

Action Brief

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Outreach: Private and Public Sector Efforts That Work

The 1997 enactment of the Children's Health Insurance Program (CHIP) has focused unprecedented attention on health care for children. Lack of health insurance is one of the major reasons children fail to receive needed health care. But simply making more children eligible for publicly subsidized health insurance does not guarantee that they will actually enroll. At least one-fifth of the children currently eligible for Medicaid are not enrolled. More significantly, in this time of decreasing welfare rolls, the enrollment rate is even lower for children whose families do not receive cash assistance. In 1994, nearly two-thirds of Medicaid-eligible "non-cash" children had not enrolled. (See M. B. Carpenter and L. Kavanagh, *Outreach to Children: Moving from Enrollment to Ensuring Access*, March 1998, National Center for Education in Maternal and Child Health.)

Moreover, getting a child covered is only half the battle. Having an insurance card removes one important barrier to accessing care but does not by itself guarantee that each child will receive effective health supervision and care appropriate to their needs. The ultimate goal is to assure that all children actually receive the care they need for healthy development.

Achieving this goal will require effective outreach. But what outreach strategies work with low-income families?

Forum Discusses "What Works"

To provide a forum in which public agencies, community organizations and private sector health plans could share outreach strategies and approaches that have been found to work, the National Institute for Health Care Management (NIHCM) convened "Outreach: Private and Public Sector Efforts That Work," a Roundtable Forum, on March 31, 1998, in Washington, D.C.

At the Forum, more than 90 participants representing key stakeholders—federal, state and local officials, child health experts and advocates, and managed care executives—heard practitioners from states and the private sector present and discuss innovative, practical outreach initiatives that

work, both to enroll children for coverage (under Medicaid or CHIP) and to get them receiving care in a medical home.

This forum was the second in a series entitled, "Bright Futures and Managed Care," which NIHCM is conducting under a cooperative agreement with the Maternal and Child Health Bureau of the U.S. Health Resources and Services Administration (HRSA).

This *Action Brief* summarizes the key issues and insights from the March forum. Because the discussion was so rich on both enrollment and access issues, we have incorporated comments from the panelists throughout the brief.

Keynote Presentations

Keynote Speakers

Jack Ebeler, health policy consultant, former Acting Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

Doris Barnette, Principal Advisor to the Administrator, U.S. Health Resources and Services Administration

Sarah Shuptrine, President, The Southern Institute on Children and Families and Director, *Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children*

"Find, enroll and serve"

Jack Ebeler helped to develop the Administration's child health initiative while serving as Acting Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services. After the rejection of comprehensive reform in 1994, he noted, political energy was channeled into a series of incremental reforms. The child health initiative was built on the recognition that one of the few things that was not changing in our dynamic, market-based system was the number of uninsured. There are uninsured children at all income levels.

The child health plan has two basic policy themes or goals: First, find, enroll and serve those uninsured children below the federal poverty level who are already eligible for Medicaid. And, second, expand coverage to children at somewhat higher income levels.

Because it is an incremental, targeted reform, the child health initiative may not satisfy everyone's policy preferences, but that is the nature of incremental reforms. Many of the same issues the Congress wrestled with will be fought out again as states debate what approach they will take to implement the new program.

But what is most important, in **Mr. Ebeler's** view, is that, once the legislative decisions are made, we come together to implement the resulting programs. "Not one kid is better off [today] than when the President signed that bill. The key is to switch into the implementation phase: to find and enroll these kids and then provide them care and service."

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—Jack Ebeler

Collaboration is Key

In February, President Clinton announced a series of efforts to enroll children in health coverage. **Doris Barnette**, Principal Advisor to HRSA Administrator Dr. Earl Fox, presented an overview of the President's Outreach Initiative, along with her own reflections based on two decades of public health work at the local, state and federal levels.

