Providing pathways to coverage: A case-evaluation of the outreach and enrollment model at a Federally Qualified Health Center Network in South Central Florida.

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Providing Pathways to Coverage

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Acknowledgements

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**Introduction**

As of 2012, approximately 47.3 million American children and adults under the age of 65 were uninsured (DeNavas-Walt, Proctor, & Smith, 2013; The Kaiser Commission on Medicaid and the Uninsured, 2013a). Studies suggest that the majority of these uninsured Americans live in low-income, working households and that approximately 8 million are children under the age of 18 (The Kaiser Commission on Medicaid and the Uninsured, 2013a). These uninsured individuals and families are less likely to access preventative care and are more likely to forego or delay necessary medical treatment (Hadley & Holahand, 2004). On average, uninsured individuals pay more when they do receive health services and are more likely to incur medical debt, which places additional financial burden on the already low-income, uninsured individual or family (Institute of Medicine of the National Academies, 2009). A disproportionate number of uninsured individuals live in “hard-to-reach” rural and migrant communities. It is estimated that, on average, 20% of American rural residents (as many as 70% in some states) and 85% of migrant and seasonal farmworkers are uninsured (Kaiser Commission on Medicaid and the Uninsured, 2003, 2005). When compared to U.S. averages, rural and migrant populations are lower income, are more likely to be uninsured and remain uninsured for longer periods of time, and have slightly poorer health outcomes than that of urban and suburban residents (Link & McKinlay, 2010; The Kaiser Commission on Medicaid and the Uninsured, 2003, 2005).

A percentage of these uninsured individuals are eligible for free or low-cost health insurance through Medicaid and other state health insurance programs but face cultural and structural barriers that prevent them from enrolling. It is well documented that community health centers (CHC) improve individual and family health care access and are particularly impactful in rural communities and communities with high numbers of migrant and seasonal farm workers (Castañeda, Clayson, Rundall, Dong, & Sercaz, 2003; Chung, Cavender, & Main, 2010; Lemak, Johnson, & Goodrick, 2004; Long, 2002; Main, Fedde, Waltz, & Chavez, 2013; Mathieson & Kronenfeld, 2003; Plaza, 2012; Ross & Hill, 2003; Summer, Carpenter, & Kavanagh, 1999; Taras, Zúñiga de Nuncio, & Pizzola, 2002). These trusted, patient-directed institutions are designed to target hard-to-reach populations and are positioned to address unique barriers to accessing care through targeted programs that are planned with the community context and needs in mind (Castañeda et al., 2003; Felland & Benoit, 2001; Long, 2002; Plaza, 2012; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b). CHCs also improve insurance rates in hard-to-reach populations by utilizing enrollment assistance programs that acknowledge and help alleviate patient barriers to enrollment (Adashi, Geiger, & Fine, 2010; Kaiser Commission on Medicaid and the Uninsured, 2013; Plaza, 2012; Rosenbaum et al., 2013).

Although the enrollment assistance programs at CHCs are context specific, several best practices for outreach and enrollment programs have emerged in the literature. Evaluators from Florida Covering Kids & Families (FL-CKF) at the University of South Florida College of Public Health assessed (FCHC) Florida Community Health Centers, Inc.’s model for enrolling eligible, but not enrolled individuals in rural South Central Florida. Drawing on results from this case-evaluation, we argue that CHC can improve health care coverage and access to other public benefits programs in hard-to-reach rural and migrant populations. Additionally, the results give demonstration to promising outreach and enrollment strategies that can be replicated in other, similar contexts.
Defining the problem: eligible but not enrolled (EBNE) individuals

A portion of the 47 million Americans without health insurance are eligible for low-cost health coverage through Medicaid and children’s state health insurance programs (CHIP) programs. It is estimated that seven out of ten uninsured children meet free or low-cost insurance eligibility requirements for CHIP. Unfortunately, over two-thirds of these eligible children (Kenney, Lynch, Huntress, Haley, & Anderson, 2012) and over one-third of eligible adults are not enrolled in available health insurance programs (Sommers & Epstein, 2010). Of these eligible, but not enrolled children and adults, those from migrant and rural communities are even less likely to be enrolled in insurance (Kenney et al., 2012; Shi, Stevens, & Politzer, 2007). This means that state and federal programs that have been designed to improve health and economic outcomes for the uninsured have trouble reaching these target populations.

Some have suggested that EBNE individuals are the primary result of ineffective outreach strategies that fail to provide people with the information they need to successfully enroll in health insurance programs (Mathieson & Kronenfeld, 2003; Plaza, 2012; Rosenbaum et al., 2013; Snow, 2003; The Kaiser Commission on Medicaid and the Uninsured, 2013b). Others suggest that, even when outreach strategies are successful, many potential consumers do not complete the enrollment process (Kendall & Sullivan, 2012; Main et al., 2013; Mathieson & Kronenfeld, 2003, 2003; Stuber, Maloy, Rosenbaum, & Jones, 2000; Summer et al., 1999; The Kaiser Commission on Medicaid and the Uninsured, 2011; Wachino & Weiss, 2009). Still others believe that the problem is more deeply rooted in poor policy decisions that limit the scope and reach of efforts to enroll consumers (Adashi et al., 2010a; Chung et al., 2010; Wachino & Weiss, 2009). These limitations are particularly important for “hard to reach” EBNE populations where standard, one-size-fits-all outreach and enrollment strategies prove unsuccessful (Cousineau, Stevens, & Farias, 2011; Kendall & Sullivan, 2012; Manos et al., 2001; Shi et al., 2007; Stevens, Rice, & Cousineau, 2007). Evidence shows that populations living in rural, migrant, and seasonal communities face specific enrollment barriers that can only be addressed through targeted, culturally competent outreach and enrollment programs (Kendall & Sullivan, 2012; Main et al., 2013; Rosenbaum et al., 2013; Snow, 2003).

Research about consumer experiences with health care coverage demonstrates that barriers in five broad categories prevent eligible but not enrolled individuals and families from applying for health benefits: 1) language and cultural barriers, 2) structural barriers1, 3) the length and complexity of the insurance application process, 4) lack of knowledge about eligibility requirements or enrollment procedures/resources, and 5) the stigma associated with government assistance programs. Researchers most frequently cite cultural and linguistic barriers to enrollment. For example, studies found that individuals were unlikely to enroll in an insurance program if they believed that insurance was unimportant (Summer et al., 1999). Similarly, individuals who mistrust the government are unwilling to provide necessary enrollment information and immigrant families were often afraid that applying for health care coverage would threaten their immigration status (Castañeda et al., 2003; Ross & Hill, 2003; The Kaiser Commission on Medicaid and the Uninsured, 2013b). Language barriers were common among eligible, but not enrolled immigrant families who needed—but could not obtain—enrollment applications in their native languages (Castañeda et al., 2003; Kendall & Sullivan, 2012; Manos et al., 2001; Mathieson & Kronenfeld, 2003; Nolan et al., 2003; Ross & Hill, 2003; Shi et al.,

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1 “Structural barriers arise when patients are faced with the challenge of obtaining health care from systems that are complex, underfunded, bureaucratic, or archaic in design.” (Betancourt, Green, Carrilio, & Ananeh-Firempong, 2003)
Structural barriers impacting enrollment include uncertain state and federal funding for enrollment and outreach efforts, understaffed government agencies, lack of resources to help communicate information about eligibility, and too few enrollment and retention assistance sites (Chung et al., 2010; Felland & Benoit, 2001; The Kaiser Commission on Medicaid and the Uninsured, 2011; Wachino & Weiss, 2009). Many studies also found that individuals who began an enrollment application often grew frustrated with its length and complexity and abandoned it if they did not have professional assistance (Chung et al., 2010; Kendall & Sullivan, 2012; Main et al., 2013; Rosenbaum et al., 2013; Ross & Hill, 2003; Snow, 2003; Stevens et al., 2007; Taras et al., 2002; Wachino & Weiss, 2009). Individuals who were unaware of their eligibility for health care coverage or who were unsure how and where to enroll were also unlikely to access health coverage (Chung et al., 2010; Felland & Benoit, 2001; Main et al., 2013; The Kaiser Commission on Medicaid and the Uninsured, 2013b; Wachino & Weiss, 2009). Finally, individuals who believed they would be criticized or belittled by friends, relatives, other members of their community, and even service providers for accessing government assistance programs were less likely apply for insurance (Castañeda et al., 2003; Chung et al., 2010; Ross & Hill, 2003; Summer et al., 1999; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013a, 2013b).

