coverage in an attempt to address the problem of the growing number of uninsured children. Despite this effort, millions of children remained uninsured leading to the passage of Title XXI of the Social Security Act, the State Children's Health Insurance Program (CHIP), in 1997. Through CHIP, approximately $24 billion were authorized to provide health insurance to low-income children not eligible for Medicaid.

The number of uninsured children is a large problem. The number of uninsured children who are believed to be eligible for existing public programs is even more problematic. Using data from the 1996 Medical Expenditure Panel Survey (MEPS), an estimated 4.7 million children 18 years and younger were eligible for, but not enrolled in Medicaid.[1] Further estimates using the MEPS reveal that 3.1 million uninsured children are potentially eligible for CHIP under the maximum federal eligibility thresholds. The authors of this study note that CHIP-eligible children tend to have the same demographic characteristics of Medicaid-eligibles with low enrollment rates. Medicaid eligible children who are not enrolled tend to be older, and residing in two-parent working families with higher levels of income and education. Some of these children also reside in immigrant families, which are disproportionately Hispanic.[2]To encourage these families to enroll their children, outreach, cost sharing, and application approaches must be developed carefully.[3]

Identifying children who are eligible and enrolling them in either CHIP or Medicaid is a requirement of the Title XXI legislation.[4] States however are faced with a difficult challenge. Many have limited resources to conduct outreach activities and there is very little information available to help them target those scarce resources into strategies that are most likely to be effective in encouraging families to enroll their children in CHIP or Medicaid programs.

To assist states in the development and implementation of strategies targeted toward families of uninsured children who may be Medicaid or CHIP-eligible, the Robert Wood Johnson Foundation (RWJF) made grant awards of over $40 million to 49 states and the District of Columbia. Through these projects, states have the opportunity to enhance current outreach efforts and to implement new strategies, particularly targeted toward the hardest-to-reach

families such as immigrants. Most states are using multiple outreach approaches that include mass media campaigns such as television, radio, and bill boards, along with more targeted approaches such as personalized assistance with applications and distribution of applications to Head Start Centers and County Public Health Units.[5] Through the RWJF, *Covering Kids* initiative, some states are also trying more labor-intensive and innovative strategies such as door-to-door outreach and payments to agencies for completed Medicaid and CHIP applications, known as finder's fee approaches.

While a systematic evaluation of the effectiveness of these various outreach strategies on identifying and enrolling eligible children would be very difficult to implement, states can use various process monitoring strategies to track their outreach approaches, the number of applications received, and the number of children enrolled. In July 1999, the RWJF, through its Covering Kids initiative, sponsored two, two-day conferences with grantees who were implementing door-to-door outreach strategies or finder's fee approaches. Grantees discussed areas they would like to monitor and evaluate, data sources available for such activities, as well as barriers they faced in conducting monitoring and evaluation.

The purpose of this document is to provide a framework for implementing process monitoring and evaluation approaches specifically targeted toward door-to-door and finder's fee outreach strategies. Examples from the July 1999 conferences are incorporated into the discussion. Because of the difficulties inherent in conducting a systematic evaluation designed to assess the effectiveness of a particular outreach strategies, the greatest emphasis in this report is placed on process monitoring strategies and descriptive analyses. This document is organized into the following sections:

- Designing the program evaluation;
- Developing a denominator;
- Using administrative databases and developing other data sources;
- Preparing monitoring and evaluation reports.

DESIGNING THE PROGRAM EVALUATION

The evaluation design for any given outreach program will vary depending on the organizational structure of the program, the goals and objectives of the program, and the resources that are available to conduct the evaluation. Experts on evaluation design emphasize that there is no "single best way to proceed"[6] In fact, " a good evaluation design is one that fits the circumstances while yielding credible and useful answers to the questions that motivate it."[7] The purpose of this section is to provide a brief overview of major considerations that must guide the planning of any evaluation design. This section is a guide only and the reader is encouraged to consult and work with an experienced evaluator. The focus in this section is primarily on developing appropriate evaluation questions within the context of the *Covering Kids* projects that focus on door-to-door and finder's fees strategies. This discussion is followed by an overview of process monitoring and evaluation approaches that may be used to assess various outreach strategies. Due to the nature of the *Covering Kids* projects, an emphasis is placed on developing process-monitoring strategies as opposed to actual impact assessments. The reasons for this emphasis are included in the section entitled *"Process Monitoring and Impact Evaluations: Factors to Consider."*

Developing Evaluation Questions

Any program evaluation begins with developing the evaluation questions. These questions serve to focus the evaluation and must take into consideration the concerns of the important decision makers and stakeholders. In addition to considering the issues that key decision makers and stakeholders expect to have addressed, those responsible for the evaluation must determine the following:

1. Are the evaluation questions reasonable and do they relate to the program that is being evaluated?
2. Are the questions well defined and measurable?
3. Are the questions answerable given the available data, expertise, and financial resources for the evaluation?

These questions have been modified from the work of Berk and Rossi and Ross, Freeman, and Lipsey. The interested reader is encouraged to obtain copies of these texts for more in-depth information.[8,9]

Working With Stakeholders: Evaluation questions must be developed as a collaborative process between the evaluator and stakeholders. Stakeholders must be included in this process because they are knowledgeable about the logistical and policy issues that confront the program. However, the evaluator is the most knowledgeable about what questions can be addressed credibly within the organizational context of the program and the available data and fiscal resources for the evaluation. Examples of the stakeholders that could be asked to participate in the development of the evaluation questions are:

- Representatives from state government agencies such as Medicaid, the State Children's Health Insurance Program, Health and Human Services, the state's Title V Children With Special Health Care Needs (CSHCN) Program, Education, and Children and Family Services, as well as others who may be participating in the implementation of the outreach strategies;
- Representatives from the governor's office or the legislative committee for health-related issues;
- Representatives from the health care provider groups; pediatricians and family physicians; and
- Representatives from the population of families served by the program.

An iterative process should be used between the individual Covering Kids Project staff, their evaluator, and the key decision makers and stakeholders that the grantees have identified. The process typically begins by asking those providing input to state the critical questions that they would like to have addressed through the program evaluation. A determination then needs to be made about whether each evaluation question is appropriate, well defined, and answerable within the context of the *Covering Kids* Project.

The Covering Kids Project staff will receive a wide variety of questions from key decision makers and stakeholders. At this stage of the process, some of the questions will be well-formulated, appropriate questions and others will be unfocused and unrealistic. Regardless of the quality of the question, the individual putting it forth will believe it is critical to the evaluation, and thus the group must give serious consideration to each question.

Questions often raised during the initial stage of the process include:

1. How many families were contacted through the outreach strategy? This question is focused, clear, and answerable.

2. How many children contacted through the outreach strategy actually enrolled in the health insurance program? This question is well focused, and with access to enrollment information from Medicaid or the CHIP initiative is answerable.

3. How many children contracted through the outreach strategy that enroll in the health insurance program remain enrolled for one year? How many of them complete the eligibility re-determination process after their initial enrollment period is complete? This question is also well developed and answerable, assuming that the Medicaid or CHIP initiative is able to provide enrollment information to the *Covering Kids* Project.

4. Does school attendance improve for children who are contacted through the outreach strategy and subsequently enroll in the health insurance program? This question is a popular one among key decision makers and stakeholders. Often, those allocating resources for health insurance programs want some demonstrable, beneficial outcomes of the program such as improved school attendance or improved health. However, the relationship between an outreach strategy, enrollment in a health insurance program, and school attendance is tenuous at best. Many factors influence school attendance such as the families' social circumstances and routine childhood illnesses that are not prevented by having health insurance. In fact, in a study of 1,400 enrollees in the Florida Healthy Kids Program, families were asked how many school days their children had missed in the two weeks preceding the interview and the reasons for the absences. Reasons included absence due to colds and flu, older children staying home to care for younger siblings, and absences due to transportation problems. Most of the reasons given for the absences were related to the poor social circumstances of the families.[10]

Reducing these kinds of absences through outreach strategies and the availability of health insurance is not likely. Therefore, this question may not be an appropriate one when monitoring outreach strategies. The following section on assessing the reasonableness of the

evaluation questions also will provide the reader with further information to consider when formulating evaluation questions.

Many other kinds of questions will be raised during the initial phases of the process monitoring and evaluation. It is the responsibility of the Covering Kids Project staff, along with your program evaluator, to work with key decision-makers and stakeholders to educate them about the kinds of questions that are feasible for the evaluation. It may be possible to refine some questions and include them in the evaluation. Other questions, such as the one about school attendance described above, should not be included. It is important to work with the individuals making the suggestions to refine a core set of evaluation questions that are focused, realistic, and within the resources available to you.

Are the evaluation questions reasonable and do they relate to the program that is being evaluated? The heterogeneous group of stakeholders that are involved in this process will have different perspectives on the evaluation questions. A major challenge facing the group is to establish realistic questions that reflect what the program can and should accomplish. Unrealistic objectives can lead to false expectations and the belief that the program has failed, when in fact it was not reasonable to assume that the stated objectives could be accomplished through the program.

For example, outreach staff at one state agency believe that a goal of outreach is to provide education to families about the advantages of enrolling their children in Medicaid. While this is an appropriate goal, the evaluation question that the agency staff developed to address this program goal, arguably was not. The proposed evaluation question was "What is the satisfaction of Medicaid enrollees with their children's health care after enrollment in the program?" The standard the staff set was that 85% of Medicaid enrollees would be satisfied with their children's health care using a standardized instrument designed to measure family satisfaction with various aspects of care such as wait times for appointments, provider-patient interaction, and so on. One of the problems with this evaluation question is that families' degree of satisfaction may be more highly related to the experiences they have with their children's providers, as opposed to education they received about Medicaid during an outreach contact. A positive or negative finding about satisfaction may have little, if any, relationship with education provided during an outreach contact. Perhaps a more appropriate question would be to ask "how many families received education about the advantages of the Medicaid

Program for their children during outreach efforts?" If there are adequate resources, another appropriate question may be "Are families who receive education about the advantages of Medicaid more likely to enroll their children in Medicaid than families who do not receive such education?"

Are the questions well defined and measurable? Evaluation questions must be well defined and measurable. For example, several Covering Kids grantees are interested in "gaining the confidence of hard-to-reach families." An evaluation question might be "has families' confidence in local health service agencies increased after the implementing door-to-door outreach?" This question is problematic. The term "confidence" is vague and ambiguous. Moreover, the question is not measurable. Does confidence mean that the family actually enrolls their child in Medicaid or the state Title XXI Program? Does confidence mean that the family states they were satisfied with their interaction with the agency staff or outreach worker? A more appropriate question might be "how many hard-to-reach families enrolled their children after contact with a site using a finder's fees approach compared to hard-to-reach families seen at a comparable site that is not using this approach?" If this evaluation question were used, the term "hard-to-reach" must be defined. For example this term could refer to families who do not speak English, families who are migrant workers, and/or American-Indian families residing on reservations. Moreover, if the resources were available to assess two sites and to make comparisons, the criteria for determining the comparability of the two sites would need to be determined. For example, two sites might be considered comparable if they are serving clients with the same sociodemographic characteristics, if they have the same mission, if they have a similar number of employees, and so on.

Are the questions answerable given the available expertise, data, and financial resources for the evaluation? This is perhaps, one of the most difficult and important questions to answer. The first issue to address is one of expertise. Commonly, stakeholders and decision-makers expect the program evaluation to address questions related to the effectiveness and efficiency of the intervention that is being implemented. In the case of outreach strategies, the question most people would like to answer is "Are door-to-door strategies more effective than other outreach strategies such as media campaigns, toll-free numbers, and so on, for enrolling children in state-sponsored insurance programs? As described in the section below

entitled *"Program Monitoring and Evaluation: Factors to Consider"*, an impact evaluation is necessary to address such a question and this type of evaluation typically requires significant expertise and is costly. There are many issues to address when considering an impact evaluation. However, a very fundamental issue is whether the necessary resources in terms of expertise and dollars are present.

The second issue to address is data availability. Data may be obtained from a variety of sources. Administrative datasets containing information about contacts made with families, applications submitted and their status, and enrollment, often form the cornerstone for any evaluation. However, often it is difficult to obtain access to datasets, typically because an agency is often too busy with its own internal requests to prepare a dataset for external research purposes. A dataset also may be available but not contain the specific data elements necessary to answer the evaluation question. For example, a Covering Kids grantee may want to know how many families submitted incomplete applications following contact with an agency participating in the finder's fee approach. The agency may track the number of incoming applications but may not track whether they were complete. Therefore the data are not available to address the question. Finally, a dataset with all of the appropriate elements may be available, but a skilled programmer to prepare the data for the evaluation team is not. Thus, lack of skilled personnel may limit the data availability for the evaluation team.

Finally, as previously mentioned, cost is an important consideration. Evaluation personnel, programming and computer time, data acquisition, and data analysis are all factors that must be considered and incorporated into the budget.

