African-American Adolescents

The uninsured rate for low-income African-American children is unacceptable at 23 percent. Low-income children 13 to 18 years of age, overall, are less likely to have health care coverage than those 12 and under.[1]

Strategies

This initiative, which began in **Guilford County** in the fall of 2000, took several months of planning and coordination between project personnel and school officials, targeted African-American families by engaging African-American high school students in a service-learning project.[2] It was undertaken in collaboration with the Director of Academic Community Service Learning at NC Central University (a historically black college/university) and a teacher and assistant football coach at a predominantly African-American high school. The community assignment was designed not only to improve "the chances that more eligible low and moderate income children would receive available health insurance," but to "show students how government works, while simultaneously teaching the valuable concept of civic duty, aimed at improving the quality of life for the citizenry."

Following a unit on government fiscal policy in a ninth-grade course on economics, legal and political matters where students examined the roles and responsibilities of government in providing for certain goods and services like health insurance for the indigent, students learned specifically about North Carolina's program for children, Health Check/Health Choice. After role-playing and demonstrating a good understanding of North Carolina's program to their parents, and developing strategies for getting information about Health Check/Health Choice into the community, the students educated other families about the program and encouraged them to apply. Students were to **provide information and distribute applications** to at least two families. They were **not to complete applications** with families (would have required obtaining income and other personal information).

Materials and Messages

Students were introduced to Health Check/Health Choice through classroom discussions about conditions or situations where children could benefit from the program.

For their outreach efforts with families, students received materials (assembled by another group of volunteers) that were developed for other campaigns in Guilford County. These materials, with the "Go Guilford – Get Healthy!" message, added a local message to State information. The students distributed "Parent Packs" which included an application, pre-addressed stamped enveloped, State-produced income card and descriptive brochure, as well as promotional materials from Guilford County: a pencil, magnet, and identifying sticker. In addition to these materials, students were also armed with an introduction script to use during outreach as well as a referral number and name from the local social services to use as a resource when families expressed interest or needed clarification.

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[1] Kaiser Commission on Medicaid and the Uninsured. (2000). Health coverage for low-income children: Key facts. Washington, DC: Henry J. Kaiser Family Foundation.

[2] The project described above was adapted from the Cascade Model by Dr. Theodore Parrish and colleagues at NC Central University. The model has been effective in disseminating student-gathered health information in other health initiatives in African-American communities. The initiative was tried in Guilford County in its purer form earlier on and simplified/redesigned because of difficulties of coordinating people who were at different institutions and geographically dispersed. In the earlier round, nursing students from North Carolina A & T, a historically black college/university in Greensboro, helped high school students develop presentations about medical problems (e.g., diabetes and sickle cell anemia) and children's health insurance programs. Those high school students, in turn, shared information and distributed insurance applications at community gatherings (e.g., public housing resident meetings) and Boy Scouts distributed information door-to-door. The redesigned effort involved one teacher and his freshmen students in a class project during the fall semester. The earlier round was a volunteer project at the end of the year for upper-classmen who, unfortunately, had other priorities.

Results

At least 120 families were reached through the initiative (approximately 40 students shared the information with their families and at least two other families). Health Check/Health Choice materials were distributed to the 80 families who were estimated to have been visited. Students reported that more than 40 families who received the information said they were interested in the program. Although coded applications were distributed, no specific applications/enrollees could be tracked to the initiative. However, according to those involved, "a lot of learning took place" which ultimately increased the awareness of this insurance program in a high school attended by a large number of eligible students. This will no doubt facilitate future enrollment efforts.

Lessons Learned

- Families who seem truly interested in the program are still likely not to follow through. While we can't know the specific reasons without following up with the families, project leaders offered the following possible explanations based on relevant theory and other work that has been done. Families were already enrolled in Medicaid or Health Choice but didn't wish to inform students of this fact. Families were not enrolled but determined that they were ineligible. Families were not enrolled and were eligible but they were "precontemplators"; or their attention was diverted to more pressing issues. Families may have encountered obstacles and were discouraged from applying (no transportation to the Department of Social Services where they could get assistance in completing the application or told by an acquaintance of the "negative attitudes" of some doctors towards Medicaid). In retrospect, it would have been helpful to have followed-up with interested families to determine the reasons why they didn't send in an application.
- Carefully target families and provide incentives. If 80 eligible and unenrolled families had been informed, project leaders believe it would have been reasonable to expect about 16 to be in the "action" stage and of those 16, at least four to five should have enrolled. To have gotten none suggests that either there were not that many unenrolled families contacted, or that these families needed greater incentives to pay attention to the issue of children's health insurance.
- Teachers and Students. If the project is to be integrated into the curriculum and successfully implemented, the teacher must be committed, attentive to details and willing to do additional work, e.g., to restructure the curriculum, get parental permission, develop safety protocols, and coordinate the community work. S/he should be recognized or compensated in some way for taking on the added responsibilities. Roles and responsibilities, expectations and rewards for all those involved need to be clear from the outset. (Note: We found that the initiative was more successful when conducted as a course requirement for lower classmen rather than a volunteer opportunity for upper level students.)

Conclusions and Recommendations

It appears that this approach succeeded in educating students and families about Health Check/Health Choice but not in getting families to apply. If repeated, we would target families more carefully to increase the likelihood that they are not already enrolled. In addition, we would follow up with those who said they were interested in applying. Students, for example, might ask families if they'd like someone to contact them (to answer questions and/or help complete an application by phone or in person) and to find out the best times and ways of reaching them. This information could be passed on to an application assister (DSS worker or adult volunteer) for follow-up. Such follow-up would not only facilitate enrollment, but would increase our understanding of the barriers that interfere with enrollment.

Incentives for families might also be considered – to move families from "precontemplation" to "action," e.g., cab vouchers to the Department of Social Services and a coupon to receive something concrete and of value once the family has applied. Materials that

are distributed should be carefully selected to ensure that they are effective in motivating families to take action, i.e., obtain input from parents.