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Parent Mentoring Program Increases Coverage Rates For Uninsured Latino Children

ABSTRACT Latinos have the highest US childhood uninsurance rate of any race/ethnicity, but little is known about effective ways to eliminate this disparity. We evaluated the effects of parent mentors—Latino parents with children covered by Medicaid or the Children’s Health Insurance Program—on insuring Latino children in a randomized, controlled, community-based trial of 155 uninsured children conducted in the period 2011–15. Parent mentors were trained to assist families in getting insurance coverage, accessing health care, and addressing social determinants of health. We found that parent mentors were more effective than traditional methods in insuring children (95 percent versus 69 percent), achieving faster coverage and greater parental satisfaction, reducing unmet health care needs, providing children with primary care providers, and improving the quality of well-child and subspecialty care. Children in the parent-mentor group had higher quality of overall and specialty care, lower out-of-pocket spending, and higher rates of coverage two years after the end of the intervention (100 percent versus 70 percent). Parent mentors are highly effective in insuring uninsured Latino children and eliminating disparities.

One in four children in the United States, or over 18.2 million, are Latino.¹ Latinos account for 51 percent of US racial/ethnic minority children, making them by far the largest such group.¹ Latino children outnumber white children in several states. They are the largest racial/ethnic group of children in New Mexico (60 percent versus 24 percent white), California (52 percent versus 26 percent), Texas (49 percent versus 32 percent), Arizona (44 percent versus 40 percent), and Nevada (41 percent versus 36 percent).¹ But as has been true for decades, they continue to be the most uninsured racial/ethnic group of US children: 7.9 percent of Latino children are uninsured, compared with 4.1 percent of white, 5.0 percent of Asian, and 5.5 percent of African American children.² Indeed, Latino children account for

one-third of all uninsured children, although they are only one-quarter of US children. Also, the number of uninsured Latino children (1.4 million) is about the same as the number of uninsured white children—even though white children outnumber Latino children in the US by more than two to one.³

Lack of health insurance is a major public health problem for children because it is associated with multiple adverse outcomes, including having suboptimal health; no regular health care provider; delayed immunizations; unmet medical or prescription needs; impaired access to specialty care; and higher odds of adverse newborn outcomes, emergency department (ED) visits, avoidable hospitalizations, injury hospitalizations, and death.⁴ Despite the long-standing marked insurance disparity for Latino children, not enough is known about what interventions

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are most effective for insuring them, particularly those eligible for Medicaid or the Children's Health Insurance Program (CHIP). There has only been one prior randomized controlled trial of an intervention specifically designed to insure Latino children.⁵ That study, conducted by our team, showed that employing community health workers was more effective than traditional outreach and enrollment methods in obtaining coverage for uninsured Latino children. But it did not differentiate between children eligible for Medicaid or CHIP and noneligible children; evaluated only four insurance-related outcomes; and did not examine health care access, care quality, satisfaction with care, or costs.

The aim of the present study, therefore, was to conduct a randomized controlled trial known as Kids' Health Insurance by Educating Lots of Parents (Kids' HELP) to evaluate the effects of parent mentors—trained Latino parents whose children had Medicaid or CHIP coverage—on insuring Latino children who were eligible for Medicaid or CHIP, including assessing the mentors' impact on health, health care access, care quality, satisfaction with care, and costs.

Study Data And Methods

DESIGN AND PARTICIPANTS Kids' HELP was a randomized controlled trial conducted in the period 2011–15 in communities in Dallas County, Texas, with the highest proportions of uninsured and low-income minority children. Extensive details on study design and participants are available elsewhere.⁶ In this article we report the results of the Kids' HELP trial for Latino children. Participants consisted of uninsured children 0–18 years old whose primary caregiver (often a parent, but not always) identified them as Latino and uninsured and reported income meeting Medicaid/CHIP eligibility criteria for the child (research staff confirmed eligibility using Texas criteria).⁷

To ensure a representative community-based sample, we recruited participants from ninety-seven community sites where uninsured children and their families were most likely to be encountered, including schools, child care establishments, community-based organizations, stores, supermarkets, churches, community centers, health fairs, public libraries, apartment complexes, and food pantries. Full recruitment details are available elsewhere.⁸

Caregivers provided informed written consent for participation in English or Spanish. Participants were allocated to the intervention or control group in a 1:1 ratio using computer-generated randomization.