Table 1 contains a summary of selected evaluation questions for door-to-door outreach and finder's fees approaches. These questions are the result of the discussions held at the Tampa meetings in July, 1999. The table also includes information about potential data sources and whether the question would involve process monitoring or an impact evaluation. A list of participants from the Tampa meetings is contained in Attachment 1.

Table 1. **Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.**

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Monitoring Questions			
1. How many children received the outreach strategy?	Process monitoring using administrative databases. This database most likely will need to be developed by the *Covering Kids* Project.	An essential and feasible step.	When developing a database, think ahead about the kind of information that you would like to have. For example, contact information such as name, address and telephone number is important. Demographic information about race and ethnicity also should be included. Fields should be available to indicate how many times a family was contacted.
2. How many families submitted applications for their children after receiving the outreach strategy?	Process monitoring using administrative databases. This database most likely will need to be developed by the *Covering Kids* Project. However, it may be possible to add information to state application forms to indicate the outreach strategy or strategies that the families may have received. This information can then be used to track the number of applications by the type of outreach strategy.	An essential and feasible step to develop a project-specific database. Important to work with state officials to include a field on the application forms to indicate outreach strategies. A mechanism for the *Covering Kids* project to receive the information, either electronically or in a written summary format, must be developed.	See comments above.

Table 1 continued. Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Monitoring Questions			
3. What is the time frame from the submission of the application to enrollment in the program?	Process Monitoring using secondary, or administrative databases. Usually obtained from state agencies or third party administrators working the Medicaid or CHIP initiative	Very feasible and cost-effective. However, there must be a mechanism within the program files to record critical dates or for tracking the elapsed time between each of the various stages of the application process. There also must be a method to indicate which applications were received from door-to-door, finder's fee, or other outreach strategies. An additional field for the specific agency submitting the application would provide for a site-specific comparison.	This type of monitoring could include: 1) tracking the total number of completed applications received from each outreach strategy; 2) calculating the time from submission of an application to approval or denial of application; 3) calculating the time from submission of the application to coverage in the health insurance program. The availability of a comparison group would be extremely helpful. For example, a comparison could be made with a group not receiving the finder's fee or door-to-door strategy. It will be necessary to work with an experienced evaluator to identify the appropriate comparison group.

Table 1 continued. Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Monitoring Questions			
4. What are the reasons that applications are rejected?	Process Monitoring using secondary, or administrative data obtained from same sources described above.	Very easy to track provided a field(s) for reason the application was rejected is included in the tracking database. Additional fields in the administrative database could include the type of strategy that was used to obtain the application and the specific agency submitting the application.	This monitoring could include: 1) the number of denials due to incomplete forms, 2) the number of applicants who were determined to be ineligible, and 3) denials due to excess income or other resources.[11] This information is very important because many Covering Kids Projects believe that their interventions will result in more complete applications and fewer denials because those who are potentially eligible will be more effectively targeted. With the inclusion of the fields to track the outreach strategy used to get the application and the identification of the agency submitting the application, comparisons can be made across strategies and across participating agencies.

Table 1 continued. Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Monitoring Questions			
5. What has been the program's experience with disenrollment and re-enrollment? How do the individuals in these two groups compare to each other and to the group of those who remain enrolled?	Process Monitoring using secondary, or administrative databases	Feasible and cost-effective if the administrative databases are accessible and include fields to indicate the months the children were enrolled. A month-by-month or quarterly enrollment field is preferable.	May need telephone surveys to obtain critical demographic data that are unavailable in the administrative databases. With this information you can compare the characteristics of each of these three groups by age of child, race/ethnicity and other important factors.
6. Are the outreach efforts culturally appropriate?	Case study data; focus group data; secondary analysis of data	Need mechanism to track the types of outreach initiatives and the groups targeted for outreach. Consider costs associated with original data collection.	Must be attentive to the vagueness of the question. What is culturally appropriate? The absence or a smaller number of applications from one cultural group doesn't necessarily imply a lack of cultural sensitivity. However, good descriptive information about the issues that those from racial and ethnic minorities experience with application and enrollment processes should be obtained.

Table 1 continued. Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Monitoring Questions, continued			
7. How much does the intervention strategy cost?	Project specific administrative databases need to be developed to track the costs for personnel, travel, and supplies associated with the outreach activity. Costs per contact, costs per completed application, and costs per enrollee can be calculated. To calculate costs per completed application and costs per completed enrollee, access to administrative databases from state agencies or the third party administrator maintaining the application and enrollment files for the Medicaid or the CHIP initiative must be provided.	Very cost effective and feasible.	This is a very important question. Outreach strategies that are sustainable from a financial perspective need to be identified.

Table 1 continued. Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Monitoring Questions, continued			
8. What are the steps in the application process? Where are the perceived barriers and how long does the process take?	Monitoring process by outline steps in application process and updating it periodically to reflect any changes in practice; telephone survey data with families; focus group data from families, health care providers and outreach staff who are involved in application and enrollment processes.	Detailing the steps involved in the application process is relatively easy but must be validated by the various groups involved with the application process. Developing telephone survey and focus group questions should be done with an experienced evaluator.	This type of information is critical in the early phases of the program implementation. In addition, it is very easy to monitor, and if reported in a timely fashion, decisions can be made to alter process to increase the timeliness of each step of the process. Primary data collection in terms of the telephone surveys and focus groups can be costly but the information is invaluable.

Table 1 continued. **Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.**

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Monitoring Questions, continued			
9. Are families satisfied with the application process?	Telephone survey data; face-to-face survey data; focus group data	Need money for telephone or face-to-face data collection or focus group. Need to seek experience from an experienced evaluator to develop the questions and to select the sample to participate in the survey.	Be attentive to potential bias introduced if face-to-face surveys are conducted at a specific site. Again, as listed above, the demographic characteristics of the respondents are critical and allow comparisons by child's age, family size, and the race and ethnicity of child or family.
10. What is the total number of uninsured children in the state? What is the number of uninsured children in a defined geographic area (regions or counties within a state)?	Secondary data such as the Current Population Survey (CPS), state-specific or area-specific survey data	Essential to have for developing a baseline. However, many of the existing national data sets only provide state estimates and some of these are not stable estimates. Most effective would be a separate survey initiative within the state but the cost involved may be prohibitive.	This is a critical question. Knowledge of this denominator can place the number of children who receive coverage within the larger context. Without this information, there is no mechanism for determining how successful the program has been in reducing the number of uninsured children in the state/area. In this report, other methods to construct a context for the outreach strategies, relying on case-study approaches have been described.

Table 1 continued. Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Important Questions but require significant resources			
11. Does door-to-door outreach efforts yield better results than site- or event-specific contact/efforts?	This question requires an impact evaluation, an experienced evaluator, and significant resources.	Probably not feasible for most of the *Covering Kids* Projects. An important question, that perhaps can be addressed at some time.	See discussion of impact evaluations in this guide.
12. Has the program affected the children's utilization of health care services? Have school absences been reduced? Has the children's health improved?	This question is interesting and important but not immediately relevant to the Covering Kids Projects where the focus is on application and enrollment. Addressing these questions requires access to health care use data and telephone or other survey data. An experienced evaluator must provide guidance to answer these questions.	Probably not feasible for most of the *Covering Kids* Projects. An important question, that perhaps can be addressed at some time.	

Advantages of Survey Research

1. Helps eliminate interviewer bias by scripting the questions to be asked and their order.

2. Provided they are trained effectively, many people can administer the same survey at the same time, thereby allowing for efficient data collection.

3. The data that result are easier to analyze than interview or focus group data. Statistical tests can be applied to the data if correctly structured.

4. With mail or telephone surveys, large numbers of people can be surveyed, and those people can be scattered geographically.

Disadvantages of Survey Research

1. Survey research is only useful if you have already identified the issues. For example, families may be resistant to having someone come to their home for door-to-door outreach. You cannot ask about a possible problem if you don't know about it already. Preliminary research, such as a focus group or a case study may be necessary to identify these issues before constructing a questionnaire.

2. Surveys are inflexible in terms of question order, wording, and content. Those who administer the surveys must adhere to the same script for every survey. Interviewers cannot probe respondents for further information or provide any additional information unless the survey specifically calls for it.

3. Questionnaire development is difficult and requires tremendous forethought. Even the order that questions are asked can affect the way respondents answer. For this reason, it is best for you to keep your questionnaires simple, use a standardized instrument, and seek advise.

4. For surveys intended to sample a large and diverse audience, sophisticated sampling methodology is required. In the academic world, statisticians who specialize in sampling are generally consulted for such surveys. It is best for you to avoid this situation by one of the following methods:

   a. When possible, interview everyone in the entire target population. This is only possible if the population is very small and your access to them is unobstructed.

   b. Identify the important members of the population (called stakeholders), and interview them. Their opinions on certain issues can be said to represent everyone in their group.

   c. If you have to resort to a so-called "convenience sample", be sure to acknowledge this in your report. Try to be as unbiased as you can be in choosing your audience, and consider factors outside your control that may influence your results.

Types of Survey Research

1. <u>Telephone surveys</u>

   a. Advantages:

      i. Cheaper to implement than one-on-one interviews, but more expensive than mail-outs;

      ii. Can be done at a central location, allowing geographically disperse populations to be surveyed;

      iii. If it is developed as part of the survey, the interviewer can assist the respondent in interpreting the questions. For example, terms can be defined. In addition, more complex questions can be asked.

iv. Reading Proficiency is not required.

v. Better able to target desired population. Interviewers can be trained to encourage participation in the surveys and thus it often is easier to obtain results from hard-to-reach populations, particularly when compared to written surveys.

b. Disadvantages:

i. Only useful for those who have telephones and depending on the population this may be more or less of a problem;

ii. Survey cannot be so lengthy that respondents drop out, usually 20 minutes is the maximum;

iii. Intrusion into people's homes and schedules must be handled with sensitivity and professionalism.

c. Cost: about $1 per minute

d. Tips:

i. Questions must be phrased in language easy for respondents to understand.

ii. Before beginning the survey, inform respondents of the approximate time required for completion. This will cut down on the number of people who drop out in the middle of the survey. Offer to reschedule the survey when the respondent can spend enough time to answer it in full.

iii. Interviewers fluent in the native language of respondents are vital.

iv. Make it clear in the first sentence that you are a researcher and NOT a salesperson. Many people will refuse to participate if they suspect you are trying to sell them something.

2. One-on-One Surveys

a. Advantages:

i. Allows rapport to be established between interviewer and respondent. This often leads to responses that are more complete, and to a higher response rate.

ii. Allows interviewer to assist in interpretation of questionnaire, but only as directed on the questionnaire.

iii. Hard-to-reach populations, including those without telephones can often be located by a well-trained field worker.

b. Disadvantages

i. Expensive in terms of personnel and travel. Interviewer must be highly trained, and often must spend considerable time with each respondent. A completed 20 minute interview can be as high as $50 or more .

ii. Interviewers must be highly trained to avoid inadvertently influencing respondents.

c. Cost: The most expensive type of survey research, often $50 pre interview or more.

d. Tips

i. Sometimes evaluators work with people known to the community to conduct interviews, particularly in areas where the subjects are very hard-to-reach. Interviewers who are already familiar to the respondent may have more success in eliciting data from the respondent. However, these individuals may also inadvertently influence the answers these respondents give. Thus the interviewers must be very well trained and supervised. Another alternative is to send a community member with a trained interviewer who is not part of the community. Thus the community member can add credibility to the process for the respondent, but not influence the respondent's answers.

3. Mail out surveys

a. Advantages

i. The cheapest type of survey research.

ii. Allows the researcher to sample a highly diverse and geographically widespread population.

iii. Many respondents who cannot be reached by telephone can be reached by mail.

iv. Less intrusive than telephone surveys, yet allows researcher to reach the respondent in his or her home.

v. Respondent can spend an unlimited amount of time answering the survey.

b. Disadvantages

i. The poorest response rate of all types of survey research.

ii. Poor quality of information because respondents often do not complete the survey correctly.

iii. Disadvantaged, illiterate, or itinerant families are hard to locate.

c. Cost: The cheapest type of survey research. The only costs are for printing the surveys, obtaining the mailing list, and postage.

d. Tips

i. Always include a stamped, self-addressed envelope with your survey.

ii. Always include a letter stating the purpose of your research, instructions for completing the survey, and contact information if respondents have questions (this should be a toll-free number).

iii. Identify who in the family should complete the survey. Obviously, anyone in the family can assist in completing the survey, but you should identify one specific household member whose responses you want.

4. <u>Focus Groups</u>

Focus groups are a popular method for data collection. A group of people are carefully selected and gathered together to discuss a topic. A trained moderator asks questions and guides the conversation during the focus groups. Usually two moderators are present, one who leads in asking questions and another who assists. Most focus groups are tape-recorded and the conversation transcribed after the session is over. Determining the number of participants, the type of participants, and developing the focus group questions is complex. An experienced evaluator can assist you with this process. Finally analyzing data from focus groups can be challenging. A knowledgeable evaluator can also work with you during the data analytic phase.

A. Advantages

i. Helpful for identifying issues.

ii. Allows for a number of opinions to be expressed. Thus, similarities and differences are spotlighted.

iii. Respondents often help trigger responses from one another. The experiences of one person may remind someone else of a similar experience.

iv. A rich source of anecdotal information that can enrich your report.