Ms. Barnette stressed that collaboration is absolutely critical to the success of CHIP—collaboration among federal agencies, collaboration between government and the private sector in states and in communities. Collaboration, she said, is what made the recent effort to improve immunization rates for two-year-olds a success. "[G]overnment and the private sector came together in states and in communities and came up with creative ideas and wonderful strategies and made this thing come together. And we enjoy immunization rates such as we wouldn't have dreamed possible in the mid-'80s."

To do its part, the White House developed a federal interagency task force, and the President directed eight agencies to develop plans for how they will address outreach and the child health insurance program. Many federal programs "touch" children (through local grantees). Getting them all involved in helping to find CHIP- and Medicaid-eligible kids is critical to [CHIP's] success, in **Ms. Barnette's** view. During the Medicaid expansions

of the late '80s, she said, "the absolute best case-finding mechanism ... were the WIC clinics—absolutely the best one." "[F]or that reason, it's imperative that we have the Department of Agriculture involved, the Department of Education [involved]." Noting Willy Sutton's famous remark that he robbed banks because that's where the money was, she urged, "We have to go where the children are."

"We have to go where the children are."

—Doris Barnette

HRSA is doing its part by collaborating with the Health Care Financing Administration (HCFA) to review the outreach strategies that states are proposing for their CHIP programs. HRSA also has the lead for special populations—children with special health care needs, the homeless, migrants, children living with HIV and AIDS, urban Indians, Asian-American Pacific Islanders.

A Role for Foundations

The third keynote speaker, **Sarah Shuptrine**, President of the Southern Institute on Children and Families, discussed the Robert Wood Johnson Foundation's new program, "*Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children*," which she directs. The \$13 million initiative is focused on the enrollment process—outreach to get children enrolled. It has three goals:

1. to design and conduct outreach programs that identify and enroll eligible children into Medicaid and other coverage programs;
2. to simplify the enrollment process; and
3. to coordinate coverage programs for low-income children.

The initiative puts great emphasis on involving private sector organizations, such as churches, businesses, health plans and providers, in addition to traditional child advocacy organizations. "*Covering Kids*" will make three-year grants to state-local coalitions. Each of those coalitions are expected to design a statewide initiative that addresses all three of these goals and to have two or three local pilot projects that address at least one of these goals. (Information on the "*Covering Kids*" initiative can be found at www.coveringkids.org)

Drawing on her many years of experience with programs for low-income families, **Ms. Shuptrine** also discussed what in her view needs to be done to assure that low-income children get enrolled in health coverage. Her remarks laid an excellent foundation for the subsequent panel discussion on what the enrollment barriers are and how they can be overcome, so in the following section this *Brief*

weaves together her insights with those of the panel participants.

Enrolling Children for Coverage

Panel on Enrolling Children for Coverage

Mary Brecht Carpenter, National Center for Education in Maternal and Child Health, Georgetown University (Moderator)

Patricia Leddy, Director of Managed Care, Rhode Island Department of Human Services

Ken Segel, Jewish Healthcare Foundation, Pittsburgh

Barbara Berger, Executive Director, Ohio Caring Foundation

Barriers to Enrollment

Why do parents not enroll their eligible children in Medicaid or other public health insurance programs? There are several reasons:

Families may simply not know that their children are eligible. The historical linkage between Medicaid and cash assistance, though now officially broken, is still strong in many people's minds. Public welfare agencies often close cash assistance cases without checking whether the family continues to be eligible for other programs, and they rarely do a good job of educating former welfare recipients about the health coverage available to them.

"We have done far too little to counter the very pervasive belief in the community, on the street, that children have to be in a welfare family in order to get health coverage."

—**Sarah Shuptrine**

For example, in a Georgia focus group, 55 percent of welfare recipients did not understand that children can still be eligible for Medicaid if their parents get off welfare because of work. When told their children were still eligible for health coverage, some recipients were angry that no one had told them. As Ms. Shuptrine noted, "Well, someone did tell them. It was [in] the information they got from their departments of social services that was very bureaucratically worded, very boring, very hard to read; and generally, they just didn't look at it."