The protocol was approved by the University of

Texas Southwestern Institutional Review Board. The study was registered online with clinicaltrials.gov (Identifier NCT01264718).

INTERVENTION GROUP The intervention group was assigned parent mentors—trained, fluently bilingual Latino parents who had had at least one child insured by Medicaid or CHIP for at least one year. We recruited parent mentors from a primary care clinic or a school and via referrals from other mentors. We screened and interviewed mentor candidates to recruit people characterized by reliability, promptness, organizational skills, persistence, and motivation to help families with uninsured children. Additional information and a video on recruitment and screening interviews are available online.⁹ We aimed to match ZIP codes of residence for mentors and participants, to promote neighborhood relationships, social support, and (through stipends to parent mentors) economic investment in underserved communities. Mentors were paid \$15 per hour.

Parent mentors attended a two-day training session.¹⁰ Session content was derived from training used in a prior randomized controlled trial of a successful CHW intervention targeting Latino children,⁵ and focus groups on barriers to insuring uninsured Latino children.¹¹ In addition, parent mentors received training manuals in English (98 pages) and Spanish (104 pages) consisting of ten sections—nine corresponding to training topics and one on sharing experiences. The training topics were why health insurance is so important for US children, the Kids' HELP program, being a successful parent mentor, mentors' responsibilities, Medicaid and CHIP, the CHIP and Medicaid application processes, next steps after obtaining Medicaid or CHIP coverage, medical homes, and study paperwork. Published data¹² document that the training was highly effective: Parent mentors' overall mean scores on a test administered before and after the training (on a scale of 0 to 100) increased significantly, from 62 before the training to 88 after its completion ($p < 0.01$); the number of wrong answers decreased (mean reduction: 8; $p < 0.01$); and significant improvements (all $p < 0.01$) occurred in six of nine topics. In addition, all of the parent mentors reported being very satisfied (86 percent) or satisfied (14 percent) with their training. Details on training and outcomes have been published elsewhere,¹² and the complete train-the-trainer resource can be accessed online.¹³

Parent mentors provided the following eight services to intervention children and families: teaching about types of insurance programs and application processes, furnishing information and assistance on meeting Medicaid or

CHIP eligibility requirements, helping parents complete and submit children's insurance applications, expediting final coverage decisions by making early and frequent contacts with Medicaid or CHIP personnel, acting as family advocates by liaising between families and Medicaid or CHIP agencies, contacting Medicaid or CHIP officials to resolve situations in which children were inappropriately deemed ineligible or had coverage inappropriately discontinued, helping parents complete and submit applications for coverage renewal, and educating parents about renewing Medicaid or CHIP coverage or reapplying after losing it. The maximum caseload at any one time was ten families per parent mentor. Additional information on the mentors' functions is available elsewhere.^{6,12}

CONTROL GROUP Control children and families received standard care, which was the traditional Medicaid or CHIP outreach and enrollment offered by the Texas Health and Human Services Commission.¹⁴ This included bilingual radio, television, and newspaper ads; messages on public transit; websites with application links and order forms or materials for community-based organizations; and outreach at day care centers.¹⁴ Beyond these state efforts, there was no additional outreach and enrollment in health care facilities in the targeted communities.

OUTCOMES Confirmed health insurance coverage for the child was the primary outcome. We also assessed the number of days it took to obtain insurance; whether coverage was sporadic; rates of insurance renewal and of long-term coverage one and two years after the intervention ended; and satisfaction with the coverage process (whether or not coverage was obtained).

Secondary outcomes assessed for all children (regardless of whether coverage was obtained) included health status, health-related quality of life, health care access, unmet health care needs, quality of care, parental satisfaction with care, use of services, out-of-pocket spending on pediatric care, family financial burden, and missed days of school and work due to the child's health. Full details on outcomes and questionnaires are available elsewhere.⁶

To minimize attrition at the one-year follow-up assessment with participants, a retention strategic framework was implemented that consisted of optimizing cultural and linguistic competency; staff training on relationships and trust with participants; comprehensive participant contact information; an electronic tracking database; reminders for upcoming outcomes-assessment appointments; frequent, sustained attempts to contact nonrespondents; financial incentives; individualized rapid-cycle quality-improvement approaches to nonrespondents; reinforcing the

study's importance; and home assessment visits. This framework has been shown to be successful; additional details on it are available elsewhere.¹⁵

DATA COLLECTION A research team member blinded to group allocation monitored outcomes. The primary outcome and all other insurance-related measures were evaluated monthly. Other outcomes were assessed six and twelve months after study enrollment—except parental satisfaction with the coverage process, which was evaluated twelve months after enrollment. Participants who had completed twelve-month follow-ups and agreed to complete long-term follow-up were surveyed quarterly for up to two additional years.

