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NOTE TO READERS

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Health, insurance, education initiatives generate lessons on outreach to "hard-to-reach" households.

The ability to identify hard-to-reach populations, to reach those populations with messaging, to motivate those populations to take desired actions, and to provide the means allowing such actions to occur, is not simply an issue confronting public utilities in general and water utilities in particular. These are issues that confront any number of industries and institutions. The water industry would be well-served to seek to learn the considerable lessons that have been generated from service providers ranging from health care, to early childhood education, to housing, to social service, to health insurance, and beyond.

Many common themes arise from the experience and study of these other industries. Many recommended actions have been identified, and verified as appropriate and effective, which the water industry would benefit from adopting as their own. No reason exists for water utilities to believe they are the first, let alone the exclusive, stakeholders to face the quandaries faced by hard-to-reach populations or that the water industry poses difficulties and circumstances that are unique, either in magnitude or degree.

Lessons from Great Britain and Australia.

One, perhaps the primary, lesson on how to "reach" hard-to-reach populations is to put effort into understanding the hard-to-reach in order to understand why it is important to address how and why to reach them. One of the best studies

of hard-to-reach populations was done in Australia.[1] This study of hard-to-reach families and children, within the context of social services, identified three types of hard-to-reach populations:

- Populations under-represented in service provision. These persons include the marginalized and socially excluded populations;

- Services users (or potential users) who may be invisible to or overlooked by service providers. These persons include those who slip through the net being cast, either because they are overlooked or because the service does not address their needs (e.g., the population believes the services are irrelevant); and

- Service users (potential users) who are resistant to service provisions. These are the persons who choose not engage. They often fear the risks of being stigmatized, are wary of engagement, or who are unaware.

Persons, of course, can be in more than one of these hard-to-reach populations at one time. It is important to engage these individual populations for a variety of reasons, the Australian study found. On the one hand, the marginalized groups may be the primary intended beneficiaries of the services. In addition, identifying and serving these populations may improve the ***aggregate*** well-being by redressing a tendency to exacerbate inequality by leaving the hard-to-reach behind and improving only the easiest to reach. Finally, identifying and addressing the needs of these populations may improve the program designed to meet the needs of the most vulnerable.

A second research project, this one British, looked at hard-to-reach populations in the provision of health care and social services.[2] Hard to reach was defined by this research as "hidden populations" and "marginalized populations." They are frequently "non-associative," meaning that they do not generally associate with other members. They are "unengaged." They were defined as "inaccessible to most traditional and conventional methods for any reason."

The British research found that "a number of participants made explicit reference to the fact that many potential service users may not engage because of their previous experiences of accessing services. In particular, it would seem that statutory services were conceived as being particularly impenetrable, thus discouraging individuals to access help."

These two sets of experiences help to explain what needs to be done to reach the hard to reach, and why certain strategies are consistently found to be important and effective. Some of the more successful strategies that have been identified, and the rationale behind the strategies, are as follows:

- Use the community as a means of identifying and engaging[3] the hard-to-reach population.

[1] Cortis et al. (2009). Occasional Paper No. 26, Engaging hard-to-reach families and children, Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs.

[2] Flanagan and Hancock (2010). Reaching the hard to reach – lessons learned from the VCS (voluntary and community sector): A qualitative study. BMC Health Services Research, 10:92.

[3] "Engaging" has two important elements: (1) enrolling the household in the service provision; and (2) maintaining the household in the service engagement.

- Collaborate when possible.
- Focus on relationship-building.
- Go to the community rather than making the community come to you.

Using other community members as a mechanism to identify and engage hard-to-reach populations has repeatedly been found to be one of the more effective mechanisms to use in service hard-to-reach populations. The Australia study on children and families refers to this strategy as a means to "limit the distance between staff and service users."

Lessons from Medicare/Medicaid.

