Local Efforts to Increase Health Insurance Coverage among Children in California

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Prepared for the Medi-Cal Policy Institute by

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Executive Summary

In California, local organizations play a central role in the state's efforts to enroll low-income children in Medi-Cal and Healthy Families. Many successful outreach programs have been designed and implemented at the local level to reach the 726,000 uninsured children who may qualify for Medi-Cal and the additional 535,000 uninsured children who may qualify for Healthy Families.[1] In the past six months, under the state's leadership, these outreach efforts have been extended to ensure successful enrollment, encourage the appropriate use of health services, and support the retention of coverage over time. This background paper examines the practices of a variety of local programs involved in Medi-Cal and Healthy Families outreach to develop a clearer picture of effective strategies.

It is difficult to generalize about local outreach efforts because each project has a unique set of characteristics that has developed in response to the needs of the local community, the history of the agency, and funding sources. Broadly speaking, however, outreach projects can be grouped into three categories based on the primary site of their activities: (1) health facilities, including public and private hospitals and clinics; (2) school-based programs; and (3) community-based organizations (CBOs) such as churches, job-training sites, and cultural organizations. Outreach programs located in different settings employ different strategies and exhibit different strengths and weaknesses:

- Because public and private safety net health facilities already provide health care to large numbers of uninsured children, many have developed Medi-Cal and Healthy Families enrollment systems. They enroll significant numbers of children, but most of them are already accessing the health care system. There is potential for excellent linkages from enrollment to the appropriate use of health care services.

- School-based programs have the potential to reach the largest number of potentially eligible children, including those who are not using the health system. However, there are significant challenges to developing a successful school-based program, including the cumbersome processes involved both in securing access to eligible children and in enrolling them in the school setting.

- Outreach programs administered by CBOs tend to be smaller in scale than those administered by either health facilities or schools, but they play an important role. Through their sustained presence in a community over time, many CBOs have been able to cultivate the trust of community members. As a result of this trust relationship, parents may seek out staff from CBOs for guidance about various issues including health insurance for their children. However, since health insurance is often not their primary activity, CBOs tend to be more vulnerable to changes in funding and high staff turnover.

Despite considerable variation in specific activities undertaken by individual programs, some common themes emerge from this qualitative analysis that are applicable for state and county policy makers:

- Successful outreach and enrollment programs at the local level build an ongoing relationship with the family to help them obtain insurance, use services appropriately, and retain coverage over time.
- More rigorous evaluations of outreach, enrollment, access, and retention programs are needed to determine which activities are most successful.
- There is a need at the state level to determine whether Medi-Cal and Healthy Families enrollment is associated with more appropriate use of health care services by children.
- There has been limited dissemination and replication of successful strategies throughout the state.
- The lack of sufficient and sustainable funding presents a major challenge for local organizations involved in these activities.
- Due to high turnover rates among Certified Application Assistants (CAAs), local programs have implemented continuous training programs.

Introduction

Between 1998 and 2001, California focused considerable resources to establish Healthy Families' program infrastructure and implement a massive outreach campaign for Medi-Cal and Healthy Families designed to inform and motivate eligible parents to enroll their children. In the current fiscal year, the Department of Health Services (DHS) and Managed Risk Medical Insurance Board (MRMIB) have focused greater attention on strategies to enroll eligible children, ensure appropriate access to care, and facilitate the retention of benefits over time. Many successful outreach programs have been designed and implemented at the local level. In response to the state's leadership, some local organizations have begun to extend their efforts to include not only outreach and enrollment, but also access and retention. To date, these innovative local efforts have not been well documented. Thus, important opportunities for shared learning and quality improvement among counties, health plans, schools, clinics, and other community-based organizations about promising approaches and potential barriers have been missed.

Medi-Cal and Healthy Families

In total, more than 3.3 million—one in three—children in the state are enrolled in either Medi-Cal or Healthy Families. Medi-Cal is an entitlement program that guarantees coverage of a specified set of benefits for all children who meet its eligibility and income requirements. Healthy Families is a block grant program that provides subsidized insurance coverage for children who meet its eligibility requirements and have incomes between 100 and 250 percent of Federal Poverty Level (FPL) ($35,300 for a family of four in 2001). Medi-Cal is the larger of the two programs, covering six times as many children as Healthy Families.

Uninsured Children

In 1999, 1.85 million of California's 10 million children lacked health insurance. Analysis of the characteristics of uninsured children by UCLA's Center for Health Policy Research indicates that

two out of every three uninsured children in California may qualify for Medi-Cal or Healthy Families. Nearly 40 percent, or 726,000 children, qualify for Medi-Cal. Another 535,000 children qualify for the Healthy Families program.[2] The remaining one-third of uninsured children in California live in families that earn more than the maximum annual income to qualify for Healthy Families (250 percent of FPL) or are undocumented immigrant children. The latter are not eligible to participate in these programs except for emergency medical services under Medi-Cal if their families have low incomes.[3]

Methodology

This background paper examines local efforts to increase the number of children with health insurance. This author conducted key informant interviews with staff members from seventeen local enrollment projects and collaboratives throughout the state. This qualitative analysis is divided into four sections. The first section highlights the characteristics of the three major settings for community-based outreach and enrollment programs: health facilities, schools, and community-based organizations (CBOs). The second section uses the Access Pathway to identify promising local strategies and practices related to outreach, enrollment, use of services, and retention.[4] The next section reviews the infrastructure required to support implementation of these strategies, and the final section highlights some lessons learned.

Most of the initiatives described in this paper are local in nature and have not been described or analyzed in a systematic manner. In order to identify projects that have implemented innovative strategies for enrollment, access, and retention, the author canvassed key informants throughout the state to generate a list of potential programs. The author then reviewed all publicly available documents about enrollment, access to care, and retention in Medi-Cal and Healthy Families to develop a survey instrument. Primary data were collected through semi-structured telephone interviews with key informants at local programs. A list of programs interviewed is included in Table A1.