ANALYSES We compared outcomes between the two groups via intention-to-treat analyses. Pearson's chi-square test, the Wilcoxon test, stepwise multivariable regression with generalized estimating equations, and analysis of variance were performed. For the primary outcome (obtaining insurance), we computed the relative risk and constructed a cumulative incidence curve. Both adjusted for relevant confounders, including the number of months that the child had previously been uninsured, the child's sex and age, parental citizenship and employment, and family income. All tests were two-tailed, with *p* values less than 0.05 considered significant. More detailed information on study data and methods is available in online appendix exhibit A1.¹⁶

LIMITATIONS Certain study limitations should be noted. First, this randomized controlled trial was conducted in urban areas of north Texas. The findings, therefore, might not necessarily be generalizable to other areas of the state or country or to rural settings.

Second, the study sample was predominantly Mexican American. Although Mexican Americans are the largest US Latino subgroup, the sample contained proportionately fewer Puerto Rican, Central American, and South American participants, compared to national percentages,¹⁷ and no Cuban Americans.

Third, although this randomized controlled trial enrolled 155 subjects (75 in the control group and 80 in the intervention group) and resulted in multiple improvements in Latino children's coverage, access to care, quality of care, and family financial burden, it would be beneficial to have larger, multicenter trials of Kids' HELP to assess outcomes when scaling up the intervention to larger populations.

Study Results

Of 34,662 potential parents assessed for eligibility, 34,488 were excluded because their children

already had health insurance or failed to meet inclusion criteria, or because parents gave other reasons for not wanting to participate (appendix exhibit A2).¹⁶ The remaining 174 eligible participants were randomized to the intervention or control groups. After additional exclusions due to eligibility changes, loss to follow-up, and withdrawals, there were 155 subjects who participated in the study and could be evaluated at one-year follow-up. The overall attrition rate at that follow-up (6.1 percent) was low, with only two in the intervention group (2.4 percent attrition) and eight in the control group (9.6 percent attrition) withdrawn or lost to follow-up.

BASELINE SOCIODEMOGRAPHIC CHARACTERISTICS At baseline, the mean child age was seven years, and there were slightly more males than females (exhibit 1). Most children were Mexican American, although seven other Latino subgroups were represented (appendix exhibit A3).¹⁶ Most children were born in the United

States (exhibit 1), and over half had special health care needs. Over 90 percent of children had health insurance previously, predominantly Medicaid (77 percent) or CHIP (14 percent) (data not shown). The median number of months uninsured was nine, with a maximum of nine years (exhibit 1). Primary caregivers were predominantly female, the child's biological mother, Latino, not high school graduates, and foreign born. Half of them were unmarried, about two-thirds were unemployed, and roughly two-thirds had limited English proficiency. Only 20 percent had health insurance (predominantly public coverage) (data not shown), and two-thirds were in less than excellent or very good health. The plurality of households had at least three children and two adults. The mean annual family income was just under \$25,000, and only 45 percent of parents were aware that their uninsured children were eligible for Medicaid or CHIP (exhibit 1).

EXHIBIT 1**Selected characteristics of participants (both children and parents) in the control and parent-mentor groups, at baseline**

Characteristic	Overall (N = 155)	Control group (n = 75)	Parent-mentor group (n = 80)
CHILD			
Mean age (years) ^a	7.1	7.1	7.1
Female	49%	60%**	39%
Born in the US	95	93	98
Has special health care needs	55	61	50
Has had health insurance before	92	93	90
Months child had been uninsured			
Median	9	12**	7
Inner 95th percentile range	(1, 108)	(1, 108)	(1, 97)
PRIMARY CAREGIVER			
Female	97%	96%	98%
Biological mother	94	91	96
Race/ethnicity			
Latino or Hispanic	98	99	97
African-American or black	1	1	1
White	1	0	1
Not high-school graduate	76	79	74
Born in the US	21	17	25
Not married	50	45	49
Unemployed	62	55	68
Limited English proficiency	72	76	68
Has health insurance	20	17	23
Health status not excellent or very good	65	64	65
Aware of child's eligibility for Medicaid or CHIP	45	46	45
HOUSEHOLD			
At least 3 children	44%	37%	51%
2 adults	50	49	51
COMBINED ANNUAL FAMILY INCOME			
Mean	\$24,659	\$25,191	\$24,160
Range	\$0–\$64,000	\$5,000–\$6,000	\$0–\$64,000