CHC are uniquely positioned to identify and address many of these consumer enrollment barriers through outreach and enrollment strategies that fit the needs of the populations they currently serve as CHC clients. In rural and migrant communities, outreach efforts may include: providing enrollment materials and assistance in Spanish or other languages; making home visits to patients with limited access to transportation; and providing hands-on enrollment assistance to those patients with lower literacy rates and limited computer access. These tailored approaches to outreach and enrollment have been effective in a variety of local contexts but specifically with “hard to reach” individuals (Adashi et al., 2010a; Castañeda et al., 2003; Felland & Benoit, 2001; Kenney & Haley, 2001; Long, 2002; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b).

Tackling the EBNE problem through outreach and enrollment at community health centers (CHC): benefits and best practices

Evidence suggests that one of the most effective means of enrolling EBNE populations is through “trusted” community health centers (Chung et al., 2010; “Community Health Centers Outreach and Enrollment | HHS.gov,” 2013; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b). According to the U.S. Department of Health and Human Services, CHCs distinguish themselves by delivering comprehensive, culturally competent health care to medically underserved communities and “hard to reach” populations. CHCs build trust in the communities they serve by delivering services in a way that reflects the unique needs of their clientele. They achieve this, in part, by employing community members and allying themselves with other local organizations and service providers (Adashi et al., 2010a; Kendall & Sullivan, 2012; Nolan et al., 2003; Rosenbaum et al., 2013; Shi et al., 2007). As trusted community organizations, CHCs successfully enroll EBNE individuals in health care coverage programs. They also help reduce lapses in coverage and ensure actual use of benefits (Adashi et al., 2010a; Shi et al., 2007). For example, CHCs draw from an existing patient pool, making it easy for staff to identify and enroll EBNE patients. CHCs are best able to provide the patients they enroll with access to health care because their organizations already provide comprehensive health care services (Adashi et al., 2010a; Long, 2002; Plaza, 2012; The Kaiser Commission on...
Medicaid and the Uninsured, 2011, 2013b). Finally, enrollment activities at CHCs reduce gaps in coverage, because they often have the resources to employ dedicated staff who provide continued application support and, in many cases, have mechanisms in place to track benefits usage information and renewal requirements.

CHCs employ a number of outreach and enrollment strategies to increase enrollment in health care coverage programs. Strategies may be as basic as raising awareness about program eligibility and enrollment or as thorough as providing application assistance and maintaining long-term, professional-helping relationships with clients to prevent lapses in coverage. The most common outreach strategies are mass media campaigns and person-to-person advertising. This can include advertising programs in print, online, through radio and television (Cousineau et al., 2011; Lemak et al., 2004; Ross & Hill, 2003; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b), and by word of mouth, a strategy that is most successful in smaller communities (Lemak et al., 2004; Plaza, 2012; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b). CHCs may also engage in outreach activities such as attending community events and meetings, through door-to-door canvassing, and by sending outreach coordinators to local schools or workplaces. Most commonly, CHCs use a strategy called “in-reach,” i.e. approaching their existing EBNE patient clientele in order to provide coverage information and direct enrollment assistance (Castañeda et al., 2003; Cousineau et al., 2011; Kendall & Sullivan, 2012; Main et al., 2013).

Some criticize CHCs for relying too heavily on “in-reach” strategies because this strategy is more likely to target people who are already accessing health care services, effectively excluding those EBNE individuals most in need of care (Long, 2002). A review of best practices for outreach and enrollment programs among CHCs suggests that using a combination of in-reach and outreach strategies is an easy way to address this particular gap. Other best practices include assisting patients at multiple stages of enrollment, utilizing tailored and culturally appropriate outreach and enrollment strategies, and employing well-trained, culturally competent outreach coordinators (Kendall & Sullivan, 2012; Nolan et al., 2003; Rosenbaum et al., 2013).

CHCs are uniquely positioned to provide pathways to health care coverage and other public benefits programs because they can easily identify EBNE individuals from an existing patient pool, have an infrastructure that promotes long-term and consistent contact with patients, and have a service structure predicated on identifying and addressing the locally specific needs of underserved communities. The results from a case-evaluation of Florida Community Health Centers, Inc.’s outreach and enrollment program is presented in the next section to illustrate the impact that CHC outreach and enrollment programs can have on EBNE patients living in rural and migrant communities.

Providing Pathways to care at Florida Community Health Centers, Inc., Evaluating a Federally Qualified Health Center

Introduction

In 2013, evaluators from Florida Covering Kids & Families (FL-CKF) at the University Of South Florida College Of Public Health’s Lawton and Rhea Chiles Center conducted an evaluation to assess the overall effectiveness of the outreach and enrollment strategies implemented by Florida Community Health Centers, Inc. (FCHC). Information was gathered to determine how the Health Benefits Coordinator program is implemented, whether it reaches its
intended audience, and how family health care access is actually impacted. Key research objectives include:

<table>
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<th>Research Objectives</th>
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<tr>
<td>Describe the overall FCHC outreach and enrollment model.</td>
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<td>Identify the goals and objectives of the FCHC program.</td>
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<tr>
<td>Identify the resources available.</td>
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<tr>
<td>Describe the patient population.</td>
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<tr>
<td>Identify the number of patients being reached.</td>
</tr>
<tr>
<td>Describe how this population is being reached</td>
</tr>
<tr>
<td>Describe the outcomes of outreach and enrollment efforts.</td>
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Results from the evaluation demonstrate that FCHC’s outreach and enrollment model increases healthcare access to rural, immigrant, migrant (hard-to-reach) and low-income EBNE patients in the six South Central Florida communities served by the organization. By alleviating patient barriers to enrollment through culturally competent outreach and direct enrollment assistance, FCHC staff improve both patient health and wellness by increasing the number of eligible community members receiving, not only health care benefits, but also benefits through other public assistance programs that impact health and quality of life. Patients are overwhelmingly satisfied with the enrollment services they receive at FCHC and staff and administrators believe the program is a significant financial asset to the organization.

**Methods**

*Florida Covering Kids & Families* evaluators conducted a case study evaluation to determine the overall effectiveness of FCHC, Inc.’s outreach and enrollment model. Telephone interviews were conducted with outreach coordinators, HBC’s, and administrators from each of the ten FCHC federally qualified health centers. In-person interviews took place at FCHC’s Dr. Fred Brown Children’s Health Center in Okeechobee City, Florida with FCHC patients.

Okeechobee City is located in the South Central region of Florida and has a population of 5,585 residents\(^2\). Both staff and clients described Okeechobee as a small, rural “tightknit” or “close” community. Seventy-five percent of the population has identified themselves as “white”, with Latinos making up the largest area minority group. Staff members working at neighboring FCHC health centers believed that their centers served a demographically similar patient population. Additionally, FCHC staff members at centers explained that a large percentage of their patients are migrant and seasonal farm workers who may not be reflected in census data but who are, nevertheless, eligible for public benefits programs.

<table>
<thead>
<tr>
<th>2012 U.S. Census Data</th>
<th>City of Okeechobee</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>White alone, percent, 2010 (a)</td>
<td>75.5%</td>
<td>75%</td>
</tr>
<tr>
<td>Black or African American alone, percent, 2010 (a)</td>
<td>9.1%</td>
<td>16.0%</td>
</tr>
<tr>
<td>American Indian and Alaska Native alone, percent, 2010 (a)</td>
<td>1.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Asian alone, percent, 2010 (a)</td>
<td>0.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander alone, percent, 2010 (a)</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Two or More Races, percent, 2010</td>
<td>2.3%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hispanic or Latino, percent, 2010 (b)</td>
<td>25.2%</td>
<td>22.5%</td>
</tr>
<tr>
<td>White alone, not Hispanic or Latino, percent, 2010</td>
<td>62.7%</td>
<td>57.9%</td>
</tr>
</tbody>
</table>

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\(^2\) All demographic data are based on the 2012 U.S. Census.
Evaluation design and instruments: Evaluators conducted semi-structured interviews with FCHC, Inc. administrators, staff members, and patients. The interview protocol was developed as a collaborative process between the evaluator (USF) and the stakeholder (FCHC, Inc.) and several iterations were tested. The evaluators also conducted ethnographic observations of an organization-wide staff training at an FCHC, Inc. clinic and collected outreach related print materials for analysis. In addition to interviews, staff members were asked to complete a short survey that included questions regarding length of employment, position title, and location of employment, educational background, and information about key outreach/enrollment considerations or strategy usage. Descriptive statistics of these data revealed general outreach and enrollment strategy trends. Finally, FCHC, Inc. provided organization-level enrollment numbers to complement qualitative interview data about the program’s impact.

