

PROMISING OUTREACH PRACTICES: ENROLLING LOW-INCOME CHILDREN IN HEALTH INSURANCE PROGRAMS IN CALIFORNIA¹

Abstract

Strategies used by outreach workers (Ows) to successfully enroll underserved and uninsured California children into low cost health insurance programs such as MediCal and Healthy Families are examined. Ows are particularly effective in enrolling and retaining hard to reach populations, especially immigrant families, in health programs. Skilled in grassroots communications and members of the communities they serve, Ows are key to building vital community support.

Effective outreach depends on the selection of Ows with appropriate personal characteristics and then training them in a number of core competencies. This article analyzes the main avenues used by Ows within the First Things First demonstration project: person-to-person contact; utilization of existing of institutions; and public communication strategies.

Structural and systemic barriers remain to enrolling children in public health insurance programs that exceed the scope of Ows. Thus effective outreach programs should address both structural issues and staff selection and training.

Key words:

Children, health insurance, Healthy Families, Medi Cal, promotoras, immigration, California, outreach, Latino

Introduction.

Covering children with public or private health insurance has been a major public policy challenge for more than a decade; 1998 national statistics indicated that one-fifth of all children had no health insurance coverage (Astra, 1998). In a major policy initiative designed to address this issue, the State Children's Health Insurance Program (SCHIP) was created. SCHIP was a federal grant-in-aid program that entitled states to federal funding for the provision of child health assistance to low-income children (Rosenbaum, et al. 1998), specifically those children in families with incomes below 200 percent of the federal poverty level or 150 percent of the state's Medicaid income-eligibility level, whichever was higher. SCHIP was designed to allow states flexibility in shaping their own programs through one of three approaches: expansion of its current Medicaid program, creation or expansion of a non-Medicaid program, or some combination of both programs (Rosenbaum, et al. 1998).

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California responded to this federal opportunity by expanding children's eligibility for Medi-Cal and creating a new health insurance program for children whose family incomes exceed the Medi-Cal threshold. California's plan consisted of: (1) the expansion of Medi-Cal to children under age 19 with family incomes up to 100% of the Federal poverty level, and (2) the creation of a Healthy Families Program for children up to age 19 between 100% and 200% of the Federal poverty level. The Healthy Families program provided private health insurance to children below 19 years of age who did not qualify for free Medi-Cal. The program provided a basic benefits package including medical, dental, and vision care and families paid a monthly premiums of \$4 to \$9 per child (a maximum of \$27 per family) depending on family size, income, and health plans they select (MRMIB, 1998)

Despite the expansion of Medi-Cal eligibility and the creation of the Healthy Families program, the number of uninsured children in California did not decline, generating widespread concern among policy-makers and health advocacy groups. A number of public and private sector initiatives were implemented to increase enrollments of eligible children in Medi-Cal and Healthy Families, and numerous studies were conducted to document the barriers to enrolling children in these programs and to propose policy changes to decrease the dramatic rise in uninsured children (Ellwood, 1999; Selden, Banthin, and Cohen, 1998; Horner, Lazarus, and Morrow, 1999; Perry, Stark, and Valdez, 1998). These studies identified numerous barriers to enrolling children in these programs, including: lack of awareness among eligible families of the Healthy Families program; confusion over eligibility requirements for both programs, lengthy and complex application forms, the stigma associated with Medi-Cal as a welfare program, and fear among immigrant families that participation in these programs would be used against them when they try to renew their visas, return to the U.S. from abroad, or apply for citizenship status. These findings, and the fact that many of the children eligible for these programs were from ethnic minority groups frequently speaking a primary language other than English, indicated that an outreach program was needed to identify eligible children and work with their families to enroll them in Medi-Cal or Healthy Families.

Background on Outreach

The concept of outreach has evolved considerably over time. Today, outreach workers also known as community health workers, health coordinators, community health advisors, family support workers and *promotoras*, work in local communities in a variety of roles (Rosenthal, 1998; Eng, 1992). Typically, they inform community residents about health programs, identify persons eligible for programs, provide information and counseling with respect to specific concerns raised by community members, and assist eligible persons in enrolling in health programs. In this way, outreach workers help to empower community residents through educational activities and increasing access to resources. Outreach