SOURCE Authors' analysis of Kids' Health Insurance by Educating Lots of Parents (Kids' HELP) trial data. **NOTES** Complete sample characteristics are in appendix exhibit A3 (see note 16 in text). Significance refers to difference from the intervention group. CHIP is Children's Health Insurance Program. ^aRange: 1–18 years. **p < 0.05

Compared to children in the intervention group, those in the control group were significantly more likely to be female (60 percent versus 39 percent), and had a higher median number of months of uninsurance (twelve versus seven) (exhibit 1). Both differences were adjusted for in outcomes analyses, and no other significant intergroup differences were noted.

STUDY MEASURES AT BASELINE There were no significant intergroup differences in study measures at baseline, except that, on average, par-

ents in the intervention group missed more workdays due to their child's illness (exhibit 2 and appendix exhibit A4).¹⁶

The overall sample at baseline was characterized by poor health, health care access, and service use. Over 40 percent of children were in less than excellent or very good health, and most parents worried about their child's health (exhibit 2). There were multiple deficiencies in children's health care access. For example, about three-fourths of the children had no primary care

EXHIBIT 2

Study measures at baseline for participants, overall and by group allocation

Measure	Overall	Control group	Parent-mentor group
HEALTH STATUS			
Not excellent or very good ^a	42%	44%	41%
Parent worries about child's health more than other people	89	89	89
Parent has emotional worry or concern about child's physical health	78	81	75
ACCESS TO HEALTH CARE			
No primary care provider	70%	71%	69%
No usual source of preventive care	50	44	55
Different sources for sick care and preventive care	59	59	60
UNMET HEALTH CARE NEEDS			
Delayed or didn't get needed health care	72%	75%	70%
Didn't receive all needed preventive care	54	59	49
Didn't receive all needed acute care	88	87	89
Didn't receive all needed specialty care	57	60	53
QUALITY OF PEDIATRIC CARE^b			
Well-child care (±SD)	8.6 (±1.6)	8.7 (±1.5)	8.6 (±1.7)
Specialty care (±SD)	9.7 (±0.6)	9.7 (±0.6)	9.8 (±0.7)
PARENTAL SATISFACTION WITH CARE			
Would not recommend child's health care provider to friends	25%	28%	21%
Doctor never or sometimes takes time to understand child's specific needs	21	19	24
Doctor never or sometimes respects parent as expert on their child	14	12	16
MEAN USE OF AND OUT-OF-POCKET SPENDING ON HEALTH SERVICES			
Doctor visits in past year (±SE)	2.9 (±0.2)	2.5 (±0.3)	3.3 (±0.3)
Out-of-pocket spending per doctor visit (±SE)	\$167 (±52)	\$197 (±108)	\$144 (±38)
Preventive care visits in past year (±SE)	1.0 (±0.1)	1.0 (±0.2)	1.0 (±0.1)
Out-of-pocket spending per preventive care visit (±SE)	\$50 (±18)	\$64 (±37)	\$38 (±10)
Sick visits in past year (±SE)	1.6 (±0.2)	1.4 (±0.2)	1.8 (±0.3)
Out-of-pocket spending per sick visit (±SE)	\$234 (±77)	\$236 (±145)	\$233 (±81)
ED visits in past year (±SE)	0.4 (±0.1)	0.2 (±0.1)	0.6 (±0.2)
Out-of-pocket spending per ED visit (±SE)	\$641 (±207)	\$637 (±460)	\$643 (±224)
PARENTAL REPORTED FINANCIAL BURDEN			
Child's health caused financial problem for family	35%	32%	38%
Family cut down on work hours to obtain health care for child	29	20	20
Need additional income to cover child's medical expenses	37	37	36
Stopped working because of child's health	10	8	13
Median missed work days due to child's illness (IQR)	0 (0, 1)	0 (0, 0.5)	0** (0, 2)

