



Managing Medicaid Take-Up

CHIP and Medicaid Outreach: Strategies, Efforts, and Evaluation

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Highlights

A decline in Medicaid enrollments in recent years and the creation of the Children's Health Insurance Program prompted many states to undertake renewed outreach efforts to those potentially eligible for medical assistance. The extent and nature of these outreach efforts, however, have varied widely across states.

- ❖ A study of 18 states shows that some have recently promoted Medicaid, others have invested heavily in seeking CHIP enrollments, some pursued both strategies, and still others did little outreach at all. We find that the states studied here were most likely to use advertising campaigns (particularly television, radio, brochures, and flyers), person-to-person contact, and direct marketing approaches for their outreach efforts. However, they also pursued a range of other approaches including publicity and public relations strategies, "branded" giveaways, and promotions.

Person-to-person outreach efforts may be the most effective strategy for states to pursue for Medicaid and CHIP take-up. Direct marketing may also be effective if the target audience is carefully selected.

- ❖ An examination of the literature on effective marketing practices and of the relationships between actual take-ups and outreach efforts in the states studied here suggest that person-to-person outreach may be the most effective strategy for states to pursue. Such efforts have been particularly effective when done in partnership with public health or other agencies that have a community presence and in conjunction with events that attract both youth and adults. This person-to-person outreach can be particularly effective when well supported by supplementary information provided in brochures, web sites, 1-800 phone lines, and the like. It is also likely that direct marketing can be an effective strategy, particularly when the target audience is carefully selected.

The literature on marketing suggests that public managers should be wary of mass media advertising as an approach to outreach.

- ❖ In order to be effective, mass media advertising may require a budgetary commitment unlikely to be available in many social service contexts. For overall effectiveness, the number of times that a message reaches (and is processed) by the target population is considerably more important than the size of the population reached. One presentation of a broadcast ad or one insertion of a print ad rarely achieves any desired communication objectives. Thus, advertising and publicity require expensive repetition in order to achieve the desired objectives. When resources are constrained, managers may opt to communicate frequently with narrow, well-defined target audiences, rather than spend limited funds communicating infrequently with broader or more poorly defined audiences.

Following the passage of federal welfare reform (*The Personal Work and Responsibility Act*, or PWORA) in 1996 and the associated “unlinking” of Medicaid and welfare eligibility determination, many states experienced an unprecedented decline in Medicaid enrollments. With the realization that uninsured low-income populations were growing in the late 1990s, numerous states adopted explicit strategies to counteract this trend and to encourage increased Medicaid enrollments and applied for and used the Medicaid take-up support funds made available under PWORA to enhance their outreach efforts. Furthermore, states also embarked on new outreach efforts in conjunction with the establishment of federal funding for the State Children’s Health Insurance Program (CHIP) in 1997. These efforts to increase the enrollment of low-income individuals and families in publicly funded health insurance programs have had to overcome numerous barriers, including, among other things, lack of information about, awareness, or understanding of the program; a perceived “welfare” stigma associated with applying for government assistance; cumbersome or confusing application procedures; lack of the time or transportation necessary to complete the application procedures; and language barriers for non-English speakers. States have experimented with a whole array of outreach efforts, some of which were designed to address these problems.

In this Management Brief, we present an overview of the findings of case studies of Medicaid and CHIP administration in eighteen states that have been the subject of ongoing research by the Rockefeller Institute of Government since 2000.¹ In particular, we report on state efforts at Medicaid and CHIP communication and outreach, the correlation between these efforts and enrollment increases across states in recent years, and how these

efforts compare with “best practices” standards derived from literature on marketing, communications, and outreach strategies. We also offer advice for general consideration in Medicaid and CHIP outreach efforts.

The findings here are based on reports prepared by Rockefeller Institute researchers employing field network evaluation techniques.² They typically relied on interviews with officials and a review of relevant documents and data from participating states. Respondents described their state’s “approach to outreach,”³ provided information on the types of and, in some cases, on the relative importance of state outreach efforts employed, and indicated whether their state applied for take-up support for Medicaid available under PWORA. In all, ten of the states studied here reported having applied for this funding.⁴

We find that the states studied here were most likely to use advertising campaigns (particularly television, radio, and brochures and flyers), person-to-person contact, and direct marketing approaches for their outreach efforts. An examination of the relationship between take-ups and various outreach efforts suggests that person-to-person outreach may be the most effective strategy for states to pursue, particularly when it is supported by information provided in brochures, websites and 1-800 phone lines. It is also likely that direct marketing can be an effective strategy, particularly when the target population is carefully selected.