B. Disadvantages

i. More gregarious participants may have more input than others. However, a well-trained moderator should be able to encourage all participants and limit those that are monopolizing the conversation.

ii. Some respondents may be unwilling to voice dissenting opinions.

iii. Requires a moderator who is skilled at eliciting relevant responses and keeping the conversation on track.

C. Cost – Travel costs for the moderator, costs for those recruiting the participants, costs for food during the focus groups, and any participant incentives must be considered. During focus groups for the Florida CHIP evaluation, about $500 per focus group was spent on travel, food, and incentives. This does not include the cost of transcribing data obtained from the focus group and analyzing those data.

D. Tips

1. It is important to choose the group carefully. You may choose to gather a diverse group of people, to elicit a wide range of experiences. Alternatively, you may choose to gather a homogenous group, to elicit more in-depth experiences of a particular group.

2. The group should consist of at least three members. The optimal number is around 6 to 8.

3. Too few respondents means you do not get a range of responses. Too many means you are unable to get in-depth responses.

4. The focus group should last no more than an hour and a half.

5. You may choose to circulate the questions you will be asking ahead of time. This allows participants to consider their responses. In addition, it may ease their apprehension.

6. Start with a "warm-up" question that makes people feel comfortable with each other. This could be a question about their children, for example.

7. It is useful to ask questions that require the respondent to tell a story. Probe participants to relate every detail. This helps them feel comfortable, but also can help to identify barriers and problems that the researcher might not have considered. An example might be to ask participants to describe their last experience in trying to obtain health insurance for their children, from the time they applied to the time they heard if their children were covered. The respondent might, for example, reply that they gave up during the process and tell you why.

PREPARING MONITORING AND EVALUATION REPORTS

Communicating your findings is a critical component of any evaluation. The following are some general guidelines that you should consider when preparing your evaluation findings:

- Your granting organization or governmental agency may have a prescribed format for your report. If not, the standard format in the social sciences is as follows: introduction, methods, results, discussion, then conclusion.

- Wherever possible, use pictures or graphical presentations to help you and your audience visualize the data and the results

- Admit the limitations you had in conducting your evaluation. Your granting organization or governmental agency will know you are not a professional program evaluator. They will also know your budget limitations. Therefore, be frank about what you could and could not do.

- Explore alternate explanations for the effects you found. Is it possible that the increase in enrollment was not due to your outreach strategy, but was due instead to some other factor? Be honest in your exploration of these possibilities. The last thing you want is to have your program held to a future standard you cannot achieve.

- Remember that knowledge and action are not necessarily linked. Just because you can state that a group of people knew about a certain program, you cannot expect they will act on that knowledge. At the same time, however, it is also true that knowledge is a necessary first step.

- In most of your evaluations, you cannot state causality. You cannot say that an action is the result of a certain cause. You can suggest it, but you cannot systematically rule out other possible causes for your findings.

- Send out advance copies of reports to stakeholders. This allows them to point out errors and to make suggestions. You may or may not choose to incorporate their suggestions. Only incorporate those that are substantiated. The stakeholders may elect to rebut some of your findings and that is their prerogative. This review process can be time-consuming but is an essential part of the evaluation.

SUMMARY

We hope this evaluation guide has been of assistance to you. It is intended as a guide only and does not replace working with key stakeholders and an experienced evaluator. In the midst of implementing all of the operational and logistical pieces that must happen as part of the *Covering Kids* initiative, it is easy to question whether you will have the time to conduct an evaluation. It is essential to make the time. Gathering some data related to two or three critical questions, can make the difference in what we know about reaching out to families. It is well within the scope of each Covering Kids Project, to gather some basic process monitoring information and to work with administrative databases. You probably will not be able to implement all of the suggestions in this guide and that is not the point or the intention of this manual. Choose two or maybe three questions and answer them very well. The findings that you obtain will help you to modify your program or to keep doing the right things with the support of good data and not just anecdote. Moreover, it will add credibility to your efforts that will benefit families and the staff working with you in the long-run.

Seek out experienced evaluators in your state. They will require some resources to work with you, but many will be very flexible and will want to assist you with your evaluation. The *Covering Kids* initiative is exciting and in addition to informing families about health insurance options for their children has the potential to enhance our knowledge about what works and what does not when attempting to reach out to families about health care for their children.

1 Selden TM, Banthin JS, Cohen JW. Medicaid's problem children: Eligible but not enrolled. *Health Affairs.* 1998;17:192-200.

2 United States General Accounting Office. Medicaid: Demographic Characteristics of Nonenrolled Children Suggest State Outreach Strategies (GAO/HEHS-98-93) March, 1998.

3 Selden TM, Banthin JS, Cohen JW. Waiting in the wings: Eligibilty and enrollment in the State Children's Health Insurance Program. *Health Affairs.* 1999;18:126-133.

4 Department of Health and Human Services, Office of Inspector General. The Children's Health Insurance Program: States' Application and Enrollment Processes: An Early Report From the Front Lines (OEI-05-98-00310). May, 1999.

5 Department of Health and Human Services, Office of Inspector General. The Children's Health Insurance Program: States' Application and Enrollment Processes: An Early Report From the Front Lines (OEI-05-98-00310). May, 1999.

6 Berk RA, Ross PH. *Thinking About Program Evaluation.* Newbury Park, California: Sage Publications, 1990.

7 Rossi PH, Freeman HE, Lipsey MW. *Evaluation: A systematic Approach, 6th Edition.* Thousand Oaks, California: Sage Publications, 1999.

8 Berk RA, Ross PH. *Thinking About Program Evaluation.* Newbury Park, California: Sage Publications, 1990.

9 Rossi PH, Freeman HE, Lipsey MW. *Evaluation: A systematic Approach, 6th Edition.* Thousand Oaks, California: Sage Publications, 1999.

10 Shenkman E, Wegener DH. School Attendance Among Healthy Kids Enrollees. A Report Prepared for the Florida Healthy Kids Corporation. Gainesville, Florida: Institute for Child Health Policy, 1997.

11 Grant V. *Guidelines for Collecting, Analyzing, and Displaying Child Health Coverage Eligibility Outcomes Data. Columbia, South Carolina: Covering Kids National Program Office; 1999.*

12 Rossi PH, Freeman HE, Lipsey MW. *Evaluation: A systematic Approach, 6th Edition.* Thousand Oaks, California: Sage Publications, 1999.

13 Rossi PH, Freeman HE, Lipsey MW. *Evaluation: A systematic Approach, 6th Edition.* Thousand Oaks, California: Sage Publications, 1999.

Covering Kids Technology Assistance Meeting
July 19-20, 1999
Participant List

Almaguer, Shelly
New Mexico Advocates for Children and Families
2407 West Picaho Ste A111
Las Cruces, NM 88005
505 525-2571
505 527-4791 (fax)
Shell@zianet.com

Bohl, Dianne
Muskegon Community Health Project
565 West Western Avenue
Huskegon, MI 49440
231 728-3401
231 728-8404
dbohl@mchp.org

Chavez, Carla
Covering Kids in New Mexico
801 Encino Place Suite F21 NE
Albuquerque, NM 87102
505 244-9509
505 244-9509 (fax)
KGChavez@hotmail.com

Cline, Greg
Michigan Public Health Institute
2440 Woodlake Circle Suite 190
Okemos, MI 48864
517 324-7389
517 324-6099 (fax)
Gcline@mphi.org

Costich, Julia
Center for Health Services
University of Kentucky
121 Washington Avenue
Room 102 CAHP, Bldg 6
Lexington, KY 40536-0003
606 257-8709
606 257-2454
JFCOST@POP.UKY.EDU

De La Garza, Marisa
Texas Association of Community Health Centers
2301 South Capital of Texas Highway
Bldg H
Austin, TX 78746
512 329-5959
512 329-9189 (fax)
MdelaGarza@tachc.org

Eckhart, Yula
Mano a Mano
302 Kings Highway Suite 103
Brownsville, TX 78521
956 982-0789
956 544-7859

Espelin, Elizabeth
Healthy Mothers, Healthy Babies – Montana Coalition
316 Fuller Avenue
Box 876
Helena, MT 59624
406 449-8611
406 449-3703 (fax)
eespelin@hmbh.mt.org

Grant, Vicki
Covering Kids
620 Sims Avenue
Columbia, SC 29205
803 779-2607
803 254-6301 (fax)
vicki@coveringkids.org

Greenberg, Joshua
Health Care for All
30 Winter Street Suite 1010
Boston, MA 02108
617 350-7279 ex 154
617 350-7545
GREENBERG@HCFA.ORG

Hall, Shana
Minnie Hamilton Health Care Center
Route 1
Grantsville, WO 26147
304 354-9244
304 354-9323 (fax)
hall@access.mountain.net

Helverson, Jennifer
The Robert Wood Johnson Foundation
620 Sims Avenue
Columbia, SC 29205
803 779-2607
803 254-6301 (fax)

Labunetz, Gerri
Healthy Mothers Healthy Babies
915 First Avenue, South
Largent School
Great Falls, MT 59405
406 268-6763
406 268-6765 (fax)
hmhb@mcn.net

Lee, Scott
Covering Kids Initiative
128 Yocum Street
Evarts, KY 40828
606 837-9158
606 837-2111

McKinney, Deena
Institute for Child Health Policy
5700 SW 34th Street, Suite 323
Gainesville, FL 32608
352 392-5904
352-846-0409
dcm@ichp.edu

Miller, Sherri
Covering Kids
1011 Fourteenth Avenue NW
Ardmore, OK 73401
or, by E-Mail :
580-220-6145
580 220-6130 (fax)
snmiller@okla.smhs.com

Paulsen, Dick
Healthy Mothers Healthy Babies
316 Fuller Avenue
Helena, MT 59624
406 449-8611
406 449-3703 (fax)
hmhboo1@uswest.net

Robinson, Frank
Partners for a Healthier Community, Inc.
PO Box 4895
Springfield, MA 01101-4895
413 794-7739
413 794-7777 (fax)
Frank.Robinson@bhs.org

Rogers, Nele
Covering Kids Oklahoma Institute for Child
Advocacy
420 NW 13th Suite 101
Oklahoma, OK 73103
405 236-5437
405 236-5439 (fax)
nelerogers@oica.org

Lisa Salary, Health Resource Advocate
Hoosier Healthwise Outreach Program
1614 West 5th Avenue
Gary, Indiana 46404
219 886-3648
219 886-2166
LSalary701@aol.com

Shenkman, Elizabeth
Institute for Child Health Policy
5700 Sw 34th Street, Suite 323
Gainesville, FL 32608
352 392-5904 ex 222
352 846-0409 (fax)
eas@ichp.edu

Steingraber, Heather
Institute for Child Health Policy
5700 SW 34th Street, Suite 323
Gainesville, FL 32608
352 392-5904 ex 236
352 846-0409 (fax)
hgs@ichp.edu

Stemmler, Margaret
Children's Action Alliance
4001 North Third Street, Suite 160
Phoenix, AZ 85012
602 266-0707
602 263 8792 (fax)
stemmler@azchildren.org

Thomas, Rosie M
Lake County Minority Health Coalition
756 Johnson Street
Gary, IN 467402
219 885-4451
219 885-0171
Rthomas601@aol.com

Covering Kids Technology Assistance Meeting
July 27-28, 1999
Participant List

Bacharach, Ann
PA Partnerships for Children
20 North Market Square, Suite 300
Harrisburg, PA 17101
717 236-5680
717 236-7745 (fax)
annbach@papartnerships.org

Bass, Kelly
Voices for Children in Nebraska
7521 Main Street, Suite 103
Omaha, NE 68127
402 597-3100
402 597-2705 (fax)
voices@uswest.net

Brammer, Cynthia
Covering Kids Health Choice
720 Carl Russell Avenue
Winston-Salem, NC 27101
336 727-2890
336 727-8491 (fax)
brammecm@co.forsyth.nc.com

Eby-Carl, Rae
Sutter Lakeside Community Service
896 Lakeport Boulevard
Lakeport, CA 95453
707 262-1611
702 262-0344 (fax)
raeebycarl@hotmail.com

Figart, Jan
Community Service Council
1430 South Boulder
Tulsa, OK 74119
918 585-5551 ex. 237
918 585-3285 (fax)
JLHFIG@aol.com

Gabel, Robyn
Illinois Maternal and Child Health Coalition
3411 West Diverey, Suite 5
Chicago, IL 60647
773 384-8828
772 384-3904 (fax)
ilmaternal@aol.com

Grant, Vicki
Covering Kids
620 Sims Avenue
Columbia, SC 29205
803 779-2607
803 254-6301 (fax)
vicki@coveringkids.org

McKinney, Deena
Institute for Child Health Policy
5700 SW 34th Street, Suite 323
Gainesville, FL 32608
352 392-5904 ex. 225
352 846-0409 (fax)
dcm@ichp.edu