workers often act as effective advocates for clients using traditional or managed care health systems. Several programs, in which outreach workers have participated, have demonstrated improvements in patient's continuity of care (Koch, 1998). Outreach workers are frequently used in community health promotion programs and in the delivery of primary and preventive care, particularly for high-risk populations in underserved areas (Witmer, 1995). The National Community Health Advisory Study (Rosenthal, 1998) reported how the work of outreach workers throughout the country has benefited thousands of people by improving health care access in underserved communities. The study concludes that outreach workers not only identify and link people to health or support services, but they also coordinate their relationships with multiple service systems. Similar studies have demonstrated that utilization of outreach workers enable community members to educate themselves about health problems and solutions as well as to understand health related norms and practices (Community Health Advisors/Workers. Selected Annotations and Programs in the United States, 1998; Community Health Workers: Who They are and What they do, 1996; Rico, 1997)

The use of community outreach workers in minority or disadvantaged communities often involves efforts to assist people who have been alienated from mainstream society to identify, examine, and act on the root causes of their oppression. In this way, the use of community outreach workers is consistent with the educational and social change theories of Paulo Freire (1968). Freire's approach involved small groups of individuals in a process of (a) identifying and reflecting on aspects of their reality (such as problems of poor health and limited access to medical care), (b) looking beyond these immediate problems to their root causes, (c) examining the implications of these fundamental issues, and (d) developing a plan of action to address the problems (Freire, 1973; Minkler and Cox, 1980). Although not all community outreach workers assist individuals and communities in working through all four of these aspects of the change process, the core idea of outreach – to assist disadvantaged persons and communities in becoming empowered through community organizing and educational activities is consistent with Freire's approach.

The First Things First Program

In 1998, the California HealthCare Foundation initiated the First Things First Program (FTF). The FTF program provided funding for the period April 1998 through October 1999 to coalitions of public and private health, education, and social service agencies in nine California communities. The communities included rural, agricultural communities and large metropolitan centers. Each community agency coalition was to identify the barriers to enrolling eligible children in Medi-Cal in their community and develop strategies for overcoming those barriers. For the reasons described above, conducting outreach efforts was a primary strategy implemented by the FTF coalitions to reach their targeted

populations and to achieve their enrollment goals. Although the focus of the FTF program was to enroll eligible children in Medi-Cal, whenever FTF outreach workers identified children eligible for Healthy Families, the outreach workers assisted the respective families in enrolling their children in that program as well. Details on the effectiveness of the FTF in enrolling children in Medi-Cal and Healthy Families are provided elsewhere (Rundall, Wong, Sercarz, Castañeda, and Clayson, 2000). Community health workers in the FTF coalitions enrolled over 31,000 children in low-cost insurance programs, and interviews with FTF program staff documented that they unanimously viewed their outreach program as the key to their enrollment success. Subsequently, the State of California initiated funding for more community coalitions to hire outreach workers thus expanding their role in the state's efforts to enroll children in Medi-Cal and Healthy Families.

Given its growing use, identifying the characteristics that contribute to effective outreach strategies are important. A review of other studies reveals that while many broad generalizations are made about the importance of outreach, little specific guidance is provided for defining and conducting "outreach" in the context of enrolling children in health insurance programs (Perry, Stark, Valdez, 1998; The 100% Campaign, 1998a, 1998b; Halfon, Inkeleas, Duplessis, and Newacheck, 1999). The findings reported in this paper are based on an evaluation of the outreach and enrollment efforts in the FTF coalitions. First, the methods employed in gathering data about outreach strategies are discussed. Second, the personal characteristics and core competencies of outreach workers found to be necessary for effective program implementation are presented. Third, promising outreach practices in the areas of person- to-person contact, utilization of existing institutions and public communication strategies are discussed. Finally, we conclude with several observations about the effectiveness of outreach when major barriers to enrolling children in Medi-Cal are embedded in state and national policies.

Methods

The evaluation employed a variety of qualitative methods to identify the lessons learned from the FTF program with respect to outreach. Data and information used in the analysis come from three main information sources: interviews conducted during three site visits; monthly telephone conference calls; and discussions with representatives of all ten FTF programs at a state-wide conference. Site visits to each of the nine FTF coalitions were conducted every six months over the 18-month period of the FTF program. Using ethnographic approaches, members of the evaluation team conducted semi-structured, open-ended interviews and participant observations with several stakeholder groups and individuals, including community health workers, the program director, coalition steering committee members, Department of Public Social Services (DPSS) representatives, and staff of local community based organizations (CBOs). The perspectives of diverse stakeholders as well as the participant observation helped us to understand both long-term outreach

strategies, and day-to-day outreach activities. A content analysis of the field reports was conducted and the notes from the telephone conference calls and the statewide conference synthesized to identify the key selection factors for community health workers, core competencies, and the outreach practices that appeared promising for enrolling children in low-cost health insurance.