Outreach Strategies Used by States

An outreach strategy can involve any of five major components — advertising, person-to-person contact, direct marketing, promotions, and

¹ The states included in the study are: Arizona, Colorado, Florida, Georgia, Kansas, Maryland, Michigan, Missouri, New Jersey, New York, Ohio, Oregon, Tennessee, Texas, Utah, Washington, Wisconsin, and West Virginia.

² Lurie, Irene (2001), “Field Network Studies,” in *Implementation Analysis: An Evaluation Approach Whose Time Has Come*, T. Corbett and M.C. Lennon, eds., Washington, D.C.: Urban Institute Press.

³ Rockefeller Institute of Government (2001), “Field Report Form: Medicaid Take-Up and Welfare Reform,” Albany, New York: Rockefeller Institute of Government.

⁴ These were Arizona, Florida, Georgia, Kansas, Michigan, New Jersey, Ohio, Washington, West Virginia, and Wisconsin. Missouri reported deciding not to apply due to what it saw as an involved application process, restrictions on activities, and overhead costs.

Advertising: Any form of nonpersonal communication about a program. It typically involves mass media (i.e., broadcast, print) that can transmit a message to large groups of people, often at the same time. There is generally no opportunity for immediate feedback from the message recipient.

Person-to-person contact: Personal communication through which the communicator seeks to provide information about and/or assist prospective clients with program enrollment. This face-to-face, individualized communication allows the communicator to tailor the message to the prospective client's specific information needs or situation. It also allows for more immediate and precise feedback.

Promotions: Activities such as coupons, contests, and premiums that provide extra value or incentives to promote program recognition and enrollment. Attention getting and value enhancing, promotions typically include a distinct invitation to apply now.

Direct marketing: Direct mail, newsletters, telemarketing, 800-number availability, internet/website communications, and the like. Direct marketing is comprised of efforts to communicate directly with, or solicit a direct response from, specific clients.

Public Relations and Publicity: Actions designed to earn public understanding and acceptance of a program. Its purpose is to establish and maintain a positive image and reputation. Public relations activities usually include events, sponsorship, public affairs activities, and the like. Publicity typically refers to nonpersonal communication that is not directly paid for or run under identified sponsorship. It usually takes the form of a news story or editorial.

public relations and publicity (*see the text box*).⁵ The uses of these strategies for Medicaid and CHIP outreach by the states studied are summarized in Table 1. All but one state (New York) reported the use of personal contact as an approach to outreach, all but two used advertising, and all but three undertook direct marketing campaigns. In addition, a handful of states reported pursuing promotions or a public relations/publicity strategies as well.

The outreach efforts reported in Table 1 relate to Medicaid, CHIP, or both. In some states (e.g., Arizona, Colorado, Florida, Michigan, New York, and Texas), outreach efforts described here tended to be primarily or completely focused on CHIP. In other states (Georgia, Ohio, Oregon, Tennessee, and Utah, for instance), the outreach has been more clearly focused on their Medicaid program. In the remaining states, the outreach efforts described included efforts targeted at both programs, either in joint or separate efforts.

Among the sixteen states that reported using advertising as part of their outreach, half report the

use of three or more *different* advertising media. This use of these media is summarized in Table 2. The most commonly used medium was purchased television and/or radio ads, followed by television and/or radio public service announcements and the distribution of brochures and flyers. In addition, a handful of states also reported using newspapers ads and/or newspaper inserts, outdoor and transit advertising, brochures and/or flyers, posters, fast food trays or placemats. In addition, one state (New Jersey) reported advertising on milk cartons. In some locations, advertising is targeted to specific population groups — Spanish-speaking populations, for instance. Again, these different media efforts variably targeted Medicaid programs, CHIP programs, or both. No particular media type was used exclusively for one or the other program.

Every state but New York reported the use of personal contact in efforts to increase enrollments, but again a variety of approaches are evident. Many of these strategies can be categorized into one of three approaches that are summarized in

⁵ This section relies on the definitions provided by George E. Belch and Michael A. Belch (1998), *Advertising and Promotion: An Integrated Marketing Communications Perspective*. Boston: Irwin McGraw-Hill.

