

Coverage for Kids: Capstone Project

A Capstone Project submitted to Southern Utah University in partial fulfillment of the
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By

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Abstract

The Utah Department of Health (UDOH) was appropriated \$50,000 in Fiscal Year 2017 to implement an outreach program to promote Medicaid and the Children's Health Insurance Program (CHIP) enrollment among Utah children who live in underserved and highly minority populated areas. With community partners and advocacy organizations requesting involvement, the Department identified a strategic plan that addressed various concerns in how to best utilize and implement the limited budget. A combination approach of grass-roots, social media and online tactics were identified and developed with the intent to increase awareness and application for these public health insurance programs.

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Approval Page

I certify that I have read this portfolio and that, in my opinion, it is satisfactory in scope and quality as a professional project for the degree of Master of Arts in Professional Communication.

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Introduction

To complete the requirements for my capstone, I chose a professional project in which I could demonstrate practical implementation of a communication campaign. I have worked for the Utah Department of Health (UDOH) for ten years as the Medicaid and the Children's Health Insurance Program (CHIP) public information officer. The Department has not had funding for any outreach, marketing or advertising efforts since 2009. Community advocates lobbied the state legislature in 2016 for funding specifically earmarked for the promotion of the public health insurance programs. The following details the background of the targeted programs, the bureaucratic processes for planning and implementing, as well as the development and implementation of the efforts thus far. The funding is available until June 30, 2017, so all of the projects will be completed for implementation at that time. However, given the timeframe for this capstone due in April, some deliverables are still in the development and approval phase.

Program Descriptions and Background

The UDOH administers Medicaid and CHIP to provide medical, dental and behavioral health services for needy individuals and families throughout the state of Utah. Medicaid serves as the nation's primary source of health insurance coverage for low-income populations. Although many people believe Medicaid provides health care services for all low-income people, the program actually only covers individuals that fit in one of the designated qualifying groups. Medicaid always considers household income when determining program eligibility and most eligibility groups limit the assets that an individual or a family may have in order to qualify. There are more than 30 Medicaid aid categories, each with varying eligibility requirements and varying benefits. These groups can be classified into the following major eligibility categories:

- Children (individuals under age 19)
- Adults in families with children
- Pregnant women
- Individuals with a disability
- Aged individuals (age 65 or older)
- Blind individuals
- Women with breast or cervical cancer
- Individuals who participate in a Medicare Cost-Sharing Program

The majority of Medicaid clients, approximately 63 percent, are children. After the downturn of the economy in 2007, children's coverage was the fastest growing enrollment category. With Utah families struggling to make ends meet due to job losses and declining home values, Medicaid has historically been a tremendous resource to parents, so they don't have to choose between paying for groceries or paying for their child's health coverage. Medicaid also serves as a health safety net when unexpected life challenges arise. For a child to qualify for children's Medicaid, a family of four can earn approximately \$32,000 per year.

Families earning more than this income limit, up to \$49,200 for a family of four, may qualify for CHIP. Many children who qualify for CHIP come from working families but employer sponsored insurance or a private health plan is still cost-prohibitive. CHIP was designed to help ease families from a no-cost entitlement program into the private market. Unlike Medicaid, CHIP uses a cost-sharing model. Families pay a quarterly premium and small co-pays for visits to their doctor or the emergency room. However, unlike a commercial plan, CHIP continues to offer financial protections for low-income families. For example, enrollees

are not required to pay more than five-percent of their household's income for out of pocket expenses like deductibles, premiums and co-pays.

Both CHIP and Medicaid offer a wide range of benefits and services to enrollees. Children and teens can get regular check-ups, immunizations, doctor and dental visits, hospital care, mental health services, prescriptions and more. Between the two programs, more than 220,000 Utah children have access to these benefits every year.

Both programs are always open for enrollment and accept applications year-round. To be eligible, children must be under age 19, U.S. citizens or legal residents, uninsured, and meet income guidelines. Parents can fill out a single application and both programs will be considered. Depending on each family's income, their child(ren) will be approved for either CHIP or children's Medicaid.

Before the economic recession, the UDOH was appropriated healthy budgets each year to conduct communication programs to improve awareness of the public health insurance programs available to low-income children. The Department was able to create integrated marketing, public relations and advertising campaigns, with a specific effort to reach statewide and diverse populations. In 2010, all state budgets were reduced to conserve funds and get the state through difficult budget cycles. Since that time, the Department has not been appropriated additional funding for any communication efforts. Until the 2016 General Legislative Session, community advocates lobbied legislators for funding that would improve communication efforts, specifically to underserved populations such as the Hispanic communities.

The state funded \$25,000 to these efforts, which was matched by the federal government with an additional \$25,000. Considering previous outreach and communication efforts spent hundreds of thousands of dollars each year, \$50,000 has required a more strategic and concerted

effort to achieve meaningful impact. Additionally, since the funding was a result of advocacy efforts, the Department felt it is important to involve community partners in the conversation and planning efforts.

The following review will outline the current literature regarding communication practices and public health insurance programs. It will also explore specific populations like the uninsured and Hispanic culture to identify barriers and recommendations for communication efforts.

Literature Review

Public health communication programs are notorious for operating on shoe-string budgets. Because of limited resources, deliverables are often implemented without scrupulous research and data collection. According to Kreps (2014), “it is critically important to conduct regular, rigorous, ongoing and strategic evaluation of health communication intervention programs to guide development, refinement and strategic planning” (p. 1449). Kreps recommends multiple research methods that have longitudinal research designs to properly capture program adoption and utilization, as well as identify audience needs and receptivity.

Since 1984, the UDOH has conducted a Behavioral Risk Factor Surveillance Survey which estimates rates of uninsured residents statewide. In 2015, the survey sampled approximately 5,000 residents on both cell phones and landlines, in English and Spanish. This representative sample concluded that the overall rate of uninsured Utahns is the lowest it has been in more than ten years. Specific to this project, however, there continue to be approximately 36,700 children who are currently uninsured yet fall within the income guidelines of Medicaid or CHIP eligibility (Utah Department of Health, 2015). This data confounds

advocates and program administrators as to why these public programs continue to be underutilized.

