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A Successful Program for Training Parent Mentors to Provide Assistance with Obtaining Health Insurance for Uninsured Children

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Abstract

Objective—Seven million US children lack health insurance. Community health workers are effective in insuring uninsured children, and Parent Mentors (PMs) in improving asthmatic children's outcomes. It is unknown, however, whether a training program can result in PMs acquiring knowledge/skills to insure uninsured children. The study aim was to determine whether a PM training program results in improved knowledge/skills regarding insuring uninsured minority children.

Methods—Minority parents in a primary-care clinic who already had Medicaid/CHIP-covered children were selected as PMs, attending a two-day training session addressing nine topics. A 33-item pre-training test to assessed knowledge/skills regarding Medicaid/CHIP, the application process, and medical homes. A 46-item post-test contained the same 33 pre-test items (ordered differently) and 13 Likert-scale questions on training satisfaction.

Results—All 15 PMs were female and non-white, 60% were unemployed, and the mean annual income was \$20,913. Post-training, overall test scores (0-100 scale) significantly increased, from a mean=62 (range: 39-82) to 88 (67-100) ($P<.01$), and the number of wrong answers decreased (mean reduction=8; $P<.01$). Significant improvements occurred in six of nine topics, and 100% of PMs reported being very satisfied (86%) or satisfied (14%) with the training. Preliminary data indicate PMs are significantly more effective than traditional Medicaid/CHIP outreach/enrollment in insuring uninsured minority children.

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Conclusions—A PM training program resulted in significant improvements in knowledge and skills regarding outreach to and enrollment of uninsured, Medicaid/CHIP-eligible children, with high levels of satisfaction with the training. This PM training program might be a useful model for training ACA navigators.

Keywords

Child; adolescent; mentors; medically uninsured; community health workers

Community health workers (CHWs) are highly effective in improving the health and healthcare of children, by reducing or eliminating numerous barriers and threats via education, connecting children and families with needed resources, providing social support, removing language barriers, and empowering parents.^{1,2,3} Studies document the effectiveness of CHWs in insuring uninsured children, managing childhood asthma, reducing miscarriages and low birth-weight rates, enhancing breastfeeding, creating home environments more supportive of children's early learning for mothers with low psychological resources, obtaining early-intervention services for young children, achieving high immunization rates, identifying childhood food insecurity in border households, and increasing childhood pesticide poisoning knowledge and safe home-storage practices in farm-worker families.¹⁻³ A randomized, controlled trial (RCT) of CHWs demonstrated that they are substantially more effective in insuring uninsured children than traditional Medicaid and Children's Health Insurance Program (CHIP) outreach and enrollment, and resulted in children obtaining insurance coverage significantly quicker, more continuously, and with greater parental satisfaction.⁴

Parent Mentors (PMs) are a specialized form of CHWs for children in which parents who already have children with a particular health condition or risk leverage this relevant experience, along with additional training, to assist and counsel other parents of children with the same health condition/risk. An RCT of PMs for minority children with asthma documented that PMs are substantially more effective than traditional care in reducing wheezing episodes, asthma exacerbations, emergency-department visits, and missed parental work days, while improving parental self-efficacy in knowing when a serious breathing problem can be controlled at home, at a reasonable cost of approximately \$60 per patient per month, and with net cost savings of \$597 per patient per asthma-exacerbation-free day gained.⁵ A 2 ½-day training session for PMs in this RCT resulted in a significant improvement in PMs' scores on a test evaluating knowledge and skills, from a mean pre-test score of 78% of answers correct to a mean post-test score of 90% of answers correct.⁵ No other RCTs (to our knowledge) have been conducted, however, on the effectiveness of PMs, and PMs have not been evaluated as a potentially efficacious means of providing Medicaid and CHIP outreach to and enrollment of uninsured children.

The study aims, therefore, were to determine whether a PM training program results in 1) improved knowledge/skills regarding insuring uninsured minority children, 2) high levels of participant satisfaction with training sessions, and 3) preliminary data showing higher rates than traditional Medicaid/CHIP outreach/enrollment of insuring uninsured children.

