



Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

State Children's Health Insurance Program Providing Coverage to Nearly Two Million Children

By Houkje Ross

Some working parents don't make enough money to afford private health care coverage for their children. But at the same time, they make too much money to qualify for Medicaid. Fortunately, a federal/state partnership program helps provide low-cost or free health insurance to children who are caught in the middle.

Signed into law in 1997 by President Clinton, the State Children's Health Insurance Program (SCHIP) provides health insurance to uninsured children of low-wage, working parents. SCHIP resulted from the Balanced Budget Act of 1997 and is also known as Title XXI of the Social Security Act.

U.S. Department of Health and Human Services (HHS) Secretary Donna Shalala announced in January that nearly two million children who otherwise would be without health insurance were enrolled in SCHIP in fiscal year 1999—double the number reported in the first full year of the program.

Eligibility requirements vary from state to state, but in most states, SCHIP applies to children who are 18 years old or younger and whose parents earn up to \$34,100 a year for a family of four.

Uninsured children

According to the U.S. Bureau of the Census, more children than ever are uninsured. The current number is approximately 11.3 million. Seven in 10 Americans losing health insurance today are children, due in large part to businesses that are cutting support for dependent cover-

age, according to the Children's Defense Fund. Since 1989, children have lost private health coverage at twice the rate of adults. More than 90 percent of these children have one or more working parents.

Not having consistent care jeopardizes a child's well-being and can cost more in the long run. "Oftentimes children without health insurance end up in the emergency room at tax payers' expense, and they are more likely to do poorly in school," says Kristine McGrath, communications specialist for the Florida HealthyKids program, one of the state's four programs that receives SCHIP funding. Having insurance and being able to go to the doctor before an illness turns into an emergency can give par-

ents an overall peace of mind, McGrath says.

By targeting working parents, SCHIP may be helping to lift the negative view that has clouded Medicaid and other federal assistance programs in the past. According to Emily Cornell, senior policy analyst for the National Governor's Association, "CHIP was designed as a program for working families who typically don't think of themselves as poor or welfare families." The goal is to insure as many children as possible and improve their overall health.

Building on Medicaid

SCHIP is administered by the Health Care Financing Administration's (HCFA) Center for Medicaid and State Operations (CMSO). The program, which will make avail-

...continued on page 2



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OFFICE OF PUBLIC HEALTH
AND SCIENCE
U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES

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February 2000

Closing the Gap is a free newsletter published by the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services. Send all correspondence to: Editor, Closing the Gap, OMH-RC, PO Box 37337, Washington, D.C. 20013-7337. Call us toll-free to get on our mailing list, 1-800-444-6472, or browse our Web site at: <http://www.omhrc.gov>.

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Inside

Minority Health Perspective.....	3
Immigrant's Fears and Eligibility Rules..	4
New Initiative to Boost Enrollment.....	5
HRSA Supports SCHIP Outreach.....	6
Student Volunteers Help Boost SCHIP Enrollment in NY.....	7
Improving Outreach in Rural Areas.....	8
Border Vision Frontiera.....	9
Access for American Indians.....	9
<i>Insure Kids Now! Through Schools Campaign</i>	10
Eight Steps to Better Media Outreach.....	10
American Indians/Alaska Natives.....	11
Resources.....	11
Conferences.....	12

able \$39 billion over the next ten years, builds on Medicaid, the federal-state health insurance program that covers 41.4 million low-income individuals.

To receive funding, each state had to submit a plan to HCFA that details how it would use SCHIP funds. States have the option of using funds to expand Medicaid, create a separate state child health insurance program, or combine the two programs. States that have separate programs are allowed cost sharing with beneficiaries. Funds are allocated to each state according to the number of uninsured low-income children, accounting for regional cost differences.

HCFA's *State Children's Health Insurance Program Annual Enrollment Report* shows that by September 30, 1999, SCHIP plans had been approved for all 56 states, territories, and the District of Columbia. Fifteen states chose to create a separate program, while 27 chose to expand Medicaid, and 14 chose a combination program. CMSO offers technical assistance to any state that requests it. Each state is assigned a project officer who can provide technical assistance on SCHIP.

Under SCHIP, states set their own eligibility rules. States that create separate SCHIP programs may define covered benefits within Congressional guidelines, determine subsidy levels, set payment rates, and select which health plans and providers participate. For states with Medicaid expansions, Medicaid rules apply. All states—except for Florida, New York, and Pennsylvania, which had existing state programs grandfathered in—must choose between three “benchmark” insurance options. They can provide coverage through:

- 1) the same health plan that is offered by the State to its employees;
- 2) the Blue Cross/Blue Shield Preferred provider option offered by the Federal employees health benefit program;
- 3) the HMO benefit plan with the largest commercial enrollment in the state.

Required services under SCHIP include inpatient and outpatient hospital services; physicians' surgical and medical services; lab and X-ray services, and well baby/child care services (including immunizations). Beyond this, services vary. For example, the state of Connecticut includes regular check-ups, school and sports physicals, prescription drugs, dental care, and vision and hearing testing in its plan. But other states may decide to include different services.

Some states provide more specialized services. For example, the Children's Medical Services program in Florida is a SCHIP-funded program that provides care to children with special needs due to diseases such as spina bifida, leukemia, and diabetes.

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How to apply for SCHIP

Families who want to apply for SCHIP or Medicaid can start by calling the national toll-free number, 1-877-KIDS-NOW. Callers are then referred to the SCHIP program in their state. Most states have a toll-free number where individuals can request applications and find out more about the program. Operators can answer questions about what the program covers, who is eligible, and the minimum qualifications.

