Improving Medical Assistance Outreach to Eligible Pregnant Women in Maryland

Final Report Presented to
Maryland Department of Health and Mental Hygiene

by

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OVERVIEW

Improving Medical Assistance Outreach to Eligible Pregnant Women in Maryland

Early access to prenatal care is seen as the cornerstone of infant mortality prevention efforts. In 2008, the Maryland General Assembly increased the eligibility ceiling for Medical Assistance to 116% of poverty for families as a strategy to increase access to care and decrease low-birth weight babies and infant mortality. Yet to-date, fewer pregnant women enroll in Medical Assistance than are eligible -- putting themselves and their unborn babies at-risk.

In Maryland, African-American mothers living in Prince Georges County have a high percentage of women receiving late or no prenatal care, a high percentage of low birth-weight babies and one of the highest neonatal mortality rates in the State (10.6) deaths per 1000 births. The majority of births in Prince Georges County occur among African–American women ages 18-24 years of age.

Maryland’s Department of Health and Mental Hygiene (DHMH) has a long-term goal of increasing the number of eligible pregnant women who enroll in Maryland Medicaid and receive prenatal services within their first trimester. This is of particular concern in Prince George’s County where neonatal and infant mortality rates among African- Americans exceed the State average. As part of their 2010 Needs Assessment process, DHMH sought answers to why and what could be done to improve communications so that eligible women enroll in Medicaid and get first trimester prenatal care.

The current study, Improving Medical Assistance Outreach to Eligible Pregnant Women in Maryland, was funded by DHMH and conducted by the Center for Health Literacy in the School of Public Health at the University of Maryland, College Park. The purpose of the investigation was to provide DHMH with recommendations for closing the gap based on the identification of possible barriers and facilitators to enrollment in Medical Assistance and early prenatal care.

A health literacy framework guided the qualitative study of eligible, pregnant African-American women ages 18-24 in Prince George’s County. Multiple sources of data were used to provide multiple perspectives on the gap. Data were collected from eleven users via focus groups. Two providers and one community advocate were interviewed. Two experts were given preliminary findings and provided their reaction to the findings based on their experience and expertise.

An assessment of materials was done using standardized instruments. Focus groups with the women and interviews with health clinic staff and a community advocate were conducted. The Medicaid application and informational materials were analyzed using the “Suitability of Materials” assessment.

Thirteen barriers and seven facilitators to enrollment and access to early prenatal care were identified. They ranged from intrapersonal to systems problems. None of the printed materials supplied by the state department of health met the standards of clear communications for health literacy; most had not been seen by the pregnant women. Findings were consistent with experiences
of experts. Recommendations for revising the application and materials and for changes in dissemination may be applicable to other counties and states.

Analysis of the data answered the following question: What health communication messages and channels are appropriate to increase health literacy and health coverage among Medicaid-eligible, un-enrolled, pregnant women?

A. What is the answer to the research question?
   - Health communications messages need to speak to the benefits of early care and of eligibility of pregnant women for state health insurance.
   - Web-messaging needs to be intuitive and user-focused.
   - Interpersonal and community group channels of communication need to be optimized.

B. What did we learn?
   - Confusion exists about the process for enrollment and accessing care among both providers and recipients.
   - Information isn’t flowing to users in a timely way using channels of communication that are easily accessed.
   - Delays in processing and initial prenatal care appointments extend well into the second trimester.

C. What could be done to reduce, remove or prevent confusion and increase enrollment and early access to care? In general, be clear, be concise, be accurate, be timely, be user-focused. More specifically:
   - Modify all current print and web materials to be sure they are written for pregnant women, meet health literacy standards and assure accuracy and consistency between all documents, messages and visuals.
   - Create new materials with input throughout the process from the intended users—eligible pregnant women, department of health personnel, other social service workers, community educators and advocates.
   - Develop a communications plan to keep health department employees, community volunteers, advocates and others who interact with pregnant women aware of eligibility, care options and routes to both.
   - Design a visual map of actions to obtain Medical Assistance and prenatal care to reduce confusion, increase understanding and provide a guide for mothers, staff and community workers.
   - Test a health navigator, community-based model to assist pregnant women and those who support them, in accessing care and insurance.
   - Provide professional development for staff to incorporate health literacy principles in daily work and reduce delays and associated costs.
   - Rewrite application separating instructions from application to comply with good formatting standards, including reduction of density of words, at least a 12-point font size and readability.
   - Evaluate all materials created or revised by engaging users during the process to increase the likelihood that the materials will be on target and users “get it and do it.”
ORGANIZATION OF REPORT

The components of this report include:

1) Overview
2) Statement of the Problem
3) Project Goals, Objectives, and Research Questions
4) Data Collection and Methodology
5) Study Findings
6) Discussion and Recommendations
7) Selected References
8) Appendices
STATEMENT OF THE PROBLEM

Early and regular prenatal care is a well-documented cornerstone of infant mortality prevention efforts. For over twenty years, Maryland’s Medical Assistance program has worked to remove the financial barriers that can prohibit women from accessing early and regular prenatal care. In fact, Maryland has one of the most generous Medicaid programs for pregnant women. Since 2001, pregnant women with household incomes up to 250% of the Federal Poverty Level (FPL) have been eligible for free, comprehensive health care. In Maryland, Medicaid further expanded coverage for families to 116% of FPL in the summer of 2008. Now more women of childbearing age are eligible for Medical Assistance before and after pregnancy.

As of 2006, Maryland ranked 39th among the 50 states with an infant mortality rate of 7.9/1000; a low birth weight rate of 9.4/1000 (1) despite the state’s standards for Medicaid eligibility for pregnant women. With Maryland’s levels of eligibility for Medical Assistance, more women should be enrolling. Yet to-date, fewer women enroll than are eligible to participate in Medicaid --putting themselves and their babies at-risk.

Rates vary by jurisdictions and race. African-American mothers living in Prince George’s County are less likely to receive early prenatal care, have a higher percentage of low birth-weight babies and, at 10.6 deaths per 1,000 births, have one the highest neonatal mortality rates in the State.(DHMH). As state policy, the governor wants to reduce the high levels of low birth weight babies and infant mortality by 10% by 2012 (1). The Maryland Department of Health and Mental Hygiene (DHMH) decided to focus on Prince George’s County and to investigate barriers to enrollment in the state’s Medical Assistance program. In particular, they wanted to learn more about the utility of their informational materials and channels for communicating key information. Both of these topics are within the field of health literacy.

Health literacy is a combination of skills needed to become and stay healthy, to prevent and manage disease. Components include listening, speaking, reading, writing, numeracy and cultural competency. Research establishes a link between health literacy and health outcomes. Health literacy has two foci—1) the ability of individuals to get, understand and use health information and services; and 2) the extent to which health environments support people as they seek, receive and use information and services.

Research suggests that poor or low health literacy contributes to disease, its mismanagement and is very costly. Studies also demonstrate that few American adults are fully health literate. Those with low health literacy are less able to understand information, to do appropriate self-care of themselves and their children, and to get preventative care. Research also establishes that health services environments can be modified to increase the ability of people to access and use those services. Changing environments requires a user-focused approach. It means that language is culturally-appropriate, plain and simple; visuals are used to get and hold attention and improve recall; information and instructions are easy to understand and act upon; and signage, directions and other navigational tools are user-friendly and user tested.
The Maryland Department of Health and Mental Hygiene identified a Long-term Policy Goal, Project Goal and Research Question:

Policy Goal: 
*Increase the number of eligible pregnant women who enroll in Maryland Medicaid and receive prenatal services within their first trimester.*

Project Goal: 
*Identify health communication messages and channels that will encourage Medicaid-eligible pregnant women to get enrolled and receive prenatal care.*

Overarching Research Question: 
*What health literacy and health communication messages and channels are appropriate to increase health coverage among Medicaid-eligible, un-enrolled, pregnant women based on an analysis of responses of the sample and using principles of health literacy?*

To achieve those goals and answer the research question, the focus of the current study was on understanding the barriers to enrollment in Maryland’s Medical Assistance program experienced by a group of women traditionally predisposed to late entry into prenatal care – African American women between the ages of 18-24. This study focused specifically on those women in Prince George’s County as enrollment rates among this population in that county are the lowest in the state.