Findings and Discussion

Who are the Outreach Workers?

In the case of the FTF projects, all community health workers were women who came to the health promotion and education arena already possessing some of the skills and abilities that enabled them to promote Medi-Cal and other insurance programs among their priority populations. In each community, the community health workers were recruited through contacts with community health activists and from community centers, health clinics, and volunteer programs serving low-income communities. In each case, the OW lived in the local community and was experienced in working on community health issues. Their knowledge of community institutions, neighborhoods, and other characteristics of their community made them uniquely qualified to help community residents to help themselves. As mentioned, the effectiveness of their work is linked to their interpersonal communication skills and their cultural and linguistic competencies.

Keys to the Selection and Training of Effective Outreach Workers

The experiences of the FTF projects indicate that effective outreach is affected by the selection of community outreach workers with appropriate personal characteristics and then training them in a number of core competencies.

Selection of Outreach Workers

Outreach workers are often the most visible component of an insurance enrollment project, and the extent to which outreach workers are effective at their work will largely determine the overall success of the project. A remarkably wide range of skills and abilities are required to effectively carry out the complex activities of health promotion, especially enrolling children in health insurance programs. The following personal abilities and characteristics of FTF outreach workers contributed to the success of their outreach work.

- Sensitivity to the needs of the cultural or ethnic group with whom they worked including having appropriate linguistic skills;
- Understanding the importance of confidentiality;
- Representing an organization with a good reputation in the community;
- Having a commitment to serving the community;
- Communicating effectively with individuals one-on-one as well as speaking effectively to groups;
- Working independently; and

- Flexibility, particularly performing a variety of tasks simultaneously.

According to the literature community outreach workers have established important cross-cultural linkages among the community and the health system, and in some cases even with academic institutions who were conducting evaluations (Hill, 1996; Meister, 1996; Hutchison and Quartaro, 1995; Eng et al, 1997; Barnes and Fairbanks, 1997; Booker, 1997). In the case of FTF, they enhanced researchers' access to community leaders, resources, and potential insurers. Also, being empathetic to the needs of others is crucial to a community outreach worker's effectiveness. Although community health workers are typically guided by an outreach strategy and a specific action plan for implementing their activities, inevitably multiple activities will have to be "juggled" and changes in activities will be required to adapt to unforeseen circumstances.

Training Required for Outreach Workers: Six Core Competencies

The outreach workers that were recruited to FTF required additional training to supplement their personal attributes and skills. Through discussions with FTF outreach workers about the competencies that contributed to successfully enrolling children in low-cost health insurance, training six *core competencies* were identified. These core competencies were:

- Outreach strategy;
- Medi-Cal and Healthy Families eligibility criteria, enrollment forms, and procedures;
- Immigration and naturalization law as it pertained to Medi-Cal benefits;
- Local community referral resources;
- Outreach efforts based on clients' concerns; and
- Privacy and confidentiality of information.

Core Competency #1: Outreach Strategy. Successful programs to enroll eligible persons in Medi-Cal have had an outreach strategy (Rundall, 2000; The 100% Campaign, 1998b). The specific strategy for reaching and educating the eligible populations depends on the unique characteristics of the community. That is, the programs' outreach activities are designed in such a way that the activities are connected in a logical plan of action. Community outreach workers must know what the overall strategy is for enrolling children, and understand how their specific responsibilities fit into that strategy. A typical outreach strategy may include:

- 1) coordinating distribution of brochures and other informational materials at community events;
- 2) conducting group presentations at clinics, schools, and workplaces;
- 3) implementing "train-the-trainer" educational programs;
- 4) referring contacts to other enrollment programs or networking with adjunct services and community-based

organizations; 5) implementing strategies that are sensitive to different cultural needs, and 6) assisting families with completing the Medi-Cal application and informing them of steps necessary to enroll their children. Combining several of these components is frequently done.

“...the most effective outreach and enrollment efforts have been through neighborhood health clinics, particularly when community outreach workers developed referral relationships with staff of the Women, Infants and Children (WIC) Program. The clinic and WIC staff members were able to identify parents without insurance and make direct referrals to community outreach workers who assisted the parents in completing the Medi-Cal application” (FTF project staff person).