Many of these efforts have been designed in response to unique local circumstances. In an effort to provide information that is relevant to the widest range of organizations throughout the state, the author chose to survey organizations operating in urban as well as rural areas, focusing on different racial and ethnic groups, and representing different geographic regions in the state. Thus, the programs described in this paper are not necessarily those programs with the highest enrollment, although several top producers have been included. Although the programs and strategies reviewed in this paper relate to children's health insurance, many could be adapted to reach the adult uninsured population if sufficient resources were made available.

California's Efforts to Promote Outreach and Enrollment

In order to place local outreach efforts in an appropriate context, it is important to understand the state's outreach efforts in California. State law requires DHS, in conjunction with MRMIB, to develop and conduct a community outreach and education campaign to help families learn about and apply for Medi-Cal and Healthy Families. In the 2000-2001 California budget, a total of $34.2 million was allocated for outreach activities, including statewide media promotion, community outreach, and payments to certified application assistants.[5] The state's activities to increase enrollment in Medi-Cal and Healthy Families can be grouped into two categories:

(1) efforts to remove administrative barriers; and (2) a community-based outreach campaign. However, despite significant efforts and funding, important barriers remain for 1.3 million uninsured children who are eligible but not enrolled.[6]

Administrative Changes

The state has adopted many strategies to remove administrative barriers to enrollment in Medi-Cal and Healthy Families. These strategies include a shortened joint application, the introduction of 12-month continuous eligibility, and the elimination of quarterly status reports under Medi-Cal.[7] These strategies will be supported by the statewide introduction of Health-e-App, developed in partnership by the state and the California HealthCare Foundation. Health-e-App is the first online enrollment system for publicly funded insurance programs, which will transmit applications to the Single Point of Entry as soon as they are completed.[8]

Currently, the state is exploring mechanisms to streamline enrollment for children who already participate in other public programs such as the Women, Infants and Children program (WIC), Food Stamps, and the National School Lunch Program. This strategy, often referred to as "express lane eligibility,"[9] has tremendous potential, given that an estimated 700,000 uninsured children participate in one of those programs.[10] Recently, state officials assessed five options under express lane eligibility: (1) referrals with follow-up capability; (2) on-site application assistance; (3) sharing eligibility information; (4) common application; and (5) resumptive eligibility.[11]

State officials have determined that the first three options in this list represent promising strategies that already occur on the local level and could be expanded to the entire state. Although the final two options listed above have merit, there are remaining legal and technical barriers that need to be addressed before they can be implemented.

Many schools and local organizations have already established mechanisms to enable other public programs to refer uninsured children. The school or organization then contacts the family to complete the enrollment process. Multiple counties, school districts, and community-based organizations (CBOs) have negotiated to provide on-site application assistance at WIC programs, Child Health and Disability Providers (CHDP), childcare centers, and food stamps offices. Recently, Governor Davis signed two laws that will permit the sharing of eligibility information between the Food Stamps program and National School Lunch Program and Medi-Cal and Healthy Families. AB 59 will allow school districts to ask families enrolled in the National School Lunch Program if they are interested in learning more about state-sponsored health care. If parents are interested, then the school district can forward income information to county welfare offices or Healthy Families for follow up. SB 493 will allow households receiving food stamps to receive a letter at recertification asking for their permission to submit income and family information to Medi-Cal and Healthy Families. Both policies are expected to increase Medi-Cal and Healthy Families enrollment.[12]

Community-Based Outreach Campaign

Beyond these legislative and administrative strategies, DHS has developed a community-based outreach and education campaign to increase public awareness and enrollment in Medi-Cal and Healthy Families among "hard-to-reach" populations.[13] DHS contracts with a variety of local organizations to conduct outreach and enrollment activities. As part of the state's overall

outreach campaign, DHS awarded $6 million in contracts in July 2001 to community-based organizations (CBOs) and $5.5 million in contracts to support collaboration between school districts, county offices of education, city/county government, and community-based organizations to implement school outreach efforts. In addition to these contracts, the state of California provides funding to counties to conduct outreach under Section 1931(b).[14] The state also pays enrollment entities and CAAs to assist families in completing Medi-Cal and Healthy Families applications. CAAs receive $50 for each successful application and $25 for each successful 12-month renewal unless their organization has an outreach contract with the state.[15]

As the state enters the fourth year of the Healthy Families program, its funding strategy has shifted from paying for community education and outreach activities to supporting the development of systematic approaches to increase enrollment and retention.[16] Under these outreach contracts, each contractor is required to enroll a specified number of children in Healthy Families and Medi-Cal from the target populations in their geographic area. For the current fiscal year, the state also requires organizations to conduct and provide documentation of activities related to access to care and retention of benefits.[17]

Primary Settings for Local Outreach and Enrollment Programs

It is difficult to generalize about outreach and enrollment efforts because each project has a unique set of characteristics that has developed in response to the needs of the local community, the history of the agency, and funding sources. Broadly speaking, however, outreach projects can be grouped into three categories based on the primary site of their activities (Table 1): (1) health facilities, including public and private hospitals and clinics; (2) school-based programs; or (3) community-based organizations such as churches, job-training sites, and cultural organizations.

Health Facilities

Because public and private safety net providers already treat large numbers of uninsured children and rely on revenues from health insurance, they tend to focus considerable energy on in-reach activities, screening uninsured children when a provider sees them. Typically, the Medi-Cal and Healthy Families application process is integrated into the facility's overall financial screening system. Depending on its size, a facility may have one or more positions dedicated to financial screening and enrollment in insurance programs. Multiple staff members are training to assist in the completion of Medi-Cal and Healthy Families applications. Given the integrated organizational structure, facility-based programs are less affected by reductions in direct funding for outreach.