Muir, Anita
Division of Public Health
2055 Limestone Road, Suite 300
Wilmington, DE 19808
302 995-8632
302 995-8616 (fax)
Amuir@state.de.us

Paschold, Amy
Goldenrod Hills Community Services
PO Box 280
1119 Avenue E
Wisner, NE 68791-0280
402 529-3513
401 529-3209

Redmond, Patricia
Philadelphia Citizens for Children & Youth
7 Ben Franklin Parkway
Philadelphia, PA 19103
215 563-5848
215 563-9442 (fax)
patredmond@aol.com

Rogers, Nele
Oklahoma Institute for Child Advocacy
420 NW 13 the, Suite 101
Oklahoma, City, OK 73101
405 236-5437
405 236-5439 (fax)
nelerogers@oica.org

Shenkman, Elizabeth
Institute for Child Health Policy
5700 SW 34th Street, Suite 323
Gainesville, FL 32608
352 392-5904 ex. 222
352 846-0409 (fax)
eas@ichp.edu

Steingraber, Heather
Institute for Child Health Policy
5700 Sw 34th, Street, Suite 323
Gainesville, FL 32608
352 392-5904 ex. 236
352 846-0409 (fax)
hgs@ichp.edu

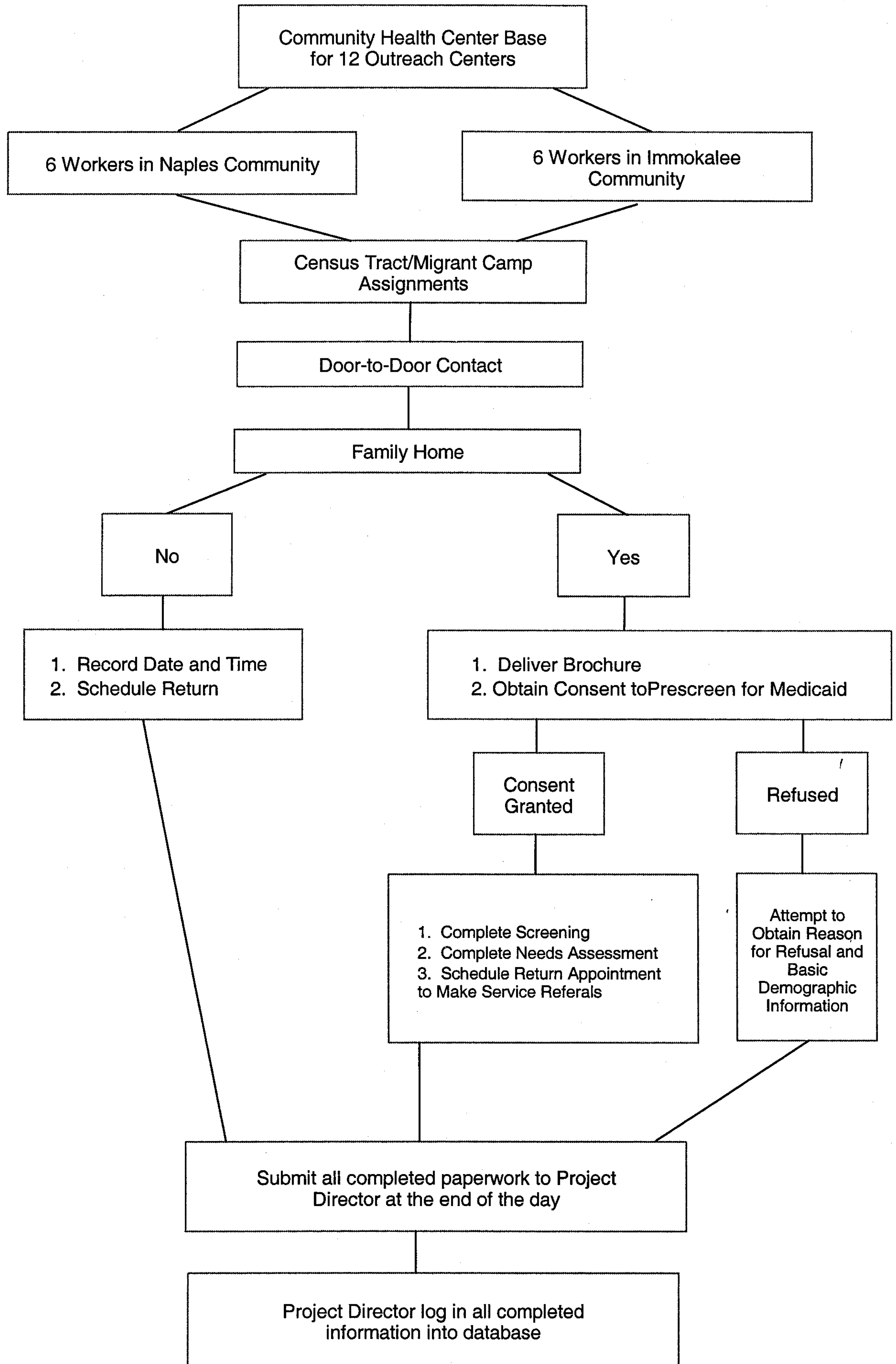
Teplin, Sara
NC Foundation on Advanced Health
Programs
322 Ashe Street
Chapel Hill, NC 27514
919 933-0079
919 968-3999 (fax)
SARIT451@aol.com

Wheeler, Betsy
Healthcare Management Services
900 West Lane
Milford, DE 19963
302 424-1495
302 424-1496
bcwhcms@aol.com

Appendix A

Sample Flow Chart of a Door-to-Door Outreach Project Conducted in Florida As Part of a Rural Health Initiative

Appendix A: Door-to-Door Outreach - Sample Flow Chart Based on a Rural Health Project in Florida.



APPENDIX B

SAMPLE COMMUNITY PROFILE – FLORIDA

Appendix B. Example of Community Profile Data from the Florida Healthy Kids Evaluation.

St. Lucie and Volusia Counties

Population Indicators

St. Lucie County covers 573 square miles on the eastern coast of South Central Florida and is bordered by Indian River County in the north, Okeechobee County in the west, and Martin County in the south. St. Lucie County is the twenty-second most populated county in the state with a population of 158,937 in 1992. *Volusia County,* located on the east coast of North Central Florida, covers 1,106 square miles and is bordered by Flagler County to the north, Lake County to the west, and Seminole County to the south. Volusia County is ranked tenth out of sixty-seven counties with a population of 383,983 in 1992.

The rural population in Florida is 15.2% of the total population. St. Lucie falls below the state average with a rural population of only 7.9%. Volusia, on the other hand, is 16.1% rural. Interestingly, St. Lucie County has three cities while Volusia County has fourteen cities.

In 1990, the state of Florida's median age was 36.4 years. Both St. Lucie and Volusia County's median age was slightly higher than that of the state of Florida. St. Lucie County had a median age of 37.9 years, while Volusia County had a slightly higher median age of 39.4 years.

The racial composition of both St. Lucie and Volusia Counties is primarily white, non-Hispanic. The state racial composition is 83.1% White and 13.6% Black. In St. Lucie County, a slightly lower percentage of Whites reside in the area (81.3%). St. Lucie County, however, has a Black population of 16.4%. This figure is higher than that of the state average, and it is significantly higher than that of the other counties studied. In Volusia County, 88.6% of the population are White and 9.0% are Black. The corresponding figures for the "other" minority populations are slightly smaller than that for the state of Florida, 2.2% of the people in St. Lucie and 2.3% in Volusia are said to be from other minorities. The percentages of people of Hispanic origin (of any race) were 4.0% in both St. Lucie and Volusia Counties.

Interestingly, these percentages are reflected in the data specific to the participants of the Healthy Kids Program from these two counties. There is a much higher percentage of Blacks in the St. Lucie County program then there are in the other program sites. This is an important

comparison because it indicates that the program has been successful in enrolling children in similar proportions to the total population of children in the county.

In 1989, 12.7% of all Florida residents lived below the poverty level. St. Lucie County had slightly higher percentage of people living below the poverty level with 12.8%. Volusia, on the other hand, had 12.2% of the population living below the poverty level. The state of Florida had 9.0% of family households living below the poverty level. Both St. Lucie and Volusia Counties had slightly lower percentages of families living below the poverty level with 8.5% and 7.9%, respectively. Overall, St. Lucie County is ranked 42nd and Volusia County is ranked 45th of 67 Florida counties for the percent of households living below the poverty level.

Based on the demographic indicators of race and income, there may not be high numbers of uninsured children at those sites. However, it is important to note that these sites rank very high in terms of the percentage of jobs that are in the service sector, particularly the tourist industry. Low-income jobs, in the service sector often do not offer health insurance, and if they do, usually do not offer family coverage. Thus these areas may be important to target outreach activities to families in these various service sectors.

When family households are examined -- that is, a household in which all people in the household are related by marriage, birth, or adoption and are considered members of the family -- interesting relationships emerge. In the state of Florida 15.1% of female-headed households lived below the poverty level. However, in these two counties the percentages were lower than the state average. In St. Lucie County, 12.3% of female-headed households lived below the poverty level and in Volusia County had 13.4% of female-headed households that lived below the poverty level.

In 1990, the total number of households in the state of Florida was 5,134,869. St. Lucie County had 58,174 households. Volusia County had a greater number of households with 153,416 in total. In addition, the 1990 average household size in Florida was 2.46 persons. St. Lucie County's average household size was slightly higher with 2.54. Volusia, on the other hand, had a household size slightly lower than the state figure with 2.33.

The median value of owner-occupied housing in Florida was $77,100. Both St. Lucie and Volusia Counties averaged lower values than both Florida. The median contract rent in renter-occupied housing units was $402 in Florida. Again, both St. Lucie and Volusia Counties averaged lower figures for median contract rent in renter-occupied housing units with $410 and

$382, respectively. These figures are indicative of the low wages earned in those counties. These low wages are often seen with certain service sector jobs.

Birth Indicators

There were 191,530 live births in Florida in 1992. Volusia County had 4,471 live births and St. Lucie had 2,305 in the same time. The teen birth rate -- the number of births per 1,000 females ages 15-19 -- was 91.5 in St. Lucie County and 55.4 in Volusia County. These figures must be compared to the state rate of 64.4 births per 1,000 females. The teen birth rate in St. Lucie County is significantly higher than that of the state, while Volusia is slightly lesser than the state average. These rates are higher when calculating the birth rate of Non-white teens. This rate was 179.3 in St. Lucie County and 103.7 in Volusia County. Again, St. Lucie County had a rate higher than that of the state average of 123.7, and Volusia had a rate lower than the state average. St. Lucie County represents an important area to target for teen outreach programs for enrollment into Medicaid or CHIP.

Child Health Indicators

In 1996, it was estimated that 16% of all children in the state of Florida did not have health insurance. However, there were 27% covered by Medicaid or other public-sector health insurance. There were not good regional or local estimates on the number of children without health insurance and the state has undertaken an ambitious data collection effort designed to yield this critical information.

Education System Indicators

In 1991-1992 public school revenues for these two counties were slightly higher than the statewide average of $5,201 per full-time equivalent student. In St. Lucie County the average was $5,623. Local sources funded 52.6% of the total revenue, while state sources funded 38.9% and federal sources funded 8.5% of the total revenue. In Volusia County, the average was $5,405, with both state and local sources funding 47.2% of total revenue. Federal sources accounted for only 5.6% of Volusia County's revenue.

In Florida, in 1990, 74.4% of the population had graduated from high school. For persons age 25 and over by April 1, 1990, 71.7% in St. Lucie County had at least a high school diploma compared to 75.4% in Volusia County. Florida, in 1992-1993, had a graduation rate of 78.7%. St. Lucie County fell below the state average with a graduation rate of 68.2%. Volusia County had a graduation rate of 79.9%, slightly exceeding the state's average. It also appears that approximately half of all persons who earned a bachelor's degree also earned a graduate or professional degree.

Between the 1990-91 and 1992-93 school years, the percentage of kindergarten, first, and second grade students receiving free or reduced-cost lunches increased substantially. Both St. Lucie and Volusia Counties showed the same marked increases throughout all three grades between the two times. St. Lucie County had exceedingly high percentages throughout all three grades during both times. St. Lucie County, in comparison to the state averages, greatly exceeded the state in students receiving free or reduced-cost lunches. The only time that St. Lucie fell below the state average was with first graders from 1990-1991. The state's average was 40.5% and St. Lucie's average was 37.3%. Thereafter, the averages greatly increased for first graders to 51.7%, and then to 58.0%. In comparison to the state of Florida and St. Lucie County, Volusia County fell consistently below the averages. The only exception to this was very slight (.1%), and it occurred in kindergartners from 1992-1993.

Thus, St. Lucie County has a higher percentage of its population with educational levels below the state averages. In addition, St. Lucie County also has a higher percentage of children in the National School Lunch Program when compared to state averages. Volusia County was somewhat higher than the state average on both indices. Therefore, St. Lucie County might be expected to have more people that are uninsured based on the demographic profiles, when compared to Volusia County.