The Uninsured

There have been multiple studies that aim to answer this very conundrum. Mittal and Griskevicius (2016) specifically sought to understand how childhood environments may later affect adult health care decisions. A “lack of money alone does not fully explain why millions of people choose to forgo health insurance” (p. 636). Through a series of experiments, the researchers concluded that growing up poor with limited resources affects more than “physical, socioemotional, and cognitive development. But childhood SES also has longer lasting effects, such as by shaping decisions in adulthood” (p. 652). Further, the environment from childhood influences risk perceptions, which play an “important role in many consumer behaviors” (p. 652) like the desire for health coverage. “People who grew up poor were generally less interested in seeking medical coverage compared to people who grew up wealthy” (p. 650).

To better understand the “uninsured” population in America, Cheong, Feeley and Servoss (2007) identified numerous statistically significant differences between the uninsured and their insured counterparts. “There exists a growing clamor in the public health sector to address the national health care crisis in America today. The burgeoning cost of health insurance, changes in poverty concentration, changing labor market conditions, increasing asset poverty and growing immigrant populations are among some of the key economic and demographic trends that are changing the picture of health insurance coverage” (p. 286). The health care system is fragmented between public health insurance programs like CHIP and Medicaid, Medicare for the disabled and elderly, employer sponsored insurance coverage, and private health plans. American families are having to navigate multiple health plans or programs, each with their own

provider network and cost-sharing provisions. Furthermore, skyrocketing health care costs impact the consumer's out-of-pocket contributions for things like prescriptions and co-payments which only magnifies the health care crisis.

Cheong, Feeley and Servoss (2007) conducted a random sample of Americans to more clearly identify the health status, demographics and health-seeking behaviors of the uninsured and insured. "The uninsured were more likely younger, less educated, and Hispanic. Findings also indicated that those without health insurance reported being less healthy and more distressed and hold a greater risk perception for cancer, compared to their insured counterparts" (p. 285). The study then addressed health-seeking information behaviors of the uninsured population. The study concludes that "the uninsured American could benefit greatly from quality, user-friendly information provided at minimal or no charge from communication media" (p. 297).

Hispanic Populations

It is well documented that Hispanics are an underserved population in the United States for being medically uninsured and having less access to health care resources. Pauline Hope Cheong (2007) conducted a survey of 737 Hispanics in Los Angeles to understand health seeking behaviors and better comprehend the channels that would best reach this hard-to-reach audience. "Survey results showed that the uninsured are less likely to have a regular place for health care, more likely to experience difficulties in obtaining health care, and more likely to have a lower income and education than the insured" (p. 160). Further, findings also indicated that "ethnically targeted media and interpersonal networks should be deployed as key health communication resources for health information dissemination to reach Hispanic immigrant communities" (p. 160).

Hispanics are not a homogeneous group. First and second generations have different needs, as well as different utilization rates of internet usage and communication channels like Spanish television and radio versus mainstream English media resources. Nonetheless, a “culture of poverty” continues to exist and communicators need to be cognizant of communication complexities in this population.

Due to the disparities among immigrant populations, Ginossar and Nelson (2010) specifically studied innovative communication interventions that effectively reached Latin communities. They focused specifically on two approaches: 1) computer-mediated health promotion and 2) grassroots community-based outreach.

“Health promotion efforts that are mediated by computers and other digital technologies or “E-health communication,” have great potential to promote positive health behavior changes” (p. 329). The researchers contend that utilizing participatory methods in the development of media content improves the community identification and interest in the health promotion messages. In this particular campaign, participation was achieved by giving community representatives control of the content, message and website creation.

In addition to the role of content creators, community members were also trained as *promotoras* to promote and educate the rest of the community about a specific health issue. “The *promotoras* share a determination to help advance their community, which faces poverty, neighborhood violence, social isolation and lack of medical insurance” (p. 330). They educate and answer questions “that their fellow community members...have related to health barriers, availability and accessibility of local health services, and to using computers” (p. 330). Ultimately this “community-based participatory health communication research framework empowers members of the community to articulate their needs, identify available resources,

mobilize them to act in ways that positively impact sustainable health outcomes and develops health consciousness” (p. 330).

Further analysis of minority health communications, identified specific statistics of Hispanics and their use of online health information. The following were highlighted:

- “The number of Hispanics using the Internet has increased, from 54 percent to 64 percent.
- In 2008, 81 percent of Hispanics who were online had Internet access at home, and 76 percent had broadband connections.
- Studies show that this population is turning to the Internet to seek medical answers and treatments.
- Among those Hispanics with online access, 56.5 percent have looked for health or medical information online either for themselves or someone else.
- Hispanics reported the Internet is a cheaper, easier and faster source of health information. As a result, many feel more comfortable finding information online as opposed to using traditional medical facilities” (p. 28).

Wertz and Kim (2015) further analyzed online health sources and the quality of online health websites targeted to Hispanics. “When compared to information that is targeted to the majority population, these finding imply that Hispanic-targeted websites have a lower quality of health information...This is disconcerting as online health information is an often-used source for health information among Hispanics that can play an integral part in reducing health disparities” (p. 33). Naturally, when the online material and content is meager, consequently the information is less likely to decrease the health disparity. The researchers recommend that

quality information is made available to Hispanics by health communicators to “hopefully reduce possible knowledge gap and health disparities within this group” (p. 35).

Media and Other Communication Tactics

Another study sought to better understand how the contemporary media landscape is seemingly ineffective in reaching and resonating with low-income populations. The researchers concluded the following assumptions. “While education and poverty typically are inversely related and certainly pose some limitations to message comprehension, there are also less obvious but equally (if not more) critical communication obstacles to reaching the poor and underinsured that stem from the structure and focus of contemporary media organizations and the daily information needs of low-income people” (Southwell, Hamilton, & Slater, 2011, p. 584). The researchers conclude that “people with low incomes often are spectators of an information environment designed for others, rather than fully engaged with content designed with them in mind” (p. 584). Southwell, Hamilton and Slater recommend that health communication efforts look beyond traditional media and search for creative methods to reach these populations, as well as carefully craft and frame the message to explain program efficacy.

Similarly, Ruth M. Parker (2012) examined the impact of the Patient Protection and Affordable Care Act (2010) which ultimately provides access to health insurance for millions of previously uninsured individuals and families. Given that statistics show nearly half of adults in the United States struggle with health literacy, Parker provided communication recommendations to states as they bolstered their programs for enrollment surges. Alice Weiss, Deputy Director for Maximizing Enrollment for Kids at the National Academy for State Health Policy, highlighted specific areas of focus including providing accessibility for issues of language, disability, families of mixed immigration status, and literacy. Weiss also emphasized the need to test materials for readability and to create materials in multiple formats (p. 373).