The traditional Medicaid application process is complicated and can be demeaning. Verification requirements are burdensome and often excessive, and complicated eligibility rules seem illogical to

parents. Eligibility workers themselves find the process complicated.

Families have to prove their income, children's birth dates, family composition and other factors. If the state imposes an assets test, even more verification is required. Gathering the necessary documents can be time-consuming and expensive, particularly if third parties like employers or non-custodial parents are uncooperative or do not understand how critical the deadlines are. As **Ms. Shuptrine** noted, because most eligibility workers are desk-bound, the verification process can generally be described as a "you-go-get-it-and-bring-it-to-me" type of system.

Moreover, in states that require monthly recertification of eligibility, noted **Barbara Berger**, even families that have made it through the application process once may get discouraged and fail to reapply.

Families whose children are currently healthy may simply not view health insurance coverage as important enough to endure these burdens. For the majority of the low-income population, the increased emphasis on preventive health care is a relatively new concept and may not be a priority for them.

Despite the separation of Medicaid from welfare, "welfare stigma" is still a concern, particularly for the new child health initiatives. Not only has Medicaid expanded to include more people than the historical welfare population, but the new SCHIP program increases eligibility to higher income levels with families not accustomed to entitlement programs.

Moreover, there are thousands of children in hard-to-reach populations, such as homeless, immigrants, and migrant families, that present special problems for enrollment efforts.

Overcoming Enrollment Barriers

Various strategies can be used to overcome these barriers to enrollment. Providing information about the programs to families at every opportunity is one of the simplest approaches. All stakeholders should be prepared to provide information to eligible families at every possible point of entry into the system—welfare offices, employers, community organizations, schools, WIC offices, Head Start sites, child care centers, and unemployment offices.

The President has called on all federal agencies that have contact with low-income families to become actively involved in assuring that their employees and grantees not only are educated on programs available to these families but also will assist families with the process of getting coverage, noted **Doris Barnette**.

In many instances, just presenting information in simple terms can have a great impact on education. As part of its goal of identifying and enrolling children in health care programs, **the Southern Institute for Children and Families** designed user-friendly brochures about health insurance. Different versions focused on families, employers and community organizations. After reading the brochures once, the participants in the Georgia focus groups (representing target groups) showed a dramatic improvement in their understanding of Medicaid eligibility.

Forum participants also pointed out that it is essential to have information materials at reading levels appropriate for eligible families, which experience suggests generally means fourth to sixth grade level. Materials also need to be written in multiple languages and should be sensitive to the mores of various cultural groups.

Rhode Island Uses Business Approach to Get Beyond "Bureaucracy as Usual"

Some states have transformed traditional public programs in order to implement successful strategies to get families enrolled for health coverage. **Trish Leddy** commented that a successful outreach program requires more than "marketing information." Rhode Island uses what she described as a "three-pronged, business-like approach" to outreach. A typical business strategy addresses marketing, product development and sales. The analogs for a public program are outreach, program, and application and enrollment. "Like a business, in Rhode Island, we've found that all three are necessary to get children eligible and enrolled," said Ms. Leddy.

Using this structured approach, the Medicaid program in Rhode Island has been transformed into a system that provides active support to eligible families. A catchy name, "**RItCare**", with a colorful theme and logo, captures attention. A 1-800 number is available 24 hours per day for families to get information about the program and the enrollment process. The 1-800 line can be accessed in English and Spanish, and receives approximately 14,000 calls per year.

RItCare uses various means of advertising the program, from targeted mailings to advertising in newspapers, on radio and TV, and on billboards. Inserts with unemployment checks proved very successful. The program also takes advantage of cooperative ventures. **RItCare** has sent brochures and posters to thousands of social service agencies, community organizations, schools, libraries and businesses such as drugstores.