Sample: Convenience sampling was used to identify 24 participants, nine staff members and 15 patients. Two of the nine staff members were dedicated outreach coordinators, five were (HBC’s) and two were administrators. Five of the 15 patients were primarily Spanish speaking so they were interviewed with the help of a translator. Institutional informed consent forms were signed by all participants prior to being interviewed and patient participants received a gift card stipend upon completing the interview.

Using a logic model: A logic model was designed to help guide the evaluation process. The interview protocol was developed to target information about organizational inputs, outputs, and outcomes. Questions regarding funding, staffing, training opportunities, organizational strengths and weaknesses, and the organization’s mission and goals were created to determine inputs; i.e. what FCHC invests in outreach and enrollment. Questions about outreach and enrollment strategies and activities, client follow up, the service population, and patient barriers to enrollment were designed to understand organizational outputs. Finally, interviews with staff and patients regarding the actual use of benefits as well as organization-level enrollment tracking data were used to determine the impact of the program on its target population. Interview responses from staff and patients were transcribed and analyzed using Atlas.ti7 and the logic model as a framework.

Organizational history

Founded in 1976, Florida Community Health Centers, Inc. is a 501(c)3 non-profit organization, comprised of a network of 10 Federally Qualified Health Centers (FQHC) in the State of Florida. These health centers are located in eight cities surrounding Lake Okeechobee in South Central Florida, serving the populations of six counties. The stated mission of the organization is “to provide accessible, cost effective, high quality, comprehensive, primary and preventative care to all persons regardless of their socioeconomic circumstances.”

Key findings

An integrated outreach and enrollment model

In addition to highly trained doctors, nurses, and administrators, FCHC has a staff of 21 dedicated outreach coordinators and Health Benefits Coordinators (HBC’s) who enroll eligible individuals and families into public assistance and benefits programs such as Medicaid, CHIP, food assistance programs, and free or low-cost transportation and cell phone services. Known institutionally as the “HBC program,” the Special Services division of FCHC began hiring HBC’s in 2007 to enroll EBNE patients who used their health center services. FCHC quickly expanded
these enrollment efforts to the broader community by integrating targeted outreach strategies into their enrollment program, supporting the organization’s mission to provide cost effective and accessible health care services to the surrounding community.

**Identifying the problem:** In the years preceding the HBC program, FCHC staff often advised their low-income patients to apply for public assistance and health benefits. This was based on their knowledge of their patients’ income and belief that these patients may be eligible for low-cost health insurance. However, staff soon discovered that very few of these patients were actually obtaining health care coverage. Staff found that language barriers, low-literacy levels, lack of computer access, and the complexity of the application process itself prevented patients from completing benefits applications. One administrator explained that in many cases, “they [patients] were having their kids miss school to do applications…they would sit all day at DCF [Department of Children and Families] and they still wouldn’t finish the application…they were paying people to take them up there and taking their kids out of school and then they still weren’t getting benefits.” According to many HBC’s, this was a common occurrence that the FCHC board of directors and administrators felt could be corrected through a HBC program that integrated tailored community outreach and culturally competent direct enrollment assistance.

**Addressing the problem:** As a federally qualified health center, FCHC staff members are able to easily identify patients who are potentially eligible for Medicaid and CHIP. HBC’s have access to income information that patients must provide in order to take advantage of sliding-scale payment options. In 2007, FCHC staff began writing grants to fund HBC’s who would help identify and enroll their EBNE patients. Beginning at the program’s inception and continuing today, FCHC relies largely on word-of-mouth from community members and on “in-reach”. FCHC’s in-reach is conducted by all staff members within the clinics who identify EBNE patients then make appointments for them to speak with HBC’s about enrollment eligibility and processes. According to HBC’s, a typical client interaction begins with an appointment made either through a clinic staff member or with the help of an outreach coordinator at a community event. At the time that the appointment is made, the individual is told precisely what documentation they need to bring to their appointment to complete an application for assistance. If possible, individuals receive telephone reminder calls prior to the meeting. At the meeting with the HBC, the individual will provide information to the HBC who then completes an online application. The HBC tracks the status of the application during the 30-day processing period and follows up each time additional information is needed or if the individual has any questions. They also keep track of renewal dates and follow up with patients when it is time for them to renew their benefits. In some cases, when individuals have limited access to transportation, the HBC will meet them off-site at a more accessible community location.

Recently, FCHC has begun increasing community outreach efforts to identify and enroll EBNE individuals who are not health center patients and who do not have access to medical or dental care. This was accomplished by hiring dedicated outreach coordinators who visit other community organizations such as schools and local businesses and who attend community events such as celebrations, back-to-school fairs, and festivals to provide information about health insurance and benefits programs. HBC staff widely agrees that the addition of dedicated outreach coordinators is a major organizational strength. One HBC explained:

“*To me, outreach is a very, very important thing. When the outreach coordinators go out into the community…they are promoting the way that our community can get knowledge on where to go and get assistance for their children, themselves. You have people that have no knowledge of what is going on and when the
outreach coordinators go out there and have events, that is when our information is brought to them."

In addition to these broader efforts, FCHC outreach coordinators report tailoring outreach strategies to target hard-to-reach individuals. They conduct outreach at locations where hard-to-reach community members are most likely to work, eat, shop, and do other daily activities. For example, outreach coordinators visit the farms where migrant workers harvest produce and the bodegas where they shop and cash their checks. They also do outreach at local food banks, churches, and schools. According to one outreach coordinator, this strategy is effective because they not only reach people who are unaware of services, but they can also speak one-on-one with hard-to-reach individuals about the benefits associated with applying for health care coverage or ease fears about the perceived risks of applying for assistance. According to one FCHC outreach coordinator, "we reach out to people who just wouldn't know we exist or maybe they do but they are afraid about their [immigration] status."

Outreach coordinators provide information about FCHC, the HBC program, and make appointments for community members who want to meet with HBC's to complete applications. The role of the outreach coordinator has also been expanded to include education on how to use health care coverage for regular checkups and preventative care. According to the administrators and HBC's, it is sometimes difficult for patients who have never had health insurance to learn how to properly utilize their health benefits. Outreach coordinators provide information directly to these patients about when and how they can use their benefits. One administrator explained the importance of this new focus:

"It’s not only getting them covered that’s important. We want to get them engaged in doing preventative healthcare...versus just having them use their benefits for an emergency... We already have the business here and we need to get them to use it other than when Johnny falls and breaks his arm. We need Johnny in for the physical. We need Johnny in for shots. We need Johnny in for his well-child check [up]."

In addition to outreach, enrollment, and follow-up duties, FCHC HBC's and outreach coordinators are also required to keep track of application volume and contacts. Using an internal Excel spreadsheet, HBC's keep track of the number of new applications they submit and the number of applications they renew as well as the number of new and renewed applications that are approved or denied at the state level. Additionally, beginning in October 2013, outreach coordinators have begun to track the number of people contacted at each event, the number of people contacted outside of official outreach events, and the number of follow-up contacts that result from each initial communication.

Best-practices for outreach and enrollment: It should be noted that key components of the FCHC "HBC program" reflect best practices for outreach and enrollment in hard to reach populations (Castañeda et al., 2003; Chung et al., 2010; Felland & Benoit, 2001; Kendall & Sullivan, 2012; Lemak et al., 2004; Long, 2002; Plaza, 2012; Snow, 2003; Stevens et al., 2007; The Kaiser Commission on Medicaid and the Uninsured, 2013b, 2011; Wachino & Weiss, 2009), likely contributing to the program’s successes. Using “best practices” identified in the available literature regarding successful outreach and enrollment at CHCs, evaluators designed a survey to target information about how often FCHC HBC staff used these specific strategies. Best practices include emphasizing cultural competency, understanding patient barriers to enrollment, extensively training outreach and enrollment specialists, forging partnerships with other trusted community organizations, providing direct application assistance, and following up
with patients during the application process to make sure all necessary documentation has been submitted, and after the application process, to ensure use of benefits.