Beyond in-reach, most clinic programs conduct some outreach activities in the surrounding communities. Several programs reported collaboration with WIC programs, which may be located in the same facility as the clinic or be part of the same parent organization. Because parents of uninsured children do not bring pay stubs and birth certificates to their medical appointments, clinics have to schedule enrollment appointments for parents to return and complete the Medi-Cal/Healthy Families application. Despite the use of incentives and subsidized transportation, most clinics reported difficulty in getting parents to return for the appointment to complete the application. In summary, clinics enroll a significant number of children, but many are already accessing the health care system. They also can provide excellent

linkages to health care services, increasing the likelihood that children will use services once they have enrolled.

School-Based Efforts[18]

Schools reach the largest number of potentially eligible children. Since school attendance is mandatory, school-based programs have the potential to reach uninsured children who currently are not using the health care system. Despite this enormous potential, it is not easy to establish and maintain a successful school-based program. A lengthy multi-stage process is required to secure access to potentially eligible children in the school setting. Due to the multiple competing demands on the school system, the process can break down at any level. First, the organization needs to convince the superintendent that poor health represents a barrier to children's learning and that increasing health insurance coverage will address these health problems. Further, they must convince him or her that the program is feasible using existing resources. Once an organization has secured district level support, it needs to gain the support of principals to conduct outreach and enrollment activities in individual schools. Finally, the organization needs to work with teachers, school health staff, and parents to reach eligible children and their parents.

Most school-based programs target their efforts to school districts with the highest percentages of potentially eligible children, using National School Lunch Program as a proxy for income. Many school districts throughout the state distribute informational fliers with National School Lunch Program applications to every parent. If parents are interested, they return the request for information. Once a parent has expressed interest, he or she can complete an application at the school or through a referral to County Department of Health staff or a local CBO.

Community-Based Organizations

Although outreach programs administered by CBOs tend to be smaller in scale than either health facilities or schools, these programs play an important role in Medi-Cal/Healthy Families outreach and enrollment. Through activities addressing multiple issues and their sustained presence in a community over time, many CBOs have been able to cultivate the trust of community members. As a result of this trust relationship, parents may seek out staff from CBOs for guidance about various issues including health insurance for their children. CBOs use the local media such as radio and community newspapers to inform families about the programs. Word-of-mouth proves to be a highly effective outreach strategy in cohesive communities.

Enrollment activities within a CBO are typically funded through a separate grant or contract. Because health coverage may not be a core function, CBOs are vulnerable to delays and reductions in funding. As health insurance is generally not their primary area of interest, however, CBOs have to hire and train outreach staff to become CAAs. Outreach staff may not be familiar with health insurance and need significant training. This combination of funding instability and unskilled staff members can lead to high rates of staff turnover and weaken institutional memory. Ultimately, this instability can lead to multiple starts and stops in activity as funding levels and staffing patterns fluctuate. Compared to health facilities, CBOs have a more limited ability to ensure the use of health care services.

Table 1: A Comparison of Three Settings for Local Outreach and Enrollment Programs

Category	Health Facilities	School-Based Programs	Community-Based Organizations (CBOs)
Organizational Structure	Programs are situated in the clinic's patient services and community health departments. Staff members are employees of the clinic who perform multiple functions in addition to serving as Certified Application Assistants.	County department of health or CBO employs managerial and administrative staff. The school district, health department, or a CBO that collaborates with the school district employs outreach staff.	Grant/contract-funded project within a larger organization that is not dedicated to Medi-Cal and Healthy Families enrollment. Staff are hired or reassigned to do outreach and enrollment activities. Some CBOs solely focus on Medi-Cal/Healthy Families enrollment.
Outreach Strategies	Health facilities' primary focus has been in-reach, enrolling children who are already accessing services. Most also conduct targeted outreach with CBOs, schools, and local businesses.	Statewide efforts to send out fliers and request for information forms with NSLP applications. Use parents, teachers, and administrators to promote programs. AB 59 should streamline the outreach process through schools.	Use local radio and print media to inform community about programs.
Enrollment Strategies	Enrollment by appointment at clinic. Larger facilities replace missed appointments by accepting walk-ins.	Either on-site enrollment at the school or referral to CBO or county that makes enrollment appointment.	Enrollment by appointment at CBO or in the community. Some CBOs visit the homes of families.
Strategies to Promote Appropriate Use	Staff makes phone calls to encourage access. Some make appointments to educate parents. They are concerned with appropriate use of services, particularly if clinic serves as primary care provider.	Staff makes telephone calls to encourage access. Some schools sponsor educational sessions led by other parents to teach newly enrolled parents how to use the health system.	Staff answer inquiries and provide assistance by phone. Some CBOs call parents to encourage use.
Retention Strategies	Staff makes follow-up phone calls to provide assistance with re-enrollment.	The cyclical nature of school years facilitates retention efforts. Follow-up phone calls to provide assistance with re-enrollment. Staff makes follow-up calls to provide assistance with re-enrollment.	Staff makes follow-up calls to provide assistance with re-enrollment.
Collaboration	There are several examples of multiple clinics collaborating to eliminate competition, coordinate training and support functions, and reduce administrative costs. Clinics also work with WIC programs, CBOs, schools, and businesses.	Programs have to receive approval at three levels to gain access to children: school district, school principal, and classroom teachers. Schools collaborate with CBOs or county department of health to strengthen their health expertise.	CBOs participate in county collaborative. They work with health departments, schools, clinics, and businesses to reach the target population.
Strengths	Enrollment activities are integrated into financial screening systems, which means that clinics are likely to maintain the program even if direct outreach funding is reduced. Families will be directed to the most appropriate program even if they do not qualify for Medi-Cal or Healthy Families.	The vast majority of children between 6 and 17 are in the school system. Programs may be able to reach children who may not use the health system currently. Schools are trusted institutions. Outreach efforts in schools can be targeted based on percent of children eligible for NSLP.	CBOs have built a large degree of trust in community. Parents seek them out for guidance and assistance. Large network for collaboration. They have access to local media.
Weaknesses	In-reach activities target children who are already accessing health care. It is difficult to get parents to return for an appointment to complete Medi-Cal/Healthy Families application.	There are multiple competing interests for limited resources in schools, which make these programs vulnerable. It is more difficult for school programs to follow up on appropriate use and retention. The entry process into schools and the referral systems used to get children enrolled are cumbersome.	Because health coverage may not be a core function, CBOs are very vulnerable to delays and reductions in funding. Outreach staff may not be familiar with health insurance and need significant training. They have limited ability to ensure the use of health care.
Programs Interviewed	La Clinica Salud Del Pueblo, Coalition of Orange County Community Clinics, Partners for Community Access, United Indian Health and Services	Health Access Through Schools in San Diego County, Bakersfield City School District, The Health Trust of Santa Clara County, Mendocino County Department of Health, Pasadena Department of Public Health	SAY San Diego, Korean Health Education and Information Resource Center, Lao Family Center of Fresno, San Mateo County Department of Health