The **RItCare** program (the "product") is a comprehensive benefits package available to all children up to age 18, and is delivered through

commercial health plans. Enrollees can choose from four health plans for coverage, and the benefits card is the same as a commercial health plan card. **RItCare** also uses consumer satisfaction surveys and other strategies to refine the program continuously to meet participants' needs.

Pittsburgh Community Groups Work Together

Catchy marketing materials, though much more likely to be read, are sometimes beyond the reach of public agencies. Collaborations among foundations and other private sector organizations can provide the needed support to supplement public initiatives, and many are active at the state and local levels.

Even before Congress enacted the State Children's Health Insurance Program, for example, the **Jewish Healthcare Foundation of Pittsburgh** brought together community stakeholders to make a concerted effort to address the extremely high number of uninsured children in western Pennsylvania. The Foundation recognized that individual stakeholders were making an effort to get program information to families, but the system as a whole was not having an impact. In partnership with the Consumer Health Coalition, an organization of groups dedicated to improving community health, and based on recommendations developed by the Allegheny County Enrollment Working Group (which the Foundation also initiated), the Jewish Healthcare Foundation set out to implement a community-wide campaign to raise public awareness of child health programs.

A public relation firm was engaged to develop a creative media campaign to get the word to the whole community that health insurance coverage is expanding for children. (Mass media campaigns, in particular, have been shown to be an excellent way to reach special populations such as homeless, immigrants and migrants.)

The Consumer Health Coalition has 150 organizations working to blanket the community with campaign materials, from posters, signs and billboards to restaurant menus and flyers distributed with paychecks. Providing information with paychecks is especially effective in reaching working families.

As **Ken Segel** noted, it is imperative to be realistic about our ability to get families to enroll children for coverage. "We know enough from efforts we've participated in over the years ... [that] parents need to be hit from three, four, five sides before they act."

"Parents need to be hit from three, four, five sides before they act."

—Ken Segel

Barbara Berger noted the importance of having consistent campaign materials—program name, logo, messages and “tag lines”—within each state. The **Ohio Caring Program** has had great success using local “Caring Councils” (local coalitions of United Ways, churches, civic organizations and school systems) to develop and implement local outreach programs using the same messages, materials, brochures and posters that the program uses throughout Ohio.

The Ohio Caring Program has been able to access the media without using paid advertising. Interviews with families who were willing to talk about their experiences have been incorporated into newspaper articles and television stories.

Summing up, **Ms. Berger** stressed the importance of listening to families to learn the best ways to reach them. “Do your homework, [do your] market research. Don’t presume that we know how these families will react or what they want to see or feel.”

Reaching Teens

The Allegheny County Enrollment Working Group found that schools are the best place to get information to one population particularly lacking insurance: children between 14 and 18 years old. The School Lunch Program can be used to identify children eligible for Medicaid or CHIP coverage. As **Doris Barnette** pointed out, adolescents have special needs and are traditionally underserved by Medicaid. School administrators, teachers and school nurses can serve as the key link to this age group on the importance of enrolling for health coverage and accessing care.

Simplify the Application Process

One of the most important steps to assure that children get enrolled is to simplify the application process. Information campaigns will be useless if the families do not follow through and actually apply because they find the process too complicated and burdensome. Many of the onerous application requirements for Medicaid remain from the old AFDC program and can be eliminated now that Medicaid coverage has been separated from cash assistance.

Some state and local agencies have used innovative as well as common-sense approaches to reduce application barriers, such as a short applications, mail-in applications, and presumptive eligibility. Out-stationing eligibility workers in community locations beyond welfare offices expands the sites where families can fill out applications and reduces stigma. Some states have one application for both Medicaid and CHIP. A single application can streamline the process and reduce the number of children that are found to be ineligible because they applied to the wrong program.

