



ANDREW YOUNG SCHOOL
OF POLICY STUDIES

**Involving Community-Based Organizations to Improve
Medicaid/SCHIP Utilization**

Mary Ann Phillips, MPH

Bernette Sherman, MPA

John A. Shoemaker, MPH

Mark Rivera, PhD

Karen Minyard, PhD

Georgia Health Policy Center

Andrew Young School of Policy Studies

Georgia State University

Corresponding Author: Mary Ann Phillips, MPH
Senior Research Associate
Georgia Health Policy Center
AYSPS/Georgia State University
P.O. Box 3992
Atlanta, GA 30302-3992
mphilips2@gsu.edu

Acknowledgements: Supported by the Georgia Department of Community Health.

Abstract

Public participation in the development of community health programs is a means to generate relevant and innovative solutions to community health promotion. To encourage such participation in improving the utilization of children's health services provided by Medicaid and SCHIP, a community grant program was designed to promote collaboration among community-based organizations, health care providers, and the State Medicaid agency. The program made six awards to community-based organizations. The six organizations' programs were evaluated retrospectively to identify the methods used to increase health services utilization, the barriers encountered, and the innovative solutions created. All six were successful in increasing programmatic activities, including adding 4,890 new or potential enrollees, providing 5,149 telephone appointment reminders, and generating 2,308 referrals to other services. The most common challenges encountered by the programs were staff turnover, lack of IT integration, lack of transportation for enrollees, and limited funding and sustainability. In response, programs developed innovative staffing patterns, created new data systems for appointment scheduling and record maintenance, and forged new collaborative relationships to support their programs. Investment in community-based organizations can lead to creative and novel solutions to improving the appropriate utilization of health services.

Introduction

“Increasingly, community involvement and collaboration have become the foundation for public health action.”¹ This sentiment, expressed here by then Assistant Surgeon General Edward L. Baker, M.D., M.P.H, in his forward to the CDC’s guide, *Principles of Community Engagement*, has been oft repeated. The Institute of Medicine has recognized that “Community organizations are close to the populations they serve and are therefore a crucial part of the public health system for identifying needs and responses...,”² and went so far as to make two specific recommendations for increasing community participation in its report, *The Future of the Public’s Health in the 21st Century*.² The first directs agencies to support community-led efforts in health improvement, and the second urges government and private funders to be sensitive to the need for ongoing community engagement and leadership for the long-term success of their projects.

Community involvement in health research has also been advocated. In a companion report, the Institute of Medicine called for students of public health to receive training in community-based participatory research (CBPR).³ A survey taken less than a year after the report’s release showed that many schools of public health were already addressing CBPR in their curricula.⁴ Even before the report, there were calls for CBPR in health,^{5,6} with suggested applications ranging from environmental health⁷ to the evaluation of social determinants,⁸ and more have been suggested since.^{9,10}

The well-known *Turning Point* initiative has acknowledged that community participation can improve America’s public health systems.^{11,12} As mentioned above, the CDC promotes community engagement in public health¹ and has embraced community involvement in its research programs.¹³ While problems with communication,^{13,14} limited capacity¹⁵, political and ideological differences,¹⁶ funding,¹⁷ and other complications still exist for public involvement in

community health, state and local health agencies are to be praised for their efforts to engage their constituencies in the business of eliminating disparities and improving health.

Providing small grants to local community-based organizations (CBOs) is one approach for engaging the community in health programs. Such programs have been shown to be effective in garnering the involvement of the local community in health promotion efforts.¹⁸⁻²¹ This report documents the Utilization Minigrant Program, one such program created in the State of Georgia to promote community involvement in efforts to improve utilization of Medicaid and SCHIP covered services for children.

Utilization Minigrant Program

The Georgia Better Health Care (GBHC) program is a primary care case management system operated directly by the Department of Community Health, Georgia's Medicaid agency. The program operates under a Medicaid waiver provided under Section 1915(b)(1) of the Social Security Act. After a phased-in implementation, the waiver has operated on a statewide basis in 159 counties since February 1998. The State's objectives through this waiver program have been to improve access to medical care, particularly primary care services; enhance continuity of care through creation of a "medical home"; and reduce unnecessary use of medical services.