Table 1 Communication Mixes Employed by States					
<i>State</i>	<i>Advertising</i>	<i>Sales Promotion</i>	<i>Public Relations/ Publicity</i>	<i>Personal Selling</i>	<i>Direct Marketing</i>
Arizona	✓			✓	✓
Colorado	✓		✓	✓	✓
Florida	✓	✓	✓	✓	✓
Georgia	✓		✓	✓	✓
Kansas	✓			✓	✓
Maryland	✓			✓	✓
Michigan	✓			✓	✓
Missouri	✓	✓		✓	✓
New Jersey	✓	✓		✓	✓
New York	✓		✓		
Ohio	✓	✓		✓	✓
Oregon	✓	✓		✓	✓
Tennessee				✓	
Texas	✓			✓	✓
Utah	✓			✓	
Washington	✓	✓	✓	✓	✓
Wisconsin	✓			✓	✓
West Virginia				✓	✓

Table 3: community-based outreach, public health/government-based outreach, and youth or adult events. In the first case, community-based outreach, it is not uncommon for states to develop relationships with community organizations (faith-based organizations, community centers, employers, retail establishments, or schools, for example) and assign a state employee/contractor to work with or through that entity. In some states, enrollment workers “ride the circuit,” traveling to prospective clients for whom visiting eligibility sites is inconvenient or impossible. Home visits are sometimes made to individuals who have recently “disenrolled,” new parents, those with disabilities, or those who have requested special help. It is not unusual for such community locations to serve as

bases for speaking engagements, public forums, and door-to-door activities, as well. Taken as a whole, we found that all but two states (New York and Utah) reported using these kinds of approaches.

Similarly, most states reported public health/government-based outreach that capitalized on the existing city, county, and/or state public health or other government infrastructure and collaborated with the programming carried out there. Again, depending on the situation, enrollment workers are assigned to these entities on a more or less continuous basis. Finally, seven states worked to staff events of interest to young people, their parents, and other adults. Fairs, malls on tax-free

Table 2
Advertising Media Employed by States

<i>State</i>	<i>Paid Broadcast Advertising</i>	<i>Broadcast Public Service Announcements</i>	<i>Newspaper</i>	<i>Outdoor</i>	<i>Transit</i>	<i>Brochures/Flyers</i>	<i>Posters</i>	<i>Tray/Place Mats</i>	<i>Milk Cartons</i>
Arizona	✓					✓			
Colorado	✓	✓	✓	✓			✓		
Florida	✓			✓	✓				
Georgia	✓		✓	✓		✓			
Kansas						✓			
Maryland	✓			✓	✓	✓		✓	
Michigan	✓		✓			✓			
Missouri		✓							
New Jersey	✓	✓				✓	✓	✓	✓
New York	✓								
Ohio		✓				✓			
Oregon						✓	✓		
Tennessee									
Texas	✓					✓	✓		✓
Utah	✓				✓	✓			
Washington									
Wisconsin		✓							
West Virginia									

shopping days, rodeos, swap meets, immunization days, and similar events provide settings for personal outreach efforts.

Following personal outreach, direct marketing campaigns were the next most common approach to outreach in the states studied. Direct marketing can involve numerous different approaches, of course. The most prominent of these approaches are direct mail advertising (i.e., postcards, letters, bro-

chures/flyers, newsletters, applications), the use of 1-800 hotlines (telecommunications), and website/internet access. With the exceptions of New York, Tennessee, and Utah, these approaches were all commonly employed and their usage is summarized in Table 4.

In addition to the major approaches to outreach discussed, nearly a third of the states also pursued some kind of promotional campaign as

**Table 3
Personal Selling Efforts
Employed by States**

State	Community-Based Selling	Public Health/ Government-Based Selling	Youth/Adult Events
Arizona	✓	✓	✓
Colorado	✓	✓	
Florida	✓		✓
Georgia	✓	✓	✓
Kansas	✓	✓	✓
Maryland	✓	✓	✓
Michigan	✓	✓	
Missouri	✓	✓	✓
New Jersey	✓	✓	✓
New York			
Ohio	✓	✓	
Oregon	✓	✓	
Tennessee	✓	✓	
Texas	✓	✓	
Utah		✓	
Washington	✓	✓	
Wisconsin	✓	✓	
West Virginia	✓	✓	