Health Care System Indicators

In 1992, Florida had 27,213 active licensed medical doctors. St. Lucie County had 198 active licensed medical doctors and Volusia County had 527. St. Lucie County had a MD: population ratio of one MD for every 803 residents. Volusia County had a MD: population ratio of one MD for every 729 residents. These are both larger ratios than that of the state of Florida (one MD for every 493).

In 1993, the federal government designated physician shortages in each of the counties studied. In St. Lucie County the shortage was for the poverty/migrant population, whereas in Volusia County the need group was the Medicaid/migrant population. St. Lucie County had the greatest shortage of primary care physicians (PCP) with a need for 3.70 additional PCPs. Of the counties with Healthy Kids Programs, Volusia County had the third greatest shortage with 3.50 PCPs needed. St. Lucie County had very few or no specialists in most areas except for internal medicine. In contrast, Volusia County had the second most family practice physicians, pediatricians, psychiatrists, surgeons, internists, allergists, orthopedists, and otolaryngologists.

Because both of these counties have been specifically designated as having health care personnel shortages for the migrant populations, further information should be obtained about these migrant communities. The areas may be an important focus for outreach activities.

Florida is ranked 17th in the United States in HMO market penetration by covered lives. In 1994, 20% or 2.8 million individuals in Florida were enrolled in some type of HMO. The market penetration of HMOs in Florida varies by region of the state. Areas located along the east and the west coasts of South Florida have the highest enrollment in HMOs. Areas located in the Florida panhandle, north central Florida and south central Florida have the lowest enrollment in HMOs (below 14%).

In June, 1995, Volusia County reported seven HMOs serving county residents. However, at the same time, the residents of St. Lucie County only had one HMO in the area. Although these figures are more current than the statistics presented in the rest of this report (1995 instead of 1992 data) the important observation is the relative difference between the two counties. Providers in Volusia County have had the opportunity to become more familiar *over time* with a managed care environment than did the providers in St. Lucie County. This experience extends to other managed care organizations other than the one holding the Healthy Kids contract in this site.

Appendix C

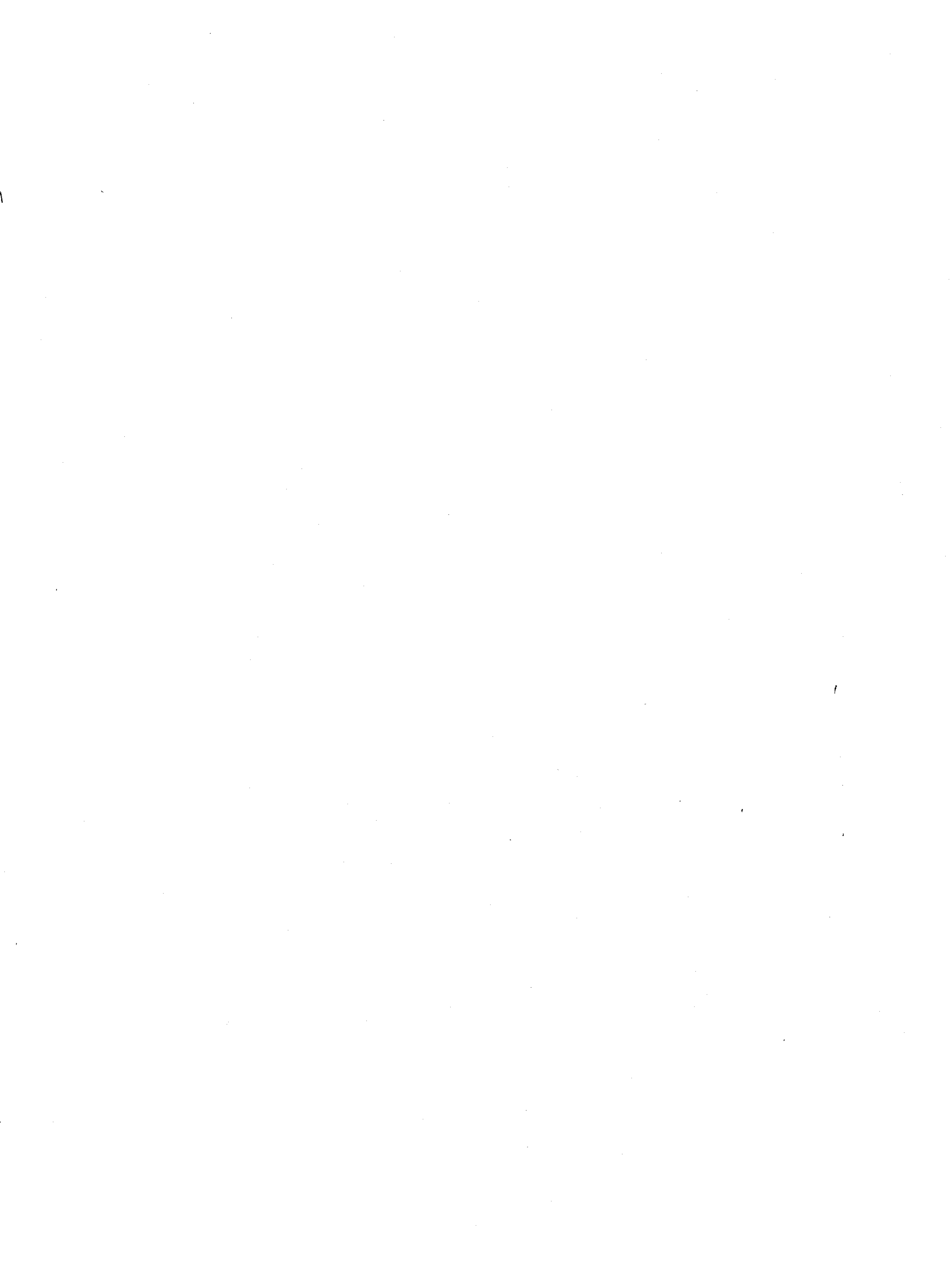
Organizational Matrix

Appendix C. Sample Matrix to Summarize Organizational Characteristics of Community Agencies Participating in Outreach Strategies

Characteristics	AGENCY 1	AGENCY 2	AGENCY 3
DATE DATA ABOUT AGENCY COLLECTED	5/28/98		
ORGANIZATIONAL STRUCTURE			
1. Key function of agency	Public health department – delivery of health care services		
2. Ownership Status of Company/Publicly traded	Not-for-profit and not publicly traded		
3. Number of years in operation	Since 1994		
4. Number of clients served	43,000		
5. Characteristics of clients	86% white, non-Hispanic, below 133% federal poverty level		
6. Number of children served	14,000		
Existing Outreach Programs			
1. Primary responsibility for program	Specifically designated staff member in Member Services Department		
2. Description of outreach program	Newsletters to schools, backpacks with insurance information inside given to children attending schools in low-income census tracts.		
3. Additional descriptions			

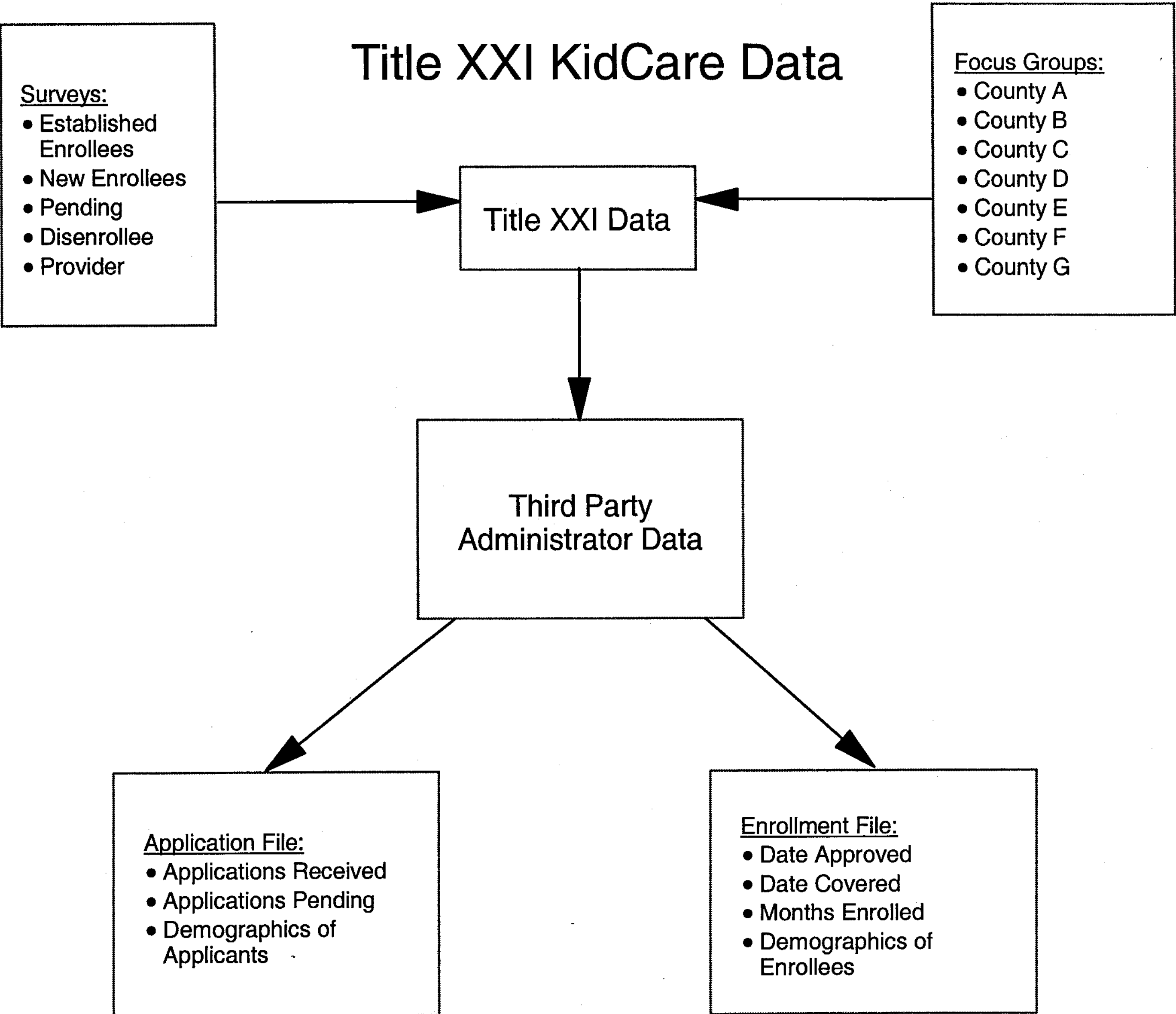
Appendix C. Sample Matrix to Summarize Organizational Characteristics of Community Agencies Participating in Outreach Strategies

Characteristics	AGENCY 1	AGENCY 2	AGENCY 3
Staffing			
1. List number of full time equivalents for staff in agency by type, i.e., number of physicians, nurses, outreach personnel, personnel dedicated to making referrals to programs for eligible families, and so on			
2. Typical referrals made to children's programs			
• Children's Medical Services (Title V) • EPSDT/Part H/Part C • Ryan White • Special programs targeted to special needs	Yes Yes No Yes, Easter Seals, United Cerebral, hospital or facility-based programs such as Shriners and the Mailman Center.		
Training Issues			
1. Specific training and guidelines to staff about outreach	Yes		
2. Written protocols for outreach	Yes		
Quality Assurance			
1. Program in place to monitor and correct implementation of outreach.	Yes		



Appendix D

Diagram of Selected Data Sources for Florida's Title XXI Evaluation


Title XXI KidCare Data
Surveys:
• Established Enrollees
• New Enrollees
• Pending
• Disenrollee
• Provider
Title XXI Data
Focus Groups:
• County A
• County B
• County C
• County D
• County E
• County F
• County G
Third Party Administrator Data
Application File:
• Applications Received
• Applications Pending
• Demographics of Applicants
Enrollment File:
• Date Approved
• Date Covered
• Months Enrolled
• Demographics of Enrollees