Core Competency #2: Medi-Cal Eligibility Criteria, Enrollment Forms, and Procedures. One of the most important core competencies for community outreach workers is the ability to assist families in completing the Medi-Cal/Healthy Families application forms.

“There is no way most of my clients could fill out the Medi-Cal/Health Families application by themselves. It is too complicated” (FTF outreach worker).

Outreach workers must understand the eligibility criteria, the correct way to fill out the combined application as well as the traditional Medi-Cal application, and be able to efficiently guide parents through the application process. Moreover, the OW must be familiar with the income and other documentation required to complete the application package. To this end, the state of California contracted with Richard Heath & Associates (RHA) to provide assistance to community organizations enrolling children into Medi-Cal and Healthy Families. The difficulty of training community outreach workers to understand complex rules and procedures during a time of regulatory confusion and bureaucratic change cannot be overestimated. Initially, many community outreach workers reported dissatisfaction with their training. In particular, the RHA trainers did not provide timely answers to many questions about Medi-Cal eligibility policy or immigration concerns. As the policy environment has become clearer and experience with the new eligibility assessment and enrollment procedures has increased, community outreach workers have reported greater satisfaction with this training.

Core Competency # 3: Immigration and Naturalization Law as it Pertains to Medi-Cal Benefits. One of the most difficult issues faced by FTF community outreach workers is how to advise clients with respect to the effect their application for Medi-Cal may have on their immigration status.

“In our Latino community, the two greatest barriers to enrolling children in Medi-Cal are parents’ negative attitudes toward Medi-Cal and their fear that enrolling in Medi-

Cal will be considered a 'public charge' and cause them to be deported or denied citizenship" (FTF outreach worker).

Unfortunately, federal and state policies have created complex rules and regulations pertaining to welfare, immigration, and Medi-Cal. For example, the Personal Responsibility and Work Opportunity Act (PRWORA) of 1996 restricted Medicaid eligibility of legally admitted immigrants. The PRWORA changes led many immigrants believe -some times erroneously- that they no longer qualified for Medi-Cal benefits, or made them afraid to apply for coverage. The legislation also added complexity to the number of steps involved in verifying immigration and citizenship status (Ellwood, 1999).

Also, community outreach workers were frequently asked whether use of Medi-Cal benefits constitutes a "public charge". This refers to portions of immigration law that identify dependence on public resources, as an obstacle to becoming a naturalized citizen. The federal government published clarifications of the meaning of "public charge" in order to decrease immigrants' fears that applying for public health benefits will result in denial of citizenship and even deportation. A great deal of confusion and anxiety existed over these laws and regulations among immigrant communities in California (Ellwood and Leighton 1998). While it would be inappropriate for community outreach workers to be offering detailed explanations, interpretations, or legal advice regarding these laws, they must be sufficiently familiar with immigration issues to be able to answer basic questions and to know where to refer clients for legal advice.

Core Competency #4: Local Community Referral Resources. Outreach workers should be aware of health, educational, and other social and welfare programs in the community. It was important that community outreach workers knew the specific contact persons, including the Medi-Cal eligibility workers in their area, and the relevant phone numbers and address information for those contacts. Community outreach workers were often in a position to know of individuals and families in need of assistance, and it was important that community outreach workers were able to quickly and accurately refer people to public and private programs that will provide that assistance. Usually FTF outreach workers were recruited directly from the neighborhood where programs were concentrated. In this sense, the main role of community outreach workers was to serve as the link between the program and the community they served, and their primary task was to gain community acceptance and encourage involvement in health educational and insurance enrollment programs. Often the priority population does not trust "outsiders" because of a long history of negative experiences (Booker, Robinson, Kay, Najera, and Stewart, 1997).

"I recently helped a young mother who had no idea she was eligible for cash assistance. I told her that she might be eligible for other programs. I referred her at the TANF office and she kept thanking me..." (FTF outreach worker)

In some cases, a family's income changes and their child is no longer eligible for one program but may be eligible for another program. Or, as is often the case, families with multiple children find that each child qualifies for a different program due to the child's age, immigration status, or other factors. These situations required outreach workers to collaborate with eligibility and verification staff of Medi-Cal, Healthy Families, and other programs to develop protocols on how to refer applications to the appropriate program in an expeditious manner. According to community outreach workers at several FTF sites, inconsistency remained related to the handling of cross referrals at both the state and county levels. Consequently, these applications were bounced around in the system for weeks, and many eventually fall through the cracks. In the meantime, families delayed care for their children while waiting for enrollment notification.