<table>
<thead>
<tr>
<th>When conducting outreach OR enrolling patients in benefits programs, I find myself…</th>
<th>Daily</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
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<tbody>
<tr>
<td>…considering clients’ cultural beliefs and backgrounds…</td>
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<tr>
<td>…considering patient barriers to enrollment…</td>
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<td>…drawing from knowledge gained during professional training…</td>
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<td>…working with other organizations…</td>
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<td>…providing application assistance…</td>
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<tr>
<td>…following up with clients…</td>
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Figure 2. Excerpt from staff survey

Results from the survey reveal that 100% of FCHC staff participants employ at least one of these best practices on a daily basis (see Figure 3 for percentages). Additionally, results suggest that these staff members place the greatest importance on strategies that emphasize cultural competency (100% daily use), understanding patient barriers to enrollment (89% daily use), drawing on professional training (78% daily use), and providing application assistance. In some cases, responses were dependent upon individual job duties. For example, when considered as a whole, just 67% of staff participants reported providing application assistance on a daily basis. However, when broken down by job type, 100% of the HBC participants reported providing application assistance on a daily basis because this is their primary job duty. 100% of the outreach coordinator and administrator participants reported providing application assistance occasionally because they only provide this kind of assistance when they need to substitute for HBC’s who are out sick or on vacation.

Figure 3. Staff strategy usage
Program outcomes and success

Though initially supported entirely through grant funding, the HBC program is now completely self-sustaining. The program currently clears approximately $2 million in Medicaid reimbursement and all but one of the 21 HBC positions is funded with this Medicaid revenue. Since the start of the program, HBC’s have helped 35,275 EBNE patients and community members apply for Medicaid and CHIP coverage. Of those assisted, 34,186 (97%) individuals have been approved. In addition to increasing the percentage of the patient population covered by Medicaid from 42% in 2007 to 60% in 2013, the program has also expanded enrollment in other health coverage and benefits programs. Their current uninsured rate is 16.2%, 8% lower than the State of Florida (24.2%) and 2% lower than the United States (18.2%) (The Kaiser Commission on Medicaid and the Uninsured, 2012). Furthermore, 100% of the participants who were enrolled in some form of health benefits coverage reported using their benefits for regular checkups (95% of sample was enrolled in health benefits program).

Through in-reach and targeted outreach strategies that emphasize cultural competency, patient advocacy, and direct application assistance, FCHC has improved access to health insurance coverage and other government benefits in hard-to-reach populations that are at the greatest risk of being uninsured. In the following sections, the perceived importance and the outcomes of using such strategies are discussed in greater detail.

The importance of building trust in hard-to-reach populations

Evidence suggests that health care coverage outreach and enrollment programs are most successful when integrated into “trusted” community organizations such as community health centers (Castañeda et al., 2003; Chung et al., 2010; Felland & Benoit, 2001; Kendall & Sullivan, 2012; Long, 2002; Main et al., 2013; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b; Wachino & Weiss, 2009). Building trust and goodwill is particularly important for organizations that wish to reach individuals in hard-to-reach populations facing linguistic barriers, living in remote areas, in need of extra assistance due to literacy issues, or who have had negative enrollment experiences in the past (Ross & Hill, 2003; Shi et al., 2007; Stuber et al., 2000; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b; Wachino & Weiss, 2009). Organizations like CHCs build trust by employing well-trained, culturally competent staff, tailoring services to reflect community needs, and providing application assistance at multiple stages of the enrollment process (Felland & Benoit, 2001; Lemak et al., 2004; Long, 2002; Plaza, 2012; Shi et al., 2007; Snow, 2003; Summer et al., 1999; Taras et al., 2002; Wachino & Weiss, 2009).

As part of an already trusted community health center, the FCHC HBC program is able to reach an existent patient population. In many cases, the organization’s long-standing ties to the community impacted patients’ decisions to utilize FCHC services. For example, several patients explained that they brought their children to Dr. Fred Brown Children’s Health Center because members of their families had been patients there for multiple generations. Despite these ties, approaching patients to enroll them into benefits programs was initially challenging for HBC’s. One administrator recalled the early stages of implementation. She said:

“\textit{I think it was difficult at first, reaching some of our patients. Especially when you are asking for personal information…patients need to know that you have their best interest at heart…our HBC’s manage patients from start to finish—some level of case management—they are in constant contact with their patients and that perspective helped in the beginning.}”
HBC’s relied heavily on “in-reach” to overcome these initial challenges. Patients are easily identified as uninsured when they utilize health center services but HBC’s must still establish rapport with the sometimes skeptical patient population through tailored case-management. Patients overwhelmingly support this case-management approach and staff members recognize the benefits of establishing long-term relationships with patients. One patient explained the relationship she has with her HBC. She said,

“She [the Health Benefits Coordinator] was with me every step of the way. I called her with questions—all kinds of concerns—and she answered them. When you come from a place of being very ill and having to sit on the phone all day with insurance companies—well, this is better. Being able to talk to a human being makes a difference. I think we are still friends. I call her to bug her all the time and she reminds me when it’s time to renew.”

This particular strategy for building trust is part of a larger emphasis on providing consistent, high quality service and addressing patients’ specific needs. HBC’s reported that, by establishing rapport with their existing patient population and by providing high quality services, they were also able to reach non-patient community members, because, in small communities individuals rely on their family members, friends, and neighbors for referrals and word-of-mouth endorsements. These endorsements can determine the success of a program. According to one staff member:

“Word-of-mouth is so important in this community. If you treat someone bad or you give them the wrong information, they will tell their friends and then pretty soon everyone knows and they won’t trust you anymore.”

In fact, the majority (close to 60%) of the patients interviewed reported learning about HBC services from friends or family members, while 40% learned about the program through “in-reach” at an FCHC health center.

While HBC’s are mainly concerned with enrolling eligible individuals in Medicaid and CHIP, they have assisted patients with a variety of other concerns that have helped build trust in the community and bolstered their reputation for providing quality, comprehensive assistance. According to staff, the level of assistance needed varies by community but the one-on-one case-management approach to enrollment assistance remains consistent in each of their service areas. In several coastal communities, the HBC role is more limited than in rural communities. Coastal community patients primarily require help setting up online accounts and entering information into web-based benefits applications. They follow up if additional information is required for their applications to process, but generally, these patients need one-time application assistance and then again when it is time to renew benefits.

Conversely, in rural and migrant communities, HBC’s address a variety of patient obstacles by providing assistance in Spanish, reading documents and explaining application procedures to low-literacy patients, and helping people with limited computer access/know-how set up and complete online applications. HBC’s in all communities also check individual eligibility for a range of other benefits programs because even those patients who are ineligible for health care coverage may be eligible for food assistance programs or need help collecting their social security benefits, accessing post mortem Medicaid to help pay medical bills after a family member has passed away, or help accessing low-cost transportation and cell phone services. Additionally, they refer patients to other organizations that provide services beyond the scope of FCHC and the HBC program. One woman explained the importance of these kinds of referrals. She said:
“I have cancer and I wasn’t eligible for Medicaid but the [the HBC’s] got me set up with food stamps and health insurance for my daughter and they referred me to the cancer center. It was the answer to my prayers. I got the care I need and now I am cancer-free. I don’t know what would have happened if they hadn’t referred me.”

To prevent lapses in coverage when migrant patients travel to other job sites, HBC’s refer them to and sometimes call to set up appointments at health centers in new cities. According to one HBC, “we want them to stay covered. They travel and sometimes work in dangerous conditions so we never want them to be without coverage.”

This kind of comprehensive service has had a huge impact on the organization’s reputation in migrant communities and FCHC staff commonly believed that establishing trust enabled them to better serve migrant families and community members who are not yet patients at FCHC centers and are sometimes fearful about providing the personal information needed to successfully complete a benefits application. One outreach coordinator described how FCHC’s reputation is an asset during community outreach. She said:

“When we go out into the community to some of these events, the people already know us. They see where we are from and they call us the Medicaid Ladies. They know exactly how we can help them and the kinds of problems we deal with. They tell their friends to call the Medicaid Ladies.”

By delivering comprehensive services through long-term, one-on-one case management, the FCHC HBC program has established itself as a trusted community asset, increasing the reach and impact of the HBC program. The sections that follow will further illustrate how strategies for building community trust have enabled FCHC to enroll EBNE individuals from hard-to-reach populations.

Successful outreach and enrollment programs use tailored and culturally competent outreach and enrollment strategies

Mass media campaigns to decrease the number of EBNE individuals have fallen short, especially in hard-to-reach populations because, while one-size-fits-all strategies may increase awareness about available insurance programs (Cousineau et al., 2011; Kendall & Sullivan, 2012; Rosenbaum et al., 2013; Snow, 2003; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b), they do nothing to address other, context specific barriers to enrollment (Castañeda et al., 2003; Cousineau et al., 2011; Long, 2002; Manos et al., 2001; Taras et al., 2002; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b). Targeted, culturally appropriate outreach and enrollment strategies are demonstrably effective in general but particularly in hard-to-reach populations where patient barriers to enrollment are more complex than simply being unaware of available programs (Castañeda et al., 2003; Cousineau et al., 2011; Felland & Benoit, 2001; Kenney et al., 2012; Lemak et al., 2004; Long, 2002; Main et al., 2013; Manos et al., 2001; Mathieson & Kronenfeld, 2003; Plaza, 2012; Summer et al., 1999; Taras et al., 2002; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b). In these communities, considering enrollment barriers and advocating for patients’ needs are important when developing and implementing an effective, tailored, and culturally appropriate outreach and enrollment program.

