# *Promising Outreach Practices: Enrolling Low-Income Children in Health Insurance Programs in California*

Xóchitl Castañeda, MA
Zoe Cardoza Clayson, ScD
Tom Rundall, PhD
Liane Dong, DrPH
Margo Sercaz

*Strategies used by outreach workers to successfully enroll underserved and uninsured California children into low cost health insurance programs such as MediCal and Healthy Families are examined. Otreach workers 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, outreach workers are key to building vital community support. Effective outreach depends on the selection of outreach workers with appropriate personal characteristics and then training them in a number of core competencies. This article analyzes the main avenues used by outreach workers 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 outreach workers. Thus, effective outreach programs should address both structural issues and staff selection and training.*

**Keywords:** *children; health insurance; Healthy Families; MediCal; promotoras; immigration; California; outreach; Latino*

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 USA, Inc., 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, Johnson, Sonosky, Markus, & DeGraw, 1998), specifically those children in families with incomes below 200% of the federal poverty level or 150% 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).

California responded to this federal opportunity by expanding children's eligibility for MediCal and creating a new health insurance program for children whose family incomes exceed the MediCal threshold. California's plan consisted of (a) the expansion of MediCal to children under age 19 with family incomes up to 100% of the federal poverty level and (b) 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 MediCal. The program provided a basic benefits package including medical, dental, and vision care, and families paid a monthly premium of $4 to $9 per child (a maximum of $27 per family) depending on family size, income, and health plans they select.

Despite the expansion of MediCal 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 MediCal and Healthy Families, and numerous studies were conducted to document the barriers to enrolling children in these

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programs and to propose policy changes to decrease the dramatic rise in uninsured children (Ellwood, 1999; Horner, Lazarus, & Morrow, 1999; Perry, Stark, & Valdez, 1998; Selden, Banthin, & Cohen, 1998). These studies identified numerous barriers to enrolling children in these programs, including the following: 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 MediCal 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 United States 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 MediCal 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 (Eng & Young, 1992; Rosenthal, 1998). 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 & Thompson, 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 undeserved areas (Witmer, Seifer, Finocchio, Leslie, & O'Neil, 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 & 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 MediCal 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 MediCal, 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 MediCal and Healthy Families are provided elsewhere (Rundall, Wong, Sercarz, Castañeda, & Clayson, 2000). Community health workers in the FTF coalitions enrolled more than 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

### The Authors

***Xóchitl Castañeda***, *MA, is director of the California-Mexico Health Initiative, California Policy Research Center, University of California, Office of the President.*

***Zoe Cardoza Clayson***, *ScD, is a professor in the Department of Health Education at San Francisco State University in San Francisco, California.*

***Tom Rundall***, *PhD, is a professor in the Department of Health Policy and Management at the University of California in Berkeley, California.*

***Liane Dong***, *DrPH, is a senior research associate in the Department of Health Policy and Management at the University of California in Berkeley, California.*

***Margo Sercaz*** *was a graduate student at the School of Public Health, University of California in Berkeley, California.*


workers thus expanding their role in the state's efforts to enroll children in MediCal 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 although 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 (Halfon, Inkeleas, Duplessis, & Newacheck, 1999; The 100% Campaign, 1998a, 1998b; Perry et al., 1998). The findings reported in this article 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 MediCal 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 the following three main information sources: interviews conducted during three site visits, monthly telephone conference calls, and discussions with representatives of all 9 FTF programs at a statewide conference. Site visits to each of the 9 FTF coalitions were conducted every 6 months over the 18-month period of the FTF program. Using ethnographic approaches, members of the evaluation team conducted semistructured, 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 observations 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 MediCal 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 outreach worker 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 (Barnes & Fairbanks, 1997; Booker, Robinson, Kay, Najera, & Stewart, 1997; Eng, Parker, & Harlan, 1997; Hill, Bone, & Butz, 1996; Hutchison & Quartaro, 1995; Meister, 1996). 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 who 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, six core competencies were identified. These core competencies were