The intended output of the study was recommendations for the Maryland Department of Health and Mental Hygiene regarding future efforts and campaigns to encourage Medicaid-eligible, uninsured pregnant women to enroll in Medicaid.

Three specific objectives guided the data collection, processing, and reporting:

Objective 1: Identify factors that serve as barriers to enrollment in Medical Assistance and early prenatal care.

Objective 2: Identify factors that support enrollment in Medical Assistance and early prenatal care.

Objective 3: Determine the health literacy demands of printed materials and effectiveness of current channels of dissemination.
DATA COLLECTION AND METHODOLOGY

Procedures:

A. Focus groups. The Department requested focus groups be conducted through the Prince George’s County Department of Health to obtain insight from women eligible for Medical Assistance and prenatal care. The PIs worked with host site personnel at the Cheverly community health clinic and WIC site and a WIC office at the Central Avenue site. The team also worked with a community church in Seat Pleasant. All were asked to assist in recruiting a convenience sample and secure space for focus groups and interviews.

Host sites had primary responsibility for recruitment with the research team’s guidance about participation criteria and informed consent. For their efforts in recruitment and hosting of focus groups or interviews, a financial incentive was provided to the two sites where focus groups were conducted. Host sites also had the responsibility for recruitment of a minimum of one staff member to participate in a 30 minute interview.

A convenience sample of eleven women participated in the study. All participants were English-speaking African-American women, living in Prince George’s County, ages 18-24, pregnant or with at least one child age 6 months or younger, and were eligible for, or receiving, Medicaid during their pregnancy(ies).

Two focus groups were conducted for up to 2 hours by an experienced and skilled moderator. Audio recordings and notes compiled by a reporter captured the conversations. The recordings were transcribed by a professional transcriber. The focus groups were scheduled after discussions between host sites and the research team at mutually acceptable times, days and locations. Healthy food and beverages were served. Participants received a participation gift of $35.00.

Three other sessions were scheduled but participants did not attend. In one case, the lone woman was interviewed following the same question protocol used in focus groups. The difficulties in recruitment were disappointing to the research team but consistent with the challenge of engaging the targeted population.

B. Interviews. To add a staff perspective on the barriers and facilitators, the Center for Health Literacy chose to conduct interviews. Two staff members at the Cheverly host site and one volunteer community advocate at a church were interviewed by the lead Principal Investigator. They were also asked questions about the current educational materials used to promote enrollment and for suggestions for improvement of enrollment methods and materials.

C. Materials Analysis. Materials used by the Department of Health and Mental Hygiene and the host sites, were analyzed by the research project team for purpose, principles of plain language and universal design. Two members of the research team under the direction of the lead Principal Investigator conducted the analysis using the well-accepted “Suitability of Materials” assessment. The Center for Plain Language was asked to conduct an analysis of the state Medicaid application and to rewrite a component.
**Instrumentation:** The focus group questions and those for the interviews were drawn from the following sources: 1) The DHMH; 2) the University of Maryland Herschel S. Horowitz Center for Health Literacy project personnel and a focus group expert consultant; 3) Data collected by DHMH which came from the Maryland Prenatal Risk Assessment, Fiscal Year 2008; 4) Maryland PRAMS report 2006; 5) DHMH Medicaid billing data (MMIS); and 6) A review of literature prepared by DHMH. The complete instruments, including questions for staff members, for the women, and for collecting demographic information, are available from the Principal Investigator.

**Analysis of Data:** Three sources of data analysis were utilized for this project:

1) The focus group moderator and co-investigators conducted qualitative analysis, using grounded inquiry, identified themes as a means of providing an understanding of the lived experiences of the women related to their enrollment in Medicaid and use of prenatal care;

2) Two external reviewers, with relevant experience and expertise, provided feedback based on the summary of findings. Two members of the research team conducted the data analysis.

3) The educational materials were analyzed using health literacy plain language and universal design practices by three members of the research team with the Medical Assistance application reviewed by two experts on the board of the Center for Plain Language.

These three sources of analysis were used for drawing conclusions and making initial recommendations. To increase the likelihood that the recommendations were relevant for future DHMH outreach efforts, women and staff were invited to a final focus group. None of the women attended. Eight county and state health department staff participated in a debriefing of findings to provide their perspectives which were used in the final conclusions and recommendations. The nearly final report was then submitted to the DHMH project team for their comments shown in the findings section.
STUDY FINDINGS

Objective 1: Determine factors that serve as barriers to enrollment in Medical Assistance and early prenatal care.

From the focus groups and interviews, we identified thirteen perceived barriers to enrollment.

1. Limited awareness of the link between prenatal care and specific issues like low birth weight and infant mortality.
2. Denial and depression about pregnancy.
3. Embarrassment and confusion among women newly eligible for Medical Assistance.
4. Possible limited awareness of expanded eligibility for family coverage and pregnancy.
5. Difficulty providing some documentation required with application.
6. Perception of the need to provide proof of Pregnancy.
7. Perception of the need to identify the father and his income, as well as the income of other household members.
8. Potential confusion about the requirement for Medical Assistance versus private plans from the same insurance companies.
9. Wait time for Medical Assistance approval.
10. Confusion about options for care while waiting for Medical Assistance approval.
11. Wait time at clinics to get an appointment and then to be seen when they go.
12. Limited access to the Internet.
13. Difficulty getting access to print materials and applications.

Note: In some cases, perception may not match reality. Determining the depth and accuracy of participants’ knowledge was beyond the scope of this project. Discrepancies are mentioned in the comments section of the charts that follow.

<table>
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<tr>
<th>BARRIERS TO EARLY PRENATAL CARE AND MEDICAL ASSISTANCE ENROLLMENT</th>
<th>Comments with Source and Additional Information</th>
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<tbody>
<tr>
<td>1. <strong>Limited awareness of the link between prenatal care and specific issues like low birth weight and infant mortality</strong></td>
<td>While the women indicated awareness of the need for self-care during pregnancy, they did not speak to the importance of early first trimester care. They did not seem to understand HOW staying healthy themselves affects their baby -- and/or that self-care and early/regular prenatal care are linked specifically with preventing low-birth weight babies, infant</td>
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In one group with women who were in their second trimester and, in several cases, also had health issues such as hepatitis, sickle cell, and suspected diabetes, the moderator asked specifically what women have heard about why prenatal care is important. Preventing low birth weight or infant mortality were never mentioned – only “having a healthy baby” in general. For example:
I guess the impression is that if you’ll keep yourself healthy then you’ll have a healthy baby. But, they don’t give you too much detail or anything. I guess the main goal is to try to have a healthy baby.