The outreach and enrollment model at FCHC emphasizes patient advocacy and culturally competent outreach and enrollment strategies that support the specific needs of their
most vulnerable patients. One staff member summarized the importance of this model’s design, saying:

“Our strength is that they hire people who are here to advocate for our patients and we have people employed who are working from the heart…I think it’s important that we actually care. We really want to—as people, we want to help…our patients because they really need it.”

In order to advocate for patients and meet their needs, it is important for HBC staff members to understand the specific social, environmental, economic, and educational factors that can limit a patient’s ability to enroll in health coverage on their own. An HBC explained, “it’s very important to know their [the patients’] background and from where they came and where they are now.”

A review of the available literature suggests that language and cultural barriers are among the most cited barriers to health care coverage enrollment, particularly in hard-to-reach populations. These populations have the highest percentages of EBNE individuals (Kenney et al., 2012; Shi et al., 2007). Findings from this evaluation support other evidence that community health centers have a broad understanding of locally specific community and client needs and can successfully enroll hard-to-reach community members by using a tailored and culturally appropriate approach to outreach and enrollment (Adashi et al., 2010a; Kendall & Sullivan, 2012; Rosenbaum et al., 2013; Shi et al., 2007). Based on interviews with staff and patients, the most common barriers to enrollment in FCHC patient populations are 1) language barriers, 2) low literacy levels, 3) limited computer access, 4) confusing and complex application processes, and 5) lack of transportation.

![Participant Enrollment Barriers by Patient Type](image)

**Figure 4. Participant enrollment barriers**

100% of the Spanish speaking participants reported concurrently facing three or more barriers to enrollment. Most commonly, English speaking patients reported limited computer access and the complicated application process as barriers to enrollment. 80% of the patients we interviewed had, at one time, tried and failed to apply for Medicaid or other benefits as a result of encountering least one of these barriers. These patients had attempted to fill out
Medicaid applications at the local health department or online without assistance and they described these experiences as confusing, isolating, and often dehumanizing. One patient recalled her experience saying, “I felt isolated I guess. Alone. Like you’re just thrown in, just ‘Here, you do it.’”

Conversely, 100% of the FCHC patients we interviewed reported that all of their specific needs had been met and that they felt better informed, less stressed, and more respected after working with an HBC. The impact of working with the HBC was explained by one patient. She said:

“Whenever I leave here I think I really feel like I’m full of information and to be able to walk to the next step…Instead of going backwards I’m going forward so I can proceed…with the information that I get from here.”

**Addressing language barriers:** According to staff, a large percentage (one HBC estimated 30%) of their patient population speaks little or no English. The majority of these patients speak Spanish but some speak Creole, particularly in coastal communities. 100% of Spanish speaking participants explained that Spanish speaking HBC’s were vital to their ability to access benefits for themselves and their families. One Spanish speaking patient recalled trying to apply for benefits at the health department, “They didn’t speak my language and they just sent me to a computer. I didn’t know what to do.”

FCHC addresses this barrier by employing HBC’s and outreach coordinators (91%) who are bilingual Spanish speakers (See “Successful programs employ well-trained, culturally competent outreach coordinators” for further discussion) and by tailoring outreach and enrollment procedures to account for limited English proficiency. Bilingual HBC’s enroll patients in both English and Spanish and outreach coordinators provide program information and informational materials in both languages. Additionally, mass media materials such as posters, fliers, and other advertisements are provided in Spanish as well as English. Bilingual HBC’s also spoke about the importance of further tailoring Spanish outreach and enrollment procedures by acknowledging and understanding different Spanish dialects. One HBC explained:

“I’m Puerto Rican but I have learned some Cuban words and some Mexican words because it helps me relate to people better and they trust me more. Like, they have this feeling that I am telling them the right information because I use the Mexican word or phrase for something and not the Puerto Rican version.”

This strategy has also been effective in coastal communities where many FCHC patients are Haitian. HBC’s have learned some Creole, not only to better help patients in need of application assistance, but also to build trust. An HBC explained, “We’ve been trying to learn some Creole for our Haitian patients. Even now, we can just say some things like “hello” and “married” or “children” but it makes a difference. They can be so afraid, but I think just hearing their language they know that we are trying. We want to help.” Spanish speaking participants agreed that they trusted and felt more comfortable with Spanish speaking HBC’s. One woman summarized this sentiment, saying:

“She [female HBC] speaks my language. I like coming here because I know I can get help in my language. I always know what’s going on. I ask questions and get the right answers. She takes care of me.”

**Addressing low literacy levels:** Four out of five Spanish speaking participants reported having difficulty reading in both in English and Spanish, which prevented them from completing health
care coverage applications on their own. In addition, two out of ten English speaking participants reported having difficulty comprehending some of the language used in the applications. By providing one-on-one, in-person application assistance, HBC’s are able to address these particular barriers. HBC’s read and explain applications to patients as they are being completed. HBC’s also reported that patients are now bringing the letters they receive regarding their application status to FCHC in order for the HBC’s to explain next steps in the enrollment process. One patient explained the importance of this kind of service:

“The HBC helped me read the application to answer the questions. I can’t read. When I get letters, I bring them to her and she reads those too. Sometimes my kids can help, but mostly I need to see the HBC to make sure I have all my information.”

Additionally, outreach strategies have been tailored to account for lower literacy levels. During the first few years of the HBC program, FCHC largely used fliers and brochures to advertise HBC services. However, staff soon realized this was less effective than one-on-one, in-person outreach. One HBC explained:

“A lot of our community can’t read so when you are doing outreach, it needs to be in-person or word-of-mouth. A flier just doesn’t have the same reaction as someone telling you where to go, what to bring, and not to worry.”

Currently, outreach is conducted primarily in person. Even informational materials have been simplified to account for lower literacy levels. An administrator recalled this shift:

“We spent so much time and money printing these beautiful, detailed fliers and brochures. I mean, they were gorgeous and we [FCHC staff members] were all so proud of them. Then we realized that they were really ineffective. Now, we give people the bare essentials: address, contact information, telephone number and we focus much more on face-to-face contact and getting them set up for an appointment.”

Addressing computer access: According to HBC staff members, many of their patients lack access to computers. Ten out of fifteen patient participants reported that lack of computer access or limited computer literacy prevented them from completing applications independently. As government agencies move toward online applications, computer access will continue to be a barrier for low-income, rural, and other hard-to-reach individuals. Even those patients who were provided computer access had little computer training and needed one-on-one assistance. For example, participants who had tried and failed to apply for benefits at DCF reported being sent to a computer to fill out their application. One participant recalled her experience:

“Well they sat me at this computer. I’m not very good with computers, but they sat me there and then there was only one other person working there. She couldn’t answer my questions and the thing kept logging me out. It was a nightmare. Eventually, I just left, but by then, I had already been sitting there for hours.”

Conversely, patients who worked with HBC’s were not required to complete online applications independently; rather HBC’s do the majority of the computer work. Patients reported that this service made the application process less stressful. According to one patient:

“The HBC helped me with all of the computer stuff…here [at FCHC] it wouldn’t take so long and it was a lot better than sitting for like an hour on the computer.”
Similarly, HBC’s believe that completing computer applications is one of the most necessary components of direct enrollment assistance. One HBC described the impact of providing this service:

“I really believe that the computers keep people from applying [online for benefits]...To me, that is really important because a lot of our community does not have access to computers. They do not know what websites to go to, what programs they have to go to, what they have to do to apply for different programs like [CHIP], Medicaid...we can help them.”

**Addressing complex application processes:** All of the patient participants who were interviewed believed that the Medicaid/CHIP application was overly complicated, confusing, and difficult to complete independently. Before utilizing the HBC services at FCHC, many patients who had tried and failed to enroll in public benefits programs recalled having negative experiences during the application process. They had difficulty understanding the particular language used on the application and what assets they were supposed to be reporting. One patient recalled her experience prior to utilizing HBC services. She said:

“I couldn’t get through it [the application process]. They needed all this information that I didn’t know. I was always worried I was filling it out wrong. I couldn’t get help from anyone and I’d call the helpline and sit on the phone all day long.”