Promising Local Strategies

Child health researchers at UCLA have described the complex process of obtaining health insurance and using health care services as the Access Pathway, which includes outreach, enrollment, use of services, and retention.[19] According to the Access Pathway, parents first must become aware of available programs through outreach activities. Once informed, they must navigate the enrollment process to ensure that their children obtain coverage. After they have enrolled, parents must navigate the health system to seek health care for their children. Each year they have to complete the annual eligibility redetermination (AER) process to maintain coverage for their children. At each step of the process, there are many barriers, which result in many children remaining uninsured and lacking access to the health system. The Access Pathway provides a useful context to identify promising efforts in outreach, enrollment, appropriate use, and retention.

Outreach Activities

Although it is widely accepted that a comprehensive outreach program is necessary, the effectiveness of individual components is not well understood.[20] In order to assess the effectiveness of its contracts with local organizations to conduct outreach for hard-to-reach populations, DHS contracted with the Center for Adolescent Services Research Center (CASRC) through the San Diego State University Foundation to conduct an evaluation. In their March 2001 report, CASRC found that the majority of contractors were health-oriented, non-profit organizations located in urban areas.[21] Among the ten community-based organizations with the highest enrollment, CASRC identified several best practices related to outreach. The study found that successful outreach programs: (1) build on prior experiences; (2) use tracking systems to monitor whether applications result in enrollments; (3) collaborate with WIC programs; and (4) give out information and make application appointments.[22] The current analysis confirms and expands on these findings.

This analysis identified successful strategies within four components of outreach:

- Identification of the target population;
- Use of media and communication;
- Use of incentives; and
- Outreach to businesses.

Identification of the Target Population

An important first step in the outreach process is the identification of the target population. The organizations interviewed employ several strategies to gather information about the number and characteristics of uninsured children in their area. The SAY San Diego program uses census data and a Geographic Information System (GIS) to create maps of low-income, uninsured children living in Northern San Diego County to help them target outreach efforts. The Health Trust of Santa Clara County and the Health Access Through Schools (HATS) program administer brief surveys to all children in a school to obtain estimates of the number of uninsured children. These surveys also identify uninsured children who require follow-up.

Other projects collaborate with publicly funded programs that have similar eligibility requirements to Medi-Cal and Healthy Families. For example, La Clinica Del Pueblo in Imperial County and the Coalition of Orange County Community Clinics (COCCC) collaborate with local WIC programs, stationing an outreach worker at the local WIC office to inform families about Healthy Families and Medi-Cal and help them complete an application for their children. This type of collaboration should become easier after the passage of AB 59 and SB 493.

Although most school-based programs, health facilities, and CBOs still conduct and participate in health fairs and other public events, they now view these events as opportunities to educate parents about health insurance for their children. These events are not seen as significant enrollment opportunities because few parents bring the documentation needed to complete an application. More often staff members who attend these events schedule enrollment appointments with parents who express interest in Medi-Cal or Healthy Families.

Use of Media and Communication

CBOs report that they use local media, including radio and community newspapers, as a primary outreach method. The Lao Family Center of Fresno and the Korean Health Education and Information Resource Center (KHEIRC) in Los Angeles report that they are able to use press releases and news stories to disseminate information, which is less expensive than purchasing advertisements. Many school programs use mailings to reach large numbers of potentially eligible children. Across California, more than 220,000 informational fliers were sent out to parents with the free and reduced lunch program application last fall. It is estimated that more than 50,000 forms have been returned.[23] When parents return these fliers requesting more information, they are contacted by outreach staff to schedule an appointment with an employee of the school district (HATS), a staff member from the project (Health Trust), or another local CBO that has agreed to assist them (Los Angeles Unified School District-LAUSD).

According to a number of organizations, word-of-mouth remains one of the most effective outreach strategies for these programs in tight-knit, ethnic minority communities. The HATS program hires parents to talk with other parents about their experiences. Communities that report positive experiences with Healthy Families initially have seen significant enrollment over time. According to KHEIRC, members of the Korean community in Los Angeles report that they have had positive experiences enrolling in Healthy Families. Many individuals who request application assistance from KHEIRC have heard about the program from other parents. Conversely, some analysts hypothesize that the initial experiences of African American families with Healthy Families were less positive, which may account for the disproportionately small number of African American children enrolled in Healthy Families.[24]

Use of Incentives

Nearly every program interviewed for this paper provides incentives to inform parents and encourage them to complete an application. Incentives typically include pens, pencils, magnets, cups, rulers, and posters advertising the programs. Due to the absence of data, it is not clear whether incentives have a positive effect on application rates. Incentives do appear to be helpful in generating responses to requests for information. As noted above, the HATS program distributes a brief survey about health insurance coverage to every child in a school. In elementary schools, they promise an ice cream party for each class that returns 100 percent of its surveys. They have found this incentive to be very effective, resulting in high completion rates

and teacher satisfaction. HATS also purchases small gifts for teachers to acknowledge their critical role in the process.