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<th>2. Denial and depression about pregnancy</th>
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<td>Although most women learned about their pregnancies during the first trimester, several did not, and said they were in denial and experiencing depression that delayed seeking insurance and care. One teen was 5 months pregnant before finding out, and just getting care at the time of the focus group. Another said she had not had any support from the baby’s father or her family, so she had avoided telling anyone for quite awhile after knowing. We heard:</td>
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<td>Some of the younger females are going through depression or denial about the situation.</td>
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<td>I didn’t see a doctor for 6 months because I wanted to keep [the pregnancy] a secret.</td>
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<td>I already knew but I guess I was in denial for a minute. [found out at 7 weeks]</td>
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<tr>
<td>We would need a larger sample to learn more about women who did not know they were pregnant until the first trimester passed.</td>
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<tr>
<td>While some women learned early on about their pregnancies and were motivated to seek care, staff told us most women are already in their second trimester when they come for care. (Team)</td>
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<th>3. Embarrassment and confusion among women newly eligible for Medical Assistance</th>
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<td>We were told that rising unemployment and hard times have increased the need for Medical Assistance among women who may not have had previous experience with it or with the Cheverly Health Department Clinic and/or Social Services programs. Both staff and the women talked about this change in those seeking assistance. We heard that embarrassment and confusion among such women may contribute to starting the process later in their pregnancies.</td>
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<tr>
<td>Life circumstances can affect the kind of messages that will connect. For example, people who are newly eligible for Medical Assistance due to unemployment may need different messages than those who have been eligible for various forms of public assistance. (Team)</td>
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4. Possible limited awareness of expanded eligibility for families and pregnancy coverage

Many of the women had children already and past personal experience with Medical Assistance during pregnancy. They had returned to the Health Department or Social Services only when they became pregnant. They may not have realized possible eligibility under the expanded program for insurance benefits even before they became pregnant. For example, we heard:

*I have to wait to have a baby before getting insurance.*

*The state [says] I can’t get my health insurance ‘cause they’re telling me that I make too much money on unemployment.*

*I’ve seen the clinic [so] I had went to the lady [who] kept saying “MCHIP” and I didn’t know what she was talking about until they said it’s a type of insurance once I got here.*

There also were some comments suggesting that staff may have difficulty keeping up with all the changes, especially with the caseloads they have. One woman said:

*My social worker, any time I called her, I never…I may get a follow-up call the next day. So, if that’s saying that she maybe has too much work on her hands or whatnot. Then, they’ve been telling me, the rules changed. That’s what they’ve been telling me. Oh, they done changed everything since last year…the qualifications has been changed from last year…And, then like if you knew that, why did you take me through this process of four months and just do it the new way. So, I don’t get it.*

5. Difficulty providing some documentation required with application

We heard in the focus groups and staff/advocate interviews that the documentation can be hard to come up with, especially proof of legal immigration status, proof of address, and proof of bank account. Many of the women we talked to did not speak English as a

Acting on previous experience and knowledge can work against the women when changes have occurred and are not widely known. (Team)

Nationally, this has become a big issue for states after citizenship documentation was required by the Deficit Reduction Act of 2005. Many low-income, citizen families that did not have readily available documentation were dis-enrolled from Medicaid. (External Reviewer)
native language. At least one said she had to wait for a green card to apply for Medical Assistance.

We also heard during a staff interview about how transient the women are and therefore, how difficult it can be for them to provide proof of address. Low literacy and psychosocial issues may also contribute to difficulty understanding requirements or following through in time for application cases to remain open. We heard:

*The process of applying for medical assistance and stuff like that – it’s your life story. They want you to cross every “T”, dot every “I”.*

*Some of them get discouraged for all of the information that they ask for.*

Everything was easy for me [to get care with the first pregnancy] but now they asked me if I am citizen or if I have a green card. I don’t have it yet so they [gave] me some paper and tell me she’s going to call me like one month—after one month.

### 6. Proof of pregnancy

We heard from staff:

* [There could be confusion...] that they can apply without the pregnancy test results...it used to be they had to submit that with the application. So, they could say, “Well, I know I can’t apply yet” because...they think they need to get in for the pregnancy test when they could really just apply [now -- before they even come in here].*  

Medical Assistance applications had to include proof of pregnancy. This can now be submitted separately, even though women may not realize it. *(Staff interviewee)*

*Proof of pregnancy has not been required since July 2001, nor is there a requirement that proof be sent in later or separately. It is very discerning that eligibility staff at the local level may still be unaware of this change.* *(DHMH)*
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<th>7. Perception of the need to identify the father and his income, as well as the income of other household members</th>
<th>Would need further research to understand the extent of this potential barrier. (Team)</th>
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<tr>
<td>We heard that this can deter some women from applying. For example:</td>
<td>For pregnancy coverage, the only income counted is the applicant’s, her spouse’s (if living in the home), and the income of any of her children under 21 living in the home.</td>
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<td>Some of the young women for the insurance for the pregnant women, they don't want to turn the babies’ fathers because the state does go after [them] …to get them liable for the insurance.</td>
<td>Confusion exists because if the mother is pregnant, lives with the father of the baby, and has other children by him in the same household, his income would be counted towards family coverage.</td>
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<td></td>
<td>If she is pregnant but does not live with the FOB she will not be denied pregnancy coverage even if she does not name the FOB. However in signing an MA application for her children she is agreeing to cooperate with seeking child support. (DHMH)</td>
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8. Potential confusion about the requirements for Medical Assistance versus private plans from the Same insurance companies

We heard:

*The clinic that I went to, she gave the number here [at the HD] and I called here...then I found out they [need to know your] income...but when I bring the pay stub, they just like [were going to take about half of it]...so I thought I might as well just try to get insurance on my own. So, when I would try like health insurance companies and stuff like that, they told me I couldn’t get it because of the fact that I was pregnant and they considered that an illness already. So, I...[go] down to Social Services...trying to figure out what I can do. I told them at the end of April [it’s now October] because they needed the paper proving that I was pregnant and everything. And, I still haven’t got insurance as of now....I keep going down there but it’s like just keep getting the run around. [She is getting prenatal care that she pays for but is concerned about care after the baby’s birth.]*

It seemed that some women were confused about the eligibility requirements and costs of Medical Assistance versus private insurance plans – perhaps because some of the private insurance plans that the women’s family and friends have are from the same companies administering Medicaid; e.g., Blue Cross/Blue Shield, Amerigroup. It may not be clear that the approval process will identify what type of coverage you are eligible for, and that after you receive approval, you still choose a specific insurance company that may also administer a family member’s or friend’s private plan. (Team)

Confusion is common across Medicaid plans. Many states entitle their programs something distinct (e.g. MiChild in Michigan) so people seeking advice from friends in other states might not know which program they are referring to. Medical Assistance itself is a general term that could lead to confusion. (External Reviewer)

Once a pregnant woman is found eligible for Medicaid she must enroll in a Managed Care Organization (MCO). Women often relate to the MCO as their insurer without realizing that they also have Medicaid. Of the seven MCOs only UnitedHealthCare is also a private insurer. (DHMH)
9. Wait time for Medical Assistance approval

Most of the women were uninsured when they became pregnant, or left a job or were laid off a job and lost insurance soon after learning about the pregnancy. Care was often delayed by the wait time for Medical Assistance approval (usually at least 30 days) if they did not have the means to pay for care in the interim (even with sliding scale fees) or had difficulty getting onto the limited schedule of sliding fee care at the Health Department.