Methods

Theoretical Framework

PMs are experienced parents with at least one child covered by Medicaid/CHIP. The guiding theoretical principle is that PMs bring a wealth of experience from successfully insuring their own children, can provide social support, and with proper training, can be highly effective in educating and assisting other parents of uninsured children in obtaining health insurance. PMs thus distinctly differ from other types of CHWs, because unlike other CHWs, all PMs: 1) are parents (not a requirement for other CHWs); 2) already have 1 child covered by Medicaid/CHIP, so that PMs bring relevant, direct experiences of successfully applying for, obtaining, and maintaining Medicaid/CHIP coverage for their child; 3) receive specific, in-depth training on obtaining insurance, being a successful PM, and assisting parents with obtaining medical homes for children; 4) are provided ongoing coaching by a Program Coordinator and staff, including regular in-person and telephone meetings; 5) are trained to provide parents with information on and referrals to non-medical assistance for families, including food, clothing, affordable housing, TANF, and WIC; and 6) are available by phone 24 hours/day to provide assistance.

In this study, PM functions originate from 1) a patient- and family-centered approach derived from prior qualitative work on parents of uninsured children and what they identified as insurance barriers and how they would best be overcome⁶; 2) an RCT of CHWs who were significantly more successful at insuring uninsured Latino children than traditional Medicaid/CHIP outreach/enrollment⁴; and 3) prior research on a highly effective PM intervention for minority children with asthma.⁵

PM training in the current study focused on knowledge and skills regarding the following: 1) providing information on types of insurance programs (Medicaid and CHIP) available to eligible, uninsured children, and the application process; 2) furnishing information and assistance on program eligibility requirements; 3) completing the child's insurance application together with the parent, and submitting the application with the family; 4) expediting final coverage decisions by early and frequent contact with program representatives for Texas Medicaid/CHIP; 5) acting as a family advocate by being the liaison between the family and Medicaid/CHIP programs; 6) contacting Medicaid/CHIP program representatives to rectify situations in which a child inappropriately was deemed ineligible for insurance or had coverage inappropriately discontinued; and 7) assisting with completion and submission of applications for renewal of coverage. A special emphasis of the PM training was how to overcome system barriers to and difficulties in Medicaid/CHIP enrollment which have been documented by our team locally⁷ and nationally,⁶ including lack of knowledge about the application process and eligibility (especially misconceptions about work, welfare, and immigration), language barriers, immigration issues, income, hassles, pending decisions, family mobility, misinformation from insurance representatives (being told insurance is too expensive and parents must work), and system problems (including lost applications, discrimination, and excessive waits).

The PM training was part of a randomized, controlled trial (RCT) called Kids' HELP (Kids' Health Insurance by Educating Lots of Parents), which compared the effectiveness of PMs

to traditional Medicaid/CHIP outreach and enrollment in insuring uninsured minority children.

Study Design and Human Subjects

This study employed a pre-test/post-test study design. The study protocol was approved by the Institutional Review Board of the University of Texas Southwestern Medical Center, and all participants provided written consent.

PM Eligibility Criteria, Recruitment, and Selection

PM eligibility criteria included: 1) Latino or African-American race/ethnicity, 2) primary caregiver for 1 child covered by Medicaid/CHIP for 1 year, 3) residing in or near a zip code within one of five Dallas regions with the highest proportion of uninsured and low-income children; 4) English proficiency, and if Latino, bilingually fluent in English and Spanish; 5) has a phone; 6) available time/commitment to assist families with obtaining Medicaid/CHIP for their uninsured children (therefore, not employed or attending school full-time, and has no children 2 years old), and 7) able to attend a one-time two-day training session. PM candidates were excluded if they were not Latino or African-American, not a primary caregiver for 1 child covered by Medicaid/CHIP for 1 year, resided outside target zip codes, had limited English proficiency, were Latino but not bilingual, had no phone, had insufficient time/commitment to assist families with insuring children, or were unable to attend training sessions.