For information about the SCHIP program in your state, contact: 1-(877)-KIDS-NOW. Or, browse HCFA's Web site at: <http://www.insurekidsnow.gov>. ❖

Joining Together to Make SCHIP Work

Editorial By Nathan Stinson, Jr., PhD, MD, MPH, Deputy Assistant Secretary for Minority Health

No child in this country should ever be without health insurance. But the fact is, more than 11 million children in America are uninsured, and the number is growing. Nearly 30 percent of Hispanic, 20 percent of African American, 17 percent of Asian American and Pacific Islander, and 14 percent of white children are uninsured, according to the Census Bureau. The consequences: one in four uninsured children has no regular source of health care or uses the hospital emergency room or hospital outpatient department for care, according to the Commonwealth Fund. Uninsured children are also 25 percent more likely to miss school than other children. We are failing our children.

The State Children's Health Insurance Program, or SCHIP, was initiated to help the states identify and provide health insurance to low-income uninsured children. Every state has a children's health insurance program under SCHIP, which collectively have enrolled some two million children. Some states are also reporting that the roll out of SCHIP has helped stimulate new enrollments of children in Medicaid.¹ But individual state uninsurance rates among children range from 6.7 percent to 24.7 percent, according to the National Children's Health Survey conducted by the Children's Defense Fund. We need to make sure that no states miss children.

To increase SCHIP enrollment we must raise awareness among parents that their children may qualify for free or low cost health insurance. We should inform families that they may still be eligible for SCHIP even though they work. We should help others to not feel ashamed of their need for insurance, and guide them through the enrollment process—especially those who may experience cultural or language barriers to obtaining SCHIP information. We should assure immigrants that lawfully enrolling their children in SCHIP will not make them a “public charge” and will not get them in trouble with the Immigration and Naturalization Service.

To insure all of America's eligible children, SCHIP and Medicaid must foster a better communication network. Up to 10 percent of SCHIP funds may be used by states for purposes such as outreach. We must work with our states in developing realistic and appropriate strategies to properly inform and enroll eligible children in SCHIP.

A population that we must give special attention is American Indians/Alaska Natives (AI/AN). The AI/AN population has a higher birth rate than any other racial and ethnic group, according to the Indian Health Service (IHS). Approximately 33 percent of this population are younger than age 15, compared with 22 percent for all other races combined. Furthermore, AI/ANs live in poverty at almost two and a half times the rate of all other U.S. citizens. According to congressional intent, the Health Care Financing Administration (HCFA) does not allow states to impose out-of-pocket costs on AI/AN children and their families. We have to educate communities that AI/ANs are eligible for SCHIP on the same basis as other children in the state in which they reside, regardless of whether they

are eligible for or receive IHS-funded care. States are responsible for consulting with tribes in developing SCHIP programs and enrollment efforts.

HCFA provides technical support to states that need guidance on SCHIP. For example, HCFA recently proposed rules to clarify parts of the law and supports several SCHIP outreach activities (see story on p. 4). The Agency for Healthcare Research and Quality has an SCHIP distance learning site available through the Internet to assist in the planning and evaluation of state SCHIP programs.

The U.S. Department of Education's *Insure Kids Now! Through Schools* campaign hopes to enroll millions of children in SCHIP by integrating health insurance enrollment into school activities. More than 1,500 schools in 49 states are committed to the project to date. We need to encourage all of our schools to get involved (see story on p. 10).

Congress is also calling on states to assess their programs' outreach and enrollment efforts. Each state will be submitting an evaluation that will include a description and analysis of the characteristics of children and families served by SCHIP; the effectiveness of service areas, time limits for coverage, types of benefits, and quality of health coverage under the state plan; a review and assessment of state activities to coordinate SCHIP with other health care and health care coverage provided to children; a description of any plans for improving the availability of health care and coverage; and recommendations for improving SCHIP.

While overall SCHIP enrollment numbers are going up, outreach remains a significant challenge. Expanding eligibility criteria is not enough to ensure coverage for our children. A recent fact sheet from HCFA shows that millions of uninsured children had been eligible for Medicaid but were not enrolled.

We don't yet know exactly how many minorities are enrolled in SCHIP. Fortunately, HCFA staff expect minority enrollment data to be included in the state evaluations of SCHIP programs due to Congress in Spring 2000. Analyzing this data will help us develop more effective and appropriate outreach strategies.

While two million children who otherwise would be uninsured are now enrolled in SCHIP, there's more work to be done. We need your help. In order to increase enrollment, we must join with our states to spread the word about how SCHIP and Medicaid programs *really* work. Then once we get eligible children enrolled in SCHIP, we must get them to use it. Too many minority children are still relying on hospital emergency rooms to treat conditions that may have been detected or prevented through regular office visits.

To learn how you can participate in various SCHIP outreach activities, browse HCFA's Web site at: <http://www.hcfa.gov>, or call Mary Kahn at HCFA, (202) 690-6145. ❖

¹Alliance for Health Reform, “Health Coverage Update: Children's Health Insurance,” March 2000.

Immigration Fears and Eligibility Rules Among Barriers to SCHIP

By Shelley Davis

Nearly one million children of U.S. farmworkers are eligible to participate in the State Children's Health Insurance Program (SCHIP) or Medicaid. But many have remained on the sidelines due to immigration concerns or state eligibility requirements. Many of these obstacles to enrollment can be overcome by streamlining state eligibility requirements and organizing community-based efforts.