Understanding the difficulty communicators experience in crafting messages that effectively capture the targeted audience's interest, one study specifically studied the techniques used by magazine editors. Using a content analysis, they reviewed health related "cover lines" published in 2012 that generated interest and were read by mothers of young children. The findings revealed that "mothers of young children reported they were significantly more motivated to read a short, health-related magazine article when cover lines had a happiness/fun, unique/special, or quick/urgency theme and were significantly less motivated to read when cover lines used a control/improve theme" (Martin-Biggers, Beluska, Quick, Tursi, & Byrd-Bredbenner, 2015, p. 766).

An example of a control/improve theme is offering advice or encouraging action like, "Reduce your family's health risks now!" Instead a happy/fun cover line may say, "Make fruits and veggies fun to eat!" The researchers concluded that the consumer may be "forced to recognize something is out of control or in need of improvement" (p. 770). Additionally the study also corroborated previous research which reported that "positively framed messages were more successful at motivating prevention-based behaviors than negatively framed messages" (p. 770). When aiming to pique the interest of parents to read educational or health-related information, using positive, upbeat messages may positively influence healthy behavior changes.

Similar to the efforts described above of mobilizing the Hispanic community to work as promotoras to create and disseminate health intervention messages, Renata Schiavo (2016) recognized the effectiveness of such strategies in underserved communities in general. However, "community ownership and participant in health communication interventions, the integration of community mobilization and citizen engagement strategies, which are key areas of health communication, is too often an after-thought in most communication programs" (p. 1). Similar

to the study with the Hispanic communities, community networks should be leveraged to not only disseminate information but to be engaged in the process from design to implementation. Schiavo (2016) asserts that “when people feel engaged and accountable for solutions, they are more likely to rally around common objectives and work together to achieve them” (p. 2).

Participation and engagement is also recognized once a program enrolls members. In a study that examined administrative and survey data of Medicaid recipients who could choose among different public health insurance plans, Walsh, Fitzgerald, Gurley-Calvez and Pellillo (2011) concluded that consumer choice does matter. Specifically, “consumers’ motivations, opportunities and abilities influence their decision strategies (active/passive) and plan enrollment” (p. 199). However, given the variety of health insurance comprehension, it is recommended by the researchers that public health insurance programs provide consumers with access to experts who can assist recipients by answering questions and guide them through the process.

The identified and highlighted body of research has helped to guide the efforts of this communication campaign.

Method

For this capstone project, my role consisted of the following functions and responsibilities: obtain buy-in from various stakeholders, develop a strategic plan, identify the process and method to use the appropriated funding given bureaucratic complexities, prepare the framework and messaging to be used by other professionals to develop campaign deliverables, provide guidance and approvals in development and ultimately oversee that the components of the campaign are finished by the end of the fiscal year. The details of these activities are described below.

Planning, Approvals and Logistics

The direction of this campaign was significantly different from previous efforts. Historically, CHIP had mobilized statewide campaigns that included school-based outreach, transit and newspaper ads, TV and radio commercials, press conferences and media relations, and a van that traveled the state visiting every county to sign up children for CHIP at local events. These efforts were supported by both Governor Huntsman and Governor Herbert, as well as legislators and congressmen. Further, healthy budgets were appropriated year after year to sustain ongoing communication efforts that encouraged uninsured families to enroll in the state health insurance plans.

During the recession, state budgets were tightened and all appropriated marketing funding was cut. At this time, there was also a philosophical shift among Utah's elected officials who were against the Affordable Care Act, also known as "Obamacare." Without funding and political support, the Medicaid and CHIP agency withdrew all efforts to promote the programs and increase enrollment.

When outreach funding was appropriated in 2016, it was clear that we would need to engage our community partners, as well as the Legislative Fiscal Analyst. All parties needed to essentially have a voice in how this funding would be utilized. After meeting with the Medicaid Director and CHIP Director, I prepared a menu of potential options to be discussed at our first kick-off meeting. Ideas ranged from developing new collateral materials to hiring an intern to help facilitate implementation, given limited staff capacity.

I invited representatives from many community advocacy organizations including Voices for Utah Children, Utah Health Policy Project, Association for Utah Community Health, Salt Lake Community Action Program, Comunidades Unidas, United Way, HealthInsight, American

Care United, Alliance Community Services, Community Health Connect and Take Care Utah. Many of these organizations currently interface with program recipients and applicants and therefore have a clearer understanding of the needs and resources of the target population. Further, several of the groups have received funding from the federal government to serve the state as “navigators” in which they help people apply for coverage, whether through the federally-facilitated health insurance marketplace or public programs like CHIP and Medicaid.

At the initial meeting, I presented our brainstormed ideas of how to use the appropriated funding. The advocates then offered their own recommendations and initiatives. There was an overwhelming endorsement from these groups to implement grass-roots, door-to-door methods of outreach. The advocates communicated that in their experience this one-on-one, in-person tactic builds trust within the underserved and Hispanic communities. This recommendation is consistent with the literature which recognizes the value and effectiveness of community-based outreach efforts. All of the advocates vocalized a desire to help with community-based outreach, as they currently have the infrastructure established within their various communities. The advocates also agreed that a social media component to the outreach would be effective and helpful to their current endeavors.

After fine-tuning the deliverables, I presented the proposed strategy to the Medical Care Advisory Committee. This Committee is required by federal regulation to provide oversight of the operation and planning of the Medicaid program. The membership of the committee includes medical professionals, consumer stakeholders and state department members who are all familiar with the needs of low-income population groups. Before proceeding with any plan, our agency needed to have the support and authorization of this committee. After my

presentation, I answered various questions posed by the members, but ultimately received their approval to move forward with the proposed efforts.

One of the most difficult hurdles to overcome for state agencies to utilize appropriated funding is the procurement process. In order to make any purchase more than \$1,000, you must abide by rules and regulations administered by the Department of Purchasing. Any expense more than \$1,000 must be handled through an approved vendor or you may issue a Request for Proposal (RFP). Once you have issued the RFP and received bids from vendors, you must contract with that organization. This process takes months from start to finish. Our campaign did not have time to waste, as the funding would expire by July 1, 2017.

Community-Based Outreach

As I was exploring how we could spend the funding, I came across information about an internal program called Bridging Communities and Clinics administered within the Department of Health's Office of Health Disparities. This program has been in operation for several years to improve community health in populations and areas affected by health disparities by partnering with community-based organizations for promotional events and mobilizing community members. The program also provides basic health screenings and referrals to free, reduced-cost, or income-based primary care and oral health services.

