OUTREACH IN URBAN CLINICS: 
A DESCRIPTIVE STUDY

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ABSTRACT: Outreach services were initially conceived as important elements of neighborhood health centers, but they have not been shown to be effective in outcome evaluations. This study examines the outreach programs in 11 community clinics in Seattle. Interviews were conducted with the program directors and outreach workers of these clinics. Outreach programs have failed to provide an adequate number of jobs and career opportunities for the poor. Workers have not been carefully selected and trained, and goals and objectives of the program have been vague. Unstable funding of outreach has affected the quality as well as the size of the programs. Reasons for the inadequate implementation of the concept of outreach are discussed, and suggestions are made for future programs.

While the war on poverty is but a faint memory, and its fortifications, the community action programs, lie as battle-scarred monuments, most of the war’s targets remain. In the health field, wide variations in health status and access to medical services continue. Special strategies to address these problems were spawned in the late ’60s. One of them, “maximum feasible participation of the poor”, created enormous tensions and lies buried in the ashes of the antipoverty program. A slightly less controversial concept that emerged from community action programs was the use of outreach workers.

Outreach programs represent the application of the New Careers model of Riessman and others to the health care system. The New Careers concept envisioned unskilled, unemployed persons from the community being placed in jobs where they would provide needed services while acquiring on-the-job training. The goals were initially twofold: to provide jobs for the community and to improve the health status of the poor. Riessman projected that the human services industry would create as many as 1 million jobs in accomplishing this purpose. In addition, advanced training would both allow the worker to move up the career ladder and provide opportunities for a genuine career with job mobility.

In its attempt to improve health services to the poor, outreach differs from the traditional systems of care in that it is initiated by the provider rather than
by the patient. This entails a change of attitude on the part of providers: it means taking responsibility for all individuals within the community, not just those who seek care on their own.

Two types of approaches were employed in outreach programs. The first was to increase the use and effectiveness of available services. The outreach worker would function as a “bridge” between the middle class professionals of neighborhood health centers and other social welfare agencies and the people of the community. The outreach worker, being a member of the community, sharing values and social networks with the clients, and at the same time possessing knowledge of the health care and social welfare system, would be in a unique position to perform this function. The position would enable the outreach worker to increase appropriate utilization of the clinic, assist the patient in following prescribed treatment, and provide a more holistic view of the patient to the medical provider.

The second approach was to have outreach workers provide additional services such as health education, home visits, and transportation to the clinic. Some of these functions could have been performed by clinic personnel without the particular attributes of outreach workers described above. However, outreach workers were a more available and economical source of labor than other personnel such as nurse practitioners.

Evaluations of the success of outreach programs have taken a variety of forms. Most of the reports are anecdotal, describing the activities of outreach workers. But a number of studies have been more analytical, evaluating the ability of programs to meet specific objectives. Stewart and Hood showed that outreach workers were able to increase the number of children immunized in a poverty neighborhood, but immunization rates fell back to their pre-intervention levels within eight months after termination of the program. Outreach workers have been used to motivate postpartum and postabortal women to return for checkups but were found to be no more successful than a reminder letter. Wingert and associates were not able to demonstrate that the use of community workers in the pediatric outpatient department benefited chronically ill children.

Two recent randomized controlled trials have examined the ability of outreach workers to increase utilization of health services in situations where the financial barriers to care have been removed. The findings suggested only a small, although positive effect of the workers in improving the utilization of health services by a medically indigent population. One of the few studies in the literature that attempts to evaluate the effects of outreach services on the health status of its participants is the work of Cowen and associates. The study showed that the outreach program was not effective in preventing or reducing illness due to common childhood diseases among children receiving the program, compared with a similar group receiving only traditional pediatric services.

A rigorous evaluation of the impact of outreach programs is dependent