One population that is frequently difficult to identify, let alone engage, involves the aged, particularly those facing medical difficulties. In response, the Medicare-Medicaid Coordination Office (MMCO), along with the Centers for Medicare and Medicaid Services (CMS), initiated a specific program toward hard-to-reach individuals.[4] Based on a focus group with representatives from seven health plans in California, Massachusetts, Ohio and Virginia that "have experience locating and engaging Medicare-Medicaid enrollees," they specifically recommended "hir[ing] staff from the community for outreach and navigation. Individuals from the community likely have existing connections with local health and social service organizations, as well as knowledge about how to find and connect with community members. Plans may require, for example, that outreach staff have lived in the community for a certain number of years or have previously worked with a community agency."[5] They recommended, based on their experiences with hard-to-reach populations, to "go into their world,"[6] and to engage "community health workers employed by providers but working in community settings."[7]

Similarly, Dr. Linda Wharton Boyd, of the D.C. Health Benefit Exchange Authority, told the Pennsylvania Association of Community Health Centers that their "outreach mantra" for "best practices for informing, educating, and enrolling hart-to-reach populations in health insurance coverage" was "reach them where they live, work, shop, play, and pray."[8] She said this approach involved "a wide-ranging grassroots approach with an army of boots-on-the-ground." The initiative entailed "a more well-defined hyper-local approach targeting consumers more at the neighborhood level." One part of their campaign was called "each one: link one," through which they promoted "because you care, be the link: reach family, reach a friend, reach a neighbor or colleague."

Lessons from Health Insurance.

It is not simply important who is charged with identifying and contacting hard-to-reach populations, but it is important how those populations are contacted as well. Making in-person contact, rather than simply providing written notices, is important. A report on the enrollment of hard-to-reach populations in health insurance under

[4] Resources for Integrated Care (Sept. 2015). Hard-to-reach populations: Innovative Strategies to Engage Isolated Individuals with Behavioral Health Need.

[5] Resources for Integrated Care, supra.

[6] Resources for Integrated Care, supra.

[7] Wharton. The Power of Innovative Tactics to Reach the Uninsured. DC Health Benefit Exchange Authority.

[8] Power of Innovative Tactics, supra.

the federal Affordable Care Act[9] stated that "consumers who received in-person help. . .were nearly twice as likely to sign up for a plan as those who tried to sign up online on their own, and they were more likely to say that signing up was very easy."[10]

The evaluation found that "trusted messengers at the national and local levels were more important than ever." Building a "sustainable outreach and enrollment community" involved "bolstering the capacity of partnership organizations and recruiting a broad network of volunteers." According to the evaluation, "Enroll America. . .partnered with enrollment coalitions in 11 target states through the Get Covered America campaign to recruit and/or train more than 2,400 volunteers –from groups such as churches, clinics, food banks, nursing homes and law schools" to serve as counselors in their communities. The evaluation found that establishing "partner collaboration has a multiplier effect. Teaming up with established, trusted institutions made it possible for Enroll America, and other organizations focused on enrollment, to meet a greater number of consumers with a higher level of credibility. Among the organizations that Enroll America surveyed this year, more than two-thirds identified collaboration as one of the most effective strategies in their toolbox. . ."[11]

Finally, the Enroll America campaign reported that making multiple contacts was an important outreach tool. "Consumers followed-up with multiple times were more likely to enroll. . .[C]onsumers were increasingly likely to report enrolling after each follow-up conversation that they had with a volunteer. The increase in enrollment rates was especially striking among populations that had higher uninsured rates in the first place. African American and Latino consumers were about twice as likely to enroll after the third follow-up, and young people were more than twice as likely to enroll after the third follow-up."

These multiple contacts are not simply necessary to convey information effectively; they are needed to develop trust. One research paper on engaging the homeless with health care programs, for example, reported that "it typically takes multiple contacts with a homeless person to develop sufficient trust before they are willing to engage in care. These contacts can take place in shelters, libraries, encampments, food kitchens, and other places were people congregate."[12]

Lessons from the Institute of Medicine.

It is important to recognize the need (and ability) to generalize from these observations about enrollment in health insurance. One study funded by Blue Shield of California, and performed by the Institute of Medicine, undertook a comprehensive review of evaluations from organizations from all across the nation that focused on "enrollment of hard-to-reach populations." The IoM report stated that "the marker of success was not only total enrollment numbers but whether outreach and enrollment were better than expected for the populations of interest."[13]

[9] Enroll America, State of Enrollment: Helping America Get Covered and Stay Covered, 2014 – 2015, What We Learned.

[10] See also, Enroll America (June 2014). The State of Enrollment: Lessons Learned from Connecting America to Coverage.

[11] State of Enrollment, at 22.

[12] National Health Care for the Homeless Council. Reaching, Enrolling and Engaging People who are Homeless in a Changing Healthcare System, Community Health Forum, at 14.