A Snapshot of Farmworker Children

Most farmworkers in the U.S. are poor immigrants who lack health insurance for themselves or their families. Seventy percent of the nation's 2.5 million hired farmworkers are foreign born, according to the U.S. Department of Labor (DOL). About two-thirds of the farm labor force is comprised of legal permanent residents or citizens. Under the Immigration Reform and Control Act (IRCA) of 1986, 1.1 million farmworkers gained legal status. But IRCA did not grant legal status to the spouses or children of farmworkers, so some of these family members remain undocumented.

Despite their hard work, most farmworker families live in poverty. Even with several family members working, farmworkers with children have a median income of between \$12,500 to \$15,000 per year. Consequently, 60 percent of farmworker families live below the poverty line. Only 24 percent of farmworkers have private health insurance and as of 1996, only 20 percent of farmworkers had family members enrolled in Medicaid. According to DOL, U.S. farmworkers have an estimated one million children under age 19 living in the United States. Approximately 250,000 of these children migrate from state to state with their parents or alone.

Immigration fears keep many from applying

Because many farmworker children live in families where some, but not all members are legal residents, fears that receipt of Medicaid or SCHIP services will have adverse immigration consequences have kept many farmworker children from enrolling in these programs (see story on p. 8).

In 1997, Congress created SCHIP to extend health insurance benefits to millions of children of the working poor. Just a year earlier,

however, Congress had passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. Law 104-193 Welfare Reform law), which sent a very different message to immigrants. This law stripped immigrants—even legal ones—of eligibility for a vast array of government benefit programs, including Medicaid and SCHIP.

For example, children or pregnant women who obtain legal permanent resident status (i.e., a green card) after August 22, 1996 are barred from enrolling in federal means-tested programs (e.g., Medicaid or SCHIP) for their first five years in the U.S. Forty-four percent of the savings to be derived from welfare reform came from eliminating benefits to immigrants.

The Welfare Reform law also requires certain state government agencies (e.g., the agency that administers cash benefit programs or public housing) to report to the Immigration and Naturalization Service (INS) any immigrant who the agency knows to be present in the U.S. illegally. These verification and reporting requirements also made many immigrant parents of citizen children fearful of enrolling their children in government health insurance programs.

Also, in the winter of 1997-98, INS officials began asking legal permanent residents returning from trips abroad whether they or their children had ever received government benefits, including Medicaid. In some cases, those who had received such benefits were asked to repay them or they would be denied the right to reenter the U.S. In California alone, \$24 million in benefits were repaid before the federal government declared this practice to be illegal. These policies led immigrants to desert government benefit programs in large numbers.

Other barriers to enrollment

The state-by-state structure of Medicaid and SCHIP and the manner in which states determine eligibility also pose a host of obstacles to the enrollment of farmworker children. For migrant farmworkers, the state-by-state structure of these programs means that parents must enroll their children in each new state they enter.

Even though federal regulations deem farmworkers to be "residents" of any state in which they come to work, the fact that they must repeatedly re-enroll their children means that services may be

continued on page 5...

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Clinton Proposes New Initiative for Insuring Children and Families

In January President Clinton announced a new initiative to further improve access and affordability of health insurance for children and families who are struggling to make ends meet. The proposal calls for \$110 billion to be spent over ten years to provide accelerated enrollment of uninsured children who are eligible for SCHIP and Medicaid. The proposal would expand coverage to at least 5 million uninsured Americans.

The Administration's plan would give states needed tools to increase coverage by:

- Allowing school lunch programs to share information with Medicaid (\$345 million over 10 years). Because 60 percent of uninsured children are in the school lunch program, sharing eligibility information can help the efficiency of outreach efforts.
 - Expanding sites authorized to enroll children in SCHIP and Medicaid (\$1.2 billion). This would include schools, child care resource and referral centers, homeless programs, and other sites.
- Requiring states to simplify Medicaid and SCHIP enrollment (\$4 billion). Most states have carried over their SCHIP simplification strategies like eliminating assets tests and using mail-in applications into the Medicaid program. Clinton's proposal would require all states to do it.

President Clinton also is proposing that states expand their options to insure children through age 20 using \$1.9 billion in funds. Nearly one in three people ages 18 to 24 are uninsured mostly because they "age out" of Medicaid or SCHIP or are no longer dependents in private plans. At the same time, they often do not have jobs that offer affordable coverage. The proposal would give states the option of covering people ages 19 and 20 through Medicaid.

Employees of small businesses would also get help with Clinton's proposal (\$313 million). Nearly half of uninsured workers are in firms with fewer than 25 employees. The President proposes to give small firms that have not previously offered health in-

surance a tax credit equal to 20 percent their contribution to go towards health insurance obtained through purchasing coalitions. This is twice the credit he proposed last year. Tax incentives would be given to foundations to help pay for start-up costs of these coalitions. The Federal Employees Health Benefits Program would make available technical assistance to the purchasing coalitions.

President Clinton's Federal Interagency Task Force on SCHIP Outreach has come up with several proposals and activities that would help to identify and enroll eligible children. Some of these include using AmeriCorps Volunteers in health care settings; advising grandparents about new health insurance options for children; and reaching families as they file their taxes. The Internal Revenue Service will provide information on SCHIP and Medicaid to more than 8,000 Voluntary Income Tax Assistance volunteers who help families complete income tax returns.

For more information, visit <http://www.whitehouse.gov>.

...continued from page 4

delayed and time may be lost from work to engage in the time-consuming enrollment process.

In addition, because farmworkers earn the bulk of their income in a concentrated portion of the year, the typical process of determining eligibility by looking at the past two-months income may disqualify some needy children whose parents' income spiked during that time period. Also, the request for a Social Security number from a parent who is only applying for a child—which is *not* required by federal law—may be an obstacle for non-citizen parents who do not have such numbers.