This delay appears to contribute to a lack of first trimester prenatal care, or regular care during those 3 months even for motivated women who started the insurance process in the first or second month of pregnancy as illustrated by these comments:

*When I came here the first time, they gave me a list of clinics [where I could go without insurance]. I came back here at almost 7 months and said I still hadn’t been able to get care.*

*Couldn’t get fitted in here [at the HD] so went to private family doctor until could get in here. I have no insurance. [When I had insurance from work] I was going to see [the doctor] once a month to once every two weeks to once a week but as of right now, I haven’t been to the doctor since September…. [I mean] August. [Amniocentesis had revealed birth defects.]*

We were told in a staff interview that the “single biggest” deterrent to early prenatal care is:

*Here in this county…it’s due to the Department of Social Services process…They never come in here…they go to DSS because… DSS is what is known in the community because if my rent is not paid and I don’t have food to eat, I’m going to go to Social Services first because I need help. So, women who end up in Social Services first, if they identify this woman as pregnant, they need to set up some type of expedited processing for her medical care.*

Even in the best of circumstances, it is at least 30 days.

Maryland does not have “presumptive eligibility” for pregnant women. Rather, Maryland has a presumptive eligibility-like process. (Kaiser State Health Facts).

Maryland’s *Accelerated Certification of Eligibility* permits pregnant prospective Medicaid enrollees to obtain services during the application period. (External Reviewer)

Recent changes in Medicaid policy, now allows the LDSS to expedite applications for pregnant women using ACE (accelerated certification of eligibility process). (DHMH)
One woman told us:

*I knew that the process was going to take forever. Forever. Sometimes before you’re even seen by the state, it’s 60 days. The process from the day when you’re filling out the paperwork can be from 30-90 days.*

The message we attempt to give in the community is – “If you are pregnant call or go to the LHD – they can expedite your Medicaid application even if you are getting other benefits from social service.”

10. Confusion about options for care while waiting for Medical Assistance approval

Apparently, it is possible to get a clinic appointment for free prenatal care even without insurance. However, women’s stories suggested that this is not well known and that it is difficult to figure out where to go for information or care. For example:

*They (WIC) haven’t been helpful [with insurance]. They’ll [only] ask about if you’re eating healthy.*

*No, it was very hard [to get information on the phone.] I had to go actually to the center... I called 411 and asked about it.*

*The first time I called [a clinic] they told me that they can’t take [me]. I have to wait or I have to call under the pregnancy family [plan]. I called a lot of [places before I found out I should call here.]*

In a conversation with a colleague who is quite familiar with the Maryland WIC program, she told me that WIC could do more to help women get insurance through Maryland’s Medical Assistance. (Team)

This is a challenge since many prenatal care providers do not want to see the women until they are enrolled in an MCO. This is why the ACE process is so important. Pregnant women can be enrolled in the MCO for at least 3 months while their MA application is being finalized. (DHMH)

11. Wait time at clinics to get an appointment and then to be seen when they go

We heard there is a time delay in getting an appointment that could push care into the second trimester. We also heard the perception that some medical practices that accept Medical Assistance treat patients differently than paying clients. And we heard that the wait at the clinic on appointment days can be lengthy and problematic, especially for women with children. We heard:

One physician in the Prince George’s County Health Clinic, speaking informally, said that they did not have enough staff to handle demand. This antidote was not investigated. Additional research would be needed to understand the adequacy of staff to patient ratio. Further research would be needed to understand the extent to which these experiences are common or exceptional. (Team)
The wait for appointment and wait when you get there [deters women from going.] We had one to say to us, she was four months pregnant — her appointment was at 8 o’clock; she didn’t get out until 4. So, the wait time, it discourages you to take a full day just to go sit up to see a doctor.

I had an appointment, but it was first come first served. I sat there all day from 7:45 to 4:00.

They estimated 30 minutes but it was 2.5 hours. I told her, “This piece of paper says 30 minutes. I’m not working but you don’t know that. Not fair.”

I’m paying $30 a co-pay just for me to come to the doctor’s for someone just to take my weight and for me to pee in restroom -- for me to be there for 2.5 hours is ridiculous.

I called to get an appointment and [it] isn’t [for another week] and I called three weeks ago. [has been told her unemployment disqualifies her for free care – and had amnio already that revealed serious fetal problems. No care since August.]

The doctor treats you different if you’re having insurance form the state rather than insurance from a job...they’ll make you wait longer if you’re insured through the state. Or it might take you longer to get the appointment than if you were insured through a job. Might wait longer in the room than if you were someone with insurance through job.

Some places are not very inviting.

Medicaid does not charge pregnant women a premium and there are no co- pays for pregnant women; even pharmacy co-pays are waived for pregnant women. (DHMH)

12. Limited access to the Internet:

We heard mixed messages about the Internet. Almost all of the women said they have e-mail and use the Internet. But we also heard from a community advocate that she doubts many women have this resource. She said:
I don’t think they do have access to the Internet. Where I’m located now, we are into our low-income high-risk, high-crime area. A lot of these young girls are single parents living on welfare, living in subsidized housing and don’t have access to it.

Even for those who have access to the internet, the DHMH website discusses the three types of health insurance but doesn’t directly mention pregnant women. Website examined: http://dhmh.maryland.gov/ma4families/

It took about three clicks to see that pregnant women are covered under Medical Assistance. It is possible that not every person continues down the page. Thus, pregnant women may not be aware of eligibility. (Team)
<table>
<thead>
<tr>
<th>13. Difficulty getting access to print materials and applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments included:</td>
</tr>
<tr>
<td>State-wise, I don’t feel, free insurance isn’t being advertised the way it should with the condition of people today. Yes, it’s up to us to take a stand and find out as much as we can. It’s not going to come to you. Word of mouth is how it’s getting around in this area here. You won’t be able to find it unless you go a resource center that will give out information. County-wise, maybe you will find it, but out on street you’re not going to.</td>
</tr>
</tbody>
</table>
| In general, focus group participants had not seen any of the DHMH materials about Medical Assistance. We heard that there is a pamphlet room at the Health Department and were given a sample of materials distributed which included a Health line telephone number. From the community advocate, we heard that it is very difficult to obtain quantities of Medical Assistance materials needed to meet the demand for them, and that it is not possible to obtain multiple copies of application forms. The community advocate said she copies these at her own expense.  

The objective analysis revealed that all materials could be improved. At least two documents used the same visuals but were not related sending a mixed message.  

The research team noted that DHMH and local Health Department materials are not as eye-catching as materials from other sources such as the March of Dimes.  

The word “family” without the word “pregnancy” and the visual for *The Medical Assistance for Families* showing a group of people may be confusing and misleading. (Team) |
Objective 2: Determine the factors that support enrollment in Medical Assistance and early prenatal care. We identified the following seven facilitating factors:

1. Mother’s awareness of pregnancy.
2. Mother’s awareness of the importance of care and assistance.
3. Mother’s previous experience with the Prince George’s County Health Department.
4. Local outreach campaigns and low-cost outreach opportunities.
5. Expedited Medical Assistance processing at the Cheverly Health Department Clinic.
6. Medical social worker support at the Cheverly Health Department Clinic.
7. Mother’s perception that application is relatively easy to complete.