PM candidates were recruited from June 2011 through August 2013 from the Continuity of Care Clinic at Children's Medical Center Dallas, which experiences approximately 11,000 visits annually, predominantly by Latino and African-American children covered by Medicaid/CHIP. Most PM candidates were screened and identified by one of the authors (ML) who has been in practice in the Clinic for two decades. One PM was recruited through RCT participant-recruitment activities at a charter school, and four others were recruited on the recommendation of established PMs. PMs were recruited over two years because of the rigorous screening process and time needed to accrue study families.

The protocol for PM selection began with the screening physician (ML) interviewing each candidate to assess her/his desire to help families with uninsured children. Additional screening criteria included on-time arrival to clinic appointments and having a trusting and long-term relationship with Clinic staff (see video clip at: <https://vimeo.com/95286928>). These interviews were followed by a discussion with the Program Coordinator (CW) about specific tasks and expectations, including questions to probe the candidate's reliability, timeliness, dependability, persistence, and interest in helping others (see video clip at: <https://vimeo.com/95286930>).

Training

PMs participated in a two-day intensive training session (see video clip at: <https://vimeo.com/95286929>). The sessions began with introductions to the training team and each team member's role. PMs were provided with a training manual in English (98 pages) and Spanish (104 pages, for bilingual PMs), consisting of 10 sections, including nine that

corresponded to the training sections and a tenth on sharing experiences. The nine training sections were: 1) Why health insurance is such an important issue for American Children; 2) the Kids' HELP program; 3) being a successful PM; 4) PM responsibilities; 5) Medicaid and CHIP; 6) the application process; 7) next steps after obtaining Medicaid/CHIP coverage; 8) medical homes; 9) and study paperwork.

Evaluation

All participants completed a brief eight-question survey about demographic characteristics of the PM and her/his children. A 33-item pre-test then was administered prior to the training session to assess PM knowledge and skills regarding Medicaid/CHIP, the application process, medical homes, and the other six topics addressed in the session (Appendix 1). The first 15 questions were structured as true/false statements, and the remaining 18 consisted of multiple-choice options. The pre-test was designed to evaluate knowledge and skills for all nine sections of the training session. Tests were scored on a scale of 0-100 points.

A 46-item post-test contained the same 33 pre-test items (ordered differently) and 13 Likert-scale questions on training satisfaction (Appendix 2). The latter 13 questions addressed satisfaction with: 1) the training program overall; 2) the relevance of topics with respect to the participant's needs; 3) the materials received and their value in preparation for session participation; 4) skill-based training emphasizing interaction and participation; 5) the participant's ability to apply the knowledge and skills from the session to help parents obtain insurance for their children; 6) learning at least one specific thing that enabled greater effectiveness in helping families of uninsured children; 7) sufficient time to cover session content; 8) relevance of the information to the participant's learning needs; 9) the materials increase efficiency in obtaining health insurance for children; 10) comfort addressing the problems of target families; 11) the knowledge and professionalism of the session instructors; and 12) the session instructors stimulating an interest in the material.

To provide constructive feedback on the session, participants also were asked to answer four open-ended questions after completing training: 1) What could be done to improve the training? 2) What did you like best about the training? 3) What did you like least about the training? And 4) Please provide us with any other comments or suggestions.

The Kids' HELP RCT is evaluating the effectiveness of the PM intervention in obtaining insurance coverage for uninsured minority children who are eligible for but not enrolled in Medicaid/CHIP. The control group receives current outreach and enrollment efforts available to all children in Texas. Participants are uninsured Latino and African-American residing in the five Dallas regions with the highest proportions of minority and uninsured children. Recruitment occurs in a wide variety of community settings, including supermarkets, public libraries, food banks, health fairs, and housing projects. Interim analyses of the ongoing RCT used Chi-square and t-tests to examine intergroup differences in insurance rates, time to insurance acquisition, and parental satisfaction.

Analysis

Statistically significant differences between the post-test and pre-test scores were identified using the non-parametric Wilcoxon test. A two-tailed $P < .05$ was considered statistically significant. Proportions of responses were calculated for each Likert-scale response option for the satisfaction questions. Complete responses to open-ended feedback questions were compiled and organized thematically.