[13] Parker, et al. Successfully Engaging Hard-to-

One purpose was to create "a conceptual model" that incorporated the successful strategies and approaches. The lessons reported by IoM included the following:

- "Every source that we examined noted that in-person assistance and 'touches' were vital to enrollment effort, particularly among hard-to-reach populations."

- "Community partnerships were also an important resource for enrollment efforts to reach hard-to-reach populations. Partnerships with longstanding and trusted community organizations provided access to hard-to-reach communities and served as trusted sources of information and trusted spaces for enrollment to occur."

- "It is important to know where the community gets its health information and who its trusted messengers are for that information. . .It is also important to understand that different groups have different needs."

The need to rely on "trusted sources" cannot be overstated based on the IoM report. The IoM evaluation stated:

> The need to create trust among consumers is the foundation upon which successful strategies rest. First and foremost, it is essential to identify community partners who are trusted resources in the population at which enrollment efforts are aimed. All of the interviewees said that the most important and successful method in reaching their intended audiences was approaching consumers through a trusted source; such an approach could occur either through their own organization, if it was a community-based trusted source, or through a partnership with groups and individuals who were trusted in the community. Although every community has different trusted sources, each community organization and coalition interviewed highlighted that identifying and working with trusted sources is key to a successful outreach and enrollment process.
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> Trusted sources varied by community and culture and included advocacy groups, social services and community support groups, faith-based groups, and federally qualified health centers. Although different, these trusted community partners had all been active in the communities prior to the enrollment process and were either already aware of or uniquely position to identify population-specific challenges and sensitive issues in the targeted populations.
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> . . .Across all successful approaches, the key for building trust was identifying the populations to be reached, assessing who would be a trusted community partner, and using those partners to reach out and educate the populations in trusted locations.

Retaining successful workers is needed as well, the IoM study found, which, in turn, implicates the need for a long-term stable funding source. "Retaining the services of individuals who are effective at interacting with and engaging hard-to-reach populations is key. Tremendous resources are invested in this training; experience

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Reach Populations in Health Insurance: A Focus on Outreach, Sign Up and Retention, and Use. Institute of Medicine, Roundtable on Health Literacy, Collaborative on Health Literacy and Access, Health Care Coverage, and Care, Washington D.C.

brings even greater understanding and effectiveness, and continuing relationships with consumers are important to the entire process. . .Having well-trained individuals who can provide consistent communication with consumers is a critical need."

Multiple contacts and in-person assistance are required for hard-to-reach populations. The IoM study "identified several approaches as successful in activating consumers to move from outreach and education to sign-up." The study said "the most important of these were the need for multiple contact points and for in-person assistance for as many of these encounters as possible."

In California, for example, 60 percent of all Latino enrollees in the ACA insurance program enrolled in person. "Consumers returned to trusted advisors multiple times to obtain more information and to understand the benefits of health insurance and the process for signing up. Multiple contact points were also needed to actually complete the sign up process. Recognizing the need for multiple contact points and follow-up, several groups developed processes to help [staff] accommodate multiple encounters. For communities that were willing to share information, enrollers who were able to follow-up contact information noted higher success rates in completing the sign-up process."

One important step is to "identify who the trusted advisors are in the various communities of interest—that is, who do people in these communities turn to for advice about what is correct information and what to do with it," IoM found. Groups focusing on Latino communities found that community health workers were "neutral and trusted advisors." "African American and rural communities often saw their faith leaders as trusted advisors." "Immigrant communities with limited English proficiency often relied on neighbors and friends for information." In some instances, particular industries "have heavy representation in hard-to-reach communities. For example, some efforts were aimed at leaders of taxicab drivers or beauty and nail salon owners as trusted advisors to help engage specific populations." These "trusted advisors" are necessary because "in addition to profound financial challenges, many also do not trust the system to advocate for them or to help them successfully navigate complex content and tasks. . ."

In short, one of the continuing themes (amongst others) of the IoM study was that "processes must be intentionally designed to build trust with targeted populations and provide actionable steps for consumers. . .[B]eing trusted by the targeted community is foundational to all implementation efforts. Deliberately considering and practically planning on how best to foster trust must be considered throughout all activities."[14]

Lessons from the Kaiser and the RWJ Foundations.