Outreach to Businesses

As the majority of uninsured children (81 percent) live in a family with at least one person in the workforce, businesses represent a promising, but largely untapped mechanism to reach potentially eligible children.[25] SAY San Diego, Partners for Community Access (PCA), and Health Trust have begun to approach local businesses to share information about Healthy Families and Medi-Cal with low-wage workers. SAY San Diego workers leave Healthy Families and Medi-Cal outreach information at the work site for employers to read and request information. In some instances, they have negotiated with the employer to make a presentation to employees at a staff meeting. Several other agencies indicated that they plan to pursue this strategy in the future. Data on the impact of these outreach activities with employers are limited.

Enrollment

Less is known about the critical factors that lead from interest to enrollment in Medi-Cal and Healthy Families. Currently, parents can mail in the joint application to Medi-Cal or Healthy Families for their children's coverage. Additionally, families may apply for Medi-Cal coverage at a local Medi-Cal office or at an outstationed site. At the state level, administrative data suggest that the majority of families who apply for coverage require assistance to complete the Medi-Cal/Healthy Families application. Overall, nearly two of every three (61 percent) applications to Healthy Families were completed with assistance. Evidence from Los Angeles County indicates that outstationed eligibility workers complete the majority of Medi-Cal applications. Between February 1997 and September 1998, more than two-thirds of new Medi-Cal applications were completed at community sites.[26]

Enrollment Sequence

Highlighting the difficulties in getting parents to make the transition from outreach to actual enrollment, PCA in San Diego reports that only 25 percent of its contacts result in an enrollment. Multiple strategies have been employed to generate actual enrollment in these programs. Clinic programs and CBOs usually schedule appointments with application assistants to help families complete the application. Some clinics have added evening and weekend hours to accommodate working parents. Others provide transportation vouchers and incentives. Despite these creative solutions, all of the agencies interviewed experience significant rates of missed enrollment appointments. Some clinic programs conduct vigorous follow up for families that miss their enrollment appointments. La Clinica Del Pueblo sends a *promotora* (community health worker) to visit families who miss their application appointment and to encourage them to return to the clinic to complete an application.

School programs have adopted different sequencing strategies to maximize enrollment. Most school-based programs operate in a number of schools simultaneously throughout the school year. In contrast, the Health Trust in Santa Clara County focuses its resources on a particular school until every potentially eligible child has been reached. During the active period, outreach workers are stationed at the school all day and in the evenings to meet with parents. Once they are finished at a particular school, they move on to the next school, planning to return to the initial school during the following school year. Another strategic decision for organizations with limited resources is whether to limit enrollment assistance to Medi-Cal and Healthy Families or

extend it to private insurance programs. Most agencies refer children to CaliforniaKids and Kaiser Permanente Cares for Kids if they are not eligible for Medi-Cal and Healthy Families. In addition, the Health Trust refers uninsured parents to a private insurance broker so that they can obtain coverage as well.

Productivity Standards

Productivity standards vary widely based on the type of program and where it is located. Urban, school-based programs reported the highest average monthly enrollments per full-time staff member. The HATS program estimates that the average full-time worker completes 25 applications per month, accounting for 50 children. Currently, the program employs seven full-time outreach workers. The Health Trust's six full-time outreach workers also complete approximately 25 applications each month. In contrast, United Indian Health and Services (UHIS) in Trinidad may complete 10 applications in a month. Given its low volume of applications, the clinic cannot justify a full-time CAA so it splits these responsibilities among several staff members.

Approval Rates

Representatives from several organizations recommend that Medi-Cal and Healthy Families improve their coordination and make the review of applications more consistent to facilitate the approval of all eligible applicants. Despite these concerns, every program has a mechanism in place to ensure that all of their eligible applications lead to enrollments. The Coalition of Orange County Community Clinics (COCCC) reports that 90 percent of the applications submitted with assistance from clinic staff are approved. COCCC provides ongoing training to outreach workers stationed at member clinics on Medi-Cal and Healthy Families and the latest policy developments. Outreach workers at SAY San Diego, HATS, and Health Trust call families approximately one month after their enrollment appointment to make sure that the application was successful. If the application was denied, staff members attempt to correct the problem, if possible.

Appropriate Use of Health Care Services

A primary goal of Medi-Cal and Healthy Families is to improve access to health care services for low-income children. Children who are uninsured are half as likely as those with public coverage to have a usual source of care.[27] Research also suggests that children's early physical and mental health is linked to school readiness and performance.[28] In California, however, there is little evidence to demonstrate the impact of enrollment in Medi-Cal and Healthy Families on children's utilization of health care services.

Recent outreach contracts at the state and county level have begun to require contractors to collect data on access to care, but it is not clear what proportion of children who enroll in health insurance actually establish a relationship with their primary care provider. According to Health Plan Employer Data Information Set (HEDIS) standards, individuals enrolled in managed care plans should be seen by their primary care provider within the first 120 days of enrollment. Even among established outreach and enrollment programs, the issue of access to care has only recently received serious attention.

Some of the most innovative organizations have begun to employ a variety of techniques designed to encourage the appropriate use of services by newly enrolled children. These techniques include:

- Contacting parents to remind them to schedule an appointment with their primary care provider;
- Providing written information about how to obtain care in a managed care system;
- Providing education and assistance in scheduling an appointment either in person or by telephone; and
- Maintaining a database to keep track of time a family is contacted.