In 2002, the Georgia Department of Community Health (DCH) and the Georgia Health Policy Center collaborated to develop a grant program that would encourage the appropriate utilization of primary and preventive care services provided by the GBHC program for children enrolled in Medicaid and PeachCare for Kids. The Utilization Minigrant Program was intended to address children's low utilization rates of primary and preventive care services from GBHC

providers that was limiting DCH's ability to ensure and document that children were receiving recommended care in the appropriate settings.

DCH contracted with the Georgia Health Policy Center to develop the request for proposals, coordinate the review and award process, and conduct an evaluation of the initiative. Grantees were asked to develop innovative ways for community-based organizations to promote and improve utilization of services. The program's design asked communities to identify utilization improvement strategies and to meet funding conditions which included submitting interim and final progress reports and participating in ongoing evaluation activities.

Grantees were asked to address one or more of the following outcomes: 1) Increasing appropriate utilization of GBHC primary care by providing basic and routine services; 2) Enhancing preventive services performed by GBHC primary care providers; and, 3) Enhancing adolescent behavioral health assessments performed by GBHC primary care providers. While achieving these outcomes was the primary goal of the individual grantees, the larger goal of the overall program was to identify those conditions under which the different grantees were able to achieve success in improving appropriate utilization and to document common challenges.

The Georgia Health Policy Center, in collaboration with the DCH, screened 22 proposals and awarded six grants. Proposals were selected for funding based on different approaches for improving appropriate utilization. Five of the grantees were funded for \$50,000; one asked for and received \$25,000. Of these six, four were submitted by local community collaboratives and two were from hospitals. Grantees had to provide matching funds and agree to participate in an evaluation. The grant period was 11 months, and the Georgia Health Policy Center provided administrative oversight.

Program Evaluation

The brief term of the Utilization Minigrants necessitated the conduct of the evaluation in a manner sensitive to problems of “formative insufficiency.”²²⁻²⁴ According to this principle, programs are sometimes assessed for level of impact before their formative development is complete. This, in turn, can lead to faulty conclusions regarding program efficacy. A common recommendation when examining new or developing programs has been to enable programs and their evaluation activities to serve a discovery capacity in which evaluation activities become a mechanism for insights regarding effective program implementation and directions for further program development.^{25,26} This formative evaluation approach was compatible with the funder’s goal of documenting common experiences to distill programmatic recommendations and lessons learned so as to provide guidance for the administration and funding of future outreach efforts.

Based on an initial review of grantee proposals, a participatory evaluation plan was developed and refined over a series of collaborative meetings among the Department of Community Health, the Georgia Health Policy Center, and the grantees. Involvement of program personnel in evaluation planning has been recommended as an integral component of successful formative evaluation design.²⁷

The primary data source was a site questionnaire. Key indicators were selected for a draft site questionnaire. The draft questionnaire was then mailed to all six grant program coordinators for their feedback as a form of member-checking for accuracy.²⁸ A one-hour telephone interview was conducted with each program coordinator to gather feedback regarding which of the program characteristics were least and most likely to produce accurate data. Based on the feedback from the interviewees, a final site questionnaire was created.

The final questionnaire was later completed by all six grantees. Follow-up telephone interviews were conducted to validate findings and ensure that successes, barriers, and aspects of sustainability not detected by other data collection means were identified. In addition, interviews provided the opportunity to gather information to ensure that the context of the funding was more fully considered.

Key Observations and Findings

The evaluation effort provided evidence regarding specific grantee activities and their outcome targets, successes achieved, barriers encountered, and lessons learned along the way. Across all six grantees, findings showed increased programmatic activity, particularly in the areas of health plan enrollment and initial contact, appointment setting and tracking, and referrals for social and other services (see Table 1).

Table 1

Programmatic Activity Gains

Programmatic Area	Key Grantee Observations
Enrollment and Initial Contact	<ul style="list-style-type: none"> ● 4,890 new and potential enrollees were identified for services during the funding period. ● The use of the telephone accounted for the largest number of initial contacts made (38 percent), followed by face-to-face contacts (26 percent). ● Despite the high levels of initial contacts made by telephone, telephone calls and letters were mentioned most often as the least effective approaches for initial contact. Letters were reported to be too impersonal and telephone calls received relatively low rates of return calls. ● Face-to-face contact was most frequently identified by grantees as the most effective strategy for initially contacting enrolled members.
Appointments	<ul style="list-style-type: none"> ● Grantees reported providing over 5,149 appointment reminders during the grant period. ● Most appointments were for Health Checks, immunizations, child preventive screenings, and well child visits. ● Approximately 77 percent of appointments scheduled were kept. ● Lack of transportation and forgetting were the most frequent reasons for missed appointments. ● The use of telephone calls for appointment reminders achieved greater success than it did for initially contacting enrollees, probably because communication and a relationship had already been established. ● Three grantees indicated that two attempts, on average, were needed to reach enrollees who had missed an appointment.
Referral	<ul style="list-style-type: none"> ● A total of 2,308 referrals to other services were reported, with nutrition counseling and transportation accounting for over half of the referrals.