The program currently contracts with many of the same community partners and advocates that expressed interest in this campaign from our initial kick-off meeting. I identified the overlap and an opportunity to work together to achieve grass-roots, targeted outreach by coordinating community events and helping community members not only get a free screening but help obtaining access to health insurance and a primary care provider. By contracting with Bridging Communities and Clinics, the program would be able to enhance their current scope of

work to include more outreach events and assist applicants through the enrollment process for Medicaid and CHIP, rather than simply referring uninsured individuals.

I set up and facilitated numerous meetings with the Bridging Communities and Clinics' administrators and staff, as well as the Medicaid and CHIP directors. We recognized an opportunity to bolster their existing program and processes by adding the health insurance application assistance to their efforts. Through this partnership, we would be able to utilize existing contracts to implement additional outreach and enrollment events targeting similar populations. Additionally, by enhancing an existing program with additional resources we would not have to re-create processes or contracts.

Since the Office of Health Disparities exists within the same Department as Medicaid and CHIP, a simple memorandum of understanding (MOU) was necessary to establish an agreement. We would not have to go through the procurement and contracting process once more. Nor would we have to contract individually with all of the community advocacy organizations. Essentially, by joining efforts, we were able to more efficiently utilize funding to maximize outcomes and enroll uninsured children in Medicaid and CHIP.

I drafted the MOU and then sent it to the Attorney General's office for review and approval. Through a series of edits and recommendations, I finalized the MOU to fund these community-based outreach efforts and submitted it for authorization.

The outreach efforts were targeted to increase Medicaid and CHIP enrollment among children living in South Salt Lake who are part of an underserved and underrepresented community. Specific zip codes were selected based upon health disparity data, as well as the highest total number of children without health insurance and living in poverty.

The following contracted community partners included in this collaborative effort included: Take Care Utah, Utah Health Policy Project, Comunidades Unidas, National Tongan American Society, Community Building Community, Somali Community Self-Management Agency, Health Access Project and Family Dental Plan.

The contractors are responsible for coordinating and organizing ten to twenty outreach and enrollment events in the identified areas per month, reaching a minimum of 50 individuals per event. All activities are tracked through a secure system, including the individual applicants. The contractor is also required to report on a monthly basis their activities and progress, with a final report of all completed activities, outcomes and recommendations by July 15, 2017. This partnership with the Bridging Communities and Clinics used \$25,350 of the total funding.

Social Media

For the remaining \$24,650, I began exploring options for engaging online and through social media. Once again, however, I was limited by the procurement process. After visiting with the Department's Communication Director, I learned that the Department of Purchasing has approved vendor contracts for marketing and advertising campaigns. If you have less than \$100,000 to spend, instead of soliciting bids through the RFP process, you can choose to work with an approved vendor. While there are still regulations to ensure a fair and equitable business opportunity for the vendors to compete, the timeline is significantly less cumbersome.

As required, I prepared a scope of work and cost proposal. I then sent it to all of the vendors under the "Digital Marketing" category on the approved vendor list. On the request for bid, I asked for a menu of deliverables with their respective costs. Based upon our budget and the actual costs to produce each deliverable, I would then be able to select which deliverables we would use a contractor and which deliverables we would manage in-house. Only one vendor

responded to the solicitation and I selected three projects to initiate a contract, with the remaining budget being spent in-house. The timeline for this portion of the budget is to have all the components developed by mid-May and with the campaign kick-off in June.

Since social media was well received by the advocates, I set out to identify the strategy. While mass media may not specifically reach our targeted demographic, social media ads can be more precisely purchased, or micro-segmented, based upon the location, age, gender, ethnicity and even politics of the user. This type of outreach has recently been one of the most effective for other programs within the Department. For minimal cost, these programs have realized significant response and interest.

While there are many social media platforms that may potentially reach the target audience, Facebook still dominates the social space. According to Schaffer (2013), Facebook has more than 1 billion users. “It’s kind of like the white pages; if you ever wanted to advertise to people, that’s where they’d be...It embraces people of all the demographic characteristics” (p. 59). So for this initial induction into the social media world, this campaign will focus the ad buy on Facebook. We plan to target parents, ages 19-45. Additionally, because the community-based efforts were focused in South Salt Lake, we will similarly target the high poverty, low rate of insurance hot spots.

We will take a two-prong approach for the ad buys. The first approach is to create organic posts on Facebook and boost the ones that are performing the highest (i.e. shares, likes, comments). Because social media allows for instant feedback, we can fine tune our approach as we identify trends of which ads are resonating best with the target audience. The second approach will create target specific posts leveraging the creative from the landing page and

micro-segmenting the ads in order to reach both targeted demographics and statewide social media users.

In conjunction with the Department's social media coordinator, we are in the process of creating ads for Facebook. The ad types will vary between photo and video. The federal "Insure Kids Now" program administered by the Centers for Medicare and Medicaid Services, has a robust library of campaigns and ads that states can use. The images can be customized with a state-specific logo and contact information. This is our starting point. We will also be using a newly developed video which is described below.

Based upon the success of other Departmental programs, we determined that \$5,500 would be allocated for a eight-week plan. Since we will be spending this money in-house, we are limited to \$1,000 purchase blocks during that timeframe. To evaluate the effectiveness, we will be tracking the click-through rate and cost per click.

Websites

Given that this outreach project utilized one-time funding, it was important to be strategic so that the efforts are impactful and long-lasting. As management discussed our social media strategy, it naturally diverted to the program websites. CHIP and Medicaid have different websites, although both programs are considered for eligibility upon application. With the intent of social media driving users to a website to apply or find out more, it became clear that we wouldn't know which website would be most helpful or applicable.

Some states have combined CHIP and Medicaid so the experience is seamless for families. In Utah, the experience is somewhat different. The application and approval process is the same, however, once a family is enrolled they may have different provider networks, cost-sharing models and even managed care plans. This can be somewhat confusing for families, as

they navigate the system, not fully understanding the differences. Further, previous marketing campaigns have really only highlighted CHIP which has built a strong and recognizable brand over the years. However, the majority of enrolled children are actually eligible for Medicaid. In Fiscal Year 2016, Medicaid had more than 200,000 children enrolled, whereas CHIP only had about 16,000.

To address any confusion, we decided to develop a “Coverage for Kids” landing page, or single webpage, that would have information about both children’s public health insurance programs. From there, users can navigate to both CHIP and Medicaid websites for further details, or directly to the online application. The social media ads will link to this page, in which we can then track user behavior and if they applied for benefits. The intent of this page is to be somewhat high-level, describing what the programs do, who is eligible, and where to apply.