well. In particular, six states reported the use of emblematic merchandise and/or raffles to increase awareness of programs. This included the distribution of T-shirts in Florida, frisbees, gym bags, hats, golf shirts, mugs in Missouri, and the raffle of a *New Jersey Nets* autographed basketball in New Jersey.⁶ Similarly, a few states (and in some senses, surprisingly few) also pursued public relations and publicity strategies. Colorado and Georgia reported issuing press releases and/or editorials. New York was successful in having legislators promote CHIP and Medicaid in their constituent newsletters. The governor of Washington held a press conference to launch *Healthy Kids Now!*, a campaign to enroll all eligible children in either Medicaid or CHIP. According to the field researchers in Washington, “this kick-off resulted in the largest one-day response to an outreach effort that the outreach contractors had ever experienced.”⁷ As part of an information saturation strategy, Florida reported distributing 20,000 press kits to promote its CHIP program, *Florida KidCare*.

Outreach Efforts and Outcomes

Ultimately, of course, we are interested in the efficacy of different outreach efforts. Relatively few states report that they undertook activities designed to evaluate the efficacy of their own efforts. Colorado does track the origin of applications and attempts to tie each to some type of outreach. In a similar vein, Michigan attempts to tie each call to their hotline to some outreach effort. Texas has contracted for an outreach efficacy study, and New Jersey and West Virginia report undertaking similar efforts. Here we look for correlations between the types of outreach undertaken and actual increases in enrollments during corresponding time periods.⁸

⁶ Similarly Ohio reported giving away key chains and magnets, Oregon distributed pencils, and Washington State distributed cups and pens.

⁷ “Washington Medicaid Take-Up and Welfare Reform.”

⁸ Further information on the efficacy of outreach efforts can be found at the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, SCHIP Outreach Information Clearinghouse (<http://cms.hhs.gov/schip/outreach/default.asp>).

Table 4
Direct Marketing Efforts
Employed by States

<i>State</i>	<i>Direct Mail</i>	<i>Telecommunications</i>	<i>Website</i>
Arizona	✓	✓	
Colorado	✓	✓	✓
Florida	✓	✓	✓
Georgia	✓	✓	✓
Kansas	✓	✓	
Maryland	✓		
Michigan	✓	✓	✓
Missouri	✓	✓	✓
New Jersey	✓		
New York			
Ohio	✓	✓	
Oregon	✓	✓	
Tennessee			
Texas		✓	
Utah			
Washington	✓	✓	✓
Wisconsin	✓	✓	
West Virginia		✓	

While examining the relationship between outreach efforts and take-ups, one must keep in

mind that any number of factors, in addition to outreach, will undoubtedly have an effect on enrollments, factors that we are unable to quantify here. For instance, population growth or decline, and changes in the demographic or income composition of a state over time may lead to changes in the eligible and enrolled population, independent of any outreach efforts. Furthermore, it is clear that in some states there is a countervailing cycle of outreach and retrenchment. When outreach efforts are *too* successful and the caseload threatens to exceed current budget authority, efforts are often scaled back or cancelled. For example, Tennessee reported that due to massive enrollments, outreach has not been emphasized. Wisconsin indicated that when enrollments rose more sharply than expected, some outreach efforts (e.g., a series of public service announcements featuring the governor) were discontinued. Similarly, in the period since this study was completed, many states have faced growing budget crises and have responded to revenue shortfalls in any number of fashions, including a curtailing of outreach efforts and changes in state eligibility standards or coverage levels. This response is the subject of another Management Brief in this series.⁹

The changes in enrollments measured here are for 16 of the 18 states under study, and cover Medicaid programs and, for nine states, those CHIP programs that were implemented as Medicaid expansions.^{10, 11} While one might like to isolate the relationship specifically between CHIP outreach and enrollments, and Medicaid outreach and enrollments, there is good reason to consider these elements all together. Officials in a number of states noted an apparently strong relationship

⁹ See “Managing Medicaid Take-Up: Is Medicaid Retrenching? State Budgets and Medicaid Enrollments in 2002” by James W. Fossett and Courtney E. Burke, Federalism Research Group, Rockefeller Institute of Government, February 2003.

¹⁰ The enrollment data used here are from “Managing Medicaid Take-Up: Medicaid Enrollment Trends, 1995-2000” by Courtney E. Burke and Craig W. Abbey, Federalism Research Group, Rockefeller Institute of Government, August 2002. Data were not available for New York or Tennessee. Data exclude coverage of disabled and elderly populations.