APPENDIX E

SAMPLE ENROLLMENT DATA DICTIONARY

RECORD LAYOUT FOR ICHP MONTHLY EXPORT FILES

Total Fields: 44

Record Length: 410

FIELD	TYPE	POSITION	LENGTH	DESCRIPTION
County Code	C	1-2	2	Unique 2 digit character code for each county (first 2 characters in record).
Insurance Account Number	C	3-14	12	Unique system generated insurance number. CONFIDENTIAL DO NOT PROVIDE
Child Social Security	C	15-23	9	Unique social security number for each child in the database CONFIDENTIAL DO NOT PROVIDE
Child Last Name	C	24-48	25	Last name of child. CONFIDENTIAL DO NOT PROVIDE
Child First Name	C	49-65	17	First name of the child. CONFIDENTIAL DO NOT PROVIDE
Child Middle Initial	C	66	1	Middle initial of the child. CONFIDENTIAL DO NOT PROVIDE
Child Birthday	C	67-74	8	Child's date of birth with format YYYYMMDD.
Sex	C	75	1	Child's sex.
Citizenship	C	76	1	Child's citizenship. U.S. Citizen or not.
Address1	C	77-96	20	The address of the child's residence.
Address2	C	97-116	20	The overflow for the Address1 field.
City	C	117-132	16	The city of residence.
State	C	133-134	2	The state of residence.
Zip Code	C	135-139	5	The zip code of the area of residence.
Parent 1 Last Name	C	140-164	25	Parent's last name. CONFIDENTIAL DO NOT PROVIDE
Parent 1 First Name	C	165-181	17	Parent's first name CONFIDENTIAL DO NOT PROVIDE.
Parent 1 Middle Initial	C	182	1	Parent's middle initial. CONFIDENTIAL DO NOT PROVIDE
Parent 1 SSN	C	183-191	9	Parent's social security number. CONFIDENTIAL DO NOT PROVIDE
Relationship	C	192	1	Identifies the relationship between the parent 1 or Guardian and child.
Home Phone	C	193-202	10	Home telephone number.
Work Phone	C	203-212	10	Work telephone number.
Parent 2 Last Name	C	213-237	25	Parent's last name.
Parent 2 First Name	C	238-254	17	Parent's first name.
Parent 2 Middle Initial	C	255	1	Parent's middle initial.
Parent 2 SSN	C	256-264	9	Parent's social security number.
Relationship	C	265	1	Identifies the relationship between the parent 2 or Guardian and child.
Work Phone	C	266-275	10	Work telephone number.
HMO Indicator	C	276-279	4	HMO Code of parent selection (codes to be provided).
Provider Number	C	280-288	9	Provider code of parent selection.
Provider Name	C	289-328	40	Providers name.
Income	C	329-336	8	The yearly family income.
Number of Adults	C	337-338	2	The number of adults living in the household.
Number of Children	C	339-340	2	The number of children living in the household.
Indicator of Health Plan	C	341	1	Indicates type of health plan MediKids (M), Healthy Kids (H) or CMS (C).
Date of signature on application	C	342-349	8	Date that parent signed the application with format YYYYMMDD.
Date of signature on Title XXI application	C	350-357	8	Date that parent completed and signed the Title XXI application with format YYYYMMDD.
Date of Receipt (T-31)	C	358-365	8	Letter issue if the application was received and entered in the system with format YYYYMMDD.

RECORD LAYOUT FOR ICHP MONTHLY EXPORT FILES (Continued)

FIELD	TYPE	POSITION	LENGTH	DESCRIPTION
Date of approval or denial (T-09 or T-05)	C	366-373	8	Letter issue if the application has met the requirements to be approved or not with format YYYYMMDD.
Insurance Effective Date	C	374-381	8	The date on which the account is to start coverage provided all the conditions of eligibility are met with format YYYMMDD.
Denial Code	C	382	1	Reason code that the account has been denied. 1- has other insurance; 2-invalid participant age; 3-no school age sibling; 4-Medicaid; 5-Manual cancellation requested by parent.
Cancellation Date	C	383-390	8	Date of last cancellation.
Last Effective Date	C	391-398	8	Date of most recent month of coverage.
Account Status	C	399	1	Account status code. A-active; C-canceled; P-pending; H-held; S-suspended; R-rejected.
Account Number	C	400-410	10	Unique identifier enabling matching between files.

APPENDIX F

SAMPLE MONTHLY REPORT USING APPLICATION AND ENROLLMENT INFORMATION

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		Oct-98	Nov-98	Dec-98	Jan-99	Feb-99	Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sep-99	Oct-99	Nov-99	Dec-99
1	Summary of Applications/Actions Taken by FHKC	16,073	12,543	15,040	26,049	25,031	22,494	17,033	21,613	17,958	20,673	16,241				
2	Number of Applications Received at Florida Healthy Kids Corporation (FHKC), overall	15,272	12,081	14,360	25,038	23,876	20,785	16,044	20,162	16,947	19,951	14,663				
3	Sent to DCF	9,060	6,389	5,627	6,663	8,200	8,540	5,934	6,013	6,339	5,644	2,729				
4	Sent to DHACS	4,319	3,679	3,415	3,497	4,671	4,468	3,279	3,012	2,802	2,796	2,432				
5	Number of Children Included on the Applications Received at FHKC, overall	30,070	19,938	21,630	38,920	40,559	35,760	26,124	34,417	29,276	34,124	23,972				
	Sent to DCF	19,054	12,011	10,349	12,393	15,406	16,114	11,013	11,198	11,806	10389	5,188				
	Sent to DHACS	8,280	6,507	5,271	6,080	8,309	7,750	5,620	5,239	4,741	4862	3,580				
6	Number of Applications Where Parent Indicates Child May Have a Special Health Care Need	617	405	472	895	915	879	689	908	816	792	563				
7	Mean Age of Children on KidCare Applications Received by FHKC	8.6	8.5	8.3	8.9	8.7	8.8	8.4	8.3	8.1	8.6	9				
8	Standard Deviation of Age of Children on KidCare Applications Received by FHKC	±4.5	±4.5	±4.5	±4.6	±4.7	±4.7	±4.7	±4.7	±4.7	±4.7	4.8				
9	Frequency of Children Age 0-1 on KidCare Applications Received by FHKC	1,213	940	1,146	1,581	1,990	1,765	1,498	2,023	1,910	1,947	1,210				
10	Frequency of Children Age 2-5 on KidCare Applications Received by FHKC	6,072	4,450	4,958	8,437	9,507	7,961	6,391	8,710	7,715	7,734	4,957				
11	Frequency of Children Age 6-10 on KidCare Applications Received by FHKC	9,783	6,691	7,201	13,511	13,463	11,848	8,540	11,162	9,198	10,676	7,330				
12	Frequency of Children Age 11-14 on KidCare Applications Received by FHKC	5,839	4,089	4,231	8,409	8,645	7,789	5,221	6,752	5,544	7,226	5,461				
13	Frequency of Children Age 15-18 on KidCare Applications Received by FHKC	3,070	2,120	2,227	5,434	5,346	4,776	3,242	4,026	3,246	4,399	3,452				
14	Mean Household Size on KidCare Applications Received by FHKC	3.7	3.7	3.7	3.7	3.7	3.6	3.6	3.6	3.6	3.6	3.7				
15	Standard Deviation of Household Size	±1.4	±1.6	±1.6	±1.4	±1.5	±1.3	±1.3	±1.4	±1.3	±1.3	±1.3				

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		Oct-98	Nov-98	Dec-98	Jan-99	Feb-99	Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sep-99	Oct-99	Nov-99	Dec-99
16	Number of Children Enrolled in the Healthy Kids Program Via KidCare							75,686	81,034	86,598	91,052	94,481	96,241			
17	Mean Age of Children in HK Via KidCare							11.5	11.4	11.4	11.3	11.3	11.2			
18	Standard Deviation of Age of Children							±3.6	±3.6	±3.6	±3.6	±3.6	±3.6			
19	Mean Household Size in HK Via Kidcare							4.0	4.0	4.0	4.0	4.0	4.0			
20	Standard Deviation of Household Size							±1.3	±1.3	±1.3	±1.3	±1.3	±1.3			
21	Mean Annual Family Income in HK Via KidCare							$20,377	$20,562	$20,843	$20,079	$21,196	$21,432			
22	Standard Deviation of Income							±$9,556	±$9,496	±$9421	±$9,330	$9,366	$9,286			
23	Number of Children Enrolled in MediKids Via KidCare							4,134	5,636	6,160	7,885	9,239	10,501			
24	Mean Age of Children Enrolled in MediKids							3.1	3.0	3.0	2.9	2.8	2.8			
25	Standard Deviation of Age of Children							±1.3	±1.3	±1.2	±1.2	±1.2	±1.2			
26	Mean Household Size of Children in MediKids Via KidCare							4.1	4.0	4.1	4.1	4.0	4.0			
27	Standard Deviation of Household Size							±1.1	±1.2	±1.2	±1.2	±1.2	±1.1			
28	Mean Annual Family Income of Children Enrolled in MediKids							$25,781	$25,177	$24,832	$24,769	$24,565	$24,484			
29	Standard Deviation of Income							$6,927	$7,030	$7,219	$7,134	$7,192	$7,229			
30	Number of Children Enrolled in CMS Via KidCare							1,233	1,629	1,920	2,199	2,535	2,775			
31	Mean Age of Children Enrolled in CMS Via KidCare							10.2	10.2	10.2	10.1	10.1	10			
32	Standard Deviation of Age of Children							±4.5	±4.5	±4.5	±4.6	±4.6	±4.6			
33	Mean Household Size of Children in CMS Via KidCare							3.9	3.9	3.9	3.9	3.9	3.9			
34	Standard Deviation of Household Size							±1.2	±1.2	±1.3	±1.3	±1.3	±1.3			
35	Mean Annual Family Income of Children in CMS Via KidCare							$21,907	$21,882	$21,760	$21,678	$21,731	$21,721			
36	Standard Deviation of Income							±$7,489	±$7,361	±$7,366	±$7,348	$7,428	$7,381			

Table 1 continued. Evaluation Questions Recommended by Grantees for Door-to-Door and Finder's Fee Strategies.

EVALUATION QUESTIONS	Data Sources/ Research Methods	Feasibility	Comments
Questions that are by-products of the intervention			
13. Do families understand the program rules? What are the unmet needs of the populations being served? What referrals have been made for families to address their needs?	Telephone survey data; face-to-face survey data; focus group data	Very feasible for those projects that are gathering these data as part of face-to-face interactions during door-to-door outreach or during encounters at health and social service agencies.	While question 13 is not directly related to the outreach strategies, during the outreach contact information about families' understanding of health insurance, program rules, as well as unmet need is being gathered. Such information is useful for future program planning and should be documented. Because of these face-to-face encounters, some projects are making referrals to social service agencies. These referrals also should be documented as an added benefit of the outreach strategies.

Process Monitoring and Impact Evaluations: Factors to Consider

Both process monitoring and evaluation activities are important components of any demonstration project. The information contained in this section is only intended as an overview so that informed choices about the evaluation can be made within the context of time, money, and qualified personnel. Information about conducting an impact evaluation, that is an assessment of the effectiveness of a particular intervention versus others on predetermined outcomes of interest, is presented first. This is followed by a discussion of process monitoring. Information about impact evaluation is presented first because questions about "what works" or "what is better" always arise whenever an intervention is implemented. However, as described below, an impact evaluation, requires extensive expertise and resources, and may not be feasible within the context of the *Covering Kids* initiative. Process monitoring is feasible and is an extremely important and often neglected evaluation component.

Conducting Impact Evaluations: As part of the Title XXI initiative, emphasis is being placed on providing insurance coverage to as many eligible children as possible. Nationally, there is concern that states are not reaching their projected enrollment targets, raising the possibility that federal funds for Title XXI will be reduced or withdrawn. In the face of these concerns, stakeholders and decision makers want to know which method or methods are most likely to result in increased enrollment of uninsured children. This type of question is best addressed through an impact evaluation. While the importance of conducting impact evaluations should not be minimized, it is probably beyond the scope of most, if not all of the *Covering Kids* initiatives.

Determining the effectiveness of a particular outreach strategy is complicated by many factors including the variety of outreach approaches that are being used. Families are exposed to media campaigns, flyers, billboards, and myriad other strategies that states are using to inform families about the availability of free or subsidized children's health insurance. In addition to this exposure, some families receive door-to-door and/or finder's fee approaches. Families also have their own unique characteristics, such as race, ethnicity, income, and perceived importance of health care that may influence their receptivity to outreach campaigns and their willingness to obtain health insurance for their children. Isolating the effects of door-

to-door and finder's fee approaches from other outreach strategies, while considering the unique, personal characteristics of the families requires the skill of an experienced evaluation team and significant resources.

The optimal method for determining the effects of an intervention is to conduct a randomized experimental trial.[12] Using this method, subjects who will participate in the study are randomly assigned to a control group or an experimental group. The control group receives no intervention and the experimental group receives the intervention. Outcomes are then measured for both groups.

The following is an example of an experimental design that might be used to assess the effectiveness of door-to-door outreach compared to no targeted intervention. This is intended as an *illustration only* of the steps that would need to be taken to assess the effectiveness of door-to-door or finder's fee approaches compared to other outreach strategies. Many factors need to be considered if such an approach were implemented for any of the *Covering Kids* initiatives. These factors are beyond the scope of this document to describe. Additionally, many different strategies could be used to identify families beyond the one described here. The interested reader is encouraged to contact an experienced evaluator for assistance with this process.

To assess the effectiveness of door-to-door outreach, groups of families need to be identified and randomly assigned to groups, in a way where the two groups are unlikely to influence each other. Identifying census tracts with families of similar sociodemographic characteristics is one approach that could be used. The census tracts would then be randomly assigned to receive the door-to-door outreach or no intervention. The intervention would then be administered. Data would be gathered from families in both the control and the intervention group about the number of uninsured and potentially eligible children, the number of applications received, the number of children actually enrolled, and the number of children denied and the reasons for denial. Random assignment eliminates or limits the possibility that some characteristics of the family led to the outcome as opposed to the intervention itself. Moreover, random assignment helps the evaluator to isolate the effects of the intervention in question from other outreach strategies that may be used. For example, families in both the experimental and the control group may have been exposed to television and radio advertisements, billboards and other outreach strategies. However, if the study is well designed and the intervention is administered as planned, only the intervention group would

have been exposed to the door-to-door outreach, thereby helping the evaluators to isolate the effects of that intervention on enrollment and other outcome variables of interest.