Results

Out of a total of 31 PM candidates who were interviewed, 15 were chosen to be PMs, and all 15 participated in the training sessions. All PMs were female, 60% were African-American, and 40% were Latino (Table 1). Over 1/3 of PMs were single parents, almost 2/3 were unemployed, and most had attended at least some college. PMs had a mean of three children and a mean annual combined family income of approximately \$21,000.

Performance on Tests Evaluating PM Knowledge and Skills

After training, PMs significantly improved their scores on tests evaluating PM knowledge and skills (Table 2). The mean pre-training score was 62, with a range of from 39 to 82. Post-training, the mean score improved to 88, with a range of from 67 to 100, and two PMs received perfect 100 scores. This change of 26 points in mean test scores represents a statistically significant improvement ($P < .01$). There also was a significant post-training reduction in the mean number of wrong answers, from 12 to four. By test section, significantly post-training improvements were noted in six of nine sections. The greatest magnitude of increase in section scores were noted for the Medicaid and CHIP (57% increase), importance of health insurance (33%), and Kids' HELP (29%) sections.

Results of PM Satisfaction Survey

PM reported high levels of satisfaction with all 12 components of the training sessions (Table 3), with the proportions “very satisfied” or “satisfied” ranging from 85% to 100%, including 100% for satisfaction with the overall program. The lowest proportion of very satisfied/satisfied responses (85%) was for comfort addressing the problems of families with whom the PMs work. In contrast, 100% of PMs were very satisfied/satisfied with the remaining 11 training components. The highest proportions of “very satisfied” responses were seen for the overall training program, value of materials received, and skill-based training.

Feedback on PM Training Sessions

Feedback on areas for improvement of the PM training included more attention to co-pays, and the training materials (Table 4). PMs cited the training effectiveness, the tools and materials, and the small groups as the best features of the training. Regarding what was liked least about the training, one PM suggested more hands-on “show-and-tell,” to get a better “feel” for what the PMs were going to be doing.

PM Effectiveness

Although the RCT of the effectiveness of Kids' HELP PMs is still ongoing (completion is anticipated in early 2015), interim published¹ and unpublished data indicate that the PM intervention is significantly more effective in insuring uninsured minority children than traditional Medicaid/CHIP outreach and enrollment. To date, for children who have completed the 12-month outcomes follow-up, health-insurance coverage has been obtained by 94% of the children in the PM intervention group (N=99), compared with only 58% of the control group (N=90) ($P<.01$). The median time to obtain insurance coverage is substantially faster for children in the PM intervention group, at 58 days vs. 111 days ($P<.01$), respectively. In addition, regardless of whether or not the child has obtained insurance, parents in the PM intervention group are significantly more likely than those in the control group to be very satisfied or satisfied with the process of obtaining insurance, at 84% vs. 54% ($P<.01$), and significantly less likely to be very dissatisfied or dissatisfied with the process, at 10% vs. 19% ($P<.01$). PMs also have been highly successful in engaging the target population, with a total of 485 home visits (mean = 19.8 per family) and 3,196 phone, e-mail, and text-message contacts (mean = 161.4 per family) documented with the intervention-group families enrolled to date.

Discussion

The Kids' HELP PM training program resulted in significant improvements in PM knowledge and skills regarding outreach to and enrollment of uninsured, Medicaid/CHIP-eligible children. The training sessions produced a statistically significant 26-point increase in the mean PM test scores, from a pre-training mean score of 62 to a post-training mean of 88, equivalent to a 42% increase. In comparison, in the only other published evaluation of a PM training program, training sessions for PMs for minority families with children with asthma resulted in a statistically significant but more modest 12-point increase, from a mean pre-test score of 78 to a mean post-test score of 90, equivalent to a 15% increase.⁵ It is possible that the Kids' HELP training resulted in a higher relative score increase because our research team carefully identified the lessons learned from the asthma PM training, integrated these learning points into the Kids' HELP training manual, and applied these lessons learned to the Kids' HELP training session. In addition, it is possible that PMs in the asthma training session had less room for improvement, as they had a higher mean pre-training score of 78, compared with a mean pre-training score of 62 for the Kids' HELP PMs.