A Kaiser Foundation study of successful outreach methods to hard-to-reach populations for the Affordable Care Act reached similar conclu-

[14] See also, California Pan-Ethnic Health Network (2014). Improving enrollment of communities of color in health coverage: Recommendations from first responders to covered California and Medi-Cal. California Pan-Ethnic Health Network: Oakland (CA); Jahnke et al. (2014). Marketplace consumer assistance programs and promising practices for enrolling racially and ethnically diverse communities. San Francisco Foundation: San Francisco (CA); Parker, et al. (2013). Amplifying the voice of the underserved in the implementation of the Affordable Care

sions. According to the Kaiser Foundation evaluation,[15] the three "keys to success" in reaching target under-served populations included:

- "Recruit a group of assisters who are able to reach key target populations. These "assisters" should "share a personal commitment to enroll people in health coverage and experience working with the populations they sought to serve." This commitment and experience, the Kaiser Foundation found, enabled assisters to build trust with consumers, which was found to be critical to breaking down barriers to enrollment.

- "Foster strong partnerships and collaborations among assisters. Assisters emphasized the importance of partnerships and collaborations across their organizations. . .Networking with other assisters was the most consistently helpful strategy for facilitating their work."

- "Build relationships with local organizations and stakeholders to reach people in their communities. Partnering with key stakeholders in the community helped assisters expand their reach. Assisters noted they could not wait for consumers to come to them; rather they went into the communities where people live and work."

Another pre-eminent health care research organization, the Robert Wood Johnson Foundation, also studied how states sought to reach hard to reach populations in the implementation of the Affordable Care Act.[16] The RWJ report found that "grass tops" education was important, which focused on "clergy and other community leaders who were equipped to educate their grassroots constituents." The RWJ evaluation found that "many states used trusted community groups to reach immigrant and Native American communities, which can be hard to reach effectively through other methods." It found that "informants in numerous states agreed that one-on-one application assistance was often essential to helping the uninsured enroll."

"Certain groups were particularly helped by in-person assistance," RWJ found. "Our informants found this to be the case for many Latinos, for people with complex health conditions or eligibility situations, people uncomfortable with computers, and people without easy internet access."

"Particular application assistance practices that proved helpful," RWJ reported, included "ensuring that application assisters go out into the community rather than stay in their offices." According to the RWJ evaluation, "many successful assisters reported that achieving high enrollment numbers requires going out into the community, investing significant time in advance to ensure successful events. In their view, assisters who wait in their offices for clients to call will enroll many fewer people."

This 2014 RWJ study built on a related RWJ study from 2013.[17] In that evaluation, RWJ built

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Act. Institute of Medicine: Washington D.C.

[15] Tolbert et al. (Sept. 2014). Connecting consumers to Coverage: Lessons Learned from Assisters for Successful outreach and Enrollment, Henry J. Kaiser Family Foundation: Menlo Park (CA).

[16] Stan Dorn (December 2014). ACA Implementation—Monitoring and Tracking, Public Education, Outreach and Application Assistance, Urban Institute for Robert Wood Johnson Foundation; Washington D.C.

[17] Hill, et al. (October 2013). ACA Implementation—

on the experience from the federal Children's Health Insurance Program (CHIP) to guide the experience for ACA:

> Arguably one of the most significant innovations to emerge from CHIP was the creation of 'application assistance' models to support outreach and enrollment. By equipping staff of community-based organizations and providers with shortened, joint Medicaid/CHIP application forms, training them in how to administer these applications, and anointing then as official program representatives certified to help families with enrollment, application assistance put 'teeth' into outreach.
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> . . .
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> CHIP and Medicaid outreach and application assistance efforts also taught policymakers the importance of enlisting the support and help of trusted community members and organizations—closely tied to ethnic and other communities of interest—in 'reaching the hard to reach.' Community partners can include a broad range of entities, including community-based nonprofit agencies, family resource centers, faith-based organizations, WIC programs and food banks, schools, Head Start and preschool programs.

RWJ finally concluded that the ACA efforts: "appear to be heeding the lessons of Medicaid and CHIP and designing outreach campaigns that combine both broad efforts to raise public awareness and community-based efforts to reach the 'hard-to-reach.' Furthermore, outreach campaigns are being supported by extensive application assistance programs, designed to provide consumers with direct, hands-on help with completing the application process."

Monitoring and Tracking, Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act, Urban Institute for the Robert Wood Johnson Foundation: Washington D.C.