SOURCE Authors' analysis of Kids' Health Insurance by Educating Lots of Parents (Kids' HELP) trial data. **NOTES** Sample sizes are in exhibit 1. Complete sample characteristics are in appendix exhibit A4 (see note 16 in text). Significance refers to difference between the intervention and control groups. SD is standard deviation. SE is standard error. ED is emergency department. IQR is interquartile range. ^aAccording to parental report. ^bAccording to parental report, using a scale of 0 (worst possible rating) to 10 (best possible rating). ***p* < 0.05

provider, half lacked a regular source of preventive care, and almost two-thirds had different sources of sick and preventive care. There were multiple unmet health care needs. For example, almost three-fourths of the children delayed or did not get needed health care, 88 percent had unmet acute care needs, and over half had unmet preventive and specialty care needs. The mean parental ratings for overall quality (on a scale of 1 to 10, with 10 being the best) were 8.6 for well-child care and 9.7 for specialty care.

One-quarter of parents would not recommend their child's health care provider to friends; one in five reported that their child's doctor never or sometimes took time to understand the child's specific need, and 14 percent reported that their child's doctor never or sometimes respected the parent as the expert on their child (exhibit 2). In the past year, children averaged 2.9 doctor visits, 1.0 preventive care visit, 1.6 sick visits, and 0.4 ED visit, with mean per visit out-of-pocket spending of \$167, \$50, \$234, and \$641, respectively. Approximately one-third of parents reported that the child's health caused financial problems for the family, the family cut down on work hours to obtain health care for their child, and more income was needed to cover the child's medical expenses. Ten percent reported stopping work because of the child's health.

OUTCOMES AT ONE-YEAR AND LONG-TERM FOLLOW-UP

► **INSURANCE COVERAGE:** At one-year follow-up, children in the intervention group were significantly more likely than those in the control group to have obtained health insurance (95 percent versus 69 percent) (exhibit 3 and appendix exhibit A5).¹⁶ The intervention group obtained coverage more quickly (a median of 61 days versus 151 days). An adjusted incidence curve reveals that a significant advantage for the intervention group in obtaining insurance emerged within the first few days of the trial and was sustained throughout the one-year follow-up period (exhibit 4). Children in the intervention group also were significantly more likely than those in the control group to renew their insurance (89 percent versus 65 percent) (exhibit 3). Eighty-one percent of parents in the intervention group were very satisfied or satisfied with the process of obtaining insurance (regardless of whether or not the child ultimately was insured), compared to 60 percent of parents in the control group. Only 5 percent of parents in the intervention group were dissatisfied or very dissatisfied, compared to 22 percent of parents in the control group. Even after the end of the intervention, coverage rates continued to be significantly higher for children in the intervention group, at both one-year (92 percent versus 72 percent)

and two-year (100 percent versus 70 percent) follow-ups.

► **HEALTH CARE ACCESS AND UNMET NEEDS:** The intervention resulted in considerable improvements in health care access and reductions in unmet needs. At one-year follow-up, only 15 percent of children in the intervention group lacked a primary care provider, compared to 41 percent of children in the control group (exhibit 3). Children in the intervention group were nine times less likely to have no usual source of preventive care (1 percent versus 9 percent) and over two times less likely to have different sources for sick and preventive care (11 percent versus 25 percent). There was a nonsignificant trend toward intervention children being less likely to have problems getting specialty care (17 percent versus 60 percent of controls; $p = 0.07$) (data not shown). Intervention children were about half as likely to delay getting or to not obtain needed health care (15 percent versus 29 percent of controls) and more than four times less likely to have unmet preventive care needs (7 percent versus 30 percent) (exhibit 3). No intervention children had unmet acute care or specialty care needs, compared to 33 percent and 57 percent, respectively, of control children. There were nonsignificant trends toward intervention children having less unmet need for dental care and prescription medications (data not shown).

► **QUALITY OF CARE AND PARENTAL SATISFACTION:** Compared to parents in the control group, those in the intervention group reported significantly higher quality of well-child care (on a scale of 0 to 10, 9.2 versus 8.6) and specialty care (9.7 versus 6.9) (exhibit 3). Intervention parents were less likely to report that their child's doctor never or sometimes takes time to understand the child's specific needs (15 percent versus 31 percent) and never or sometimes respects that the parent is the expert on the child (11 percent versus 28 percent). There were nonsignificant trends toward intervention parents being less likely to report that the doctor never or sometimes understands how the parent prefers to raise the child and to not recommend the child's health care provider to friends (data not shown).