Addressing concerns

In an innovative effort to identify the reasons why parents were reluctant or refusing to enroll eligible children in SCHIP or

Medicaid, a consortium of Florida groups, Health Choice Network, Economic Opportunity Family Health Center, Community Health of South Dade, Camillus Health Concern and Florida Legal Services, interviewed 253 parents from September 1998 to March 1999. The two primary reasons cited by parents were problems of getting to or dealing with the Medicaid office (44 percent) and fears related to immigration consequences (31 percent).

Fortunately, efforts to overcome immigration concerns are underway. In May, 1999, the Clinton Administration announced important new immigration guidelines. These guidelines make clear that the lawful receipt of Medicaid or SCHIP benefits will not be considered in determining whether to grant an application for legal resident status. To get out the word on its new policy, INS is attending community meetings, airing public service announcements,

and issuing brochures in many foreign languages. Community groups can download copies of INS brochures from the INS web site: www.ins.usdoj.gov.

States also have options that can simplify the process for enrolling farmworker children. Under current law, they can use presumptive eligibility for children, eliminate the request for Social Security numbers from non-applying family members, consider annual income, and institute a mail-in application process (Also see story on p.7).

States can also outstation eligibility workers in community-friendly locations and allocate funds for community-based groups to do outreach. Most importantly, they can consider ways to create state-to-state portability so that farmworker children who are found eligible in one state will be automatically eligible in others.

Shelley Davis is Co-Executive Director, Farmworker Justice Fund, Inc.

How HRSA Programs Support SCHIP Outreach

By Aimee Ossman

The implementation of the State Children's Health Insurance Program (SCHIP) and state Medicaid expansions have created great opportunities and challenges for programs supported by the Health Resources and Services Administration (HRSA). HRSA strives to ensure access to health care for underserved, vulnerable, and special needs populations.

HRSA Administrator Dr. Earl Fox believes "all of HRSA's programs need to pull together to find eligible children, enroll them, and get them into care." HRSA-supported projects that work in urban neighborhoods, remote regions, and everywhere in between are stepping up to this challenge.

Four main avenues are HRSA's Area Health Education Centers (AHEC), Healthy Start projects, Rural Health Outreach Programs, and Community and Migrant Community Health Centers.

Building community and educational partnerships through AHEC

HRSA's Area Health Education Centers (AHEC) Program aims to increase access to care by improving the supply and distribution of health care professionals. The emphasis here is on primary care through community/academic partnerships.

According to Marcia Brand, special assistant to HRSA's Administrator, the 40 AHEC programs and 160 AHEC Centers are in a good position to distribute SCHIP and Medicaid information. AHECs can reach 21,000 health professions students and 50,000 health care providers who participate in their programs annually.

For example, the Massachusetts AHEC/Community Partners, a program of the University of Massachusetts Medical School, coordinates the Health Access Networks program. Through the program, 500 community outreach workers, program supervisors, advocates, and state agency staff participate in monthly regional meetings to discuss state outreach efforts. The National AHEC program also supports an initiative in Texas that focuses on training community health workers or *promotores* to work in their own communities to enroll families into SCHIP and other programs (also see story on p. 8).

Linking SCHIP and Medicaid with infant mortality outreach

Many of HRSA's Healthy Start projects are integrating SCHIP and Medicaid outreach into their existing activities relating to infant mortality prevention. Healthy Start is a community-based program that provides services, job training, and education to pregnant women and their families to ensure the birth of healthy babies.

The Cleveland Healthy Start project uses indigenous community health workers to reach women in such places as beauty shops and check-cashing establishments. The project, which targets African American women, has also developed culturally sensitive educational materials. Because of its success, Cleveland's outreach model has been replicated for outreach on children's health insurance.

The Syracuse Healthy Start project has supported the efforts of Onondaga County Health Department in enrolling children in Child Health Plus, New York's SCHIP program. The project also includes material on Child Health Plus in literature on teen pregnancy and healthy behavior.

Improve rural health outreach through personal approaches

The purpose of HRSA's Rural Health Outreach is to support projects that demonstrate new and innovative models of outreach and health service delivery in rural areas that lack basic health services. Grants are awarded either for the direct provision of health services to rural populations or to enhance access to and use of existing services. HRSA's Office of Rural Health Policy oversees this program.

Some examples of grantees involved in SCHIP and Medicaid outreach include Iowa, Oregon, and Florida. The Iowa project has a community school nurse who makes direct contact with families to enroll them in HAWK-I, the state's SCHIP program. It is time-consuming but the grantee reports it is the only way to ensure follow-through. In Oregon, an outreach worker travels to most rural areas of a county and provides information about SCHIP at health fairs and children's festivals. Florida's grantee has two full-time staff members involved in outreach to American Indians/Alaska Natives, Hispanics/Latinos, and African Americans. Literacy volunteers help families complete applications as needed.

Getting results with community health centers

The Mid-Atlantic Association of Community Health Centers has conducted a variety of activities such as distributing a bilingual (English/Spanish) newsletter to underserved areas in Maryland, working with minority schools, reaching homeless persons through soup kitchens, and developing partnerships with the faith community. Because of these efforts, member health centers have experienced a 3.7 percent increase in newly covered children last year.

The Association of Utah Community Health has worked with the state to translate the two-page SCHIP application into Spanish. California's Primary Care Association has partnered with the state on many activities such as training the certified application assistants and advocating for outreach grants for community-based organizations.