As stated previously, the primary goal of the evaluation was to provide the Department of Community Health with programmatic recommendations/lessons learned about community-based organizations and the administration and funding of future grantee efforts. An examination of programmatic successes reported in final reports, site questionnaires, and interviews revealed common themes regarding program characteristics to which grantees most frequently attributed their levels of success. These characteristics can be called facilitators of success.

The most common facilitators were related to data systems, staffing approaches, and collaboration. The development of new data systems resulted in improved scheduling, enhancements or adjustments to other data collection efforts, improved management of efforts at multiple locations, and effective implementation of new reporting efforts. Successes were also attributed to staffing approaches in that grantees experienced increased capacity and continuity through a dedicated staff position, increased effectiveness and efficiency in service delivery when the dedicated staff member had a broad skill set, and improved access to enrollees through strategically located staff. Collaboration improved access to care, created effective sharing of resources to enhance program reach, and served as a catalyst for new partnerships. Elaboration on each of the facilitators of success led to the development of several key recommendations to the Department of Community Health as guidance for future outreach funding programs (see Table 2).

Table 2
Facilitators of Success

Area	Key Recommendations
Staffing	<p><u>Identify staff skill sets.</u> When possible, identifying staff with multiple skill sets is clearly advantageous given limited resources.</p> <p><u>Locate staff within partner organizations.</u> Funding staff within a partner organization is an effective means of providing enrollees with access to staff expertise and resources the grantee does not possess internally. Having the grantee and partner organization enter into a memorandum of understanding may address HIPPA concerns.</p>
Data Systems	<p><u>Enhance scheduling/data collection systems.</u> Use funding as an opportunity to improve existing scheduling and data collection efforts. The level of improvement can more than make up for the upfront investment, outlive the funding, and increase ability to meet client needs.</p> <p><u>Cross train staff on scheduling and data collection systems.</u> Regardless of any enhancements to scheduling and data collection systems, cross-training of staff can preserve institutional memory.</p>
Collaboration	<p><u>Recognize the power of referrals.</u> Reinforcing and expanding referral networks is key. Referrals for serious health issues discovered during Health Checks were a compelling success of the program.</p> <p><u>Use networks to reach enrollees.</u> To provide services to hard-to-reach populations, identify other community organizations that already have close working relationships with the target communities. When such partnerships are unavailable, community events may be a less-threatening means of reaching these clients than one-on-one approaches such as home visits.</p> <p><u>Involve physicians in networks.</u> Inviting physicians to provide input into the selection and development of programmatic offerings strengthens partnerships and increases the utility of what was developed.</p>
Addressing Barriers	<p><u>Use health education focused incentives.</u> Choose incentives that are appealing and also have a healthy focus. Consider a range of inexpensive incentives for enrollees who keep appointments and are on time. In addition, partner organizations may provide incentives to attract hard-to-reach populations.</p> <p><u>Recognize transportation barriers.</u> Transportation barriers are common, but local solutions may demand resources in excess of the grant. DCH and grantees may need to work together to identify other creative solutions to reduce transportation challenges.</p>

Discussion

Local outreach and marketing efforts have been shown to be effective means of promoting Medicaid/SCHIP enrollment and utilization.²⁹⁻³³ Georgia's Utilization Minigrant Program and other Medicaid/SCHIP outreach programs like it are just one example of how a State-level agency may engage a community in creating innovative solutions to local health problems.

The variety of outreach methods used by the grantees in the Utilization Minigrant Program are similar to those reported in other programs. Although the effectiveness of these techniques was not the subject of the present evaluation, grantee impressions of the relative effectiveness of their efforts, such as in-person contact versus telephone contact, seem consistent with the findings of others.³⁴⁻³⁹

The grantees also recognized the value of changes in office systems and practices to improve utilization. The need for improved data and scheduling systems, provider participation in encouraging appropriate utilization of services, and other practice changes have been documented by others as well.⁴⁰⁻⁴²

Despite the practical and constructive guidance gained for future programs by the evaluation of the Utilization Minigrant Program, one might reasonably ask if the key recommendations generated might have been more easily (and inexpensively) reached by expert State agency staff working alone? Although the expediency of such a simple top-down solution may be attractive, such an approach has several shortcomings that are well-addressed through community involvement.