► **SERVICE USE, OUT-OF-POCKET SPENDING, AND FINANCIAL BURDEN:** Compared to children in the control group, in the past year, those in the intervention group averaged a higher number of preventive care visits (1.3 versus 0.8), but their mean out-of-pocket spending was significantly lower on all doctor visits (\$9 versus \$50), sick visits (\$12 versus \$55), and ED visits (\$3 versus \$120) (exhibit 3). Compared to parents in the control group, those in the intervention group were more than three times less likely to report

EXHIBIT 3
Study outcomes at one-year follow-up and for long-term insurance coverage for participants in the control and parent-mentor groups

Outcome	Control group	Parent-mentor group
Primary outcome: child obtained health insurance	69%	95% ^{***}
Adjusted relative risk (95% CI) ^a	Ref	1.37 (1.21, 1.32)
Median number of days to obtaining insurance (IPR ₉₅)	151 (23, 311)	61 ^{***} (4, 249)
Renewed insurance ^b	65%	89% ^{***}
PARENTAL SATISFACTION WITH PROCESS OF OBTAINING INSURANCE		
Very satisfied	18%	53% ^{***}
Satisfied	42	28 ^{***}
Uncertain	18	14 ^{***}
Dissatisfied	11	4 ^{***}
Very dissatisfied	11	1 ^{***}
LONG-TERM INSURANCE COVERAGE AFTER END OF PARENT MENTOR INTERVENTION		
Health insurance coverage 1 year after ^c	72%	92% ^{***}
Health insurance coverage 2 years after ^d	70	100 ^{***}
ACCESS TO HEALTH CARE		
No primary care provider	41%	15% ^{***}
No usual source of preventive care	9	1 ^{**}
Different sources for sick care and preventive care	25	11 ^{**}
UNMET HEALTH CARE NEEDS		
Delayed or didn't get needed health care	29%	15% ^{**}
Didn't receive all needed preventive care	30	7 ^{***}
Didn't receive all needed acute care	33	0 ^{***}
Didn't receive all needed specialty care ^e	57	0 ^{***}
QUALITY OF PEDIATRIC CARE^f		
Well-child care (±SD)	8.6 (±1.2)	9.2 ^{***} (±1.3)
Specialty care (±SD)	6.9 (±2.8)	9.7 ^{***} (±0.5)
PARENTAL SATISFACTION WITH CARE		
Doctor never or sometimes takes time to understand child's specific needs	31%	15% ^{**}
Doctor never or sometimes respects you are expert on your child	28	11 [*]
MEAN USE OF AND OUT-OF-POCKET SPENDING ON HEALTH SERVICES		
Preventive care visits in past year (±SE)	0.8 (±0.1)	1.3 ^{***} (±0.2)
Out-of-pocket spending		
Per preventive care visit (±SE)	\$ 50 (±11)	\$ 9 ^{***} (±3)
Per sick visit (±SE)	55 (±13)	12 ^{***} (±5)
Per ED visit (±SE)	120 (±67)	3 ^{***} (±2)
PARENTAL REPORTED FINANCIAL BURDEN		
Child's health caused financial problem for family	16%	5% ^{**}
Need additional income to cover child's medical expenses	12	4
Family cut down on work hours to obtain health care for child	9	3

SOURCE Authors' analysis of Kids' Health Insurance by Educating Lots of Parents (Kids' HELP) trial data. **NOTES** Sample sizes are in exhibit 1. CI is confidence interval. IPR₉₅ is inner 95th percentile range. SD is standard deviation. SE is standard error. ED is emergency department. IQR is interquartile range. ^aRelative risk of obtaining insurance, adjusted for number of months that child had been uninsured, child's sex and age, parental citizenship and employment, and family income. ^bAmong children covered by Medicaid who were required to renew coverage after six months. ^cAt the two-year follow-up assessment, one year after the end of the parent-mentor intervention, when ninety participants agreed to provide long-term coverage data. ^dAt the three-year follow-up assessment, two years after the end of the intervention, when forty-two participants agreed to provide long-term coverage data. ^eAmong parents who reported that their child needed specialty care. ^fAccording to parental report, using a scale of 0 (worst possible rating) to 10 (best possible rating). ***p* < 0.05 ****p* < 0.01