One clinic in San Francisco's Chinatown, Northeast Medical Services, ran SCHIP radio ads on Chinese stations and made a public service announcement for a Chinese television station. The result: 97 percent of Chinese people who are eligible for the program are enrolled. Chinese families were 20 times more likely to hear about SCHIP through the clinic ads than any other state efforts.

For more information, call Tina Cheatham, HRSA's senior policy analyst for SCHIP outreach at (301) 443-0649.

Aimee Ossman is a public health analyst at Health Resources and Services Administration. ❖

Student Volunteers Boost SCHIP Enrollment in NY

By Houkje Ross

William Ching was uninsured as a child and considers it an injustice for any child to go without healthcare. That's why he volunteers for the Student Health Outreach Project (SHOUT), an effort of the Children's Defense Fund (CDF) to use student volunteers in SCHIP outreach and enrollment efforts.

"As a future physician, I have an ethical and moral obligation to do this," says Ching, a senior at New York University's School of Medicine and a member of the student section of the American Medical Association (AMA).

SHOUT began in 1998 as a partnership between the CDF's New York chapter (CDF-NY), Northern Manhattan community-based organizations, and student volunteers from Columbia University. Their charge was to increase enrollment of uninsured children in the heavily African American and Hispanic Washington Heights and Harlem neighborhoods.

During the six-month pilot phase, SHOUT succeeded in enrolling approximately 200 children using 25 student volunteers, according to Sarah Katz, project coordinator for SHOUT at CDF-NY. "Families have responded well to the young students' energy and enthusiasm," she says.

Expanding the Pilot Project

This year, SHOUT has continued as a student-run effort, Katz says. The project takes many different forms, but the overall goal is to recruit and train students and then link them to community-based efforts to educate families about the availability of free and low-cost health insurance. Students are trained to see families through to enrollment. SHOUT students receive training on New York's Medicaid and SCHIP eligibility guidelines, application processes, how families access health care through the programs, confidentiality issues, and outreach strategies.

Ching and other medical students from the student section of AMA then educate their peers and the medical community about

issues of the uninsured. "We want to make sure that medical students are acutely aware of the issue, and that the problem doesn't get lost in the shuffle," Ching says.

The student section of AMA has taken SHOUT on as its national service project, involving 40,000 medical students at 140 medical schools across the country. "The Albert Einstein College of Medicine is holding workshops in educating medical students, hospital staff, and attending physicians at local hospitals about the scope of the problem of uninsured children," Ching adds. Medical students provide hospitals with information about their local population and whom to contact concerning enrollment. Medical students are also being trained on how to carry out enrollment themselves.

Other student activities include:

- **Conducting educational presentations** to parents at day care centers, schools, tenant associations and other community meetings. They also talk with families and inform them of the SCHIP program.
- **Passing out flyers** in commercial districts, laundromats, check-cashing sites, and public housing facilities. Flyers are in English and Spanish, and list all SHOUT sites and times when student volunteers are available to help families. Each enrollment site has its own version of the flyer with specific hours of services and phone numbers.

- **Sharing SCHIP information at community forums**, including coalition meetings and staff meetings of community-based organizations. Students also encourage organizations to refer families to SHOUT sites. Volunteers attend at least one community event per week.
- **Helping families fill out SCHIP documents**, including helping families understand requirements and doing follow-up work to ensure that applications are completed.

There are now seven SHOUT projects in the state of New York, which uses student volunteers from several universities, high schools, and youth organizations. Each project is different but most focus on outreach and education, Katz says. "Students in the Columbia SHOUT project are the only ones who currently help families enroll at two community-based sites, but this could change as the other programs develop," she says.

"The CDF plans to launch similar efforts all across the country," says Marian Wright Edelman, president and founder of the CDF. "The student volunteers are an important part of our nationwide effort to be sure that every child receives the quality health care they deserve."

For more information about the SHOUT Project, contact Sarah Katz, project coordinator, (212) 697-2323. ❖



Improving SCHIP Outreach in Rural Areas

By Houkje Ross

SCHIP outreach in rural areas is a slow process, says Jody Ross, co-director of Michigan Center for Rural Health. “It must be done community by community and with the help of trusted community leaders.” Part of the problem of getting families enrolled is that the enrollment process seems burdensome, according to a report by the Kaiser Family Foundation entitled, *Express Lane Eligibility*.

“Filling out forms seems easy to me, but I’m used to filling out forms,” Ross says. “However, it’s not as easy for some of these families, who are proud and private people.” Many of the questions on these forms are perceived as invasive, she says. Complex enrollment procedures or eligibility rules and a lack of knowledge about the program are common barriers to reaching and enrolling children.

Strategies that have improved enrollment in some rural areas:

- **Offer to talk to parents one-to-one.** Sitting down with parents and helping them fill out application forms or explaining procedures for Medicaid and SCHIP is one of the best ways to get children enrolled in these programs, says Steve Hirsh of the Health Resources and Services Administration’s (HRSA) Office of Rural Health.
- **Work with other agencies that know the families in your target area.** Farm Bureau or public housing agencies don’t carry the same stigma as human service agencies, Ross says. That’s because some human service agencies are seen as part of the “welfare to work” effort, which makes some families less inclined to sign up for public assistance.
- **Work with small businesses.** Small business owners should be encouraged to help their employees fill out forms and enroll in Medicaid and CHIP, Ross suggests. In Michigan, small employers are allowed to pay the \$5 premium for the SCHIP program, lowering out-of-pocket costs for families, she says.
- **Offer bilingual application information and assistance.** Keep in mind that for many migrant farmworkers, English is not their first language, says Emily Cornell, senior policy analyst at the National Governor’s Association Center for Best Practices. Providing bilingual services reduces language and cultural barriers. For example, Utah has a special information campaign targeted to Native American populations and employs bicultural and bilingual workers.
- **Make mail-in application forms an option.** Utah parents can submit applications via the mail. Some states used to require face-to-face eligibility interviews. “You had to go down to social services and apply, talk to an administrator, and prove you were eligible,” Cornell explains. Using mail-in forms has helped eliminate some of the stigma families may feel when asked to verify and prove eligibility.
- **Establish presumptive eligibility.** This allows a family to go to a provider or center for medical services under temporary eligibility. The provider will make a rough determination of income and assets