<table>
<thead>
<tr>
<th>FACILITATORS TO EARLY PREGNATAL CARE AND MEDICAL ASSISTANCE ENROLLMENT</th>
<th>Comments with Source and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Mother’s awareness of pregnancy</strong></td>
<td>A larger sample is needed to learn more about women who did not know until the first trimester passed. While some women learned early on about their pregnancies and were motivated to seek care, staff told us most women are already in their second trimester when they come for care. (Team)</td>
</tr>
<tr>
<td>Several of the women knew they were pregnant fairly early in their first trimester and were motivated to get coverage and care. They had done one or more home pregnancy tests and sometimes had been to a doctor already to confirm the pregnancy. At least one had planned the pregnancy with her boyfriend. An example of how motivated some of the women we talked with were:</td>
<td></td>
</tr>
<tr>
<td><em>I knew I was pregnant and wanted to get care…I kept calling and calling other places. Then I went to the Internet, searched “pregnant and don’t have money”, found a [local] forum with other women to get advice. When I called (where they recommended), I was told it would cost. I found out about calling here because of my address.</em></td>
<td></td>
</tr>
<tr>
<td><em>I just want to make sure that I go for my baby….</em></td>
<td></td>
</tr>
<tr>
<td><strong>2. Mother’s awareness of the importance of care and assistance</strong></td>
<td>Determining the depth and accuracy of their knowledge was beyond the scope of this project.</td>
</tr>
<tr>
<td>Most of the women were aware of quite a few important things to do when pregnant (e.g., eat healthy, rest, take prenatal vitamins). Most understood that prenatal care is important and often were proactive about seeking care soon after learning they were pregnant, and/or seeking Medical Assistance to obtain care.</td>
<td></td>
</tr>
</tbody>
</table>
Women said:

*It's important to go to prenatal appointments every month.*

*It's important to get your medical insurance and stuff so you can help the baby.*

*Drink more water. Make sure you get your vegetable intake for each day. Cut back on sweets.*

*No smoking. No alcohol or drug use.*

*No medications except those given by doctor.*

As stated in the barriers, the women we talked with did not seem to understand HOW staying healthy themselves affects their baby—and/or that self-care and early/regular prenatal care are linked specifically with preventing low-birth weight babies, infant mortality or other fetal/baby development issues. (Team)

<table>
<thead>
<tr>
<th>3. Previous experience with the Prince George’s County Health Department</th>
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</thead>
<tbody>
<tr>
<td>We were told by staff that many women have had previous contact with the Health Department for a variety of services, including care for past pregnancies. We heard from staff:</td>
</tr>
</tbody>
</table>

*They may have had a pregnancy before they came here…it doesn't have to be recent. It could have been maybe seven years ago and [even though] there are changes in the healthcare system every year…they remember that that they came here to the HD. It could have been also that they access another service and by coming here, they may have seen on the sign what other services we offer such as prenatal care.* |

Past exposure to services and/or to information about prenatal care may help them return earlier in a new pregnancy, even if past contact was quite awhile ago. (Team)

<table>
<thead>
<tr>
<th>4. Local outreach campaigns and low-cost outreach opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women told us they had seen some posters on buses about the county Health Line program. One staff member said:</td>
</tr>
</tbody>
</table>

*…our county actually has materials out in the community…we did a media campaign some years ago to promote our Health Line so those materials are still out in the community. And, we just started a new media campaign actually Monday Healthy Living, Healthy Lives…to encourage women to call for [general wellness services, not just prenatal care].* |

There have been some media campaigns in the state and Prince George’s County as well as some ad hoc community outreach efforts to alert women to the importance of care and the process for getting insurance and other benefits (e.g., Food Stamps, housing vouchers, SCHP, etc.).

Time did not permit in-depth probing of these channels of information delivery. (Team)
The women also told us that they have obtained health information and/or would recommend some of the following channels, all common and relatively low-cost for information dissemination:

- word of mouth in the neighborhood from friends, neighbors
- school
- work
- internet forums with local women
- grocery store
- community centers
- lampposts
- churches
- library
- barbershops
- community coordinator or advocate

Many of the women we talked with said they had cell phones with text service. Although the community advocate told us she doubted many women have computers, the women in the group seemed to be regular cell and Internet users. One showed an example of an ad she received on her cell phone as one avenue for communicating information to women. Another, previously quoted, used the Internet to get information from other local women about where to go for help.

5. Expedited Medical Assistance processing at the Cheverly Health Department Clinic

Apparently, if a woman applies for Medical Assistance at the Health Department, there is an expedited processing system that is supposed to result in faster approval than if she applies at the Department of Social Services (DSS). We heard from staff:

*We do have in-house eligibility determination. We have regional access centers that are housed within the Health Department that process MCHP applications.*

The research team was unable to explore the expedited process. We cannot speak to the differences and the extent to which women are familiar with, and likely to go to, DSS rather than the Health Department for Medical Assistance. We did not hear about any approvals under 30 days, regardless of where the application was first completed. (Team)
6. Medical social worker support at Cheverly Health Department Clinic

Staff said:

We have a social worker in our clinic, a full-time social worker and every client sees [her]. [She] assists our client by providing them with actual MCHIP applications and with the application process. So, [she] would give them the application and tell them that they need to complete it. [She] kind of goes over it with them...what documentation needs to be submitted...on subsequent visits, if they need help with the application, they can still see the social worker and she can still continue to assist them...we play an integral role actually in enrolling them in Medicaid.

Women told us:

The lady [at the clinic] —she was very helpful trying to find me insurance and...send me to somebody who would help me...and, that's when she found the number here. She worked with me about a couple of weeks until we found it.

You have like the lady, she’s a social worker, and she helps me every time I come here, anything new that’s going on. It’s like they basically... they’re like more here for you. They kind of make sure you’re okay...they’re always calling and letting me know “Well, can you come in?” or why don’t I come in. Most of the time, I don’t even wait—I might wait five minutes and then they tell me to come to the desk. [This was about the HD clinic at the hospital]

Note, however, that some women also mentioned that they were not sure staff were familiar enough with the rules to provide accurate guidance. For example:

You would think that the social worker is the one who will give you that information. It’s easy to hand it and say this is the way to go about it and they act like they don’t even know the rules.

Apparently, every client at the Cheverly Health Department Clinic meets with a full-time social worker who helps women understand the process for getting Medical Assistance and prenatal care. The social worker also provides educational materials that match each woman’s needs and situation. At the end of the study, the social worker was no longer employed at the clinic. As evidenced by the women’s comments, the social worker was a great asset. The absence of a skilled worker could become a barrier. (Team)
7. Perception that application is relatively easy to complete

We heard mixed messages about the application forms from the women, staff and community advocate. On the one hand, we heard the forms are relatively easy to fill out, and that women show up sometimes with the form completed. Staff and the community advocate told us:

*I always thought from the beginning that the application was a good application. It was put together by the state, because it’s really not that long and it’s actually straight and to the point…easy to understand…they were able to fill it out.*

*The Primary Adult Care program for an example will only take you about 7 minutes to fill out one piece of paper that’s not asking for nothing other than your name, address, social security number and if you have different monies coming in.*

We did not hear a lot of complaints about the form itself, from the women. However, we did hear that the accompanying documentation – of address, bank account, citizenship, and so forth can be daunting. So there are aspects of the paperwork that are both a facilitator *and* barrier to enrollment.

We were told by staff that on a scale of 1-10 with 1 being “easy” and 10 being “hard” to complete, the form rated a “3.”

<table>
<thead>
<tr>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is not enough evidence available to understand if women who brought completed applications to the clinic were able to complete the application themselves or if they were helped, who helped. There is a cost associated with time spent doing or teaching women how to complete the application. (Team)</td>
</tr>
</tbody>
</table>
Objective 3: Analyze the health literacy of printed materials used to inform potential enrollees about Medical Assistance.

Background: Health literacy is based on the principle that people can understand what is being told to them orally and in writing and that they can put into practice what they are being asked to do. For this to occur, those who provide messages need to do so in keeping with the literacy levels and cultural diversity of their targeted audience. The field of health literacy science has created a number of assessments of materials and recommendations for health literate-sensitive documents.