Lessons from Health Care for HIV/AIDS.

A training manual published by the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HRSA), directed toward institutions providing health care to HIV/AIDs populations, states that the "hallmarks of successful models of HIV care" include creating strong partnerships with other providers; providing active linkages and referrals, where patients are personally guided into systems of care, rather than being given a list of names, addresses and appointment dates; and putting into practice policies and procedures that "facilitate access to and ongoing engagement in care.[18]

Lessons from SCHIP Outreach.

The ability to generalize these lessons is also learned from state and private efforts to identify and enroll children in the federal Children's Health Insurance Program (CHIP, sometimes

[18] Health Resources and Services Administration, HIV/AIDS Bureau (January 2013). Training Manual: Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care, U.S. Department of Health and Human Services: Washington D.C. ; see also, Cabral, et al. Outreach program contacts: do they increase the likelihood of engagement and retention in HIV primary care for hard-to-reach patients", AIDS Patient Care STDS. 2007:21 (Supp. 1): S59-67; see also, Rajabiun, et al. Making the Connection: Promoting Engagement and Retention into HIV Medical Care Among Hard to Reach Populations. Boston University School of Public Health: Boston (MA).

known as SCHIP, State Children's Health Insurance Program). One review of CHIP initiatives, for example, stated that "regardless of the field of program in which outreach is used, a goal of developing an outreach strategy, or an outreach campaign consisting of several strategies, is to generate awareness, educate the public and, in this case, enroll people in health insurance coverage."[19] The National Academy reported, as with examples cited above, that important outreach elements identified from their survey of CHIP programs included, for example, the use of community-based organizations as partners.

> According to a 2008 NASHP survey of CHIP programs, the percentage of programs using CBOs [community-based organizations] to conduct outreach activities surpassed the percentage using state agency staff compared to a similar survey from 2005. In addition, a 2011 evaluation noted that states reported partnerships with CBOs as the most effective partnerships due to the 'prominence and trust' these organizations have within their communities.

The Academy's report noted that "CBOs are viewed as trusted members of a community and have well-established relationships and means of communications that could prove beneficial to the state." The personal contact, again, was noted as important. "The level of engagement of partners varies, from volunteering to disseminate information about the programs to actually contracting with the state to assist parents and other guardians of eligible children complete an enrollment application."[20]

Lessons from Early Childhood Education.

Special efforts have been made and documented in the effort to make early childhood education as universally available as possible. The Illinois Hard to Reach Families Project Evaluation, for example, performed at the University of Illinois (Champaign-Urbana), examined the six agencies who received ARRA funds in 2012 "to develop effective and innovative strategies to recruit young children from families considered 'hard to reach' and enroll them in quality early care and education (ECE) programs."[21] The six programs were "aimed at identifying recruitment strategies that worked." The Illinois programs identified "hard to reach" as those "families. . .who are unaware of or unable to access Preschool for All services."

"Consistent contact" was perhaps the most important strategy found by the Illinois ECE programs. This contact should "expose [the families] to the benefits of early education services, whether through a voluntary drop-in preschool, child parent socialization groups, or home visits." Once someone was identified by one of the six programs, "immediate follow-up calls or vis-

[19] National Academy for State Health Policy (August 2012). Lessons Learned from Children's Coverage Programs: Outreach, Marketing, and Enrollment; see also, Wachino (2009). Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Maintaining Eligible Children, National Academy for State Health Policy: Washington D.C.).

[20] See also, Chung, at al. (2010). Trusted Hands: The Role of Community Based Organizations in Enrolling Children in Public Health Insurance Programs, The Colorado Trust: Denver (CO); California Coverage and Health Initiatives (2011). A Trusted Voice: Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act, California Coverage and Health Initiatives: Sacramento (CA).

[21] Fowler, et al. (2013). Illinois Hard to Reach Families Project Evaluation, University of Illinois Urbana-

its were critical for maintaining communication with the family." This was true even if the ongoing contact was not the full array of early childhood education services, but was instead "some interim service" that would simply maintain the contact.

The evaluation noted that all six agencies were "required to use a data system to track and stay connected with families identified as hard to reach. As a result of using tracking systems, several pilot programs had one or more staff members maintain regular contact, such as weekly calls with families, until they could provide services or enroll their child in an ECE program."