Presumptive eligibility allows the state to enroll a child for coverage on the first contact and follow up later to complete the application process. As **Doris Barnette** pointed out, the President’s 1999 Budget proposes broadening the definition of “qualified entities” authorized to make presumptive eligibility determinations beyond Head Start sites and WIC offices to include child care resource and referral centers, child support enforcement agencies, schools, and CHIP eligibility workers.

States presently have the option to adopt shorter, simpler applications, to eliminate the assets test that was more relevant to the welfare program, and to allow Medicaid applications to be returned by mail.

Accepting mail-in applications reduces barriers for low-income families by eliminating transportation costs and the need to take time off from work. Mail-in applications also go a long way in addressing the stigma attached to welfare programs by eliminating the added tension of a visit to a social services office.

Accessing Care

Panel on Getting Children into Care

Laura Kavanagh, National Center for Education in Maternal and Child Health, Georgetown University (Moderator)

John Monahan, General Manager, and **Chris Champlin**, Medi-Cal Programs, Blue Cross of California

Melissa Tobler, Supervisor of Disease and Case Management, Meridian Managed Care, Milwaukee, Wisconsin

Mona Jordan, Manager, Case Management Services, Gateway Health Plan, Pittsburgh

Susan Lieberman, Director of Maternal and Child Health, Philadelphia Department of Public Health

The ultimate goal of any outreach program is to assure that children actually access the primary and preventive care appropriate to their needs. But in many ways this is the most difficult part of outreach. There are numerous barriers to accessing care, some within the health care system and others due to socioeconomic factors.

Multiple system barriers hinder families from accessing care. Overcrowded clinics and physicians’ offices result in long and stressful waits to receive care. More troublesome in many areas is the insufficient number of providers available or willing to care for low-income children.

Too many locations for accessing care are

inconvenient and have unrealistic hours of operation. These problems will be magnified once a larger number of working families covered by CHIP start to enter the system.

Lack of transportation is a primary barrier for families attempting to access care, particularly in non-urban areas without a strong public transit system. In addition, there may be non-medical transportation needs for child care for other members of a family.

These problems cause enormous stress on families at a time when the goal is to encourage them to access care. “[V]iewing [the health care] system from the eyes of a family that is trying to access that health coverage program is absolutely critical,” said **Sarah Shuptrine**.

Diverse languages and cultures are of particular importance in some communities. In their initial attempts to contact newly-enrolled Medi-Cal (California’s Medicaid program) beneficiaries, **Blue Cross of California** encountered unexpected challenges. Only 40% of enrollees had telephones, and they spoke over a dozen languages other than English.

Moreover, many low-income families are resistant to accessing primary and preventive care because they are unfamiliar with the concepts. Most of these families are accustomed to seeking care only when a child is sick, and then they use the emergency room for services.

Such personal reasons for not accessing health care are in many ways the most problematic barriers to address. As **Laura Kavanagh** pointed out, “personal barriers are based on a family’s previous experience in dealing with the health care system, their culture, their expectations of what’s going to happen in the health care system, their health beliefs, and also their ability to make getting to a provider a priority for them.”

Improving Access to Care

States, local agencies and health plans are addressing most of these barriers while attempting to educate constituents on the importance of maintaining continuous care.

Breaking Down System Barriers

The most immediate need is to increase the number of providers, particularly physicians, willing to treat Medicaid enrollees. **RiteCare** has been successful at increasing the number of providers servicing its program beneficiaries by requiring its health plans to use the same network of providers for both Medicaid and commercial populations. That was a controversial provision, **Trish Leddy** noted, but Rhode Island did not want a two-tiered system of health care. So it requires all health plan providers,

whether physicians, nurses, hospitals, or laboratories, to be open to RiteCare participants.

RiteCare Access Results

- Increased participation from 350 to over 800 primary care physicians.
- Increased average per-enrollee physician visits from 2 per year to 5 per year in one year.
- Decreased emergency room visits and hospital utilization each by more than one-third.

Expanding the number of providers relieves some of the related barriers of long waits, limited locations and inadequate hours. It also may help to alleviate some transportation problems.