Reminders and Follow-up
The most common technique to encourage families to access care is to have an application assistant contact the family 30 to 60 days after they have enrolled to remind them to make an appointment with their primary care provider and the dentist. Organizations contact parents by different means based on the number of children that they enroll each month and the size of their outreach staff. If an organization enrolls a large number of children each month, it is not feasible to have each child schedule another appointment to educate them on the use of the health system. Thus, larger organizations in urban areas are more likely to make telephone calls to newly enrolled families. Some smaller organizations with sufficient outreach staffs, such as La Clinica Salud del Pueblo, schedule parents to return for another appointment to educate them about the health system. In terms of organizational structure, some organizations assign one staff member to make all follow-up contacts with families, while others assign a group of families to each application assistant based on geography or who made the initial contact.

Written Information
The San Diego Kids Health Assurance Network (SD-KHAN) has developed a brochure that is distributed to all newly enrolled families to educate them about appropriate use of the health care system. The brochure contains information about managed care and how to make an appointment with the PCP. SD-KHAN distributes the brochures to local organizations that mail one to newly enrolled parents.

Appointment Assistance and Parent Education
If a parent is experiencing extreme difficulty in scheduling an appointment, some organizations actually contact their primary care provider while they are on the line with the parent to schedule one for them. Outreach workers at the San Francisco Health Plan will contact a provider on behalf of the parent to schedule an appointment for children who do not know how to access services. The Pasadena Department of Health refers newly enrolled parents to a course organized by a local CBO that teaches parents how to use the health care system and helps them to collect important information about their children's health in a single binder.

Client Tracking Systems
All of these follow-up strategies require an information system that contains accurate contact information and their application status. A client tracking system facilitates ongoing contact with the family. Although the names of the health plan and primary care provider are listed on the

Medi-Cal/Healthy Families application, many organizations do not transfer this information into their tracking systems. This omission limits their ability to encourage access to care. The COCCC, SAY San Diego, and HATS now collect and analyze this information. The Health Trust recently conducted a telephone survey of parents of newly enrolled children. They found that an astonishing 95 percent of children that they had enrolled reported seeing a provider within the first 90 days of coverage.

Retention

Due to the voluntary nature of health insurance in the United States, the challenge of retaining coverage impacts every segment of the health insurance system. The retention of benefits over time is important to establish continuity of care. In the absence of continuous coverage, insurance programs become another financing mechanism to pay for episodic care when children are ill. In addition, under Healthy Families, children can be locked out of coverage for six months if they are disenrolled.

According to the most recent published data, only about one in three (37 percent) of families with children that qualify for Medi-Cal due to their income levels remained enrolled after 12 months.[29] Medi-Cal retention rates for children should improve with the elimination of the quarterly status report and 12-month continuous eligibility for children. Retention rates in Healthy Families are considerably higher at about 75 percent at 12 months after enrollment, which is comparable to private health insurance coverage.[30] Of the 681,000 children who have enrolled in Healthy Families since its inception, 212,000 have disenrolled from the program. In 2001, on average, 12,000 children have disenrolled each month. Of these, approximately one in three disenrollments were considered to be unavoidable.[31] MRMIB considered two-thirds of disenrollments to be potentially avoidable, as they were the result of nonpayment of premiums or failure to complete and return AER information. The efforts described here all focus on potentially avoidable disenrollments.

Each stage in the re-enrollment process is essential for children to maintain coverage. These stages include:

- notification;
- reapplication;
- eligibility redetermination;
- client tracking and application; and
- measurement of re-enrollment and retention.[32]

State and County Roles

State and county agencies assume much of the responsibility for notifying families when they are due for the AER process under Medi-Cal and Healthy Families. For a child enrolled in Healthy Families, MRMIB sends a notice to families 60 days before a child's coverage expires. They send a second notice 30 days before termination and make a follow-up phone call 10 days prior. Families must complete the reapplication and submit it to the state, which determines whether or

not they are still eligible based on the information provided. MRMIB has begun to track the reapplication process and collect data on re-enrollment and retention rates.

For children enrolled in Medi-Cal, the county Medi-Cal office will send a redetermination form to be completed and returned by the parents. Typically, they will send reminder notices to the parents to complete and return the forms. Because Medi-Cal families tend to move frequently, they may not receive this information. Depending on the county, eligibility workers may call the family to help them complete the process. If the state does not receive a completed redetermination form, the child is dropped from coverage.

The implementation of SB 87 should improve retention in Medi-Cal and Healthy Families. One objective of the law is to improve communication between county Medi-Cal and welfare offices, managed care plans, and beneficiaries. The law requires the state to shift individuals to Medi-Cal-only programs such as 1931(b) and Transitional Medi-Cal when they move off of welfare. Counties also must send information to beneficiaries to help them understand and navigate the redetermination process. Finally, the law requires the county to notify a beneficiary's health plan when eligibility is being redetermined. With this information, the health plan can remind families to complete their forms and provide assistance. This combination of policy changes may prevent unnecessary disenrollment.

Reminders

Local organizations play a facilitating role in the retention of coverage. Several programs reported that they contact families at least three times over the course of a year to follow up on enrollment status, answer any questions about the use of services and managed care, and prepare families for the AER process. This frequent contact allows the organization to build an ongoing relationship with the client. The Health Trust and the HATS program in San Diego have developed tracking sheets that remind the outreach worker to follow up with every family at the time of AER process. Once they contact the family, they repeat the steps in the enrollment process. First, they ensure that the families have received notification from the state and answer general questions about the process. If necessary, the outreach worker can help families complete the reapplication form. As they do with enrollment, these organizations track the reapplication process and measure the retention rate for their clients.