FCHC addresses the complex application process by extensively training HBC’s in Medicaid policy and application procedures. They also address this barrier by providing face-to-face, direct application assistance. Participants commonly believed that face-to-face application assistance was beneficial because the HBCs’ knowledge of the complex application and eligibility requirements improves their own understanding of the process and makes applying for benefits less stressful. According to these patients:

“It [coming to FCHC, Inc.] was much better, because I didn’t know much and they helped me with everything. I got help, info, everything. They explained what I had to do, what I needed to report. There [at the Health Department], they just sent me to the computer. I couldn’t ask questions.”

-Patient

“It was a lot easier because they [the HBCs] already pretty much knew everything I needed to turn in...I knew what to be prepared to bring in and everything so we got the process done a lot faster. I’m confident in their ability to get everything taken care of for me.”

-Patient

“What I like most was their knowledge and the fact that they could answer a question, instead of trying to go to a hotline where you’re on hold forever before you try to get an answer from somebody that really doesn't care whether they give you the right answer or not.”

-Patient

**Addressing transportation problems:** 40% of the patient participants reported that access to transportation was a significant barrier that prevented them from independently applying for health care coverage. These patients did not have computers at home and often paid for rides
to DCF to fill out online applications. One woman explained, “I need a ride and I could never get to DCF in time. So I could never finish the application.” HBC’s are able to address this problem by enrolling patients off-site in more convenient community locations and by providing application assistance at special outreach events. Outreach coordinators are also cross-trained as HBC’s so they can provide enrollment assistance at outreach events to individuals with limited access to transportation. One FCHC health center even partners with a free bus service called Good Wheels that transports eligible patients to and from health centers.

**Successful programs employ well-trained, culturally competent outreach coordinators**

Another strategy that has helped the FCHC HBC program build trust in hard-to-reach communities has been to primarily employ outreach and enrollment staff from the surrounding areas and thoroughly train them to enroll people in benefits programs. This strategy is supported by evidence suggesting that CHCs have more successful interactions with hard-to-reach populations when they hire and train culturally competent staff members directly from the communities they serve. For example, several studies have found that community health centers working to enroll Native Americans in health care coverage programs were more successful after they hired Native American outreach coordinators because they were aware of specific taboos related to discussing health and illness and could take this into account (Kaiser 2011, Mathieson and Kronenfeld, 2003). Similarly, hiring Spanish speaking, bilingual community members as outreach coordinators has improved enrollment rates in areas with large EBNE Spanish-speaking populations (Castañeda et al., 2003; Manos et al., 2001; Stuber et al., 2000; Taras et al., 2002; The Kaiser Commission on Medicaid and the Uninsured, 2011, 2013b).

Overwhelmingly, FCHC HBC’s and outreach coordinators live in the communities they serve. HBC’s and outreach coordinators explained that community members make better patient advocates and are, therefore, better equipped to identify and address local patient needs and barriers to enrollment in health care coverage programs. An HBC summarized the impact that community membership has on patient advocacy. She said, “I live here myself so I understand what their [community members’] needs are. What they are most grateful for is somebody that is passionate and can relate to them.” Close to 70% of the patients we interviewed reported that working with HBC’s who are community members makes them feel comfortable and puts them at ease. One patient explained:

“I keep coming back here because I just love the staff. I’ve known [a particular HBC] since I was a kid and she always makes me feel comfortable—confident, you know. All of the staff, really, they just put you at your ease, make you feel like you are being taken care of.”

In addition to being community members, 91% of the FCHC HBC’s and outreach coordinators are bilingual Spanish speakers, which better enables them to assist their migrant patients. In a 2000 study, Stuber et al. discovered that Latinos were three times more likely to be EBNE due, in part, to the lack of translators provided at enrollment sites. Culturally competent and bilingual outreach coordinators not only help organizations provide practical, linguistically appropriate assistance to clients, but also help build trust between the organization and its clientele because they are literally “speaking the same language” (Castañeda et al., 2003; Chung et al., 2010; Long, 2002; The Kaiser Commission on Medicaid and the Uninsured, 2013b).

Overall, staff recognized that Spanish language assistance is an integral part of providing comprehensive services that build trust and allay fears in migrant communities. An HBC explained:
"In these smaller towns, if you don't have a level of trust, then you can forget it. They [migrant community members] always wanted to see me because I speak Spanish...they had to know that their stuff wasn't going to get [misplaced] and that their information was going to be private."

HBC’s and outreach coordinators who reside in the communities and speak Spanish have established relationships with community members by building on a common background. One HBC explained this approach to enrollment assistance. She said:

“You know, building that trust—it’s very important, especially in this small town that we have here. It helps that I’m from this background. People trust me and they know I’m trying to help. It makes things easier for people who don’t know the [health care coverage] system and have never used Medicaid so they aren’t afraid to speak up and ask questions.”

Additionally staff need to be well trained in eligibility criteria and enrollment processes to assist clients at multiple stages of the application process. FCHC HBC’s and outreach coordinators have access to extensive and continuous training opportunities. According to FCHC staff and administrators, this is a primary strength of the organization’s outreach and enrollment model. The Director of Special Services explained, “I think the biggest strength is that we’re [FCHC administrators] very deliberate, that we’ve laid a lot of groundwork in terms of training and support for our HBC’s.” New HBC’s receive four to six weeks of hands-on, one-on-one training with a mentor and, according to the HBC staff, they regularly receive continuing training. While official training sessions are conducted on a monthly basis, the Director of Special Services sends important policy and procedural updates to staff via email on a daily basis. HBC staff reported that the majority of the in-person, monthly training they receive is related to ongoing changes in policy, organizational and application assistance procedures. One HBC explained that having continuous access to these in-depth training sessions allowed her and her colleagues to better serve their patient population.

“Well, in our department we are constantly training...we are constantly reading, learning, training...I feel like the more training you have, the better information you can give to our patients and customers because they expect a lot from you as a Health Benefit [Coordinator]. We have to train and re-train so when they [customers] come and ask questions and want us to guide them to the right direction we have knowledge of any information, any changes to help our customers and our patients.”

Similarly, HBC’s and outreach coordinators believed that being well-trained allowed them to better advocate for their clients. According to one HBC, “training is so important. With this information, it's easier to be the advocate for our client. We know what they are eligible for and we can make sure they get what they need." Administrators believed that investing in staff training ensures that staff members do not become overwhelmed with new information, but always feel confident in their ability to do their jobs. It also eliminates high employee turnover, which helps FCHC maintain community ties and build necessary trust. According to one HBC, “I just feel like the training helps us stay updated, stay current. It’s important to have that security. It makes you feel like you can answer all of their [the patient’s] questions and be an advocate.”

Casteneda et al. (2003) also suggest that knowledge of naturalization and immigration policy is beneficial in large EBNE immigrant or migrant populations, as the fear of jeopardizing immigration status is a common barrier to enrollment. FCHC HBC’s and outreach coordinators reported that they are trained to answer questions about how applying for benefits impacts immigration status. According to one HBC, this is important because, “some of these people do
have these immigration worries and their kids could be eligible [for benefits] but it keeps them from applying. They need to hear from us that, “yes, these services are here for you” and “no, this will not affect your immigration”; I think we deal with that a lot out in the community.”

**Successful programs assist clients at multiple stages of enrollment**

Evaluators frequently report that lengthy and complicated enrollment applications deter people from enrolling in health care coverage programs (Mathieson & Kronenfeld, 2003; Snow, 2003; Stuber et al., 2000). Additional evidence suggests that, while providing printed informational materials or actual applications to clients is an important enrollment strategy, it proves less effective when outreach coordinators do not follow up with direct application assistance (Manos et al., 2001; Plaza, 2012). Applications that are simply distributed often end up lost or forgotten or are not completed because clients have trouble locating necessary documentation (Long, 2002; Nolan et al., 2003; Taras et al., 2002). While FCHC outreach coordinators do pass out fliers and brochures and provide information about applications, their primary objective is to schedule appointments for community members to meet with HBC’s for one-on-one application assistance. According to one outreach coordinator, “that one-on-one assistance is what is most important. We set those appointments right there, on the spot, to get them in to see the HBC.” Additionally, these outreach coordinators tell individuals the exact documentation that they will need to bring to their appointment with the HBC, thus reducing the likelihood that applications will be incomplete.