Leading the way in clear communications is the federal government who established the need for plain language in the 1990s. A variety of initiatives, reports and funded projects have ensued. Health professionals and adult literacy professionals are expanding the focus on creating environments where the health literacy demands are decreased so that people of varying literacy levels can know, understand and act upon health information. Unfortunately, based on the 2003 National Assessment of Adult Literacy, the majority of people are below proficient in their health literacy.

The Analysis & Findings: Part of the current investigation was to analyze printed materials used to inform potential enrollees about Medical Assistance. To that end, DHMH provided the research team with seven documents: Affordable Health Services and Care in Maryland; PAC-Primary Adult Care Program; Working Families: Get the Health Insurance Your Children Need; Working Families and Small Businesses Health Coverage; Selected Health Coverage Initiatives At a Glance and the Medical Assistance information and application packet, Facts about Applying for Medical Assistance.

The analysis was done by a doctoral research assistant and the program management specialist under the direction of the PI. The materials were critiqued by a customized version of the Suitability of Materials by Doak, Doak & Root (2) and the Print Materials Assessment Tool created by Rudd & Anderson (3). (See Appendix A for a copy of this assessment instrument).

The Medical Assistance application form was critiqued by two members of the board for the Center for Plain Language, each with extensive experience in writing and critiquing government documents. They redesigned the first segment of the application as a model for improvement using principles of plain language.

For this report, three categories of assessment of the materials were created: a) Well-done; b) Moderately Well-done and c) Not done well. The summary of the overall assessment appears in Table 1. Four components of the documents were assessed: 1) Writing Style; 2) Organization and Design; 3) Type style, size of print, and contrast with paper; and 4) Photographs, illustrations, symbols and diversity. The overall assessment is followed by general observations of the aspects of the materials that are satisfactory and those that are problematic.

For specific assessments, two tables were created. Table 2 shows each document by component and the assessment of how the material performed. In Table 3, the same assessment is shown, but is enhanced through color-coding: Green = well done; Yellow = moderately well-done; and Red = Not done well.
The intent of both the assessment and presentation of findings is to enable those responsible for the documents to make improvements in keeping with standards of health literacy of publications. The assessment critique will also help those who create new documents. For specifics within each component, the user should locate the Rudd and Anderson guide, *The Health Literacy Environment of Hospitals and Health Centers* is available at: [http://www.ncsall.net/index.php?id=1163](http://www.ncsall.net/index.php?id=1163). Also, users of this report should study the Center for Plain Language website: [http://www.centerforplainlanguage.org/](http://www.centerforplainlanguage.org/)

**The Medical Assistance Form—A Special Case:**

Analysis of government forms is a special case. A 2009 article by Wilson, Wallace & DeVoe (4) examined the readability and design of state Medicaid enrollment applications. Readability ranged from 11th to 18th grade level, well above the recommended 5th to 6th grade level. All state applications required revisions to comply with good formatting standards including reduction of density of words, at least 12 point font size and readability (5).

When the research team examined the Maryland application, it was determined that it, too, requires improvement in those areas. The PI further asked that the Center for Plain Language create an example of how to modify the form. They were asked to focus only on Section A. Their example of how to modify the Maryland application for Medical Assistance appears in Appendix B.

The Maryland application is 11 pages. Of those, 5 pages are background information and instructions; 6 pages are the application itself. This mix of instructions and application became confusing for the analysis team. Lack of numbering of the pages was also a problem. When separated, the team was not sure of the correct page order. If the analysis team was confused, it is expected that the same confusion occurs with applicants.

There are other areas of confusion. In one case, the applicants are instructed to read information before signing the application. However, that instruction comes after the signature page and might be not seen by the applicant. In the case of the reminder to sign and include citizenship evidence, information about citizenship documentation is lost in the mix of information. The information is separate from the instruction. An improvement would be to put the reminder prominently after the signature line where the applicant is more likely to see it.

Additionally, the lengthy set of instructions requires a proficient level of ability to understand and remember instructions when completing the extensive application. The application is word dense with smaller-than-recommended font size. Both conditions could discourage the applicant from completing the form.
Summary of Document Analysis:

Table 1: Overall Review of Seven DHMH Documents

<table>
<thead>
<tr>
<th>Components of Material</th>
<th>Well-done</th>
<th>Moderately well-done</th>
<th>Not done well</th>
</tr>
</thead>
<tbody>
<tr>
<td>Writing Style</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Organization and Design</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Type Style, Size of Print, and Contrast with Paper</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photographs, Illustrations, Symbols, and Diversity</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Overall observations:

Satisfactory aspects of the materials:
- Font was easy to read
- Bullets were used to break down large amounts of information
- High contrast between the print and paper
- Headings were used to organize materials

Problematic aspects of the materials:
- Lack of graphics
- Graphics not relevant to written information
- Bullets within bullets are confusing
- Cluttered appearance of materials (not enough white space, small margins)
- Definitions for legal or medical terms were not provided
- Vocabulary slightly advanced
Table 2: *Overall review of specific DHMH materials*

<table>
<thead>
<tr>
<th>Material</th>
<th>Writing Style</th>
<th>Organization and Design</th>
<th>Type Style, Size of Print, and Contrast with Paper</th>
<th>Photographs, Illustrations, Symbols, and Diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Health Services and Care in Maryland (brochure)</td>
<td>Not done well</td>
<td>Moderately well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
<tr>
<td>PAC-Primary Adult Care Program (brochure)</td>
<td>Moderately well done</td>
<td>Moderately well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
<tr>
<td>Working Families: Get the Health Insurance Your Children Need (brochure)</td>
<td>Moderately well done</td>
<td>Well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
<tr>
<td>Working Families and Small Businesses Health Coverage (pamphlet)</td>
<td>Not done well</td>
<td>Well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
<tr>
<td>Selected Health Coverage Initiatives At a Glance (pamphlet)</td>
<td>Moderately well done</td>
<td>Well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
<tr>
<td>Medical Assistance for Families (flyer)</td>
<td>Well done</td>
<td>Well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
<tr>
<td>Medical Assistance for Families (blue bookmark pamphlet)</td>
<td>Not done well</td>
<td>Well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
<tr>
<td>Facts about Applying for Medical Assistance</td>
<td>Not done well</td>
<td>Well done</td>
<td>Well done</td>
<td>Well done</td>
</tr>
</tbody>
</table>

Herschel S Horowitz Center for Health Literacy
University of Maryland School of Public Health
**Table 3: Color-coded review of specific DHMH materials**

<table>
<thead>
<tr>
<th></th>
<th>Affordable Health Services and Care in Maryland (brochure)</th>
<th>PAC-Primary Adult Care Program (brochure)</th>
<th>Working Families: Get the Health Insurance Your Children Need (brochure)</th>
<th>Working Families and Small Businesses Health Coverage (pamphlet)</th>
<th>Selected Health Coverage Initiatives At a Glance (pamphlet)</th>
<th>Medical Assistance for Families (flyer)</th>
<th>Medical Assistance for Families (blue bookmark pamphlet)</th>
<th>Facts about Applying for Medical Assistance (information included with Medical Assistance application)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Writing Style</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Organization and Design</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type Style, Size of Print, and Contrast with Paper</strong></td>
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<td></td>
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<tr>
<td><strong>Photographs, Illustrations, Symbols, and Diversity</strong></td>
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</tbody>
</table>

- **Well done**
- **Moderately well done**
- **Not well done**
DISCUSSION AND RECOMMENDATIONS

A. What did we learn?

- Confusion exists about the process for enrollment and accessing care among both providers and recipients.
- Information isn’t flowing to users in a timely way using channels of communication that are easily accessed.
- Delays in processing and initial prenatal care appointments extend well into the second trimester.