In the absence of appropriate funding and a skilled evaluation team, addressing questions of impact generally are not possible. There are other research designs that are less stringent than the randomized experimental design and that can yield useful information about the effectiveness of outreach strategies. Such designs should be discussed with an experienced evaluator to determine if it is appropriate for a given *Covering Kids* initiative and if it will yield credible results.

It is often the responsibility of the evaluator and of those responsible for the evaluation to educate stakeholders and decision makers about what can be evaluated and why. In the next section, process-monitoring strategies that are realistic for most projects are described. These strategies can yield very valuable information about how the interventions were implement and general descriptive information. It is not possible, however, to infer causality, that is to state that a particular intervention led to certain outcomes

Conducting Process Monitoring: Process monitoring is intended to provide information about how the program was implemented and whether it reached its intended audience. As part of the process evaluation, descriptive information can be provided about the number of children enrolled in state-sponsored insurance programs from the sites where the door-to-door or finder's fee approaches were implemented. However, there is no attempt to attribute causality or to indicate that particular outreach strategies led to outcomes of interest, i.e., enrollment in state-sponsored insurance programs. Process monitoring is vitally important. Often programs are not implemented in the way they were originally envisioned. Failure to complete health insurance applications or to actually enroll children in insurance programs may result from poor implementation of a good idea as opposed to failure of the concept itself. Process monitoring also provides rich descriptive data about who is applying for health insurance programs and why, whether their children are actually enrolled, and how much the intervention cost to administer. Steps for program monitoring are outlined below.

Step 1 – Develop a flow chart describing the outreach strategy that will be implemented and **gather data about the implementation process on an ongoing basis.** An example of the flow chart is provided in Appendix A. For example, many sites using finder's fee approaches are paying a finder's fee to agencies that have frequent contact with families whose children are likely to be eligible for state-sponsored insurance plans. Each agency is using somewhat different strategies to implement the finder's fee approach.

The *Covering Kids* Projects using finder's fee approaches must document their process AND the agency's process for implementing the strategy. For example, the *Covering Kids* Project may have a simple procedure of paying the community agency for each completed application resulting in enrollment. The flow chart would document this fact as well as the procedure that will be used to inform the *Covering Kids* Project about applications resulting in enrollment. In addition, the flow chart should contain documentation about each participating agency's process for working with families to complete Medicaid/CHIP applications. For example, one agency may choose to screen all families contacting the agency for Medicaid/CHIP eligibility by assigning one employee to that task. This employer would then refer prescreened families to another staff member in the agency who would assist them with the application process. Another agency may train all of its social workers to screen families and assist them with applications at the time of the screening. Yet another agency may prescreen families and given them an application but not assist them with completing the form. Such seemingly minor variations are important to note because they may be related to the number of completed applications and children enrolled.

Similarly, those using door-to-door approaches must document the exact process including: the number of outreach workers available, the method for assigning cases to the outreach workers, the approach for identifying families, the strategies used to encourage families to talk to the outreach worker, and the steps taken to complete the application process.

The flow chart should be clear and as detailed as possible. The development of the flow chart is not a one-time endeavor. The process should be reviewed quarterly and changes incorporated into the flow chart with dates noted beside each change. If major changes are occurring, the flow chart should be revised at the time of the change without waiting for the quarterly review.

Step 2 – Determine data elements to be collected and develop standard process monitoring tools for data collection. Table 2 contains a summary of data elements that may be considered for inclusion in the process monitoring. Routinely collected process monitoring information includes the number of clients screened for Medicaid or SCHIP eligibility, the number of clients referred for further eligibility determination, the sociodemographic characteristics of the clients referred, and the costs of conducting the outreach strategies. Many of these categories may already be collected by an existing agency and the data need to be made available to the *Covering Kids* Project.

Data elements may also include outcomes such as the number of families referred through the *Covering Kids* Project and the number of those families whose children actually became insured. Other outcomes might include the satisfaction of families who received the outreach strategy with the strategy used. It is important to note that gathering data about outcomes is not the same as measuring the impact of the outreach strategy on achieving those outcomes. As Rossi, Freeman, and Lipsey[13] note:

> Measuring and monitoring the target social conditions, however, are not sufficient to show that the program activities have actually been the source of the changes observed. To demonstrate program impact on the conditions, the effects of the program must be distinguished from the effects of other influences on those conditions, such as outside social forces, natural trends, and ameliorative actions taken by other social programs or policies or by members of the target population themselves. (p. 203)

So, in the case of the *Covering Kids* initiative, it is possible and highly recommended to gather data about the number of families experiencing the outreach strategy whose children become insured. However, it is not possible to determine if the outreach strategy used actually resulted in the families enrolling their children. The families could have been exposed to other outreach strategies such as media campaigns or they may have decided that their children needed health care. Although the impact cannot be assessed, describing outcomes is an important component of process monitoring. More detail about choosing data elements, developing data sources, and managing data bases will be included in the section *Using Administrative Data Bases and Developing Data Sources*.

DEVELOPING A DENOMINATOR

Gathering baseline measures is an important step for any evaluation activity. However, such measures are often costly to obtain. For example, if one wanted to measure the number of children covered by Medicaid or SCHIP out of the number potentially eligible for such programs, baseline measures of the number of uninsured children in the state and preferably in regions within the state are needed. This information would then provide a denominator, so that the number of children who receive coverage can be placed within a context. That is, it can be stated that x children in the state received coverage out of an estimated number of y uninsured children.

Some states are fielding large surveys within their states designed to provide reliable estimates of the uninsured at regional levels within the state. Two such states are Florida and New Hampshire. The survey design and sampling methodology to estimate the uninsured requires strong expertise and the interested reader is urged to contact those with survey research experience in their states for further assistance. While this type of information is desirable, such a large-scale study can be costly and is beyond the resources available for many states. Thus, *Covering Kids* Projects, must find other ways to create denominators to place their projects within a community or regional context.

In this section alternatives for creating a denominator or denominators are described. There are many ways to create a context and the emphasis does not have to be exclusively on estimating the number of uninsured children. Other denominators, such as the number of non-English speaking families in a community may be used to create a context for the outreach strategies.

Use of Current Population Survey Data

First, an explanation of Current Population Survey (CPS) data to estimate the number of uninsured is provided because most states are using this data source and because understanding the number of uninsured is important (but not the only denominator that can be constructed). The CPS is a large nationally representative survey that contains sufficient information about family income and insurance status to allow researchers to calculate Medicaid and other insurance eligibility. Because of the sampling strategy and the number of people sampled, the CPS may provide unreliable estimates, particularly within smaller states.

Moreover, estimates cannot be developed at a regional or county level in the state. Therefore, if a particular *Covering Kids* initiative is targeting a certain county, the number of uninsured children in that county (to use as a denominator), cannot be determined from CPS estimates.

Developing a Community Profile

Many Covering Kids Projects are operating within certain communities. Thus the development of a comprehensive community profile will provide an important context for the outreach strategies that are being conducted. Moreover, a community profile, while not providing estimates of the uninsured, should provide information about those living in poverty, unemployment rates, the number of minorities in the community, and the percentage working in service industry, as an example. Children residing in families with one or more of these characteristics may have a greater likelihood of being uninsured than other children.

The successful implementation of any new or innovative program is dependent, in part, on the environment it enters. An assessment of the preexisting system or environment provides an idea of the "raw materials" that are available to design and implement outreach strategies for children and their families who may be eligible for Medicaid or SCHIP. Analysis of these raw materials enables the evaluation team or program staff to better understand the foundation on which the program is built and the potential difficulties that might emerge during the implementation phase. Moreover, such an analysis provides an important context within which to view the data collected because of process monitoring.

There are five critical indicators of the existing system to examine. These indicators represent the general demographic, socioeconomic, health, education, and health care system characteristics of an area. Data for these indicators should be available at the state level as well as on a local (county or regional) level. Once these data are obtained, comparisons of the indicators at the local level to the state totals or to contiguous geographic areas are informative and provide a context in which to evaluate the local area.

These indicators are as follows: (1) Population Indicators, (2) Birth Indicators, (3) Child Health Indicators, (4) Education System Indicators, and (5) Health Care System Indicators. Examples of available data in each of these areas are detailed below. In addition, an illustrative example of ways this descriptive information can be used is provided in the Appendix B. Table 2 lists the data and the potential sources of the data.

Population Indicators: The data of interest in this category include the size of the geographic area and the relationship of the local area to the larger region or state. Also of interest is the percentage of the population that is considered rural since issues like availability of transportation and services, both medical and non-medical are additional factors to consider in a rural area. For example, door-to-door outreach in rural areas may be hampered by long driving times and large distances between homes. Finder's fee approaches in rural areas, where an agency is paid a finder's fee for enrolling eligible clients, may be hampered because clients are not able to drive to the agency to be screened.

Other demographic data such as median age, family size, and the racial and ethnic composition of the population are also important. Knowledge of these indicators for a county or local area provides a benchmark against which one can compare the characteristics of the children and families approached for outreach and who actually enroll in a health insurance program to the overall composition of the population in that community.

Economic indicators include the median income, the percentage of families below the Federal Poverty Level (FPL), and the percentage of female-headed households below the FPL. Child-specific economic indicates are estimates of the percentage of children living in poverty and extreme poverty, the percentage of children living in households where the parent doesn't have full-time employment, and the number or percentage of children on Medicaid. Additional indicators include unemployment rates, and the median value of owner-occupied or rental unit housing.

Birth Indicators: Many Healthy Start data elements would be appropriate to report under this category. These include the number of live births, the percent of low birth-weight babies and the infant mortality rate. Given the concerns for both the mother and the infant when the mother is an adolescent, a critical birth indicator in a community area is the teen birth rate (the number of births per 1,000 females ages 15 – 19) for both whites and non-white teens. An additional indicator is the percent of births covered by Medicaid, for both teen and non-teen births. Such information might be important when targeting outreach strategies to adolescents.

Child Health Indicators: As already described, with the introduction of Title XXI and children's health insurance programs, there is increased interest in obtaining reliable estimates of children who do not have any health insurance. Also of interest are the numbers of children who are insured by the state Medicaid program and those who may be Medicaid-eligible but who are not enrolled in Medicaid. Estimates of the uninsured may not be available for each local or regional area at present but many states are developing strategies to obtain this information. Information about Medicaid coverage should be available in each state.

Education System Indicators: There are multiple indicators of the education system in an area. Some of the more critical indicators for understanding the context of a health care program might be the percent of the young elementary students who are receiving free or reduced lunches. This is a proxy for poverty in an area and is specifically related to children and readily available through the school district. It is important to note that the number of children enrolled in the National School Lunch Program may be an under-representation of those with low incomes. Some eligible children, particularly adolescents may not be enrolled in this program for a variety of reasons. However, the number of those enrolled in the National School Lunch Program and the percentage this represents out of the total number of students enrolled in the district provides general information about the economic circumstances of families in the area.

An indicator of the wealth of a community area is the money available to the public school system. There are at least three revenue streams for education funding that should be examined. These revenues include federal, state and local money that is provided to the public schools. The percent of students who graduate from high school and the percent of teens that are high school dropouts are also good educational indicators for an area. Also available is the education levels of the general population of an area.

Health Care System Indicators: These indicators provide the context within which the provision of health care occurs. The indicators included in this category are the total number of licensed medical doctors and other health care professionals in an area, the percent of physicians who are Board-certified, and the number of pediatric specialists in the area. In addition to these numbers, the ratio of physicians to the population in an area and the

designation of physician shortage areas provide insight into the availability of physicians to provide health care to the children enrolled in the program.

In addition to the availability of physicians and other health care professionals, it is important to examine the availability and size of the health care facilities and safety net providers in the area. Knowledge of the community and tertiary care facilities and the presence of a public health department or other publicly funded health care facility contribute to the "raw materials" available to the community.

Information about the health care system can be used to plan outreach strategies. For example, safety net providers and certain health care facilities may be targeted to participate in outreach because they are likely to serve children who may be eligible for Medicaid or CHIP.

Summary of the Community Profile: The preexisting system or environment is a critical component to assess when evaluating any program. The "raw materials" provide the foundation on which community leaders, school district personnel, health care providers, and the managed care companies could design, locally customize, and implement a comprehensive outreach program for uninsured children. Moreover, creating a community profile provides a context within which to view the outreach efforts. The information typically can be obtained from administrative data bases available at the state and local level. Table 2 lists indicators that can be used to develop a community profile and an example of a community profile created for the Healthy Kids evaluation in Florida is included in Appendix B.

Table 2. Potential Data and Data Sources (National and Florida-Specific Examples Included. Please check with your state officials to determine if similar documents are available in your state.)