Many states, local agencies and health plans have focused on the need to provide transportation to appointments. Working with health plans, **RiteCare** found that missed appointments was the greatest concern of providers in Rhode Island. RiteCare now has three-party contracts with health plans and the Public Transit Authority to provide free bus passes, taxi vouchers or van rides to appointments. The program not only helps decrease the no-show rate, it also helps to support the transit system.

Another priority for many child health programs is addressing language and culture differences. As with enrollment materials, information on accessing care needs to be written at a low reading level and in multiple languages. **Blue Cross of California** has materials for its Medi-Cal enrollees in ten different languages.

Along with developing appropriate information materials, health plans hire workers who are familiar with the communities and the members they contact. **Blue Cross of California** outreach workers are multilingual and multicultural, have a knowledge of the Medi-Cal program, know the communities they serve and are familiar with community resources.

Health Plans Are Creating Support Systems

When **Blue Cross of California** began its Medi-Cal program, it set its goals and developed an outreach program in which workers would actively advocate accessing care. The plan continued its existing collaboration with community-based organizations, but also found that hiring its own outreach workers was an essential element to improve care for its Medi-Cal members.

Blue Cross of California Medi-Cal Program Outreach Goals

- Increase Immunization Rates for Children Ages 0-2
- Increase % Members Getting Initial Health Exams
- Decrease Inappropriate Emergency Room Utilization (46% reduction in pilot county, while primary care visits increased 133%)
- Improve Birth Outcomes Through Increased Prenatal Visits

To educate its outreach workers, **Blue Cross of California** worked with a local university to develop a comprehensive training program. The curriculum includes training on the types of issues facing low-income families, on managed care concepts and on plan operations.

Outreach specialists are taught how to report data and information and how to link information to an enrollee's primary care doctor. They pull together a new enrollee's medical history and give that information to the member's physician. The next step is to get the member to visit the physician. "It's extremely important for us to link [new enrollees] up to the primary care physician and to get their medical records from point A to point B, their new medical home," said **Chris Champlin**.

Blue Cross of California outreach specialists continuously follow members and assist families in maintaining their health. "[W]e partner with our obstetricians and link them up with our outreach workers, so if their patients are missing prenatal visits, they can call us, and we'll help them get their patients in for prenatal care," said **John Monahan**.

Local Collaborations

At the local level, state and local agencies are collaborating with community groups and health plans to assist families in accessing care. In **Philadelphia**, the Medicaid program operates under a mandatory managed care system. Although the local health department, managed care plans and community organizations work with the same populations, the health plans concentrate on outreach to enrolled members, and the local health department has shifted its focus and most of its funding to address the needs of the hard-to-reach and underserved populations. Working with about 63 different community-based organizations and non-profit groups, the city health department provides "support, training, help with supervision and collaboration." "All of [the community-based organizations] have different levels of expertise, but they all command a deep respect and

credibility in their own community," noted **Susan Lieberman**.

Working together and supporting each other's goals can enrich the efforts of state and local agencies, community-based organizations and health plans to reach children. **Chris Champlin** emphasized that collaborating with community-based organizations and public agencies who want to help create support networks not only improves plan programs but stimulates community-wide participation.

Education on Primary and Preventive Care

Dennis Johnson of the Children's Health Fund commented that one particularly challenging aspect of outreach is educating parents about primary care and why it is important to be in a medical home. Some states and private organizations have developed educational programs and have expanded existing programs to stress the importance of continuous access to care.

During its enrollment process, **RiteCare** produced videos for families that stressed the role of the primary care physician in maintaining care. To emphasize the importance of continuity of care, the program encouraged enrollees to choose a plan in which their current physician participated.

"I think that it's not only the education, it's the experience of actually having that security of a doctor [available] 24 hours a day, 7 days a week that really does it for people," said **Trish Leddy**. As enrollees become accustomed to the concept of primary and preventive care, their satisfaction level rises.