Core Competency #5: Outreach Efforts Based on Client's Concerns. Outreach workers should receive training in how to sensitively approach individuals and families about their health insurance issues. Conversations included a larger array of topics than insurance. Sensitive issues such as marital status, legal guardianship of children, immigration status, and illness history required community outreach workers to be patient, understanding, and careful about what they said and asked.

Core Competency #6: Privacy and Confidentiality of Information. Outreach workers also needed training with respect to providing individuals with privacy when they were discussing health and health insurance matters and the critical importance of keeping all such information confidential. Specific techniques for collecting and storing information, copies of applications, contact/information sheets, etc. should be provided to every outreach worker.

"In our agency we keep all client records in locked file cabinets. Staff members personally pick up and transport client documents as needed, and we shred any unnecessary files" (FTF outreach worker).

Promising Outreach Practices for Health Insurance Enrollment

The following section describes the three main avenues used to achieve successful outreach within FTF: person-to-person contact, utilization of existing institutions, and a variety of public communication strategies. A combination of these three avenues appeared to meet with the greatest success. In addition, coordination between agencies involved in children's health insurance was central to overall success.

1) Person-to-Person Contact

Personal contact with an informed and culturally competent outreach worker has been a key strategy for effective targeted outreach. The effectiveness of these kinds of approaches has shown

that social interaction plays a major role in health promotion activities. Outreach work is based on social power and interpersonal influence (Raven and Litman-Adizes, 1986).

The Promotora person-to-person outreach model

Home visits were conducted by some FTF coalitions, following the *Promotora* outreach model. This person-to-person outreach method enables community members to educate themselves about health problems and solutions and then brings about changes in community norms and practices including knowledge about the availability of health insurance. It is based on the Community health workers participation in family-based individual problems within the community (Meister, 1996). The model provides a credible source of information because OWs from within the priority population's socio-economic, ethnic and cultural networks, are the source of the information. Barriers encountered and strategies for solving problems are openly discussed and shared among peers in a culturally and linguistically friendly environment.

"Home visits were planned in advance [like the Tupperware strategy] at a neighbor's house, where peers (generally women) organized potlucks. Information about health related matters, including Medi-Cal, was provided directly, and there were opportunities to ask questions, regardless of class and language barriers. The feeling of informal, friendly and more humanized conversations facilitated our work" (FTF outreach worker).

For the FTF program, this model has worked best in small communities located in rural or isolated areas. Less positive experiences were reported by urban-based FTF coalitions, where door-to-door approaches were perceived negatively because people are tired of solicitors bothering them at home and personal safety in the home is a concern. Also, door-to-door contact were less successful as an outreach method in urban communities simply because of the number of contacts required.

Street outreach in "El Barrio" provides opportunities for effective one-on-one promotion of health insurance in urban communities.

Utilizing popular advertising was a helpful strategy for reducing the stigma related to welfare in general and Medi-Cal in particular in some ethnic communities. For example, in some Latino "Barrios" OWs have used megaphones installed outside cars to promote health fairs and other Medi-Cal enrollment events. The program broadcast through the roving car-speaker alternated Mexican folk music with health information.

"This strategy was useful in many ways: reminding people of the event (usually some days in advance and the same day); explaining what documents they need to bring in order to be enrolled; and informing them of the benefits of having health insurance. As a Border County, we have to adapt our strategies to the culture of Mexican-origin people

that frequently go back to Mexico for seeking health. Promotion of health insurance in this scenario is very attractive and joyful” (FTF outreach worker).

Site visits to agribusiness fields and packing companies have been very effective methods of providing information about Medi-Cal to hard-to-reach migrant farm workers.

This approach was most effective when it was implemented in phases. First, “Promotoras” sensitized business owners, staff members or union leaders about the importance of health insurance. This step was crucial for gaining access to the fields or packing companies. Second, they usually conducted information sessions at breakfast/lunch breaks. Third, late in the afternoon, when parents pick-up their children at schools, they re-contacted parents to complete the application and enrollment procedures.