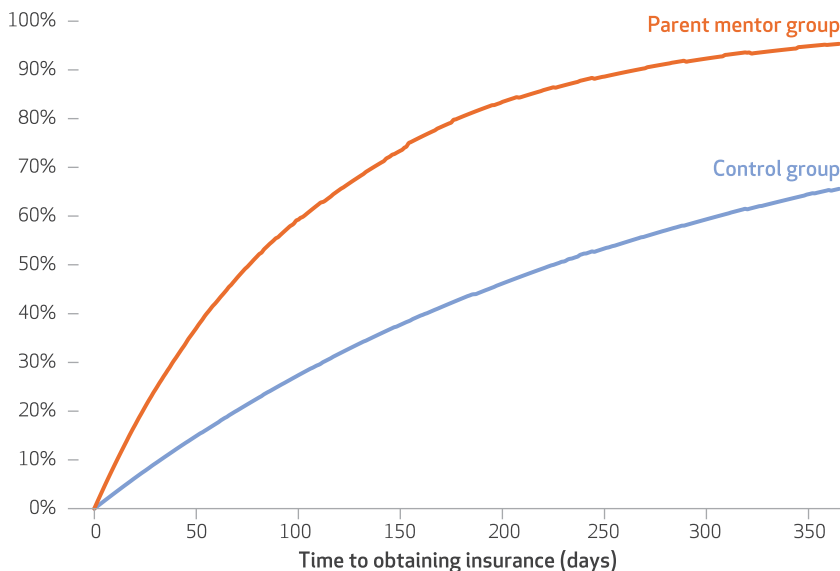
that the child's health caused financial problems for the family (5 percent versus 16 percent). And there were nonsignificant trends toward intervention parents being less likely to report the need for additional income to cover the child's medical expenses and that the family cut down on work hours to obtain health care for the child.

Discussion

A rigorous randomized controlled trial documented that the Kids' HELP intervention eliminates disparities in insurance coverage for Latino children. During the five-year study period, the intervention reduced the uninsurance rate from 100.0 percent to 5.0 percent for Latino

EXHIBIT 4

Adjusted incidence curve of health insurance coverage obtained during the one-year follow-up period for study participants, by group



SOURCE Authors' analysis of Kids' Health Insurance by Educating Lots of Parents (Kids' HELP) trial data. **NOTES** In this adjusted incidence curve, covariates that were adjusted for include the number of months that the child had previously been uninsured, sex, age, parental citizenship and employment, and family income.

children, which was lower than the 5.6 percent uninsurance rate for white children nationally³ and well below the 11.9 percent uninsurance rate for white children in Texas¹⁸ during the same five-year period. Thus, the intervention achieved equity in insurance coverage for Latino children.

Kids' HELP resulted in noteworthy improvements in health care access, reductions in unmet needs, and increases in quality of care. At one-year follow-up, Kids' HELP children were almost three times less likely to have no primary care provider, nine times less likely to have no usual source of preventive care, and less than half as likely to have different sources of sick and preventive care. Compared with children in the control group, Kids' HELP children had about half the unmet health care needs and a quarter of the unmet preventive care needs. Indeed, unmet needs for acute and specialty care were entirely eliminated for intervention children, whereas 33 percent and 57 percent of control children, respectively, still had unmet needs in those areas. Although the reasons for these marked benefits for Kids' HELP children were not studied, one could speculate that they might be by-products of parent mentors using knowledge and skills from training sessions and their own experiences to educate and provide role modeling for parents on the importance of medical homes, health care appointments, and

communicating effectively with health care providers.