Conclusion

Community involvement in health programs encourages us to adopt a broader perspective on the populations, inputs, and variables that are implicated in addressing large-scale health concerns. Engaging those who live and work within the systems provides us with unique insights and new points of view not commonly held by those who pull the strings from a distance. Such insights seem not only desirable, but are also consistent with the calls to integrate community partnering⁴³ and introduce broader systems theory and thinking⁴⁴ into our health promotion strategies.

References

1. *Principles of Community Engagement*. Centers for Disease Control and Prevention. Atlanta, GA: CDC; 1997.
2. Institute of Medicine. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press; 2002.
3. Institute of Medicine. *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century*. Washington, DC: The National Academies Press; 2002.
4. Shortell SM, Weist EM, Sow MSK, Foster A, Tahir R. Implementing the Institute of Medicine's recommended curriculum content in schools of public health: A baseline assessment. *Am J Public Health*. 2004;94(10):1671-1674.
5. Travers KD. Reducing inequities through participatory research and community empowerment. *Health Educ Behav*. 1997;24(3):344-356.
6. Lasker RD, Weiss ES. Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *J Urban Health*. 2003;80(1):14-47.
7. Green LW, Mercer SL. Community-based participatory research: Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities? *Am J Public Health*. 2001;91(12):1926-1929.
8. O'Fallon LR, Deary A. Community-based participatory research as a tool to advance environmental health sciences. *Environmental Health Perspectives*. 2002;110(Suppl.2):155-159.
9. Shulz AJ, Krieger J, Galea S. Addressing social determinants of health: Community-based participatory approaches to research and practice. *Health Ed Behav*. 2002;29(3):287-295.

10. Leung MW, Yen IH, Minkler M. Community-based participatory research: A promising approach for increasing epidemiology's relevance in the 21st century. *Int J Epidemiol*. 2004;33(3):499-506.
11. Veazie MA, Teufel-Shone NI, Silverman GS, Connolly AM, Warne S, King BF, Lebowitz MD, Meister JS. Building community capacity in public health: The role of action-oriented partnerships. *J Public Health Management Practice*. 2001;7(2):21-32.
12. Lewin Group, Inc. *Community Participation Can Improve America's Public Health Systems*. Battle Creek, MI: WK Kellogg Foundation; 2002.
13. Public health benefits when communities participate and help to guide research. *Chronic Disease Notes & Reports*. 2002;15(1):20-24.
14. Lasker RD, Weiss ES. Creating partnership synergy: The critical role of community stakeholders. *J Health Human Serv Admin*. 2003;26(1):119-139.
15. Parker E, Margolis LH, Eng E, Henríquez-Roldán C. Assessing the capacity of health departments to engage in community-based participatory public health. *Am J Public Health*. 2003;93(3):472-476.
16. Morgan LM. Community participation in health: Perpetual allure, persistent challenge. *Health Policy and Planning*. 2001;16(3):221-230.
17. Minkler M, Blackwell AG, Thompson M, Tamir H. Community-based participatory research: Implications for public health funding. *Am J Public Health*. 2003;93(8):1210-1213.
18. Paine-Andrews A, Francisco VT, Fawcett SB. Assessing community health concerns and implementing a micro-grant program for self-help initiatives. *Am J Public Health*. 1994;84(2):316-318.