PMs reported high levels of satisfaction with the training sessions, with 100% reporting being very satisfied or satisfied overall and with 10 of the 11 training components. Several aspects of the training might account for these high levels of satisfaction. The PM candidate screening process assiduously emphasized selection of only the most committed, reliable, punctual, dependable, persistent individuals who explicitly articulated an interest in helping others. The physician screening PM candidates carefully assessed candidates' desire to help families with uninsured children, track record for on-time arrival to clinic appointments, and having a trusting and long-term relationship with Clinic staff. PM candidates closely matched the background and shared experiences of the target study families, including

minority race/ethnicity, already having children covered by Medicaid/CHIP, residence in the same underserved regions, and low mean family income. Almost two-thirds of the PMs were unemployed, so an added benefit was part-time employment through the Kids' HELP Program, as those completing the training were then paid a monthly stipend for each family whom they assisted as a PM. The training sessions emphasized interactive, small-group formats. PM feedback was integrated after each session, so that there was an ongoing quality-improvement process. An emphasis was placed on instruction that was stimulating and enjoyable, including role-playing exercises. Our team also leveraged key past experiences in educating asthma PMs⁵ to maximize success in the Kids' HELP training sessions.

In addition to improving knowledge and skills and achieving high levels of PM satisfaction, it is critical that the Kids' HELP PM training sessions produce PMs who are effective in insuring uninsured children. Although the Kids' HELP RCT is not yet complete, both published¹ and unpublished interim analyses document that the PMs trained in this study are significantly more effective than traditional Medicaid/CHIP outreach and enrollment in insuring uninsured minority children, and insuring them faster and with higher parental satisfaction. A forthcoming article will detail the final Kids' HELP RCT results, including rates of insurance coverage, time to coverage, parental satisfaction, health status, access to healthcare, unmet healthcare needs, use of health services, parental satisfaction, financial burden, missed work/school days, and costs.

Limitations

Certain study limitations should be noted. PMs were recruited from the greater Dallas area, so findings may not necessarily generalize to PM trainees residing in other regions or in rural or suburban areas. PMs unexpectedly were found to have a relatively high educational attainment; the reasons for this finding are unclear, but might possibly reflect a greater willingness among those with a more extensive formal education to undergo the didactic sessions and training required to become a PM. Given the PMs' 100% overall satisfaction rate with the PM training, it is possible that the high unemployment rate among PM candidates, coupled with the subsequent employment of PMs who completed the training, may have biased the satisfaction responses. Although pre-post improvements in scores on the knowledge and skills test were statistically significant, the final sample size of 15 participants is relatively small, and additional evaluation of the training with a larger sample would be useful.

Implications

Trained PMs have the potential to be a powerful tool for outreach to and enrollment of uninsured children who are eligible for but not enrolled in Medicaid and CHIP. PMs are a highly patient-centered intervention, given that PMs already have successfully obtained Medicaid and CHIP for their own children, and therefore have a deep appreciation and understanding of the process, which can be leveraged with target families of uninsured children. Nine percent of US children—equivalent to 6.6 million—are uninsured⁸, and 65% of uninsured US children are eligible for but not enrolled in Medicaid or CHIP.⁹ Kids' HELP training sessions therefore have the capacity to supply knowledgeable and skilled PMs who

can provide trained outreach to the 4.3 million uninsured American children who are eligible for but not enrolled in Medicaid or CHIP.

This PM training program might also be a useful model for training knowledgeable and skilled Affordable Care Act (ACA) navigators. Section 1311 (i) of the ACA requires the state insurance exchanges to establish a navigator program; under the law, these navigators have five duties, which are to 1) conduct public education about the availability of qualified health plans; 2) distribute fair, impartial information regarding enrollment in qualified health plans and availability of premium tax credits and cost-sharing assistance in the exchange; 3) facilitate enrollment in qualified plans; 4) refer people who need help resolving a problem with their health plan or with their premium assistance to a consumer assistance or ombudsman program or to another appropriate agency that can help with a grievance or appeal; and 5) provide information in a culturally and linguistically appropriate manner to populations served by an exchange.¹⁰ Because PMs completing Kids' HELP training obtain considerable knowledge and skills in each of these five domains, the Kids' HELP training sessions may prove to be a useful model for training effective ACA navigators.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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What's New

A Parent Mentor training program resulted in significant improvements in knowledge and skills regarding outreach to and enrollment of uninsured, Medicaid/CHIP-eligible children, with high participant satisfaction with the training. This program might be a useful model for training ACA navigators.