¹¹ An overview of the different administrative arrangements is provided in another Management Brief in this series, “Managing Medicaid Take-Up: Building Administrative Capacity for CHIP and Medicaid: Image, Outreach, and Organization” by Christopher Plein, Federalism Research Group, Rockefeller Institute of Government, December 2002.

between CHIP *outreach* and Medicaid *enrollments*: children reached regarding CHIP, or the adults in their families, often turn out to be Medicaid eligible. Some states reported a reluctance to pursue CHIP outreach strategies because of this, knowing that the resulting flood of *Medicaid* applicants would put untenable budget pressure on their Medicaid programs (Oregon and New York, for example). In some other states, intent on increasing Medicaid enrollments (Kansas, for instance), the “spillover” from CHIP outreach efforts was noted as a beneficial side-effect for Medicaid take-up

With these caveats, we tentatively test whether a relationship exists between the qualitative description of the outreach efforts, the advertising media chosen, personal contact efforts, or the direct marketing efforts conducted by individual states and the Medicaid and CHIP/Medicaid expansion enrollments reported by those states. Any association found does not *prove* causality, but can be suggestive of a relationship. For purposes of this analysis, percent change in *total average monthly enrollment*, *average monthly enrollment for adults*, and *average monthly enrollment for children*, for the years 1998 to 1999, 1999 to 2000, and 1998 to 2000, displayed in Table 5, were treated as outcomes variables. We use statistical analysis to test for correlations between these outcomes and the mix of outreach strategies used, the type of advertising media chosen, the use of personal contact methods, and the direct marketing efforts reported by the states covered in this study.¹² We find that with the exception of personal contact outreach, there was no relationship between CHIP and Medicaid take-up and the various communications efforts employed by the states participating in this study. An analysis of personal contact outreach revealed a positive and significant impact on percent change in *average monthly enrollment for children* 1998-1999, 1999-2000, and 1998-2000. In particular, public health- and gov-

ernment-based efforts and youth/adult events appear to be effective.

Strengths and Weaknesses of Different Types of Outreach

These findings are not unexpected and are consistent with our broader understanding of the strengths and weaknesses of different types of outreach efforts. Based on experience and the state efforts described here, it might be expected that many of the advertising, publicity, and direct marketing activities were not carried out with sufficient frequency to affect CHIP and Medicaid take-up. Furthermore, in studies of marketing and communications, there is little evidence to suggest that promotions and public relations events would have much effect on take-up. In contrast, while person-to-person interactions are the most expensive of all communications efforts (measured on a “cost per customer contact” basis), they are often considered to be among the most effective.

In order to be effective, mass media advertising requires a budgetary commitment unlikely to be available in many social service contexts. One presentation of a broadcast ad or one insertion of a print ad rarely achieves any desired communication objectives. For example, while about 88 percent of the audience is exposed to the average TV commercial, only about 60 percent will have watched enough of the ad to be able to *recognize* it later. This compares with about 49 percent recognition for consumer magazine ads, 43 percent for general circulation newspaper ads, and 30 percent for radio commercials.¹³ Moreover, it is a long way from recognition to actually processing and understanding the message. While 43 percent of readers actually notice the average newspaper ad, the brand name featured in newspaper ads is noticed by 34 percent of readers, and only 19 percent actually reads half or more of the copy.¹⁴ To achieve communication objectives, advertising requires

¹² This analysis utilized a regression approach to single-factor analysis of variance.

¹³ Rossiter, John R. and Larry Percy (1997), *Advertising Communications and Promotion Management*, New York: McGraw-Hill Companies, Inc.