This project was one of the selected deliverables to contract with an approved vendor. I drafted the webpage copy and am currently working with a designer and programmer to develop the page. We have currently gone through round one of conceptualization and design. I reviewed the first draft and provided feedback and direction for the end product. I also worked with state technical support to register a web address for the landing page. I will continue to oversee this project and provide art direction and final approval. Once the page goes live, it will be found at: www.coveringkids.health.utah.gov

In addition, now that more web traffic will be driven to the CHIP website, I recommended that we update the current site. The current CHIP website was designed and launched ten years ago. While the information on the site is current and accurate, it needs to be updated. This effort will not only improve the look and feel, but will improve usability and mobile compatibility.

I also recommended that we enhance the Spanish page to make the information more interactive than what is currently available as a stagnant, single webpage. Previous literature identified a disparity in the quality of information available to the Hispanic population. This concern has been identified on the CHIP website. Given that approximately 25 percent of CHIP families self-identify as Hispanic, it is important that the website provides helpful information as they are looking to insure their children.

I am currently working with our contracted vendor to develop a new template for the CHIP website. The content and navigation will remain similar in length and style, but offer additional features that are not currently available on the site. The website will be built in a content-management system to make updating more user-friendly than the HTML currently utilized. Google analytics will be implemented throughout the site, as well mobile responsive behavior that adjusts to fit mobile screens. This project will be completed by the end of the fiscal year and I will provide oversight and final approval until completion. This component of the overall campaign will have a long-term benefit as it will be available and useful beyond the funding timeframe.

Social Media Video

The final component of this campaign is to produce a live-action social media video. It is well researched that consumers are more likely to click through from a post with a visual component. And videos have an even higher click-through rate than a static photo. The video will be edited to 30-seconds for social media ads, however a longer 90-second version will be on the newly developed “Coverage for Kids” landing page. Once completed, the new webpage will have written content, images, an infographic element (displaying income eligibility) and a live-

action video. By offering information in multiple formats, it will help the visitor digest the material and make the serious subject matter of health insurance more interesting and appealing.

The video will use storytelling in an interview-style format to highlight the benefits and features of the programs. After speaking with numerous individuals and advocates for a referral, I have found a current Medicaid family to tell their story about their experience enrolled in the program. The family has used Medicaid in three ways: their foster sons, their daughter with medically-complex needs, and as a family during difficult financial times. They know and can speak to the benefits of the state program, as well as their recent ability to become more self-sufficient and provide health insurance for the rest of their family (aside from the foster children and disabled child). They are enthusiastic about the service that Medicaid provides for families in need.

This is the third project that has been outsourced to the contracted vendor. While they will handle the production logistics, I have written the interview guide and will attend the video shoot, review the video editing, and provide final approval. We are scheduled to shoot the video in the next three weeks and have it finished by mid-May.

Results and Discussion

This project has exposed the logistical complexities of implementing a communication campaign. While every organization may not have the same bureaucratic barriers, the reality of overseeing any project involves administrative oversight and navigation. While it would be ideal to finish this capstone with pretty deliverables fully implemented, my role has been to oversee this campaign from start to finish. Pretty deliverables may be what is viewed to be the culmination of a campaign, however, the efforts and responsibilities to get to that point are often

unknown and unrecognized. My role has really been to align all the moving parts so that we have stakeholder agreement and buy-in, contractors selected and funded, and a strategic plan designed and implemented. These responsibilities laid the foundation for any deliverable to be developed.

Further, the reality in the world of communication is that most campaigns are a collaborative effort. Together Medicaid and CHIP are a \$2.5 billion agency, yet I am the only communication professional in the agency. However, this does not mean I operate free from collaboration and teamwork. I am not a graphic designer, web programmer or videographer. In order to produce any of these deliverables I have to collaborate with these other professionals. My job is to ensure that what is communicated, both through written and spoken word, as well as visual appeal, is effective, meaningful and consistent. Without my guidance and framework, these professionals would not be able to do their job.

To ensure that these aims are met, I have developed messaging, written content and provided art direction. It is my role to provide the holistic vantage point so that these efforts have impact and objective. I have passed the baton on the websites and video so that trained professionals can utilize their skill sets to produce my vision. While this capstone is at its conclusion, I will continue to fulfill my duty to see these task to completion by the legislative deadline.

As for the social media component, there are numerous tracking mechanisms including Facebook analytics, as well as our own website analytics that will be used to ultimately identify quantitative measurement like ad click through rates, cost per click and ultimately, the actual application for the assistance. Online advertising provides the ability to evaluate the overall

success of the campaign in real measurable data. This data will be of value when we report this campaign to the legislature, as they will want to see outcomes for the allocated funding.

As far as the community-based outreach, we have collected the first two months of tracking. The contractor has created “heat maps” in various zip codes to determine neighborhoods with the highest need for insurance coverage. They have broadened their reach by adding additional community organizations to partner in the effort of promoting the programs and helping families to apply. These organizations have included the Maliheh Free Clinic, the Salt Lake School District, the Hartland Community 4 Youth and Families, the Mountain View Community Learning Center, Volunteer Income Tax Assistance (VITA) sites, local libraries and Hispanic markets. So far there have been 12 outreach and enrollment events, reaching 185 individuals. The contractors will continue to help individuals who apply for coverage, through the enrollment process.

Beyond the enrollment events, there has also been success conducting door-to-door knocking in targeted areas to educate neighborhoods about their health coverage options. Working one-on-one with families in underserved communities seems to improve success rates of completing applications and obtaining coverage, especially for Hispanic and immigrant families. This process has also helped to reduce fears about the misnomer that a government program will report their immigration status. The Department does not report any immigration information to the U.S. Immigration and Customs Enforcement. However, given the current political climate, the fear of deportation is prevalent. By working individually with families, the worries have been assuaged by learning that they only have to report citizenship status for those applying for benefits, which is often children in mixed-immigration families. This specific finding is a testament to grass-roots and community-based efforts. By the end of the contract

with Bridging Communities and Clinics, a final report will be produced to show processes, outcomes and recommendations for future partnership efforts.

As documented throughout, the limitations of this campaign were the budget and the actual administrative barriers. After months of planning, preparing and navigating bureaucratic realities, I am anxious to see the final deliverables and implement the social media component. Nonetheless, this project has demonstrated real-world experience of practical application.