Advance Payment of Premiums and Change of Address Forms

In an attempt to address the single most cited reason for discontinuing coverage, non-payment of premiums, application assistants for the Health Trust encourage families with children in Healthy Families to pay for nine months at the time of enrollment. Prepayment will eliminate the need to make monthly premium payments. The SD-KHAN has developed a brochure that contains information about paying Healthy Families bills, the AER, and contact information if families experience problems with the program. It also includes a pre-addressed form that allows families to notify MRMIB about any changes of address. The brochure is mailed to every family as they enroll in the program. They have not yet evaluated the impact of the brochure on retention.

Passive Support Systems

In certain close-knit ethnic communities, CBOs have developed such a strong reputation that they support the re-enrollment process solely by reacting to client's inquiries. For example, KHEIRC does not call its clients to alert them to AER; instead, they wait for clients to call them

and respond to their inquiries. Statewide, rates of disenrollment from Healthy Families among the Korean population are lower than among other ethnic groups. Without more information, it is not clear whether this is due to demographic differences in the Korean population, efforts of agencies such as KHEIRC, or some other factors. This passive arrangement appears to be the exception rather than the rule.

Creating a Sustainable Infrastructure to Support These Activities

The importance of developing strong relationships with families over time emerged as a common theme in these interviews. Most programs view the application process as more than a single transaction. It is the beginning of at least a one-year relationship that will include multiple contacts. In order to establish these relationships, programs report that they need to have a sustainable infrastructure, which includes data and tracking systems, long-term funding, ongoing training, and action-oriented collaboration. Staff members from numerous programs recognize that counties and the state play important roles in creating and supporting their program's infrastructure.

Client Tracking and Management Information Systems

This analysis highlights the need to develop excellent data collection and tracking systems to address enrollment, access, and retention issues in a systematic manner. Without the appropriate data tracking systems in place, it is nearly impossible to develop an ongoing relationship with newly enrolled families. Based on the experiences of these organizations, a data system does not need to be complex. Many organizations have developed them using Microsoft Access or other commercial software packages. It does require an investment of time and money. Partners for Community Access hired a computer consultant to create their client-tracking database. Once created, the database increases an organization's ability to track families over time, generate important management reports, and facilitate evaluation of their efforts. As part of its Healthy Kids, Healthy School project, Consumers Union has commissioned consultants to develop a customized database application that can be used to track outreach, enrollment, and retention. *Healthy Tracker* is a stand-alone database built on the Filemaker Pro system that is ready to use. Consumers Union plans to distribute the database on CD free of charge to interested outreach entities beginning in March 2002.

In most organizations, information is collected from a variety of sources. Some is collected from the parent, while other information is extracted from the completed application. For example, the Health Trust collects demographic and contact information from the family, including primary language, number of children in the family, and contact information. The tracking sheet is updated after each contact with the family during the course of the year. The outreach worker also enters the name of the health plan, the referral source, the date the application was completed, the date it was approved, and the outreach worker's own identification number from the application. For each child in the family, they enter:

- name;
- Social Security number;
- date of birth;

- program enrolled in;
- effective date of coverage; and
- dates he or she accessed health care and dental care.

In addition to individual client tracking, several programs generate regular management reports to monitor enrollment and financial trends. Several organizations and collaboratives are engaged in continuous quality improvement. They produce regular reports that allow them to evaluate the effectiveness of particular strategies and to revise them accordingly. Typical revisions include changes in outreach activities, additional staff training, and process improvements. For example, a supervisor in the SAY San Diego program tracks the number of applications completed, enrollment rates, and retention rates for each staff member to provide a snapshot of their productivity and the overall effectiveness of the organization's strategies. This supervisor also analyzes denial rates to determine if there is a need for additional staff training on a particular issue.

Long-term, Sustainable Funding

The lack of sufficient and sustainable funding presents a major challenge for all local organizations involved in these activities. Although there are multiple sources of funding from federal, state, local, and private sources, the competition for outreach funds is intense. During the current fiscal year, DHS funded 30 community outreach programs and 25 school-based programs, and 2 organizations to conduct training. The California Endowment will provide $3 million to support outreach and enrollment efforts in Los Angeles County. Counties represent an additional funding source for outreach activities. They can fund activities with county funds or pass through federal or state funds to CBOs. For example, Los Angeles County's Department of Public Social Services awarded more than $20 million to CBOs to facilitate health insurance coverage among individuals leaving welfare in its Long-Term Family Self Sufficiency (LTFSS) program.

Outreach and enrollment projects highlighted in this report have budgets that range from $17,000 to $1.1 million per year. As a reference, only one-quarter of organizations awarded a contract from DHS in 1999-2000 received more than $100,000.[33] Although organizations are eligible to receive $50 per successful application and $25 per successful renewal if they do not have an outreach contract with the state, timely payment of these funds has been problematic since the inception of the program.[34]

Financial uncertainty can cause institutional instability, which leads to high turnover among staff and the loss of institutional knowledge. A previous evaluation of state outreach contractors found that projects had more success if they were able to initiate activities in the face of late contracts or cash flow problems.[35] Unfortunately, late contracts and delayed payments appear to be chronic problems for DHS. Contracts for the fiscal year beginning July 1, 2001, were late in being finalized, and organizations only received funds in January 2002. While many organizations have begun to implement activities under the contract using their own funds, others have decided to wait until the funds are available. Partners for Community Access did not begin to implement its state contract until funds were made available. The two-year grant cycle should

alleviate some of the negative impacts caused by the state's delay, but it will not address the underlying instability caused by cyclical grant funding.