I. It is challenging for women to obtain accurate and clear information about both the Medicaid enrollment process and options for care while awaiting enrollment.

- High reliance on friends and family whose circumstances and experiences may have been different (e.g., employment, household income, immigration status)
- Different procedures and approval periods at different entry points
- Difficulty providing supporting materials (birth certificate, stable address)
- Changing eligibility requirements that may not be well-publicized or easy for staff to explain clearly
- Language diversity

Implications:

- Delayed care.
- Increased challenge for staff, especially with budget cuts.

II. Existing materials do not communicate key messages and information as clearly as they could. In addition, it appears that the materials are not readily available.

For example, even the brochure called Medical Assistance for Working Families does not specifically indicate that it applies to pregnant women. If it is possible to revise at least this brochure, there also are some opportunities to alter the text and visual features to improve health literacy. Most of the women we spoke with had not seen any of the materials. And a community advocate said she has difficulty obtaining a supply.

Implications:

- Print materials seem to be both in short supply and potentially contributing to confusion for women.
- More burden on staff to keep up with current information and explain it verbally.
III. There may be some good, low-cost opportunities to make more use and/or more creative use of channels for communicating with women.

Women identified a wide range of sources for their health information in general. Some of these may be untapped for information about Medicaid enrollment resources and procedures, as well as the importance of early and regular prenatal care. There also appear to be some good opportunities for supporting staff and community advocate efforts with professional development training in health literacy, briefings about Medicaid enrollment support, and so forth.

Implications:

- More effective communication and earlier enrollment.
- Reduced burden for staff to address confusion.

B. What is the answer to the research question?

What health communication messages and channels are needed to increase health literacy and participation in prenatal care among Medical Assistance-eligible, pregnant women?

- Health communications messages need to speak to the benefits of early care and of eligibility of pregnant women for state health insurance.
- Web-messaging needs to be specifically user-focused and intuitive.
- Interpersonal and community group channels of communications need to be optimized.

C. What could be done to reduce, remove or prevent confusion and increase enrollment and early access to care?

1. Modify all current print and web materials to meet health literacy standards and assure accuracy and consistency between each document and between messages and visuals.

2. Create new materials with input throughout the process from the intended users—eligible pregnant women, department of health personnel, other social service workers, community educators and advocates.

3. Develop a communications plan to keep health department employees, community volunteers, advocates and others who interact with pregnant women aware of eligibility, care options and routes to both.
4. Design a visual map of actions to obtain Medical Assistance and prenatal care to reduce confusion, increase understanding and provide a guide for mothers, staff and community workers.

5. Test a health navigator, community-based model to assist pregnant women and those who support them, in accessing care and insurance.

6. Provide professional development for staff to incorporate health literacy principles in daily work and reduce delays and associated costs.

7. Rewrite application separating instructions from application to comply with good formatting standards, including reduction of density of words, at least a 12-point font size and readability.

8. Evaluate all materials created or revised by engaging users during the process to increase the likelihood that the materials will be on target such that users “get it and do it.”

D. What are other states doing?

Maryland is not alone in searching for ways to increase enrollment in Medical Assistance and early prenatal care for pregnant women. Experiments and lessons from other states and other research could inform changes in channels of communications and messages.

Lake Snell Perry and Associates (5) conducted focus groups in 2003 to explore factors that affection decisions of low-income parents to enroll themselves in Medicaid. The study was not specifically of pregnant women but findings have some utility. They found that previous experience with public assistance could negatively affect their willingness to enroll. Being told that enrollment is “simple” didn’t always fit with their previous experience. Parents believe the information they had was adequate though the information was often outdated. Enrollment messages were tested. Those addressing low-cost health coverage and those addressing the concept that better care for a parent was good for their children were most appealing. Low cost coverage was thought to be better than free.

The Robert Wood Johnson Foundation launched a Covering Kids and Families National Program (6) designed to enroll adults and children in public health insurance. The program had three key components: outreach, simplification and coordination. Outreach efforts focused on encouraging enrollment; Simplification on making policies and procedures easier; Coordination on helping applicants if they apply for the wrong program. Follow-up studies found that two-thirds of efforts by states were in simplification, renewal and coordination (3).
Selected References


Appendix A

Print Materials Assessment Tool - Rating Sheet

Part 2: Print Communication Rating

Type of material being assessed (please check one):

- Community relations
- Patient/client orientation
- Forms patients fill out
- Follow up notifications
- Patient education materials
- Legal materials
- Discharge preparation

Purpose of the material being assessed (please check one):

- Deliver information (e.g., patient education about asthma)
- Provide directions (e.g., directions for using a peak flow meter)
- Collect information (e.g., a health history form)

Please check the ONE response that most accurately describes the print material using the following rating scale:

1. This is something that is not done.
2. This is done, but needs some improvements.
3. This is done well.

A. Writing Style

1. The material emphasizes and summarizes the main points.
2. The information is grouped into meaningful sections.
3. The material is written in the active voice and in a conversational style.
4. The material uses devices to engage and involve the reader, such as question and answer format, true-or-false, stories, or dialogues.
5. The words and sentences are generally short, simple, and direct.
6. If medical terms (such as “dosage” or “monitoring”) are used, they are clearly explained with helpful examples.
7. The reading grade level is that of the average U.S. adult (8th grade or below).
8. Translations use plain, everyday words, and short sentences.
Part 2: Print Communication Rating (continued)

Please check the ONE response that most accurately describes the print material your hospital or health center uses, using the following rating scale:

1. This is something that is not done.
2. This is done, but needs some improvements.
3. This is done well.

B. Organization and Design

9. The material uses headings, subheadings, or other devices to signal what is coming next. □ □ □
10. The labels for sections, headings, and subheadings are clear. □ □ □
11. The material looks uncluttered, with generous margins and plenty of white space. □ □ □
12. The graphic design uses devices such as contrast, bullets, and indentation to signal the main points and make the text easy to skim. □ □ □
13. The material uses bullets effectively (size, shape, spacing, and color.) □ □ □
14. Explanatory illustrations, diagrams, tables, charts, and graphs are clearly labeled and placed near the text that introduces them. □ □ □

C. Type Style, Size of Print, and Contrast with Paper

15. The font size is 12-point or greater. □ □ □
16. The text uses CAPITAL letters only when needed grammatically. □ □ □
17. The text avoids splitting words across two lines. □ □ □
18. There is contrast between the printed text and the paper. □ □ □
19. The print does not overlay pictures or designs. □ □ □
### Part 2: Print Communication Rating (continued)

Please check the ONE response that most accurately describes the print material your hospital or health center uses, using the following rating scale:

1. This is something that is not done.
2. This is done, but needs some improvements.
3. This is done well.

<table>
<thead>
<tr>
<th>D. Photographs, Illustrations, Symbols, and Diversity</th>
<th>1</th>
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<tbody>
<tr>
<td>20. The material uses photos, illustrations, symbols, patterns, and other visuals to reinforce key messages.</td>
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<td>21. The material avoids using cartoons, humor, and caricature, which may be understood as offensive.</td>
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<tr>
<td>22. The people and activities shown in photos or illustrations are contemporary.</td>
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<tr>
<td>23. The people and activities shown in photos or illustrations are representative (in their demographics, physical appearance, behavior, and cultural elements) of the intended audience of the materials.</td>
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<td>24. The material shows awareness of and respect for diversity, and uses culturally appropriate words and examples.</td>
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Appendix B

Medical Assistance (MP) MCHP Application for Families, Pregnant Women and Children 8-09

To illustrate how the language of the application could be modified to be more health literacy sensitive, Section A was revised according to principles of plain language. The analysis was conducted by the Center for Plain Language for the University of Maryland’s Horowitz Center for Health Literacy. The original Section A follows for comparison.