Conclusion

The facts are compelling: children with health insurance coverage receive better health care than children without insurance. They stay healthier because they receive medical care sooner and more regularly. Healthy children learn better and do better in school. And ultimately society benefits if we have healthy children. Unfortunately, the public health insurance programs, Medicaid and CHIP, are considerably underutilized.

Research has identified numerous explanations including specific population nuances and communication barriers to better explain why people remain uninsured. Based upon recommendations of community partners, which was corroborated by the literature, the Department conducted a two-fold outreach campaign with the allocated funding. The first is partnering with an existing grass-roots, community-based outreach program to utilize their contractor network and enhance their current scope of work. The funding leveraged a specific focus to inform communities about the available programs, as well as assist them through the application process. Second, the funding supported an online communication campaign by developing a campaign landing webpage and social media video, improving and updating the current CHIP website, as well as promoting the programs through social media ads. The

Department is hopeful that this strategic approach will address the issues and concerns raised by community partners, as well as have a longer-lasting impact than the six months of implementation.

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Appendix A***Medicaid/CHIP Outreach Planning Agenda***

Start Time: 3:00 p.m.
End Time: 4:00 p.m.
Location: Room 114
Cannon Health Building
288 North 1460 West
Salt Lake City, UT, 84114

Agenda Items

1. Welcome
2. CHIP Outreach/Marketing History
3. New Outreach Funding FY2017
 - Target population
 - Targeted program (CHIP and/or Medicaid)
 - Contracting options/limitations
 - Review UDOH recommendations
4. Feedback from Community Partners

Appendix B



Medicaid/CHIP Outreach Options

1. Intern (\$8,000 - \$10,000)

To address the need for additional staff to assist with the implementation efforts of new outreach ventures, it is recommended that the Division hire a temporary intern.

2. Material Development (\$5,000 - \$10,000)

The Division has never developed and distributed informational materials to promote Medicaid. All promotion related to public health insurance programs has specifically targeted CHIP and UPP. For this outreach endeavor, we would work with a state contracted graphic designer to create a brochure/poster/flyer that promotes both CHIP and Medicaid for children. The material would be printed and distributed.

3. Update the CHIP Website (\$10,000 - \$15,000)

The current CHIP website was designed and launched nearly 10 years ago. We believe that it could be enhanced to be more current, informative and compelling for today's users. This focus would have a long-term benefit as it would be available and useful beyond the funding timeframe. Additionally, the Spanish pages would be enhanced to make the information more interactive than what is currently available, as a stagnant, single webpage.

4. Online/Social Media Ads (\$5,000 - \$10,000)

An example of an online ad could be banner ads on KSL.com. These ads could be directed to the classified sections where families looking for items or jobs would see them in their searches. KSL.com is one of the most visited website in the state. Alternative social media ad placements could include Facebook and Twitter where demographics and geographic area can be strategically targeted. Online ads could include a stagnant ad or video ad (produced in house).

5. Soccer League Sponsorships (\$15,000 - \$20,000)

There are currently 4 Hispanic soccer leagues that can be partnered with to promote CHIP/Medicaid and build trust with the Hispanic/Latino community. Sponsorships may include ads on distributed materials, banners on soccer fields, tables at opening and closing ceremonies, and radio ads during broadcast games.

Another soccer league that provides opportunities for youth to play soccer regardless of financial ability, is the Utah Development Academy. They partner with neighborhood schools and community-based nonprofits to provide programming for more than 400 boys and girls, ages 4-18, of all skill levels through recreational and competitive soccer as well as free community soccer clinics.

Appendix C

Talking Points from the Medical Care Advisory Committee Meeting

- During this past legislative session, the Division of Medicaid and Health Financing received \$25,000 to implement program outreach. With the federal match, we will have \$50,000 in total funds.
- We initially met with various community partners and advocacy organizations to solicit feedback on the Division's direction to use these funds.
- There was an overwhelming recommendation from these groups to implement grass-roots, door-to-door methods of outreach. They voiced that in their experience this one-on-one, in-person tactic builds trust within the communities.
- Given that the funding is not significant enough to purchase mass media or replicate advertising and marketing efforts CHIP used in the past, we have outlined some areas that we believe would have the most impactful and long-lasting.
 - Our community partners did support a **social media ad campaign**. Social media sites like YouTube, Facebook and Twitter can specifically target certain demographics and geographic locations. This type of outreach has recently been one of the most effective for other programs within our Department. For minimal cost, they have resulted in significant response and interest. We estimate spending between \$5,000-10,000 for this campaign.
 - Next, as we are advertising coverage for kids, we want a place to send interested individuals. We would like to develop a **"Coverage for Kids" landing page** that has more information about both CHIP and Medicaid and then links from there to the application and respective websites.
 - Additionally, the advocates recommended focusing on the promotion of CHIP. CHIP has a strong and recognizable brand that has been built over the years. The current **CHIP website** was designed and launched ten years ago. We would like to update the site to improve usability and mobile compatibility. We would also like to enhance the Spanish page to make the information more interactive than what is currently available as a stagnant, single webpage. This update would have a long-term benefit as it would be available and useful beyond the funding timeframe. We feel that if we are promoting interaction on the social media sites, we need to have a current and informative web presence, once they begin exploring online. We have individuals in our Department that we will be working with which will significantly reduce costs for this type of project. We estimate spending between \$5,000-10,000 for web development.
 - Finally, we are in discussions with a program within the Department of Health called **Bridging Communities and Clinics** administered by the Office of Health Disparities. They have been operating for several years to improve community health in populations and areas affected by health disparities. They currently contract with many of the community partners we initially spoke with to coordinate community events and help community members get access to health insurance and a primary care provider. We feel like there is an opportunity to potentially work through them to achieve this grass-roots, targeted outreach effort. Without having to re-create processes and contracts, we believe there is an opportunity to enhance their current program with additional resources. Like I mentioned, we are in the initial stages of discussions and negotiations, but think there is certainly some potential to use the remaining funds in collaboration with this existing program.

Appendix D



Medicaid/CHIP Outreach Proposal

1. Online/Social Media Ads (\$5,000 - \$10,000)

Social media sites like YouTube, Facebook and Twitter can specifically target certain demographics and geographic locations. This type of outreach has recently been one of the most effective for other programs within our Department. For minimal cost, they have resulted in significant response and interest. Online ads could include a stagnant ad or video ad (produced in house).