Borrowing on the "benefits coordinator" concept that many companies employ, two years ago the **Ohio Caring Program** instituted volunteer-led benefit sessions for families where they are told about the benefits and choose a primary care physician. During these sessions, counselors stress the importance of bringing children to see the doctor.

Health plans also incorporate education about the importance of obtaining primary and preventive care and how to access services into some of their disease and care management programs. Providing coordinated care increases access for children with chronic conditions (commonly referred to as disease management). Some of these managed care programs have been shown to reduce emergency room visits and improve quality of life.

"[I]t's about education, and it's about educating parents on the signs and symptoms of what to look for and how to intervene on behalf of their children before you get to the point where you have to take your child to the emergency room," said **Mona Jordan** of **Gateway Health Plan**.

A disease management program is a population-based intervention program in which all patients at various severity levels can be monitored. The strategy, **Melissa Tobler** noted, allows the plan to devote time and resources to prevention. "We achieve our goals at **Meridian** by assisting patients to have an active role in the management of their chronic illnesses, thereby creating healthy outcomes for the patient while still impacting the utilization of health care resources," said Ms. Tobler.

"[O]ur program intervention centers around patient education, patient empowerment, and patient involvement."

- Melissa Tobler

For the pediatric population, the plan does a "disease specific assessment" with both the parents and the child. **Meridian** considers it important to involve the child whenever possible. And the care managers follow up regularly, particularly with the patient.

The plan also uses age-appropriate educational materials, home health care education programs, community educational opportunities, and local support groups to keep families and patients active in managing a chronic condition. When requested by the patient or family, **Meridian** contacts school teachers and administrators, sports teams, or friends to educate them about a child's health problems.

Most importantly, **Meridian** works closely with the primary care physician to insure that the physician knows that a child is in a disease management program. Care managers then continuously relay all information that they receive that may be important to the child's treatment.

Gateway Health Plan, which serves Medicaid enrollees in Western Pennsylvania, has a "special needs unit" that carries out various case management, disease management and perinatal programs. The plan employs both outreach workers and "member educators."

Gateway's member educators respond to providers and community organizations that encounter Gateway members who need assistance with benefits or care. As **Mona Jordan** pointed out, practically everyone, not just low-income families, needs to be re-educated continuously about benefits. Member educators also take the opportunity to reinforce the importance of seeing the primary care physician and when it is appropriate to use the emergency room.

While promoting proactive involvement in various aspects of members' care, **Melissa Tobler** stressed that continual contact with the families and children

makes the difference in whether outreach efforts are successful.

Bright Futures

Bright Futures Update

Dr. Woodie Kessel, Assistant Surgeon
General and Director, Division of Science
Education and Analysis, Maternal and
Child Health Bureau, HRSA

Outreach efforts to educate families about health coverage and especially to assure that children receive care are a primary focus of Bright Futures. Bright Futures is a comprehensive program designed to assure that all children receive care appropriate to their needs. **Dr. Kessel** provided an overview of the projects Bright Futures is working on, and noted that an updated version of the comprehensive *Bright Futures* anticipatory guidelines will be available in a few months.

The most recent materials to be distributed are two health supervision encounter forms, one for providers and one for parents and families. The encounter forms present an easy-to-follow outline of recommendations for care found in the *Bright Futures* anticipatory guidance materials. *Bright Futures in Practice: Oral Health* also is available.

Additional books on nutrition, mental health and physical activity are being developed. Also, Bright Futures is working on materials from the family perspective.

Other potential projects for the future include producing materials on Bright Futures and adolescents which will be directed towards teenagers rather than the families and practitioners, materials for children with special health care needs, materials on nursing perspectives, and information for communities.

Dr. Kessel welcomed additional suggestions for projects that will enhance or expand Bright Futures. Information about Bright Futures and all of the materials can be found and downloaded from the Web site at www.brightfutures.org.

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