Section A: Household Members

Table 1 - First list the names of those who are applying for either Medical Assistance or Maryland Children’s Health Program. The instructions below the table will show you how to fill it out.

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1. Name: Last name, First name, Middle Initial
For example: Smith, Mary, L.

2. Relationship: If filing for yourself = Self
For others, write their relationship to you
For example: son, daughter, mother

3. Date of Birth: MM/DD/YY Use 2 numbers for each part of the answer
Example -If the date of birth is May 17, 1997 write: 05/17/97

4. Gender: F = Female
M = Male

5. Marital Status: M = Married
S = Single
D = Divorced
P = Separated
W = Widowed

6. U.S. citizen: Yes No – If no, complete Section B
7. Social Security Number: For example: 111-11-1111
   If you do not have a Social Security number, we will help you get one.

**Table 2** - Next, list the names of people in your house who are not applying for benefits. Follow the same instructions for filling this out that you used for the first table.

**Table 2 - Household Members NOT Applying for Benefits**

<table>
<thead>
<tr>
<th>1. Name</th>
<th>2. Relationship</th>
<th>3. Date of Birth</th>
<th>4. Gender</th>
<th>5. Marital Status</th>
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**Table 3** - We are also collecting information about race and ethnicity for our records. You do not have to give us this information if you don’t want to. We will not use this to decide if you are eligible for benefits. If you are willing to tell us, fill out the table below. The instructions below the table will help you do this.

**Table 3 – Optional Race and Ethnicity Information**

<table>
<thead>
<tr>
<th>1. Name of household member</th>
<th>2. Race</th>
<th>3. Hispanic or Latino</th>
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</tbody>
</table>

1. Name: Write the same names of all your household members you listed in the 2 tables above.
   Last name, First name, Middle Initial
   For example: Smith, Mary, L.

2. Race: Write the race of each person, using the list below:
   • Black or African-American
   • White or Caucasian
   • American Indian
   • Alaska Native
   • Native Hawaiian
   • Pacific Islander
   • Asian

3. Ethnicity: Check this box if the person is Hispanic or Latino.
Current First Section of Application

MEDICAL ASSISTANCE (MA)/MCHP APPLICATION
FOR FAMILIES, PREGNANT WOMEN, AND CHILDREN

Head of Household Name (Last, First, Middle)  Home Telephone  Work Telephone  Cell Telephone

Where Do You Live? (Number and Street)  Apt. #  City  State  Zip Code

Mailing Address (If different from home address)

What language do you speak?  ☐ English  ☐ Spanish  ☐ Other _______________________

Do you have any unpaid medical bills from the past 3 months?  ☐ Yes  ☐ No  ☐ If yes, what month(s)?  _______________________

Are you or anyone in your household pregnant?  ☐ Yes  ☐ No  ☐ If yes, who?  _______________________

Are you or anyone in your household disabled?  ☐ Yes  ☐ No  ☐ If yes, who?  _______________________

Have you ever received assistance?  ☐ Yes  ☐ No  Under what name?  _______________________

SECTION A. HOUSEHOLD MEMBERS
Fill in the blanks for all of the people in your household. Write YES for each person you are applying for. Write NO for each person you are not applying for.

<table>
<thead>
<tr>
<th>APPLYING FOR MEDICAL ASSISTANCE/MCHP</th>
<th>NAME (Last, First, Middle)</th>
<th>RELATION TO YOU</th>
<th>DATE OF BIRTH MM/DD/YY</th>
<th>GENDER M=Male F=Female</th>
<th>MARRITAL STATUS M=Married D=Single D=Divorced D=Separated W=Widowed</th>
<th>RACE (Indicate below for each person) A=Asian B=Black/African American C=White N=Amish-Indian or Alaska Native N=Native Hawaiian or Pacific Islander (You may select more than one code)</th>
<th>ETHNICITY H=Hispanic/Latino N=Non-Hispanic/Non-Latino</th>
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<td>SELF</td>
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</table>

*(You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.)*

GO TO NEXT PAGE—
You may attach extra pages if you need more space.

DHMH/OES1000 (8/09)
Appendix C  Expert Reviewers

ELAINE BRATIC ARKIN

Work related to prenatal care and Medicaid has included:

--Communications director for the Robert Wood Johnson's Covering Kids and Families 7-year national program. Conducted award-winning market research and developed and tested materials to motivate enrollment in Medicaid and SCHIP.

--Developer of the Healthy Mothers, Healthy Babies national coalition. Conducted market research with low income pregnant women, developed, pre tested and evaluated educational materials for them.

--Wrote and evaluated US Dept of Health and Human Services publications Prenatal Care and Health Diary: Myself/My Baby (interactive)

--Developed and pre tested materials for training WIC counselors and educational materials for their pregnant clients

--Worked with USDA Food and Nutrition Service to establish a national breastfeeding coalition.

--Was consultant to Healthy Start communications program (HRSA)

Biographical Summary

Elaine Bratic Arkin has worked in the fields of health communication and social marketing for more than 25 years. At the U.S. Public Health Service, she was responsible for the government's anti-smoking mass media campaign, and for the development of the Cancer Information Service, a national toll free counseling hotline. At the U.S. Department of Health and Human Services, she served as Deputy Assistant Secretary for Public Affairs, and as National Coordinator of the Healthy Mothers, Healthy Babies Coalition.

As a consultant, she works primarily with Federal agencies, national voluntary associations, and foundations on a wide variety of health issues, including drug and alcohol abuse prevention. She currently is the communications director for the Robert Wood Johnson Foundation (RWJF) Commission to Build a Healthier America. Previous RWJF assignments included leading the Foundation’s coverage communications national campaigns (Cover the Uninsured Week and Covering Kids & Families).

She was the author of Making Health Communications Work: A Planner's Guide (“the pink book”) and consulted on the development of CDC's health communication CD ROM, CDCynergy. She is an Editorial Board member for the Social Marketing Quarterly.
KAROLINE MORTENSEN

Karoline Mortensen is an Assistant Professor in the Department of Health Services Administration, School of Public Health, at the University of Maryland College Park. Prior to joining Maryland in August 2009, Dr. Mortensen was an Assistant Professor of the Practice at Rice University. She is also affiliated with Academy Health, the American Society of Health Economists, the Association for Public Policy Analysis and Management, and the International Health Economics Association.

Her research interests are focused on vulnerable populations. Her research examines the interaction between health insurance and health care utilization, particularly utilization of Medicaid enrollees and the uninsured. She also explores health insurance transitions and the health status and healthcare utilization of Hurricane Katrina evacuees in Houston. Mortensen’s most recent research in health has been published in Medical Care, Health Affairs, and the Journal of Health Care for the Poor and Underserved. She is a co-investigator on a grant from the Houston Endowment creating the Mental Health Policy Analysis Collaborative at the University of Texas Health Science Center at Houston.

Dr. Mortensen is involved with several projects examining factors that affect health care utilization patterns of Medicaid enrollees. Current research and future projects explore the geographic variation in health care utilization in Medicaid, and the effects of emergency department copayments on utilization of physician visits, outpatient visits, and hospitalizations. Dr. Mortensen is collaborating with colleagues in Houston to examine the effects of the Medicaid Section 1115 emergency waiver on health care utilization of Hurricane Katrina evacuees in Texas. She is also working with colleagues and the CDC to further prevention strategies to improve nutrition and reduce obesity in Prince George’s County, Maryland.