2. Develop a “Coverage for Kids” Online Landing Page (\$2,000)

As we are advertising coverage for kids online, we want a place to send interested individuals. We would like to develop a “Coverage for Kids” landing page that has more information about both CHIP and Medicaid and then links from there to the application and respective websites.

3. Update the CHIP Website (\$5,000 - \$10,000)

The current CHIP website was designed and launched nearly 10 years ago. We believe that it could be enhanced to be more current, informative and compelling for today’s users. We also want to improve its usability and mobile compatibility. This focus would have a long-term benefit as it would be available and useful beyond the funding timeframe. Additionally, the Spanish pages would be enhanced to make the information more interactive than what is currently available, as a stagnant, single webpage. We feel that if we are promoting interaction on the social media sites, we need to have a current and informative web presence, once users begin exploring online. We have individuals in our Department that we will be working with which will significantly reduce costs for this type of project.

4. Bridging Communities and Clinics Partnership (\$25,350)

Bridging Communities and Clinics is administered by the Office of Health Disparities within the Utah Department of Health. They have been operating for several years to improve community health in populations and areas affected by health disparities. They currently contract with many of the community partners we initially spoke with to coordinate community events and help community members get access to health insurance and a primary care provider. Through this partnership, we will be able to utilize existing contracts to implement additional outreach and enrollment events targeting similar populations. We believe there is an opportunity to enhance their current program with additional resources, without having to re-create processes or contracts. By joining efforts, we are more efficiently utilizing funding to maximize outcomes and enroll uninsured children in Medicaid and CHIP.

Appendix E

Memorandum of Understanding: SPECIAL PROVISIONS

I. Purpose and Authority

This Inter-Agency Agreement sets forth the responsibilities between the Utah Department of Health's Division of Medicaid and Health Financing (**PRIMARY AGENCY**) and the Division of Family Health and Preparedness, Office of Health Disparities (**PERFORMING AGENCY**) in order to claim administrative Federal financial participation (FFP) in costs incurred to promote, facilitate, and support the delivery of effective health promotion, education and enrollment in the public health insurance program through the "Bridging Communities and Clinics" outreach efforts.

Authority for this Agreement is recognized in the Utah Department of Health's approved Cost Allocation Plan.

II. Definitions

1. **Administrative Federal Financial Participation (FFP)** refers to the Federal share of Medicaid payments authorized and directed under Section 1903(a) of the Social Security Act, which are available to the State Medicaid agency, or another qualified governmental agency under an interagency agreement with the Medicaid agency, for costs incurred to perform delegated administrative functions.
2. **Outreach** for purposes of this Agreement refers to enrollment efforts and outreach conducted for the purpose of providing information, education and assistance enrolling targeted populations in public health insurance programs.
3. **Target population** is the group intended to benefit from outreach and to which the outreach is directed. This population is defined as individuals including children and parents who live in underserved and highly minority populated areas who will potentially become eligible to enroll in Medicaid and/or CHIP.
4. **State Matching Funds** refers to the State's current percentage or "share" of Medicaid expenditures as defined under 42 CFR 433.10.

III. Performing Agency Responsibilities

A. The PERFORMING AGENCY shall:

1. Through the use of community outreach; promote and facilitate outreach to the target population for the purpose of assisting individuals in the target population by providing information, education and assistance enrolling in public health insurance programs.
2. Oversee that outreach efforts are accurate, consistent with the PRIMARCY AGENCY policy, and compliant with all applicable federal and state laws.

3. Consult the PRIMARY AGENCY, in writing, of any proposed changes to the focus or target population at least 10 business days prior to any proposed change.
4. Participate with and assist the PRIMARY AGENCY in the oversight of this Agreement.
5. Submit final report detailing activities performed and achieved objectives under this contract for the state fiscal year to the PRIMARY AGENCY by July 31, 2017.

IV. Primary Agency Responsibilities

- A. The PRIMARY AGENCY shall:
 1. Administer and oversee this Agreement in accordance with current Federal and State laws and the State's approved Cost Allocation Plan.
 2. Review total costs claimed under this Agreement to ensure:
 - a. The reasonableness of Medicaid's financial participation;
 - b. That total State and Federal funds paid do not exceed allowable costs; and
 - c. That payments do not exceed the maximum total funding authorized for the period covered by this Agreement.
 5. Provide guidance to assist the PERFORMING AGENCY in meeting its responsibilities under this Agreement.

V. Billings and Payments

- A. The PERFORMING AGENCY's claims for outreach costs shall include both Federal and State proportional share of costs.
- B. The PRIMARY AGENCY will strive to ensure that the State matching funds used for Medicaid claiming are Public Funds allowed to be used for the State share of financial participation meeting the federal requirements in 42 CFR 433.51.
- C. All payments under this Agreement shall be made in accordance with the Utah Department of Health's approved Cost Allocation Plan, and are subject to technical review and correction by the PRIMARY AGENCY's Bureau of Financial Services.

VI. Mutual Agreements

- A. The focus of each outreach event must comply with the law and be necessary to the proper and efficient operation of the Medicaid program to allow the PRIMARY AGENCY to draw federal Medicaid funds.
- B. The PRIMARY AGENCY shall pay in full for any disallowance of FFP resulting

- solely from the PRIMARY AGENCY's failure to notify the PERFORMING AGENCY of applicable Federal directives, policies, or regulations that affect this Agreement.
- C. The PERFORMING AGENCY shall pay in full for any disallowance of FFP resulting from the:
1. Failure of the PERFORMING AGENCY to comply with the provisions set forth in this Agreement;
 2. Failure of the PERFORMING AGENCY to implement any corrective action specified by the PRIMARY AGENCY, in writing, within a reasonable and mutually agreeable implementation period; or
 3. PERFORMING AGENCY's mismanagement or misuse of the funds or mismanagement of the outreach activities.
- D. If Federal funding is reduced by any amount for any reason while this Agreement is in effect, the parties shall renegotiate this Agreement to take into account the reduction in Federal funds. In the event that the PERFORMING AGENCY's State matching funds are reduced due to an order of the Legislature or the Governor, or changes in Federal or State law, the parties shall renegotiate this Agreement to take into account the reduction in State funds.
- E. The PRIMARY AGENCY will fund the PERFORMING AGENCY as outlined in the budget below. The PERFORMING AGENCY will invoice the PRIMARY AGENCY for the activities rendered for the Bridging Communities and Clinics Medicaid/CHIP Outreach, in accordance with the approved budget.