Available Data	Source
Population Indicators: Total Population, Rank in State % Rural Population Median Age Racial Composition % Minority Median Income % Below Federal Poverty Level (FPL) % Female-headed Households Below FPL % of Children in Poverty and Extreme Poverty % of Children Living with Parents Who Don't Have Full-Time Employment % of Families with Children Headed by a Single Parent % Receiving Medicaid or Food Stamps Unemployment Rates Average Household Size Median Value of Owner-Occupied Housing Median Rent of Rental-Occupied Housing	• 1997 Florida Statistical Abstract. (1997). Bureau of Economic and Business Research, University of Florida. University Press of Fl: Gainesville, Fl. • 1996 Area Resource File (ARF). County-specific health data available at a cost from HRSA on CD-ROM. • Current Population Survey (CPS), Population Reference Bureau. U.S. Bureau of the Census. 1994 – 1998. • Special Studies Undertaken by State or Local Areas. • 1999 Kids Count Data Book: State Profiles of Child Well-Being (1999). The Annie E. Casey Foundation: Baltimore, MD. (provides national and state statistics)
Birth Indicators: Number of Live Births Teen Birth Rate Non-White Teen Births Percent of Teen Births Occurring to Mothers Who Smoke % Low Birth-Weight Babies Infant Mortality Rates Percent of Births Covered by Medicaid	The 1998 Florida Kids Count Data Book. (1998). Florida Center for Children & Youth: Tallahassee, FL. (State version of the National Publication with county-specific data. 1999 Kids Count Data Book: State Profiles of Child Well-Being (1999). The Annie E. Casey Foundation: Baltimore, MD. (provides national and state statistics)

Table 2. Potential Data and Data Sources (National and Florida-Specific Examples Included. Please check with your state officials to determine if similar documents are available in your state.)

Available Data	Source
Child Health Indicators:	
Percent of Children Without Health Insurance Percent of Children Covered by Medicaid or other public-sector health insurance Percent of 2-Year Olds Who Were Immunized	1999 Kids Count Data Book: State Profiles of Child Well-Being (1999). The Annie E. Casey Foundation: Baltimore, MD. (provides national and state statistics) Current Population Survey (CPS), Population Reference Bureau. U.S. Bureau of the Census. 1994 – 1998.
Health Care System Indicators:	
Number of Licensed Medical Doctors MD to Population Ratio Numbers of Health Care Professionals Designated Primary Care Physician Shortage Status % of Board Certified Specialists Number of Pediatric Specialists HMO Penetration Rates Number of HMOs Presence of a Public Health Department Number of Community Hospitals Number of Tertiary Hospitals	1993 Florida Health Care Atlas. (1993). Agency for Health Care Administration: Tallahassee, FL. Florida Hospital Association Environmental Assessment (Tenth edition). (1994, November). Florida Hospital Association: Orlando, FL. 1995 National Directory of HMOs. Group Health Association of America. Washington, DC 1996 Health Data Sourcebook: A Compendium of Information on Health and Health Care in the Region (1996). Local Health Councils in Florida and the Agency for Health Care Administration (AHCA).

Creating an Organizational Profile

Many of the Covering Kids Projects are working with different health care and social service agencies in the community to conduct their outreach strategies. For example, one of the projects is providing a finder's fee to different community agencies that are providing outreach to their clients about Medicaid and CHIP. These agencies are then paid a finder's fee for the number of clients whose children were enrolled in Medicaid or CHIP. Other Covering Kids Projects may be working with community agencies on door-to-door or other outreach approaches.

Because these community agencies may and probably do have different functions and different organizational capacities to carry out the proposed outreach strategies, developing an organizational profile may be an important part of understanding some of the evaluation findings. For example, as part of the Healthy Kids Program evaluation in Florida, an organizational profile is developed of each managed care organization (MCO) participating in the program. The MCOs are all organized in somewhat different ways. Understanding their organizational structures allows the evaluation team to better understand the findings about the children's health care use and families' satisfaction with health care. For example, some MCOs participating in the Healthy Kids Program have more stringent criteria for specialist referrals than others do. Thus, the amount of specialty care the children are receiving in the program and families' satisfaction with such care can be viewed with the context of the MCOs' referral and prior authorization policies. Understanding this context would not be possible unless an organizational profile was created for each MCO. This profile is constructed from in-depth interviews with administrators from each MCO and from analyzing documents provided by the MCO about their quality assurance programs, their new member outreach programs, and other factors.

For the Covering Kids Projects, understanding the organizational context where the outreach strategies are being conducted is critical. For example, if two agencies are participating in a finder's fee strategy, issues such as the number of staff members in the agency available to conduct outreach, the number of clients served in the agency, and the in-service training approaches to teach the staff about the outreach strategy may influence how well the strategy is implemented and subsequently the number of clients enrolled.

As part of the Healthy Kids evaluation, a matrix is created of the important organizational features of each MCO with a brief summary of the findings. An example of a matrix that could be developed for community agencies participating in outreach strategies with the *Covering Kids* Projects, is contained in Appendix C. Developing a matrix will assist the Covering Kids Project team to understand why a strategy may have worked in one setting and not in another. While this step may seem time-consuming, it is well worth the effort because it enhances your ability to interpret your findings.

USING ADMINISTRATIVE DATABASES AND DEVELOPING OTHER DATA SOURCES

Many data sources can be considered for any evaluation. Administrative data bases, such as application records, enrollment information for Medicaid and CHIP enrollees, and health care encounter files contain information that are routinely collected by most state agencies. They are often a rich information source about program enrollees and are generally affordable to use. Administrative databases usually are designed for specific purposes may not contain all of the information that you would like to have to monitor your outreach approach. Therefore, these databases typically must be supplemented with more costly data collection efforts such as telephone surveys. For example, while Medicaid or CHIP application databases contain information about the number of applicants and their demographic characteristics, information about how they learned about the program is often not available and must be obtained in another way.

In this section, information about working with administrative databases is provided. This discussion is followed by an overview of other common methods for obtaining information for use in evaluations. These methods include the use of focus groups and telephone surveys.

Using Administrative Data Bases

Administrative databases are maintained by all agencies, albeit with varying degrees of usefulness and sophistication. Such data bases form the core data set for the CHIP evaluation in Florida and include application and enrollment information provided by a third party administrator (TPA) and health care claims and encounter data provided by the insurance companies working with the CHIP initiative. In addition, data are provided by the agency determining Medicaid eligibility (the Department of Children and Families) and the agency determining eligibility for the state Title V Children with Special Health Care Needs Program (Children's Medical Services – Florida's Title V Agency). These data are supplemented with focus group and telephone survey information. A diagram contained in Appendix D outlines the data that are being used to assess outreach and enrollment strategies for the Florida CHIP evaluation. While, it may be beyond the scope of many of the Covering Kids Projects to obtain

the comprehensive data described in the diagram, it should be possible for each project to obtain some administrative records and certainly to be maintaining their own outreach and tracking records. If you are working with multiple data sources, a diagram of those sources is recommended for both project documentation and for presentation to others about the sources you used to obtain your findings.

The following steps should be taken when developing and working with administrative databases:

1. As described in the section on developing evaluation questions, for each question, determine the data elements that you want to collect. Refer to Table 1 for potential data sources associated with each evaluation question.
2. Determine the source of those data elements. As part of this process, determine the data elements that will be collected as part of the Covering Kids initiative and those that will be available through others. For example, if you are conducting door-to-door outreach, you most likely will need to develop a computerized log to track the number of contacts that you made to the homes. However, you also will need to obtain enrollment data from your state Medicaid or CHIP initiative to determine if those that you reached through the door-to-door approach actually enrolled their children.
3. Develop a list of the data elements that you have and/or want and their definitions. This list can then be shared with other agencies so that you can discuss the data elements that you need for your evaluation. In the case of the Florida evaluation, the evaluation team developed the evaluation questions with the CHIP administrators. The questions about application and enrollment were discussed with the third party administrator managing the enrollment files. At that time, the third party administrator, in collaboration with state agencies, had already developed their database and provided the data dictionary contained in Appendix E to the evaluators. Fortunately, this database was comprehensive and contained most of the information that the evaluation team wanted from the administrative database. Missing items are being supplemented with focus group and telephone survey data. Most *Covering Kids* Projects will likely have to work with existing databases to some extent. When it is possible to develop your

own database, think broadly and include information that is critical for your project.

These data elements described in Appendix E are used to track application and enrollment information to address questions about (1) the number of applications received, (2) the demographic characteristics of those applying, (3) the number of pending applications and the reasons, (4) the number of cancelled and denied applications and the reasons, (5) the number enrolled, (6) their enrollment date and coverage date for insurance, (7) the number of closures, and (8) the number of redeterminations.

These data also are used by the evaluation team to construct an enrollment profile of each child so that the length of time of enrollment is tracked along with disenrollment rates. In addition, the data are used in analyses of children's health care use patterns to determine the relationship between health care use and length of program enrollment and to determine the number enrolled but not using health care services. Thus this one database has multiple, important uses. The *Covering Kids* Projects should work with state agencies to whether such data are available and can be provided in their states.

5. Obtaining administrative data for a project is a time-consuming and sometimes discouraging effort. Often the data are available but not accessible due to staffing shortages and workload issues. In our experience, most of the data needed for the evaluation are available but encouraging information systems staff to set aside the initial time to write a program to extract those data is difficult. It is essential that you gain the support of administrative staff in agencies holding the data that you need for your project. The agency administrators play a crucial role in setting priorities and can work with information systems staff to provide the data that are needed. Once the initial program is written to provide the data that your project needs, the most time-consuming part of the work is finished.

6. Once you have reached an agreement, ask for a "test" data set if you are receiving electronic data or for a "test" report if the data are being provided to you in a written format. Obtaining this "test" data is critical because you usually will find that information was not provided as requested for a variety of reasons. Sometimes you also will receive information that was not requested.

   As part of the CHIP evaluation in Florida, application and enrollment information is received each month in electronic format. After the first data submission, we prepared a report that addressed the following questions:

   - Was each data element present as described in the data dictionary?
   - Did the results make sense after reviewing them with program administrators and other stakeholders?
   - Were there additional data elements or codes in the electronic file that were not described on the data dictionary?

   During two to three conference calls with the third party administrator, any issues were resolved and the data are now submitted once a month with only occasional questions on the part of the evaluation team. Each *Covering Kids*, Project should follow a similar process of quality review and verification after receiving data in electronic or report format, particularly after the first submission. After the initial programming to provide the data and the initial quality review process, the time required to submit data at regularly scheduled intervals to you project should be minimal.

7. Work with and review data immediately after it has been received. It becomes much more difficult to resolve questions or problems and to understand the data if you do not work with it regularly. Appendix F contains a copy of the monthly report that is generated using the data listed in the data dictionary contained in Appendix E. The third party administrator also provides additional data about applications received and this information is used in constructing the monthly report. This report is prepared each month and shared with state agencies for review.

Developing Additional Data Sources

As previously described, administrative databases will usually need to be supplemented with other information. In this section, a brief overview of survey methods and the use of focus groups is provided. Supplementing administrative databases with survey and focus group data can provide a rich source of information to address your evaluation questions.

Survey Research

In survey research, a standardized set of questions is drafted, and this same set of questions, in the same order, is asked of everyone who is sampled. For most questions, the respondent must choose from a list of possible answers. The Current Population Survey, the National Health Interview Survey, and other national surveys, all follow a standardized format where respondents are asked a series of questions by trained interviewers. There are many other good examples of survey instruments. Developing surveys is very difficult. It is beyond the scope of this document to describe survey development strategies. How the questions are asked, the sequence in which they are asked, and other factors, are all critical and will influence the findings you obtain from the surveys.

In the case of application and enrollment processes and satisfaction with outreach, very little information is available about existing instruments. Thus for Covering Kids grantees, some survey development may be necessary. It is highly recommended that existing instruments are used to the extent that they are available or that the Covering Kids Projects work with a person that is skilled in survey development. A skilled survey developer can assist you in avoiding costly mistakes and can help you to obtain survey data that are useable, reliable, and valid.

In this section, the advantages and disadvantages of survey research are described. In addition, different approaches for conducting survey research also are presented (i.e., telephone versus written surveys, and others).

Advantages of Survey Research

1. Helps eliminate interviewer bias by scripting the questions to be asked and their order.

2. Provided they are trained effectively, many people can administer the same survey at the same time, thereby allowing for efficient data collection.

3. The data that result are easier to analyze than interview or focus group data. Statistical tests can be applied to the data if correctly structured.

4. With mail or telephone surveys, large numbers of people can be surveyed, and those people can be scattered geographically.

Disadvantages of Survey Research

1. Survey research is only useful if you have already identified the issues. For example, families may be resistant to having someone come to their home for door-to-door outreach. You cannot ask about a possible problem if you don't know about it already. Preliminary research, such as a focus group or a case study may be necessary to identify these issues before constructing a questionnaire.

2. Surveys are inflexible in terms of question order, wording, and content. Those who administer the surveys must adhere to the same script for every survey. Interviewers cannot probe respondents for further information or provide any additional information unless the survey specifically calls for it.