19. Maurana CA, Clark MA. The Health Action Fund: A community-based approach to enhancing health. *J Health Commun.* 2000;5(3):243-254.
20. Hartwig KA, Bobbitt-Cooke M, Zaharek MM, Nappi S, Wykoff RF, Katz DL. The value of microgrants for community-based health promotion: Two models for practice and policy. *J Public Health Management Practice.* 2006;12(1):90-96.
21. Bobbitt-Cooke M. Energizing community health improvement: The promise of microgrants. *Prev Chronic Dis.* 2005;2(Nov):A16. Available from: http://www.cdc.gov/pcd/issues/2005/nov/05_0064.htm
22. Scriven M. Beyond formative and summative evaluation. In: McLaughlin M, Phillips D, eds. *Evaluation & Education: at Quarter Century.* Chicago, Il: University of Chicago/National Society for the Study of Education; 1990.
23. Wholey JS, Hatry HP, Newcomer KE. *Handbook of Practical Program Evaluation.* San Francisco, Ca: Jossey-Bass; 1994.
24. Wiess, CH. *Evaluation: Methods for Studying Programs and Policies.* Englewood Cliffs, NJ: Prentice-Hall; 1998.
25. Leviton LC, Schuh RG. Evaluation of outreach as a program element. *Evaluation Rev.* 1991;15(4):420-440.
26. Stake RE. *The Art of Case Study Research.* Thousand Oaks, Ca: Sage Publications; 1995.
27. Chancon-Mascoso S, Auguera-Argilaga MT, Perez-Gil JA, Holgado-Tello FP. A mutual catalytic model of formative evaluation: The interdependent roles of evaluators and local programme practioners. *Evaluation.* 2002;8(4):413-432.
28. Miles MB, Huberman AM. *Qualitative Data Analysis: An Expanded Sourcebook.* Thousand Oaks, Ca: Sage Publications; 1994.

29. Stine WF. The effect of local government outreach efforts on the reciprocity of selected Medicaid programs. *Inquiry*. 1991;28(2):161-167.
30. Moore JD. CHIP and Medicaid Outreach and Enrollment: A Hands-On Look at Marketing and Applications. Issue Brief No. 748. Washington, DC: National Health Policy Forum, 1999.
31. Felland L, Benoit AM. Communities play key role in extending public health insurance to children. *Issue Brief Cent Stud Health Syst Change*. 2001;44(Oct.):1-4.
32. Castaneda Z, Clayson ZC, Rundall T, Dong L, Sercas M. Promising outreach practices: Enrolling low-income children in health insurance programs in California. *Health Promotion Practice*. 2003;4(4):430-438.
33. McAlearney JS. Opportunities for outreach. Medicaid participation among children in Ohio. *J Health Care Poor Underserved*. 2004;15:357-374.
34. Selby-Harrington M, Sorenson JR, Quade D, Stearns SC, Tesh AS, Donat PL. Increasing Medicaid child health screenings: The effectiveness of mailed pamphlets, phone calls, and home visits. *Am J Public Health*. 1995;85(10):1412-1417.
35. Lieu TA, Capra AM, Makol J, Black SB, Shinefield HR. Effectiveness and cost-effectiveness of letters, automated telephone messages, or both for underimmunized children in a health maintenance organization. *Pediatrics*. 1998;101(4):E3.
36. Vivier PM, Alario AJ, O'Haire C, Dansereau LM, Jakum EB, Peter G. The impact of outreach efforts in reaching underimmunized children in a Medicaid managed care practice. *Arch Pediatr Adolesc Med*. 2000;154:1243-1247.
37. Biem HJ, Turnell RW, D'Arcy C. Computer telephony: Automated calls for medical care. *Clin Invest Med*. 2003;26(5):259-268.

38. Crawford AG, Sikirica V, Goldfarb N, Popiel RG, Wang C, Chu JB, Nash DB. Interactive voice response reminder effects on preventive service utilization. *Am J Med Qual.* 2005;20(6):329-336.
39. Stoskopf CH, Samuels ME, Ciesla JR. Findings from a demonstration outreach project at a community health center. *J Health Care Poor Underserved.* 1993;4(1):51-64.
40. Rodewald LE, Szilagyi PG, Humiston SG, Barth R, Kraus R, Raubertas RF. A randomized study of tracking with outreach and provider prompting to improve immunization coverage and primary care. *Pediatrics.* 1999;103:31-38.
41. Bordley WC, Margolis PA, Stuart J, Lannon C, Keyes L. Improving preventive service delivery through office systems. *Pediatrics.* 2001;108(3): E41.
42. Margolis PA, Stevens R, Bordley WC, Stuart J, Harlan C, Keyes-Elstein L, Wisseh S. From concept to application: The impact of a community-wide intervention to improve the delivery of preventive services to children. *Pediatrics.* 2001;108(3):E42.
43. Best A, Stokols D, Green LW, Leischow S, Holmes B, Buchholz K. An integrative framework for community partnering to translate theory into effective health promotion strategy. *Am J Health Promotion.* 2003;18(2):168-176.
44. Leischow SJ, Milstein B. Systems thinking and modeling for public health practice. *Am J Public Health.* 2006;96(3):403-405.