Evidence from the literature highlights the importance of providing direct enrollment assistance. A 2013 Kaiser Commission report cites programs in Massachusetts, Utah, Kansas, Mississippi, and California where the likelihood of health care coverage enrollment dramatically increased if outreach and enrollment workers provided direct application assistance to families. On average, families receiving direct application assistance were three times more likely to enroll in health care coverage than families who received no assistance. Applications completed with professional assistance were more thoroughly completed than applications received by unassisted individuals, thereby expediting the application process (Chung et al., 2010; Plaza, 2012). As stated previously, 100% of FCHC patient participants reported that applications were simply too complicated to get through without assistance. As previously noted 80% of the patient participants had previously tried and failed to independently apply for benefits. Conversely, 97% of the applications submitted by FCHC HBC’s have been approved, making the application process easier and less stressful for patients.

While providing direct application assistance is an effective strategy, other evidence suggests that prolonged application case-management helps EBNE individuals overcome multiple barriers to enrollment (Summer et al., 1999). FCHC HBC’s will assist patients at every step of the enrollment process. HBC’s gather necessary documentation from each individual, help them set up online accounts, fill out applications, and assist when it is time for patients to recertify benefits. HBC’s will also follow up with patients if they get letters or phone calls requesting additional information. Community health centers that monitor their clients are more likely to keep them enrolled because they can track eligibility and prevent lapses in coverage (Castañeda et al., 2003; Kendall & Sullivan, 2012; Kenney & Haley, 2001; Plaza, 2012; The Kaiser Commission on Medicaid and the Uninsured, 2013b). Assistance after initial receipt of benefits was particularly important to the 20% of FCHC patient participants who were able to apply for benefits with limited assistance, but reported regularly being dropped from coverage because they failed to provide follow up documentation. One woman recalled her experiences before coming to FCHC. She said:
“It [keeping my child enrolled in Medicaid] was a chore to say the least...It was constantly the same. They’re dropping her because they needed another piece of information that I didn’t even know they needed.”

HBC’s estimated that approximately 1/3 of their monthly caseload was application renewals and re-certifications. According to one HBC, “we keep track of all of our families. We know when it’s time to recertify and we make sure that happens because we don’t want there to be any lapses [in coverage]. We also recertify food stamps every six months. That is very important.” Similarly, evidence suggests that enrollment facilitators working closely and building trust with families are best able to ensure actual use of benefits because they can act as information resources, helping families find health care services and navigate the managed care system (Adashi et al., 2010a; Kenney et al., 2012; Lemak et al., 2004; Manos et al., 2001; Shi et al., 2007). When asked how often they used their health insurance benefits, 100% of participants reported that they and/or their children visited the dentist and primary care physicians for regular check-ups thanks to reminders from their HBC’s and staff members at the health centers.

Conclusions and next steps

Results from this evaluation show that FCHC’s outreach and enrollment model increases healthcare access to low-income and hard-to-reach EBNE patients in the six South Central Florida communities served by the organization. FCHC patients face barriers to enrollment that include limited English proficiency, low literacy levels, lack of computer access, lack of transportation, and complicated application processes. 87% of the patient participants interviewed reported facing more than one barrier to enrollment and 100% of the Spanish speaking participants reported concurrently facing three or more barriers to enrollment. 80% of patient participants reported that they had, at one time, tried and failed to apply for Medicaid or other benefits as a result of encountering least one of these barriers.

By using a combination of in-reach and outreach strategies, assisting patients at multiple stages of enrollment, utilizing tailored and culturally appropriate outreach and enrollment strategies, and employing well-trained, culturally competent outreach coordinators, the FCHC “HBC program” has helped alleviate patient barriers to enrollment and improved both patient health and wellness by increasing the number of eligible community members enrolled, not only in health care benefits, but also benefits through other public assistance programs that impact health and quality of life. By hiring and training community members, FCHC has assembled a dedicated staff of HBC’s and outreach coordinators who are highly invested in their community and who have built long-term working relationships with FCHC patients. Not only does FCHC enroll hard-to-reach EBNE individuals into health care coverage programs, they also work to prevent lapses in benefits coverage, and promote actual use of benefits. (See logic model below.) We suggest that these promising practices could be replicated in other similar contexts by CHCs and other Federally Qualified Health Centers with “hard-to-reach” populations who are more likely to be uninsured. Implementing such a program would require that a CHC:

- Invest in initial and continuing training for outreach and enrollment staff.
- Identify SMART (Specific, Measurable, Assignable, Realistic, Time-related) outreach and enrollment goals and communicate them to staff members to measure program effectiveness.
- Identify patient population’s barriers to enrollment.
- Design culturally competent outreach and enrollment strategies that alleviate these barriers.
- Utilize “in-reach” and outreach strategies to advertise services to current EBNE patients and non-patient community members.
• Focus on in-person outreach strategies.
• Provide face-to-face, direct application assistance.
• Track patient benefits and provide continuing recertification assistance.
• Facilitate use of benefits through education and outreach.
• Develop and implement an institutional tracking system to measure program successes.

CHCs like FCHC are uniquely positioned to provide pathways to health care coverage and other public benefits programs because they can easily identify EBNE individuals from an existing patient pool, have an infrastructure that promotes long-term and consistent contact with patients, and have a service structure predicated on identifying and addressing the locally specific needs of underserved communities. By strategically investing in well-trained staff and tailored, culturally appropriate outreach and enrollment strategies, they have the potential to positively impact hard-to-reach eligible but not enrolled populations.
The Health Benefits Coordinator Program at Florida Community Health Centers, Inc. enrolls eligible but uninsured hard-to-reach community members into benefits programs.

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Participation</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What we invest!</td>
<td>What we do!</td>
<td>Who we reach!</td>
<td>Results of our Program!</td>
</tr>
<tr>
<td>21 bilingual Health Benefits Coordinator s (HBC’s) and Outreach coordinators</td>
<td>Bilingual outreach and enrollment</td>
<td>6 counties in South Central Florida</td>
<td>35,275 EBNE patients and community members reached since start of program in 2007.</td>
</tr>
<tr>
<td>Staff members receive 4-6 weeks of in-depth training in enrollment procedures and policies.</td>
<td>“In-reach” via referral specialists at FCHC health centers</td>
<td>Primarily low-income, rural, or migrant, i.e. “hard-to-reach” patient population</td>
<td>97% application approval.</td>
</tr>
<tr>
<td>Monthly continuing training.</td>
<td>In-person outreach at schools, local businesses, community events, and festivals</td>
<td>FCHC targets eligible but not enrolled community members.</td>
<td>16.2% uninsured rate</td>
</tr>
<tr>
<td>Approximately $750,000 dollars allocated to employ HBC staff</td>
<td>HBC’s provide face-to-face, direct application assistance and prolonged case-management, including initial application, benefits renewal, and facilitating use of benefits.</td>
<td>Patient barriers to enrollment include: 1) limited English proficiency, 2) low-literacy levels, 3) lack of computer access/literacy, 4) complicated application process, and 5) lack of transportation.</td>
<td>87% patient participants were also enrolled in SNAP (food stamps).</td>
</tr>
<tr>
<td>10 Federally Qualified Health Centers</td>
<td>Outreach coordinators and HBC’s provide at-home application assistance in some cases.</td>
<td>100% of insured participants report regularly use of benefits for medical and dental checkups</td>
<td></td>
</tr>
<tr>
<td>Tracking system to monitor:</td>
<td></td>
<td></td>
<td>100% of participants report that they are satisfied with the assistance they have received at FCHC</td>
</tr>
<tr>
<td>- # of applications submitted</td>
<td>HBC’s enroll individuals into Medicaid, CHIP, SNAP, and free and low-cost transportation and cell phone services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- # of applications approved, denied, and pending</td>
<td>Patient participants most often found out about FCHC through word of mouth endorsements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- # of individuals reached by outreach coordinators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- # of individuals reached by outreach coordinators that resulted in follow-up contact</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 5.** HBC program logic model
References:


Institute of Medicine of the National Academies, (first). (2009). America’s Uninsured Crisis: Consequences for Health and Health Care. *Institute of Medicine.* Retrieved October 4,


Appendices
Staff Interview Protocol: Outreach worker

Thank you for agreeing to participate in this interview today. We are interested in your experiences assisting with enrollment in benefits programs.

The interview is broken into four parts. Part 1 asks about your role at FCHC, training, and the organization’s structure. Part 2 asks about patient barriers to enrollment. In Part 3, we will ask you about goals and specific outreach strategies and activities. Finally, in Part 4, we will ask you a few questions about following up with clients.