¹⁴ Rossiter and Percy, *op. cit.*

Table 5
Percent Change in Average Monthly Medicaid Enrollment

State	Total 1998- 1999	Total 1999- 2000	Total 1998- 2000	Adults 1998- 1999	Adult 1999- 2000	Adults 1998- 2000	Children 1998- 1999	Children 1999- 2000	Children 1998- 2000
Arizona	7.03%	14.57%	25.91%	-4.25%	9.86%	5.19%	5.01%	11.90%	17.51%
Colorado	3.10%	8.30%	12.53%	-1.08%	10.59%	9.39%	4.33%	8.66%	13.37%
Florida	11.19%	58.01%	168.15%	15.53%	24.23%	43.52%	16.51%	173.61%	218.79%
Georgia	-0.90%	-1.99%	-2.82%	-5.79%	-2.48%	-8.12%	0.63%	-1.79%	-1.17%
Kansas	6.47%	7.80%	15.97%	-10.81%	2.68%	-8.42%	11.21%	9.58%	21.87%
Maryland	6.90%	9.78%	19.06%	2.67%	7.09%	9.95%	10.22%	12.91%	24.44%
Michigan	-1.91%	5.17%	3.47%	-2.46%	4.42%	1.86%	1.48%	4.20%	5.74%
Missouri	19.71%	14.11%	45.00%	45.29%	34.40%	95.28%	10.29%	7.99%	19.10%
New Jersey	-1.03%	12.67%	13.35%	-15.70%	-8.00%	-22.44%	3.61%	20.28%	24.62%
New York									
Ohio	-0.14%	2.97%	2.92%	-2.79%	3.11%	0.24%	2.31%	3.02%	5.39%
Oregon	0.70%	-1.92%	-1.19%	0.62%	-3.10%	-2.51%	0.78%	-0.91%	-0.14%
Tennessee									
Texas	-4.75%	1.07%	-3.50%	-13.57%	0.16%	-13.43%	-2.62%	1.26%	-1.39%
Utah	3.83%	1.67%	5.75%						
Washington	-1.03%	10.85%	11.03%						
Wisconsin	4.99%	21.72%	34.46%	16.61%	57.61%	83.79%	1.72%	17.09%	19.11%
West Virginia	-1.62%	-4.50%	-5.84%	3.27%	-4.31	-1.17%	-3.40%	-4.31%	-7.56%

numerous, expensive repetitions within a carefully prescribed period of time. Compared with advertising, direct mail campaigns receive somewhat greater recognition. On average, people open 74 percent of the direct mail they receive. Of all direct mail received, 45 percent of it is read, at least to the extent necessary to determine the subject matter.¹⁵ Nevertheless, direct mail can require frequency and repetition in order to be effective.

It is plausible that promotional efforts could stimulate someone to enroll in CHIP or Medicaid. However, empirical evidence that this would be the case is largely absent from the literature.¹⁶ Public

relations and publicity efforts suffer some of the same drawbacks as advertising. In order to have an impact, earned media stories, editorials, and the like must occur with sufficient frequency to be noticed, processed, and understood. Success from either of these strategies is not clearly evident among the states studied here. Thus, states are probably ill advised to invest in promotion activities, public relations, or publicity strategies purely for the purpose of stimulating CHIP and Medicaid enrollment.

In contrast with some of these other outreach methods, personal contact allows face-to-face in-

¹⁵ Rossiter and Percy, *op. cit.*

¹⁶ Blattberg, Robert C. and Scott A. Neslin (1990), *Sales Promotion: Concepts, Methods, and Strategies*, Englewood Cliffs, NJ: Prentice Hall.

teraction for the purpose of making customized presentations, answering questions, and explaining the application process. Moreover, when augmented by the brochures, 1-800 phone lines, websites, and other sources of information, personal contact can be especially powerful in making prospective clients aware of appropriate programs, creating or changing attitudes towards those programs, stimulating enrollment intentions, and, ultimately, facilitating enrollment. It also allows for more immediate and precise feedback.

This view is supported by our statistical analysis and by a review of the approaches taken by those states that were most successful in increasing their Medicaid and CHIP enrollments over this period. In Florida, for instance, an extensive outreach campaign for CHIP was pursued through school districts, other public agencies and community organizations. One and a half million applications were distributed to families through school districts and 3,000 outreach training sessions were conducted, reaching individuals in nearly 5,000 community organizations. Local outreach efforts that resulted in police carrying applications in patrol cars, county health department employees attending community events (such as school orientations, county fairs, and tax-free shopping days at shopping malls), and churches providing outreach to homeless centers, food banks, and subsidized housing facilities in low-income neighborhoods. Florida also ensured that families had multiple venues for asking for and receiving help and information: they established a toll-free hotline, printed and distributed a million flyers, brochures and fact sheets, and established a web page (www.floridakidcare.org).