and allow the child to obtain services on the spot, says Cornell. “In rural areas your provider may be located at a health clinic 100 miles away. If you are eligible for SCHIP, you may have to go another 100 miles in the opposite direction to get paperwork or fill out forms. Presumptive eligibility eliminates this,” Cornell says.

- **Offer continuous eligibility.** This ensures that a child is covered continuously for a set time period without having to re-verify eligibility every few months. “This prevents children from going on and off the rolls,” Cornell adds.
- **Conduct outreach at high schools.** “In many rural areas the high school is the main community center. It is usually the largest facility in the area and the place where most activities revolve around. Town meetings, dancing lessons, CPR classes may all be held there,” Cornell says. It is an ideal place to reach the most people.

Established by the State Department of Community Health and Michigan State University, the Michigan Center for Rural Health is an organization devoted to the health of rural residents.

For more information, contact the Michigan Center for Rural Health, 517-432-1066, or HRSA’s Office of Rural Health Policy at 301-443-0835. ❖

Health Care Crisis Rising in Border Region, HRSA Says

A recent report from the Health Resources and Services Administration (HRSA) shows a rapidly rising health care crisis for the approximately 11 million people living in the border region. Poverty, poor housing, and inadequate sanitation all play a part.

A high percentage of those living in the area are Latino/Hispanic or Native American families, says Eva Moya, senior project coordinator for the HRSA-funded *Border Vision Fronteriza Project*. “Health insurance for your children is considered a luxury, not a basic human right, in this region,” Moya says.

Some communities in this region have a 30 to 35 percent rate of uninsured children, according to Moya.

For many families in the border region, traveling to Mexico is the preferred choice for health care. “This is because health care establishments in Mexico are often open longer hours, waiting time is less than in the States, costs are lower, and access to pharmacies is often easier,” Moya says of the “sister cities” across the U.S.-Mexico border. ❖

Border Vision Fronteriza: Tapping Into Community Workers and Volunteers

By Houkje Ross

To conduct effective outreach to families, you need to know where they live, work, go to school, and play, says Eva Moya, senior project coordinator for Border Vision Fronteriza (BVF). One of the best ways to do this, she adds, is through community health workers and volunteers that live and work in the communities they serve.

The Health Resources and Services Administration (HRSA) funds BVF, which is administered by the University of Arizona Rural Health Office. BVF enrolls children in SCHIP and Medicaid programs along the four U.S.-Mexican border states of Texas, New Mexico, Arizona, and California.

BVF has been highly successful. According to a BVF progress report released in the fall of 1999, more than 800 community specialists and volunteers have visited approximately 3,807 families and 6,519 children to discuss Medicaid and/or SCHIP and to educate families about the availability of primary health services.

Between April and September 1999, BVF sought to enroll 4,500 children in SCHIP or Medicaid. The project exceeded that goal and enrolled 10,325 children. BVF had the help of community health centers,

border area health education centers, community or state government agencies, health councils, public schools, and state border health offices.

The program's success is due in large part to its use of highly trained volunteers and community specialists. The community specialists are considered experts in their field and natural leaders in their communities. "They are the heart and soul of the project," says Moya. "They take the lead in crafting their own strategy for their community and doing the best with what they have."

Volunteers or *Promotores* work under the guidance of community health worker specialists and of partner organizations. They receive only basic training in children's health issues and the SCHIP program. As of April 1999, there were about 524 *promotores* and 52 community health specialists.

Specialists are individuals who have been working in the communities in existing health and human service organizations, or have had a good track record of being involved in the community and civic activities, says Moya. About 95 percent of these individuals are women. They range in age from 17 to 65. Many of these individuals come from work-

ing poor communities and have experienced being uninsured or under insured," says Moya. They are culturally, linguistically, and socio-economically representative of the community being served.

The specialists receive between 40 and 100 hours of formal training that includes understanding the different laws and regulations, knowing who is eligible for each program, and understanding how to fill out forms, referrals, and documentation. Training also includes education and outreach skills, children's health, pediatric care, immunizations, and how to recognize emergencies.

The University of Arizona's Rural Health Office is responsible for overall coordination of the project. BVF is the only U.S.-Mexico border multi-state initiative that has a unified data collection system. Core BVF partners, which include a variety of community health centers, projects, and foundations from each of the four states involved, help support BVF initiatives either fiscally or by assisting with recruitment, placement, and training.

For more information on Border Vision Fronteriza, contact: Eva Moya, senior project coordinator, (915) 585-7612; or by fax, (915) 833-7840; or moyae@usmbha.org ❖

Increasing SCHIP Access for American Indian Children

By Michelle Meadows

Trying to convince some American Indian/Alaska Native (AI/AN) families that the State Children's Health Insurance Program (SCHIP) is beneficial is like trying to tell people in the desert they need flood insurance, says Phil Smith, M.D., maternal and child health coordinator with the Indian Health Service (IHS) "It's hard to see the need for it right then," he says. But six months later a heavy storm hurls through and washes the house away.