The Illinois program found lessons similar to those learned from health care and health insurance regarding the use of community members. One specific recommendation was to use "parents from the community as recruiters." Successful agencies trained volunteers, "usually parents who had received services and could serve as ambassadors for the program." Another lesson learned, similar to the health care and health insurance programs, was the advantage of taking the services to the constituency rather than making them come to the service providers. "Agencies that expected parents to come on site to enroll their child reported losing parents between the point of recruitment and the point of enrollment. Agencies that sent staff to the families to help them complete paperwork typically reported successful enrollment."

One lesson reported by the Illinois project was the lack of success from attending community fairs. ". . .community fairs and activities were not very effective in finding families who had never been served. [Staff] noted that 'only the families who know about our services already come to our community events: the hard-to-reach families either don't know about these events or don't see the value in them.'"

In contrast, Illinois reported, "the most successful pilot programs shifted their recruitment efforts and some service provision from program-centric to family-centric, taking the recruitment, enrollment, and some services to where the families live and spend their time. These programs recognized that enrollment is a complex process for many families, requiring multiple meetings, appointments, and forms."

In sum, the Illinois ECE experience reported that "the three most successful and potentially sustainable [strategies] include: (a) increased collaboration with larger agencies; (b) increased collaboration with other stakeholders within the community; and (c) the use of the drop-in preschool in local neighborhoods." Each of these strategies would have their beneficial counterparts in the utility industry. The "drop-in preschool" equivalent, for example, is simply an example of one of the "interim services" so successfully used by the Illinois ECE initiatives.

Lessons from Head Start.

These lessons extend on to the closely-related program of Head Start. One analysis examined how Head Start is promoted in Chicago.[22] According to one community organization, called Community Organizing and Family Issues (COFI), "it is well established that peer-to-peer

Champaign: Champaign (IL).

[22] Community Organizing and Family Issues (COFI). How we got Johnny, Jada, Jose into Preschool: Briefings from the Ground Up, Head Start Ambassadors Connect with 'Hard-to-Reach Families, Promising practices to enroll hard-to-reach families in quality early learning programs, COFI: Chicago (IL).

outreach is a game changer in low-income communities. Public health practitioners long-ago realized that the messenger is as important as the message. The successful transmission of the message often depends upon the legitimacy and 'street cred' of the person delivering the message." The Chicago Head Start outreach involves "Head Start Ambassadors."

Over the most recent three year period, the Ambassadors have had peer-to-peer conversations with nearly 20,000 families, about half of whom have children under age five. According to HOFI, the effort of Head Start Ambassadors "works" for reasons which include, but are not limited to, the fact that "Parent Ambassadors build relations." HOFI states that Parent Ambassadors not only "share valuable information," but when they do so, they "speak from experience." The program was created because "parent leaders understood that information would be best processed if it came from people that the families could relate to—other low-income parents and grandparents who have similar life experiences."

According to Vanessa Rich, from the Chicago Department of Family and Support Services, through the Ambassadors program, the City has "surpassed [its] enrollment goals every year—and we've surpassed them earlier each year."

Lessons Regarding Life Difficulties.

One attribute of hard-to-reach populations is the constant set of life difficulties facing them on a daily basis. These difficulties not only create emotional barriers, but create physical and time-use barriers as well. "Frequent and regular contact with service staff may also be difficult where families face daily stresses and have chaotic routines, especially for care givers in low-income families, sole parents, and those with children with disabilities, or where parents are experiencing complex problems like depression or postnatal depression, poor literacy, learning or community difficulties, mental health issues or substance abuse."[23]

The study found that "many vulnerable families who refused were unable to understand information about service provision, while others felt too burdened by the complexity of their lives to be able to think about the possible benefits of a new service." "[T]hey're disengaged from so much in their lives. To access a support service is so hard if you haven't slept properly or eaten that day. It's hard to step outside that cycle."[24]

Summary

The lessons from this diverse group of non-water initiatives appear clear for water industry efforts (or the efforts of any utility) to define, reach, and engage hard to reach populations. While the lessons stated above may appear to be repetitive, they are intended to be repetitive, because they are becoming generally accepted. There is little, indeed no, reason for the water industry to begin anew, or to ignore the lessons and recommendations almost universally advanced by other practitioners and researchers.

For more information regarding hard-to-reach populations, please write:

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[23] Engaging hard-to-reach families and children, supra.

[24] Engaging hard-to-reach families and children, supra.

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