- outreach strategy;
- MediCal and Healthy Families eligibility criteria, enrollment forms, and procedures;
- immigration and naturalization law as it pertained to MediCal 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 MediCal have had an outreach strategy (The 100% Campaign, 1998b; Rundall et al., 2000). 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 (a) coordinating distribution of brochures and other informational materials at community events; (b) conducting group presentations at clinics, schools, and workplaces; (c) implementing so-called train-the-trainer educational programs; (d) referring contacts to other enrollment programs or networking with adjunct services and community-based organizations; (e) implementing strategies that are sensitive to different cultural needs; and (f) assisting families with completing the MediCal 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 MediCal application. (FTF project staff person)

*Core competency 2: MediCal 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 MediCal/Healthy Families application forms.

> There is no way most of my clients could fill out the MediCal/Healthy 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 MediCal application, and be able to efficiently guide parents through the application process. Moreover, the outreach worker 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 MediCal 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 MediCal 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 MediCal 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 MediCal may have on their immigration status.

> In our Latino community, the two greatest barriers to enrolling children in MediCal are parents' negative attitudes toward MediCal and their fear that enrolling in MediCal 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 MediCal. 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 to believe—sometimes erroneously—that they no longer qualified for MediCal 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 MediCal benefits constitutes a so-called 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 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 & Leighton, 1998). Although 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 MediCal 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 in which 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 et al., 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 because of the child's age, immigration status, or other factors. These situations required outreach workers to collaborate with eligibility and verification staff of MediCal, 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 fell 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 and information sheets, and so forth, 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.

### *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 & 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 bring about changes in community norms and practices including knowledge about the availability of health insurance. It is based on the community health worker's participation in family-based individual problems within the community (Meister, 1996). The model provides a credible source of information because outreach workers from within the priority population's socioeconomic, 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 MediCal, 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, in which 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 was 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 MediCal in particular in some ethnic communities. For example, in some Latino "barrios," outreach workers have used megaphones installed outside cars to promote health fairs and other MediCal 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 MediCal 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 or lunch breaks. Third, late in the afternoon, when parents pick up their children at schools, they recontacted parents to complete the application and enrollment procedures.

When working in the fields, we began our outreach activities around 4:00 A.M. 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*

Although it was helpful to simplify the MediCal/Healthy Families application, in most cases, personal

follow-up was required for the application to be complete. In one county, the DPSS staff indicated that 90% of its mail-in applications were incomplete, incorrectly completed, or lacking sufficient documentation. These applications were then placed on hold status for 30 days 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 MediCal*

Often, multiple personal contacts were required for enrolling eligible children and families in MediCal. Community health workers often contacted parents or guardians three to four times before a child was successfully enrolled in the system. Because of the number of systemic barriers affecting the MediCal program (stigma of MediCal, the public charge issue, complexity of the program, and so forth), community outreach workers spent one to two sessions educating and demystifying the program, while becoming familiar and building trust with adult family members.

Clarification of eligibility criteria was another priority that the state needed to address to increase enrollment of uninsured children. For example, there was confusion about MediCal eligibility enrollment requirements. Basic information regarding income requirements, links to welfare or Temporary Assistance for Needy Families, 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 et al., 1998; Shuptrine, Grant, & McKenzie, 1998; Smith, Lovell, Peterson, & O'Brien, 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 cannot 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 MediCal 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 MediCal. For these reasons, follow-up by community outreach workers and certified assisters is important to ensure retention and reenrollment 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 MediCal-managed care plans are particularly aggressive in their outreach efforts to retain MediCal 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)

### *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 MediCal 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 schoolwide 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 MediCal 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. 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 in which 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 affect 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)

### *Public Communication Strategies*

Within this category are community-wide approaches, including community events and radio coverage. These strategies, although individually important, should be linked to more personalized efforts to achieve results. They complement 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 a 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 MediCal, 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. Outreach workers 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 everyday 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 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. Although 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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