Redacted Budget Details

Appendix F

Medicaid Outreach and BCC Program: Monthly Template

Outreach Targets

Outreach and Enrollment events/ efforts	# of individuals per event/effort	Community Partner Outreach and Enrollment events/efforts	# of individuals per event/effort
5 to 10	Minimum of 50	10 to 20	Minimum of 50
Performed this month			

Enrollment Progress

Contractor				
# of individuals who scheduled an appointment	# of individuals who applied	# of individuals who completed an application	# Approved	# Denied
Sub-contractors				
# of individuals who scheduled an appointment	# of individuals who applied	# of individuals who completed an application	# Approved	# Denied

Activities Performed This Month

Partnerships Utilized & Developed

Appendix G

Coverage for Kids Social Campaign Solicitation to Bid

General Scope of Work

Scope of work related to campaign, including, but not limited to, the following:

Goal:

Increase awareness and application for the state's public health insurance programs, Medicaid and CHIP. Explain the difference between Children's Medicaid and CHIP, as well as encourage parents to get coverage for their uninsured children. The campaign will target parents and high risk groups including Hispanic/Latino families and locations specifically affected by health disparities.

Deliverables **may** include:

- Create and develop a campaign landing page for our current website
- Produce video for social media (interview style, discussing program and interview with family)
- Create a social media awareness campaign for driving traffic to the landing page
- Drive social media efforts through multiple digital ad buys
- Create and develop a template for CHIP current website (refresh current website)

Cost Proposal

Budget for all activities and deliverables cannot exceed \$24,500. Campaign deliverables must be billed and paid by June 30, 2017.

Evaluation

Vendors will be evaluated based upon the turnaround time (timeline) and ability to maximize funding.

Appendix H

Sample of Social Media Newsfeed Ads



Appendix I

Coverage for Kids Landing Page

Are your kids covered?

Keeping your children healthy is important. But without health insurance, it isn't always easy. Medical costs can quickly break your budget.

Medicaid and CHIP offers free or low-cost health insurance for kids and teens. Children can get regular check-ups, immunizations, doctor and dentist visits, hospital care, mental health services, prescriptions and more.

Children's Medicaid

Your children get medical and dental services at no cost to you if they qualify for Children's Medicaid. It helps more than 200,000 Utah kids stay healthy and get the medical care they need every year.

Children's Health Insurance Program (CHIP)

If your children get CHIP, you may pay up to \$75 every three months. You may also pay small co-pays for services like a visit to the doctor. Many children who qualify for CHIP come from working families but do not have other health insurance.

Who Can Get It?

- 1 Find your family size on the left side of the chart below. Follow that row to the right.
- 2 Is your family's income less than the monthly or yearly income shown in the orange Medicaid section? If so, your children might get Medicaid.
- 3 If your income is higher, follow the row to the green CHIP section. Your children might get CHIP if your income is less than the monthly or yearly income shown in the green section.

1 Find your family size here		2 May Qualify For Children's Medicaid		3 May Qualify For CHIP	
Family Members (Adults plus children)	Monthly Family Income	Yearly Family Income	Monthly Family Income	Yearly Family Income	
1	\$1,354	\$16,245	\$2,021	\$24,250	
2	\$1,833	\$21,992	\$2,736	\$32,828	
3	\$2,312	\$27,738	\$3,451	\$41,406	
4	\$2,789	\$33,468	\$4,163	\$49,959	
5	\$3,268	\$39,214	\$4,878	\$58,537	
6	\$3,747	\$44,960	\$5,593	\$67,115	
7	\$4,224	\$50,690	\$6,306	\$75,668	
8	\$4,703	\$56,436	\$7,020	\$84,246	

*Families meeting these income guidelines may qualify. (Income limits may change in March 2016.)

**Income is money you get paid before taxes are taken out.

Apply any day, any time.

One application covers both programs. Fill out the application and we will let you know if your children are able to get Children's Medicaid or CHIP.

Online. Fill out and submit an application [online](#). Click "Apply for Benefits" to start creating an account. Once you've logged in, you can apply, find out what's happening with your application, send in additional information, and manage your case.

Call 1-888-222-2542. You can call with questions and request an application to be mailed to you.

Appendix J

Covering Kids Landing Page Mock-up





ARE YOUR KIDS COVERED?



IT'S IMPORTANT

Get ahead by getting your kids covered. Parents who get Medicaid or CHIP often receive services for their children that can help them stay healthy and get the most out of their education. It's important to get your kids covered as early as possible. Call your local health department for more information.

APPLY NOW

MEDICAID

Your children's medical and dental services are covered by Medicaid. They qualify for Children's Medicaid if they are under 21 years old, live with you, and get the Medicaid from their parent every year.

CHIP

It's not always just CHIP coverage that is needed. Some children may also qualify for Medicaid. Many children who qualify for CHIP also may qualify for Medicaid. Contact your local health department.

Apply for Medicaid, CHIP, or both applications online from the Department of Health and Human Services. You can also apply for Medicaid or CHIP by phone. Call 1-800-332-2148 for more information.

Visit the Department of Health website. You can also visit the Department of Health website for more information. Call 1-800-332-2148 for more information.



WHO CAN GET IT?

	MEDICAID	CHIP
1	\$96,435	\$24,250
2	\$21,092	\$12,828
3	\$27,720	\$41,406
4	\$33,480	\$49,950
5	\$39,214	\$58,537
6	\$44,960	\$67,115
7	\$50,690	\$75,693
8	\$56,436	\$84,286

1. If your child is under 19 years old, you can apply for Medicaid or CHIP.

2. If your child is under 19 years old, you can apply for Medicaid or CHIP.

3. If your child is under 19 years old, you can apply for Medicaid or CHIP.

4. If your child is under 19 years old, you can apply for Medicaid or CHIP.

5. If your child is under 19 years old, you can apply for Medicaid or CHIP.

6. If your child is under 19 years old, you can apply for Medicaid or CHIP.

7. If your child is under 19 years old, you can apply for Medicaid or CHIP.

8. If your child is under 19 years old, you can apply for Medicaid or CHIP.

Appendix K
Social Media Video Interview Guide

Please tell me about your experiences before your children were insured.

How did not having coverage make you feel?

Did your children ever need to see a doctor or require medical attention while they were without coverage?

Did your children see a regular doctor?

How did you hear about CHIP or Medicaid?

Can you tell me how Medicaid has impacted your family?

What has been your experience while on the program?

What has it meant to have your kids covered?

Is there anything else you would like to share?