The results indicate that Kids' HELP empowers Latino families and their underserved communities. Compared to parents in the control group, those in the intervention group were substantially more satisfied with the process of obtaining insurance, regardless of whether their children ultimately obtained coverage. Interactions with health care providers were enhanced, with intervention parents considerably more likely to report that their child's provider takes time to understand the child's needs and respects the parent as the expert on the child. We hypothesize that these findings may be a by-product of greater continuity of care (that is, of the child's being more likely to have a primary care provider and the same source of sick and preventive care) and of parent mentors teaching parents to ask their child's primary care provider more questions and be more engaged in the child's care. Compared to children in the control group, those in Kids' HELP obtained coverage a median of three months earlier, and out-of-pocket spending and financial burden due to the child's health were significantly lower for their parents. Kids' HELP parents retained key knowledge and skills even after the intervention ended, with 100 percent of Kids' HELP children insured two years after the intervention ceased (versus 70 percent of controls). Hiring parent mentors also provided employment in underserved communities with some of the highest unemployment rates in the region.¹⁹

Policy Implications

The study findings have timely and important implications for health policy on the federal, state, and local levels. An evidence-based intervention is now available that not only is highly effective in obtaining health insurance for Latino children—the racial/ethnic group of children at greatest risk of uninsurance—but also eliminates their coverage disparities, while resulting in faster coverage with greater parental satisfaction. Kids' HELP improves a wide variety of health care processes and outcomes, including enhancing access to care, reducing unmet needs, improving care quality, and decreasing parental out-of-pocket spending and financial burden.

The evidence indicates that implementing Kids' HELP reduces families' financial stress, creates jobs in vulnerable communities, and might save money—all of which are important national and state policy priorities. Compared to parents in the control group, Kids' HELP parents had average out-of-pocket spending that was more than five times lower for children's doctor

visits, more than four times lower for sick visits, and forty times lower for ED visits (which probably was a by-product of more intervention group families' having insurance, and more control group families' paying entirely out of pocket), and were more than three times less likely to report that their child's health caused financial problems for the family. Kids' HELP created jobs for Latino parent mentors in low-income communities with some of the highest unemployment rates in Dallas County.¹⁹ A preliminary cost analysis suggests that Kids' HELP might save \$698.49 annually per child insured from a societal perspective (appendix exhibit A6).¹⁶ This analysis gave us pause, however, and must be interpreted with caution, as larger studies of costs with higher numbers of inpatient admissions are needed.

Forty-seven states and the District of Columbia have used community health worker models to address some of the most challenging issues in health care, including racial/ethnic disparities.²⁰ Parent mentors are a special category of these workers, so Kids' HELP would be an excellent fit with and complement to current state community health worker models. Twenty-one states have some form of Medicaid reimbursement for community health worker services.²⁰ Amending state regulations and statutes to allow for Medicaid and CHIP reimbursement for Kids' HELP parent mentors to provide outreach, enrollment, and mentoring has the potential to improve outcomes while creating jobs, not only in states that already have Medicaid community health worker reimbursement but also in others considering it. We believe that Kids' HELP has the potential to be useful in all states—regardless of the prevalence of childhood uninsurance or current programs in place—because it uniquely recruits parent mentors from the most vulnerable communities, creates jobs, and provides training for mentors that addresses families' social determinants of health and health insurance literacy, in addition to helping families obtain, renew, and maintain coverage.

Kids' HELP also would seem to be a promising intervention at the federal level, regardless of the outcome of current federal debates about Medicaid, CHIP, and future directions and financing for these programs. More covered Latino children, better outcomes, reduced costs, higher care quality, improved parental satisfaction, and job creation would seem to constitute a potent combination of benefits for the nation. Indeed, based on these study findings and other Kid's HELP successes,²¹ the Child Health Outreach and Mentorship Program Act was introduced by Congressman Ben Luján in the US House of Representatives in June 2017.²² The act aimed to amend Title XXI of the Social Security Act to allow parent mentors to be eligible to receive outreach and enrollment grants under CHIP. It subsequently was passed by unanimous House consent as a mark-up of the CHIP reauthorization legislation that was approved by Congress and signed by President Donald Trump on January 22, 2018.²³ This legislation makes organizations that use parent mentors eligible to receive \$120 million in grants for CHIP outreach and enrollment activities through 2023.

Conclusion

A rigorous randomized controlled trial documented that the Kids' HELP intervention is significantly more efficacious than traditional Medicaid and CHIP methods of insuring Latino children. Kids' HELP eliminates coverage disparities for Latino children, insures children more quickly and with greater parental satisfaction than among control parents, enhances health care access, reduces unmet needs, improves the quality of well-child and subspecialty care, reduces out-of-pocket spending and family financial burden, empowers parents, and creates jobs. Kids' HELP could be implemented as part of existing state community health worker models and federal Medicaid and CHIP outreach and enrollment grants. ■

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NOTES

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