“When working in the fields, we began our outreach activities around 4:00 AM because that is the time when the people begin to work. We have to adapt our schedules to the farm worker’s time availability” (FTF outreach worker).

The mail-in application requires person-to-person follow-up

While it was helpful to simplify the Medi-Cal/Healthy Families application, in most cases, personal follow-up was required in order for the application to be complete. In one county, the DPSS staff indicated that 90 percent of its mail-in applications were incomplete, incorrectly completed or lacking sufficient documentation. These applications were then placed on hold status for 30 to 45 days. Fortunately, the FTF coalition in this county had a close working relationship with its DPSS office and received a disposition status report on who these families were and what was required for completion of their application. However, this was not necessarily the situation in all counties and resulted in large numbers of children being “on hold” in the system. The results were twofold: potentially eligible children remained uninsured during this period and additional resources were spent determining how to effectively reach their parents or adult family members to finalize the application process.

Multiple person-to-person contact is crucial to successfully enrolling children and families in Medi-Cal.

Often, multiple personal contacts were required for enrolling eligible children and families in Medi-Cal. Community health workers often contacted parents or guardians three to four times before a child was successfully enrolled in the system. Due to the number of systemic barriers impacting the Medi-Cal program (stigma of Medi-Cal, the public charge

issue, complexity of the program, etc.), community outreach workers spent one to two sessions educating and demystifying the program, while simultaneously becoming familiar and building trust with adult family members.

Clarification of eligibility criteria was another priority that the state needed to address in order to increase enrollment of uninsured children. For example, there was confusion about Medi-Cal eligibility enrollment requirements. Basic information regarding income requirements, links to welfare/TANF, and immigration status are issues that needed to be clarified. Several studies have documented that seemingly eligible individuals often do not enroll because they do not understand the eligibility criteria (Dubay & Kenney, 1996; Selden, Banthin, and Cohen, 1998; Smith, Lovell, Peterson, and O'Brien, 1998; Shuptrine, Grant, and McKenzie, 1998).

"The fact that all children in a family may not be eligible for insurance is problematic. It is difficult to explain to families that their U.S. born child is eligible and yet their older undocumented child is not. This practice would be contrary to family norms which require that children be treated equally." (FTF project director).

"Lawyers do not have consistent answers regarding "public charge." Families are concerned and do not trust the system, particularly when they can not get a definitive clarification on this issue which may effect their current documentation status and later ability to apply for citizenship" (FTF outreach worker).

Monitoring and follow-up with families is essential to maintaining their enrollment in Medi-Cal over time.

Outreach workers reported that clients often were confused about how often they needed to reconfirm their eligibility status and about what steps were necessary to maintain eligibility for Medi-Cal. For these reasons follow up by community outreach workers and certified assisters is important to ensure retention and re-enrollment when necessary. For many families, community outreach workers must function as case managers and advocates to ensure continuity of insurance. It is interesting to note that county Medi-Cal managed care plans are particularly aggressive in their outreach efforts to retain Medi-Cal eligibility for their members.

"The Managed Care Network has observed a steady increase in the numbers of families that are in danger of becoming disenrolled and are dedicated to ensuring that the family remains eligible and continues to receive services. It is to the network's advantage to retain members to ensure they receive capitated per member per month payments. This is an interesting strategy because it links organizational

self-interest with continued insurance coverage and continuity of care for low income families” (FTF project director).

2) Utilization of existing institutions

Schools. Elementary and middle schools were the major source of referrals for children requiring health insurance. Nurses, teachers and administrative personnel were informed by FTF coalitions through personal contacts, presentations, training, and materials. On some occasions, meetings with parents were arranged and community outreach workers conducted presentations, completed Medi-Cal applications or scheduled later appointments. These meetings were crucial for informing parents about the importance of preventive health care. In addition, the bilingual competency of community outreach workers was important to successfully educating parents regarding the benefits of health insurance, the enrollment process, and retention requirements.

“Schools provide access to families directly, through on-site clinics, parent organizations, and Healthy Start sites. The school nurse connection was crucial. As a result of an announcement in the school newsletter phones were ringing off the hook” (FTF outreach worker).

School clinics. Where they were available, school clinics were strategic sites for placement of community outreach workers. They were able to establish contacts with parents when their children sought services. Parents were often initially contacted at school-wide presentations and follow-up clinic appointments were scheduled at that time.