The challenge lies in the fact that members of federally-recognized tribes already re-

ceive many health services through IHS facilities, including preventive care such as immunizations and well-baby checkups. But many don't know that SCHIP brings some additional benefits. "For example, if there were an emergency and a child needed services in a non-IHS facility, SCHIP could help pay for that," Dr. Smith says.

IHS participates in all federal insurance programs and spent more than \$100,000 on SCHIP outreach in Fiscal Year 1999. Outreach activities have included two national meetings on SCHIP for tribes and the

development and distribution of culturally-appropriate promotional materials.

IHS determined that one of the largest barriers to SCHIP was the co-payment required of families. In November 1999, IHS announced a major milestone—all SCHIP cost-sharing for AI/AN children would be waived, eliminating any co-pay, Dr. Smith says. IHS has also worked with HCFA to help American Indian and Alaska Native families determine the eligibility of their children for SCHIP.

continued on page 11...

Insure Kids Now! Through Schools Campaign

Schools across the country are reaching out to help families enroll their children in SCHIP programs so that all students come to school healthy and able to learn. Parent, community, and religious organizations are partnering with schools to spread the word about insurance options, assist families in the application process, and support state or county outreach activities.

The U.S. Department of Education (ED) launched the *Insure Kids Now! Through Schools* campaign to encourage schools and communities to work together to enroll children in health insurance programs. Secretary Riley wrote to superintendents across the United States asking for involvement in the campaign. Schools also received a list of state contacts who can help enroll children in health insurance programs; ideas on how each school can support the campaign; and a pledge form to participate. So far there are about 800 pledges from either individual schools or school districts, according to a representative from the ED.

ED suggests several ways schools and districts can help families get involved in the *Insure Kids Now! Through Schools* Campaign. Making certain all school staff members know about children's health insurance is a good place to start, according to the agency. Principals, school nurses, school lunch staff, social workers, guidance counselors, teachers, athletic directors, coaches and school aides have direct contact with children every day. These workers should be aware of children's health insurance programs, informed about current activities, and ready to share the information with families.

Another way schools can help families get involved is by integrating health insurance enrollment into school activities. ED suggests the following:

- **Make enrollment a part of the school registration process.** Add a question about whether a student has health insurance to school enrollment and emergency contact forms. Follow up with families who indicate a need for coverage by providing them with an application and a person to contact for more information and assistance.
- **Work with the School Lunch Program.** Children who are eligible for free and re-

duced-price school meals are usually eligible for free or low-cost health insurance programs. Work with state and local eligibility agencies to provide information about health insurance with school lunch applications or when families are notified of their children's eligibility for free or reduced-price meals. The U.S. Department of Agriculture has developed two prototype school meal applications that indicate exactly how schools can use the application as a means for health insurance enrollment. Forms are available at <http://www.fns.usda.gov/cnd/Lunch/Default.htm>

- **Collaborate with school nurse and school-based health center staff.** School-based health facilities staff members play a critical role in providing students' health care. If your school or district has school nurses or school-based health centers, these are natural resources to connect with and to help provide families with information or assistance in enrolling their children.
- **Identify school or district-based staff who**

can help families with the application process. Schools are trusted places for parents. Assigning a staff member or parent outreach worker the role of answering basic questions and referring families for more help will make a big difference for family members. Staff can also link with local outreach workers from community-based organizations.

- **Send information materials home with your regular mailings.** Include brochures and applications in back-to-school packets that are sent home with families. Publish an article in your school newspaper or feature information in school nurse publications. Sending these materials separately also focuses attention on them. Tell families to call 1-877-KIDS-NOW toll-free to be connected with state health insurance workers and begin the enrollment process.

For more information on the Campaign, contact the Department of Education's Information Resource Center at (800) USA-LEARN, or visit the Web site: <http://www.ed.gov/chip>. ❖

Eight Steps to Better Media Outreach

At the request of the Health Care Financing Administration, the Academy for Educational Development and Alan Newman Research assessed SCHIP promotional materials in July 1999. Researchers evaluated the effectiveness of materials in reaching different SCHIP-eligible audiences and gathered information that can guide future promotions.

Testing six print advertisements, seven radio ads, and ten television ads that ran in English and Spanish, researchers found these strategies most effective:

1. Use focused, specific communications. The fewer messages a marketer tries to get across in a campaign, the better.
2. Be clear about what action the audience should take. Materials that clearly state what the audience should do are more effective than those that leave the audience confused.
3. Identify sponsor in the promotional material. Promotion efforts are more successful

when materials indicate the sponsor.

4. Include more information on income eligibility requirements. This may help motivate parents of eligible children to call. There needs to be sufficient information to encourage action.
5. Set reasonable expectations for what an ad can accomplish. For example, brief exposure of ad in a movie theater may pique curiosity but is unlikely to prompt calls.
6. Make a positive emotional appeal. Ads that connect the intended action with clear benefits and rational will fare best.
7. Tap into core values, such as, "keeping children healthy."
8. Make promotions locally relevant. In general, ads tested with audiences from the states where they were produced were more effective than national ads (without local ads). Local ads also produced the clearest understanding of who sponsors the ads. If national ads are used, states may want to try adding a local tag line. ❖

Organizations

Agency for Healthcare Research & Quality
Center for Organizational and Delivery Studies
2101 East Jefferson Street, Suite 605
Rockville, MD 20852
(301) 594-6768
www.ahrq.gov

Administration for Children and Families
370 L'Enfant Promenade SW
Washington, DC 20447
(202) 401-9215
<http://www.acf.dhhs.gov>

Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244
<http://www.hcfa.gov>
<http://www.insurekidsnow.gov>
(410) 786-3000
(877)-KIDS-NOW

Health Resources and Services Administration
5600 Fishers Lane
Room 1820
Rockville Md, 20857
<http://www.hrsa.gov>
SCHIP Outreach Contact:
Tina Cheatham at (301) 443-0647

National Association of Child Advocates
1522 K Street NW, Suite 600
Washington, DC 20005
(202) 289-0777
<http://www.childadvocacy.org>

Children's Defense Fund
25 E Street NW
Washington, DC 20001
(202) 628-8787
<http://www.childrensdefense.org>

Family Voices
P.O. Box 769
Algodones, NM 87001
(505) 867-6517
<http://www.familyvoices.org>

National Association of Children's Hospitals
401 Wythe Street
Alexandria, VA 22314
(703) 684-1355

Families USA
1334 G Street, NW
Washington, DC 20005
(202) 628-3030
<http://www.familiesusa.org>

The Children's Partnership
1351 3rd St. Promenade, Suite 206
Santa Monica, CA 90401
(310) 260-1921
www.chidrenspartnership.org

Publications

The State Children's Health Insurance Program Annual Enrollment Report: October 1, 1998-September 30, 1999;
Available on the Health Care Financing Administration's website at: <http://www.hcfa.gov>

Retention and Reenrollment of Children in SCHIP and Medicaid, National Governor's Association Center for Best Practices, 1999.
Available at <http://www.nga.org/Pubs>

Express Lane Eligibility: How to Enroll Large Groups of Eligible Children in Medicaid and CHIP. December 1999. Available from the Henry J. Kaiser Family Foundation's Web site at <http://www.kff.org>; or call (800) 656-4533.

CHIP Outreach and Enrollment: A View from the States. Available from the American Public Human Services Association. June 1999. Call their publication services at (202) 682-0100.

Implementation of the State Children's Health Insurance Program: Outreach, Enrollment, and Provider Participation in Rural Areas. *November 1999. Available from Project HOPE Walsh Center for Rural Health Analysis, (301) 656-7401, <http://www.projhope.org>.*

CHIP Toolkit: A Community Guide to Enrolling Children in Free and Low-Cost Health Insurance Programs. January 2000. Available from the Children's Defense Fund at <http://www.childrensdefense.org/publications/healthtoolkit.html>.

Why is Rural Important? Enrolling Rural Children in CHIP and Medicaid.
Available from HRSA's Office of Rural Health Policy at: <http://www.nal.usda.gov/orhp/orhppub.htm>.

SCHIP & Access for Children in Immigrant Families. Available from the National Conference of State Legislatures at <http://www.ncsl.org/programs/immig/schip.htm>.

...continued from page 9

Smith says a major goal is to better coordinate agency efforts, so that IHS strengthens linkages with HCFA staff and SCHIP administrators, along with social workers in the Bureau of Indian Affairs.

The U.S. Department of Health and Human Services created an Interagency Task Force on SCHIP Outreach in the Summer of 1998. Through this task force, several states such as Michigan and Washington have formed committees dedicated to insuring more American Indian children.

IHS plans include using the 2000 Census to identify areas with large numbers of American Indians so that SCHIP outreach can be more directed, organizing a leadership team to champion outreach activities within IHS and the tribes, and assigning tribal workers to serve on federal and state SCHIP workgroups and committees. ❖

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Conferences: Year 2000

March 22-28: National Association of Community Health Centers (NACHC), *2000 Policy and Issues Forum*. Washington Hilton and Towers, Washington, DC. Call (202) 659-8008. For Hotel Reservations call: (202) 483-3000.

April 14-16: Sisters Network Inc.'s Second Annual National African American Breast Cancer Conference. Renaissance Concourse Hotel, Atlanta. Contact: (713) 781-0255.

April 26-29: 15th Annual Educational Conference, Exhibition and Business Meeting: Strategies for Maintaining Health Care in the Millennium. Sponsored by the National Association of Health Services Executives. Hyatt Regency Hotel Houston, TX. Call (202) 628-3952 or e-mail NAHSE@compuserve.com

April 29-May 2: Community-Campus Partnerships for Health, 4th Annual Conference. *From Community-Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century*. Washington, DC. Contact: (415) 476-7081 or e-mail: sarena@u.washington.edu

May 4-7: National Farmworker Health Conference. Sponsored by the National Association of Community Health Centers. Portland Marriott Downtown. Portland, Oregon. Call: NACHC (202) 659-8008. For hotel reservations, call (503) 226-7600.

May 5-7: International Parent-to-Parent Conference 2000. *Pioneering Spirit—Blazing New Trails*. Sponsored by the Parent Network, University of Nevada. Includes strategies for addressing challenges of diversity & culture. Reno Hilton Casino and Resort. Contact: Cheryl Dinnell, (775) 784-4921, ext. 2352.

May 12-16: American Academy of Pediatrics and the Pediatric Academic Societies Joint Meeting, "Advancing Children's Health 2000," at the Hynes Convention Center in Boston, MA. Contact: (281) 419-0052.

May 25-27: National Rural Health Association's 23rd Annual Conference. New Orleans, LA. Contact: NRHA, (816) 756-3140.

June 12-13: Surgeon General's Conference on Children and Oral Health, "Face of a Child," at the Hyatt Regency in Washington, DC. Contact: (301) 588-6000.

June 28-July 1: Head Start's 5th National Research Conference, sponsored by HHS' Administration for Children and Families and others, at the Hyatt Regency Washington on Capitol Hill. Contact: (212) 304-5251.