Part IA: Staff role

1. Please introduce yourself and state your position title.
2. Please describe your service area.
3. As a [restate position title] some of your duties?

Part IB: Training opportunities

1. How often do you receive professional training?
2. What kinds of information are covered in these trainings?
   a. How much of this training is related to direct enrollment assistance activities?
   b. How much of this training is related to cultural competency?
   c. How much of this training is related to changes in enrollment policy or procedure?
3. In your experience, does participating in these kinds of training exercises and discussions help you when you are assisting families? In what ways?

Part IC: Organizational Strengths and Weaknesses

4. Please consider the outreach and enrollment model at FCHC. In your experience, how does it fit with the FCHC’s organizational mission?
5. What are some major strengths of this model?
6. What are some of its weaknesses? How do you suggest fixing these weaknesses?

Part 2: Patient barriers to enrollment

7. In your experience, what are some of the biggest patient barriers to enrollment in the communities you serve?
8. In addition to the barriers you just mentioned, how common are barriers related to:
   - literacy
   - transportation
   - access to technology such as computers
   - and language

9. How do you address those barriers? What strategies or tools do you use?
10. Can you think of a situation where knowing about someone’s cultural or language background has helped you build trust with a client or make them feel comfortable?

Part 3A: Outreach goals

TURN →
11. On average, how many outreach events do you think you attend each month?
12. About how many potential clients would you say you meet at these events?

Part 3B: Outreach activities and strategies

13. What specific public benefits programs are advertised through FCHC outreach activities?
14. Please list and describe some of FCHC’s outreach activities. How does FCHC inform the public about available programs and services?
15. In your experience, what strategies are most useful when informing the public about these programs and services?
16. Which outreach strategy/ies have been most effective in identifying eligible uninsured families?
17. Which other organizations do you collaborate with when conducting outreach activities? How effective is this approach?
18. How do you know when an outreach activity or strategy has been effective? Do you use some form of tracking that information?

Part 4: Following-up

19. How often do you follow-up with clients after an outreach event?
20. Can you describe some of these follow-up activities?
21. In your experience, what kind of impact does following up with potential clients have on enrollment in public benefits programs?
22. In your experience, about how many clients does your organization serve as a result of your outreach activities?

Thank you so much for agreeing to participate in this interview today. Before we finish, is there any information I didn’t ask you that you would like to add?

Thank you.
Staff Interview Protocol: Navigators

Thank you for agreeing to participate in this interview today. We are interested in your experiences assisting with enrollment in benefits programs.

The interview is broken into four parts. Part 1 asks about your role at FCHC, training, and the organization’s structure. Part 2 asks about patient barriers to enrollment. In Part 3, we will ask you about goals and specific enrollment strategies and activities. Finally, in Part 4, we will ask you a few questions about following up with clients.

Part IA: Staff role

4. Please introduce yourself and state your position title.
5. Please describe your service area.
6. As a [restate position title] some of your duties?

Part IB: Training opportunities

7. How often do you receive professional training?
8. What kinds of information are covered in these trainings?
   a. How much of this training is related to direct enrollment assistance activities?
   b. How much of this training is related to cultural competency?
   c. How much of this training is related to changes in enrollment policy or procedure?
9. In your experience, does participating in these kinds of training exercises and discussions help you when you are assisting families? In what ways?

Part IC: Organizational Strengths and Weaknesses

10. Please consider the outreach and enrollment model at FCHC. In your experience, how does it fit with the FCHC’s organizational mission?
11. What are some major strengths of this model?
12. What are some of its weaknesses? How do you suggest fixing these weaknesses?

Part 2: Patient barriers to enrollment

13. In your experience, what are some of the biggest patient barriers to enrollment in the community you serve?
14. In addition to the barriers you just mentioned, how common are barriers related to:
   • literacy
   • transportation
   • access to technology such as computers
   • and language
15. How do you address those barriers? What strategies or tools do you use?
16. Can you think of a situation where knowing about someone’s cultural or language background has helped you build trust with a client or make them feel comfortable?

Part 3A: Enrollment goals
12. On average, how many outreach events do you think you attend each month?
13. About how many potential clients would you say you meet at these events?

**Part 3B: Enrollment activities and strategies**

14. Please list some of the programs you have helped families enroll in.
15. Consider a typical client interaction. Can you walk me through the process of getting them enrolled in a public benefits program from initial contact through use of benefits?
16. In your experience, what kinds of help do families most often need from you during the enrollment process?
17. How many of these assistance needs are met by staff at FCHC?
18. In your experience, which strategy/ies or tools have been most effective when helping clients navigate the public benefits application process?

**Part 4: Following-up**

19. Consider a typical client. How often do you follow-up with this individual after initial contact?
20. In your experience, what kinds of follow up assistance do clients most often need after applying for public benefits? What follow-up questions do clients typically ask?
   a. [PROBE] Can you describe some of these follow-up activities?
21. How long does it generally take to respond to client requests or questions?
22. How often do you assist families with application renewal or use of benefits? Describe these activities?
23. In your experience, what kind of impact does following up with potential clients have on enrollment in public benefits programs?
24. In your experience, about how many clients does your organization enroll into public benefits programs?

Thank you so much for agreeing to participate in this interview today. Before we finish, is there any information I didn’t ask you that you would like to add?

Thank you.
Customer Interview Protocol

Thank you for agreeing to participate in this interview today. We are interested in your experiences enrolling in health care coverage through Florida Community Health Centers, Inc.

This interview should take about 10 minutes and to thank you for agreeing to participate you will receive a $10 Wal-Mart gift card at the end of the interview.

Part I: Introduction

1. Please introduce yourself.
2. What services have you used at FCHC?
3. What public assistance programs did you or your family members enroll in at FCHC?
   □ Cell Phone  □ Medicare  □ SNAP  □ Transportation
   □ KidCare    □ Medicaid   □ Social Security □ Other: ________________
   ________________
   ________________

4. How many members of your household enrolled in a public assistance program here at FCHC?

Part 2: Outreach

1. How did you find out about enrolling in public assistance programs through FCHC?

Part 3: Enrollment

2. **BEFORE** coming to FCHC, had you ever tried to enroll in any public assistance program, such as health insurance, food assistance, etc.?
   a. [IF YES]: What was your experience like? Did you finish the application process? Did you receive benefits?
   b. [IF NO]: Why not? What stopped you from enrolling?
3. How was your experience different when you came to Florida Community Health Centers?
4. What kind of help did you need from the employees here at FCHC when you were applying for public assistance programs?
5. Do you feel that your specific needs were met by the employees here at FCHC? Why or why not?
6. How often do you call FCHC staff to ask questions or get help? What kind of help do you typically ask for?

Part 4: Using benefits

7. How often do you use the benefits you applied for at FCHC?

Part 5: Outcomes

8. How do you feel when you leave FCHC
   a. What do you like most about your experiences at FCHC?
   b. What would you change about your experiences at FCHC?
Thank you so much for agreeing to participate in this interview today. Before we finish, is there any information I didn’t ask you that you would like to add? Thank you.
Demographic questionnaire
Please fill out the following information about yourself. This information will **NOT** be linked to your identity in any way.

<table>
<thead>
<tr>
<th>Please answer the following questions in the box to the right.</th>
<th>Your Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long have you been working for FCHC?</td>
<td></td>
</tr>
<tr>
<td>What is your position title?</td>
<td></td>
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<tr>
<td>In which centers or locations do you primarily work?</td>
<td></td>
</tr>
</tbody>
</table>

I am...

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

My current level of education is...

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<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I did <strong>NOT</strong> graduate from high school.</td>
<td>I have a GED.</td>
<td>I have a high school diploma.</td>
<td>I have vocational training.</td>
<td>I attended some college but did <strong>NOT</strong> graduate.</td>
<td>I Graduated from college.</td>
</tr>
</tbody>
</table>

When conducting outreach OR enrolling patients in benefits programs, I find myself...

<table>
<thead>
<tr>
<th></th>
<th>Daily</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>...considering clients’ cultural beliefs and backgrounds...</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>...considering patient barriers to enrollment...</td>
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<td></td>
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<td></td>
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<tr>
<td>...considering organizational goals...</td>
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<tr>
<td>...drawing from knowledge gained during professional training...</td>
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<tr>
<td>...accessing technology...</td>
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<td>...working with other organizations...</td>
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<tr>
<td>...providing application assistance...</td>
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<tr>
<td>...following up with clients...</td>
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<td></td>
</tr>
<tr>
<td>...using more than one outreach or enrollment strategy...</td>
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</table>