“For me, the walk-in appointment at the school clinic is basically the norm. The fact that I am out-stationed at a place where parents naturally go increases my credibility. School clinics legitimize my work. If somebody identified that I am working at the school, maybe when they see me again (for example giving Medi-Cal information at a mall), they will make the connection” (FTF outreach worker).

Local hospitals and health clinics. These institutions confronted the multiple problems of uninsured persons on a daily basis. Moreover, uninsured patients were a financial drain on these providers; therefore they have a clear self-interest in increasing insurance coverage. Many hospitals and health clinics played a major role in the promotion of health insurance. In the majority of cases, they were receptive to community outreach workers and several FTF coalitions stationed their community outreach workers at local hospitals.

Health clinics linked to schools, churches or employers provided examples of sites with institutional *legitimacy*. As Schauffler stated (1999: 116), "To conduct a well-designed

education campaign, the state should work with schools, religious organizations, and a variety of community-based organizations". These sites also provide parents or adult family members numerous opportunities to interact with community outreach workers (as compared to one-time events), and their activities were in effect "sanctioned" by a known entity. Community health clinics are also sites with an established presence in the community where parents come more prepared to discuss health insurance options for themselves and their children.

Other institutions. Churches, unions, neighborhood associations, day care centers and ethnic specific community-based organizations provided effective settings for FTF outreach efforts, making it possible to reach low-income children and families who for some reason could not be contacted through schools, hospitals, and clinics. Often staff or volunteers at these institutions possessed linguistic and cultural capabilities that increased the impact of the outreach activities.

"Churches want to be involved, and we are beginning to see results... particularly in getting the word out to the African American community" (FTF outreach worker).

3) Public Communication Strategies

Within this category are community wide approaches including community events, and radio coverage. These strategies, while individually important, should be linked to more personalized efforts to achieve results. They compliment the previously mentioned practices.

Community Events. Health and charity fairs, local and ethnic celebrations, feasts, and mall presentations have provided important opportunities for promoting health insurance to specific populations. These events served as points of entrance to hard-to-reach populations. Outreach activities at these events focused on providing information about existing services and basic enrollment advice. Outreach at these events helped to raise public awareness, providing an effective way to "get the word out," provide points of contacts between community outreach workers and potential clients, and sensitize people about the benefits of having insurance. The educational messages contained culturally specific approach, which was appreciated by recipients.

"Health fairs are well attended and very attractive, especially because some services are provided at the fair, and because the atmosphere is joyful and familiar. There is music, a lot of food, games for children, and people see each other, talk in their language and had fun" (FTF outreach worker).

Radio Coverage. Many low-income families listened to the radio at home or at work. Although television, newspapers, and brochures were useful in making people aware of Medi-Cal, Healthy Families, and other programs they required more personalized follow-up efforts such as using a 1-800 number to talk directly to community outreach workers.

Radio talk shows were particularly important for immigrant communities because the concept of health insurance is complex and difficult to internalize by people only familiar with health systems from other countries. Recent immigrants frequently ask *“Why do I need to pay for health insurance if I am not using it?”* or *“Why do I need to pay in advance for something that I may not use.”*

“We invited a Mexican public health specialist to talk about health insurance benefits. After the program, a considerable amount of calls were received. OWs made appointments for application assistance. The specialist remarked that there are some differences between what people were used to receiving from public/government clinics and hospitals in Mexico, and what similar institutions will provide in the United States. With every-day examples, she covered sensitive topics” (FTF project director).

Conclusions

Conducting outreach efforts was a primary strategy implemented by the FTF coalitions to reach their priority populations and to achieve their enrollment and educational goals. The experiences of the FTF projects demonstrated that effective outreach depends on the selection of community outreach workers with appropriate personal characteristics and the training of those workers in a number of core competencies. The combination of the personal characteristics and training of the community outreach workers with the approaches of person- to- person contact, utilizing existing community institutions, and public communication strategies provided the best results.

Outreach workers have proved to be effective health promoters. Skilled in grassroots communication, they are key to building and maintaining the community support vital to many health promotion programs. However as suggested by the Urban Institute (1999), and confirmed by the experience of the FTF projects, there are structural and systemic barriers to enrolling children in public health insurance programs that exceed the scope of community health workers and outreach strategies.

Medicaid enrollment problems go beyond the need for better outreach. While states hope that outreach efforts will assist them in addressing Medicaid enrollment declines, it is clear that these strategies are essential, but not enough to effectively enroll all eligible children.

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