Similarly, New Jersey and Missouri also provide good examples of community-based and personal-contact driven outreach efforts. New Jersey has embarked on a broad-based approach that provides for extensive personal contact between families and outreach workers. They have over 400 enrollment sites throughout the state that include neighborhood-based organizations, Head Start centers, hospitals, churches, and public schools. Sites may provide information, applications, and on-site enrollment assistance. Many specifically target rural, urban, and Hispanic populations. Mis-

souri successfully undertook a community-based outreach strategy that relied on a pre-existing system of neighborhood-based social service centers. This “Caring Communities” program brings services from a host of state departments (including Social Services, Education, Mental Health, and Public Safety), as well as access to their Medicaid and CHIP programs, to neighborhoods around the state. In addition, Missouri outstationed 50 case-workers in hospitals around the state. These case-workers provide information, applications, and enrollment assistance for CHIP and Medicaid health insurance coverage, as well as for other forms of public assistance (such as TANF and Food Stamps).

Other Considerations for Planning Outreach Strategies

Understanding the strengths and weaknesses of different outreach strategies allows management to use the combination of methods that will best deliver information to clients. A well-constructed outreach plan should integrate appropriate elements, allow for careful targeting, and send a consistent, unified message. The particular media used for any particular outreach effort should be chosen for its ability to reach the target audience.

A review of the practice-oriented literature suggests that advertising and publicity require expensive repetition in order to achieve the desired objectives. Sales promotion and public relations events might plausibly affect enrollment, but the empirical evidence suggests that this is relatively unlikely. Given constrained state budgets, and because personal selling and direct marketing activities can be highly customized and often require lower frequency, face-to-face interactions and direct mail appear to offer the most effective means by which states can communicate with potential CHIP and Medicaid clients.

In addition, several other factors should be kept in mind. First, for overall effectiveness, the number of times that a message reaches (and is processed) by the target population is considerably more important than the size of the population reached. When resources are constrained, managers should opt to communicate frequently with nar-

row, well-defined target audiences, rather than spend limited funds communicating infrequently with broader, or more poorly defined, audiences.

Second, the most effective communication investments are the result of systematic and strategic planning and evaluation processes. Strategizing should begin with the specification of program objectives to be achieved, followed by the choice of well-defined target audiences, the development of a coherent message and creative strategy, the estimation of minimum frequency, and the development of a media plan that will deliver the required message frequency to the target audience. When budgets are fixed and/or highly constrained (as they most frequently are), it is sensible to more narrowly limit the target population before limiting the minimum number of times that population is reached. The smaller the budget, the more narrowly and better defined the audience must be. The choice of media and the message content should then be customized to appeal to the information needs of that high-priority audience.

Lastly, person-to-person outreach efforts that leverage the existing public health and government

infrastructure and events that appeal to both young people and adults in the target market seem to produce the best Medicaid and CHIP take-up results. Personal outreach efforts augmented by brochures, 1-800 numbers, and websites can be particularly effective. CHIP and Medicaid take-up would be well served by efforts that maximize the effectiveness of these efforts.

As with other outreach methods, person-to-person contact should be directed to well-defined and well-understood target markets. It is also worth considering Kotler and Andreasen's observation that "nonprofit salespeople are...likely to be order takers," that is, passive transaction processors.¹⁷ Thus, those responsible for face-to-face interactions would likely benefit from additional training. Outreach, negotiation, and relationship training can help state employees and contractors become "need satisfiers" who recognize that prospective clients have unmet needs that constitute opportunities to serve, appreciate receiving the information necessary to solving their problems, and are responsive to those who have their long-term interests at heart.

¹⁷ Kotler, Philip and Alan R. Andreasen (1996), *Strategic Marketing for NonProfit Organizations*, Upper Saddle River, NJ: Prentice Hall, p. 583.

The Nelson A. Rockefeller Institute of Government

The Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

The American Federalism Group

The Institute's American Federalism Group was established in 1997 in response to the growing importance of state governments in the American federal system and the devolution of social programs. Despite the ever-growing role of the states, there is a dearth of high-quality, practical, independent research about state and local programs.

The mission of the American Federalism group is to help fill this gap. The Group conducts research on trends affecting states and serves as a national resource on issues such as welfare reform, and Medicaid Managed Care for public officials, the media, public affairs experts, researchers, and others. The Group is directed by Tom Gais, who has spent the last decade analyzing state and local issues with federalism. Jim Fossett oversees research in the area of public health programs.

This Report

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