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Table 1Selected sociodemographic characteristics of Parent Mentors ($n = 15$).

Characteristic	Proportion or Mean
Female	100%
Race/ethnicity	
African American	60%
Latino	40%
Marital status	
Married	33%
Widowed	27%
Single	40%
Employment status	
Part-time	40%
Unemployed	60%
Educational attainment	
Never completed high school	13%
High-school diploma or GED	7%
At least some college	53%
College graduate	27%
Mean number of children (range)	3 (1, 7)
Annual combined family income (range)	\$20,913 (\$2,400, \$75,000)

Table 2

Comparison of pre-training and post-training performance of Parent Mentors on tests evaluating knowledge and skills regarding outreach to and enrollment of uninsured minority children.

Performance Measure	Mean, Number, or Mean % Correct		P
	Pre-Training	Post-Training	
Total score ^a (range)	62 (39, 82)	88 (67, 100)	<.01
Number of wrong answers ^b (range)	12 (6, 20)	4 (0, 11)	<.01
Mean % correct on Section 1: Why health insurance is such an important issue for American children	48%	81%	<.01
Mean % correct on Section 3 ^c : Kids' HELP	68%	97%	<.01
Mean % correct on Section 4: Being a successful Parent Mentor	87%	92%	.25
Mean % correct on Section 5: Parent Mentor responsibilities	96%	99%	.36
Mean % correct on Section 6: Medicaid & CHIP	12%	69%	<.01
Mean % correct on Section 7: The application	71%	89	.01
Mean % correct on Section 8: Next steps	97%	100%	.17
Mean % correct on Section 9: Medical home	87%	95%	.04
Mean % correct on Section 10: Study paperwork	84%	99%	<.01

^aMaximum possible score = 100 points.

^bOut of a total of 33 questions.

^cSection 2 consisted only of sharing experiences, so there was no test for this training unit.

Table 3

Results of the Parent Mentor satisfaction survey.

How satisfied are you with...	Proportion of Parent Mentors Choosing Response ^d		
	Very Satisfied	Satisfied	Neutral
Training program overall?	86%	14%	-
Relevance of topics with respect to your needs?	71%	29%	-
Materials you received and their value in preparing you to participate in the sessions?	86%	14%	-
"Skill-based" training which emphasized interaction and participation?	86%	14%	-
Your ability to apply the knowledge and skills from the session to helping parents and children obtain health insurance?	71%	29%	-
Learning at least one specific thing that enabled you to be more effective in helping the families you work with?	71%	29%	-
There being sufficient time to cover the content during the training sessions?	71%	29%	-
Receiving information that was relevant to your learning needs?	57%	43%	-
Materials increasing your efficiency in getting children health insurance?	57%	43%	-
Your comfort addressing problems of families you are working with? ^b	71%	14%	14%
Training personnel's knowledge and professionalism?	57%	43%	-
Training personnel stimulating an interest in the material?	57%	43%	-

^aThe other two response options for each question were "dissatisfied" or "very dissatisfied," but no Parent Mentor chose these responses for any survey item.

^bTotal does not sum to 100% due to rounding.

Table 4

Responses of Parent Mentors to open-ended questions on training sessions.

Question	Response
What could be done to improve the training?	<ul style="list-style-type: none"> • More on the co-pay for medical clients with a primary insurance • The training was really great, and all in all, I felt and still feel good with what I learned. • Nothing • Training materials • Training is great the way it is
What did you like best about the training?	<ul style="list-style-type: none"> • Effectiveness • What we were given, all the tools that were going to be needed, material wise and knowledge wise • I enjoyed all! • Everything • The small groups
What did you like least about the training?	<ul style="list-style-type: none"> • Maybe we could have had show-and-tell a few more times, to get the feel of what we're going to do
Please provide us with any other comments or suggestions.	<ul style="list-style-type: none"> • I'm joining ya in June