It is important to acknowledge the fragile financial status of many CBO outreach projects. They are very susceptible to sudden shifts in funding, which can virtually eliminate successful programs from one year to the next. Last year, the Lao Family Center of Fresno employed two full-time staff members in its outreach project, enrolling 50 children in Medi-Cal and Healthy Families each month. This year the program lost nearly all of its outreach and enrollment funding. The remaining staff member will continue to provide these services on a very limited basis, but all momentum has been lost. The program will only help families to complete their applications when requested and will not be able to track and support families that have been enrolled previously.

Ongoing Training

To a large extent, Medi-Cal and Healthy Families rely on CAAs to help families complete and submit applications. Nearly two-thirds (61 percent) of Healthy Families applications were completed with assistance. Thus, CAAs play an important role in a decentralized enrollment system. However, due to low pay, long hours, and the uncertainty of future funding, the turnover rate among CAAs is very high. As a result, the state has difficulty maintaining an accurate list of CAAs. County Departments of Health provide training for CAAs stationed at public and private agencies. For example, the Los Angeles County Department of Health Services has contracted with the National Health Foundation's CHAMP program to provide ongoing training for all of its financial screeners at health facilities.

Local programs find the need to implement continuous training programs to train new and continuing staff members. The National Health Foundation in Los Angeles and the Child Abuse Prevention Council of Sacramento each received a $100,000 contract to provide training for CBOs. The California Rural Indian Health Board (CRIHB) holds monthly conference calls with all outreach workers at all Indian Health programs throughout the state. On these calls, CRIHB staff answer technical questions about the programs, update staff on any policy changes, review Medi-Cal/Healthy Families enrollment and retention statistics for American Indian children, and organize guest speakers from DHS and MRMIB. In addition, one issue of CRIHB's managed care newsletter, *Tuesdays with Turtle*, is dedicated to Medi-Cal and Healthy Families outreach and enrollment issues each month. The COCCC provides its own ongoing training for workers at member community health centers. They report difficulty filling vacant positions.

Collaboration

Collaboration is essential for outreach, enrollment, and retention. Most counties in the state have created a coordinating committee for Medi-Cal and Healthy Families outreach and enrollment. Collaboration typically functions under a formal agreement between an organization and its collaborating agencies that include a detailed description of services provided and expected activities.[36] In order to be meaningful, collaboration has to be action-oriented. More successful collaboration appears to occur when it is focused on action items and has the full support of collaborators.

Counties play a critical role in supporting collaboration. Many counties have developed networks of public and private organizations that are involved in children's health insurance with the

primary aim of sharing information and coordinating their efforts.[37] The San Diego Kids Health Assurance Network (SD-KHAN) represents an example of the benefits of these collaborative structures. They have developed innovative materials to support access to care and the retention of benefits, which they share with all members of the network. In addition, they have developed a supplemental program using volunteer physicians to provide free primary care services to children who do not qualify for Medi-Cal or Healthy Families.

Counties also can provide funding and technical support to encourage CBOs to participate in Medi-Cal/Healthy Families outreach and enrollment activities. In San Mateo County, there were no CBOs conducting outreach and enrollment activities. In order to expand the scope of its outreach efforts, the County Health and Human Services Agency has distributed a portion of its state outreach contract to four CBOs located in different areas within the county. Currently, the department is providing training about Medi-Cal and Healthy Families and technical assistance to these CBOs as they launch outreach programs. This model may represent a useful strategy for rural counties that may not have numerous CBOs active in the health sector.

Functionally, it is important to specify the exact nature of the collaboration through a Memorandum of Understanding (MOU) between the partners. An MOU simply defines the nature of the relationship between the organizations and what is expected from each. For example, a Bakersfield City School District project expects each school district to provide a phone, a desk, and a private place for the outreach worker to work so that they can help families enroll children in these programs. MOUs can be more complex depending on the relationship between the organizations. They can address confidentially of records, information sharing, and supervision responsibilities. MOUs are very common among these programs and appear to minimize conflicts that may arise about roles and responsibilities.

Some organizations report that they faced competition from other enrollment entities within their service area. In some cases, the competition results from the insecure funding cycles described above. In other cases, it reflects organizational and cultural differences between public and private institutions. Where possible, these organizations have attempted to collaborate in an effort to define responsibilities and minimize competition, with some limited success.

Lessons Learned

Despite considerable variation in specific activities undertaken by individual programs, some common themes emerge from this qualitative analysis that are applicable for state and county policy makers:

- **Successful outreach and enrollment programs at the local level build an ongoing relationship with the family to help them obtain insurance, use services appropriately, and retain coverage over time.**

  As noted in previous evaluations of outreach programs, the most critical aspect of successful outreach is the cultivation of a positive relationship through approaches that build and maintain the trust of the target population, address applicants at a reachable and teachable moment, and provide personalized guidance as they navigate the system.[38]

- **More rigorous evaluations of outreach, enrollment, access, and retention programs are needed to determine which activities are most successful.**

  To date, few of these programs have been subjected to formal evaluations. In the absence of rigorous evaluations, it is difficult to determine which aspects of a program are effective and which are not. The lack of data makes it difficult to target resources appropriately and replicate successful programs. Given the state's significant financial investments in outreach and health insurance coverage, it has a strong incentive to determine the cost-effectiveness of its efforts. It is important to note that this is a qualitative study, presenting the experiences and perceptions of these organizations about their activities.

- **To date, there has been limited dissemination and replication of these strategies throughout the state.**

  This project identified several instances where multiple organizations have developed the same strategy independently, starting from scratch. This evidence suggests that there is poor diffusion of innovation occurring. This is not surprising given that local organizations are very focused on ensuring the success of their own project. They do not have the time or resources to disseminate information about promising strategies. County collaboratives and advocacy organizations such as Consumers Union, the 100 Percent Campaign, and Community Health Councils, Inc. have begun to develop information and conduct workshops to help other organizations replicate promising strategies. These efforts needed to be expanded dramatically to meet the needs of the entire state.

- **There is a need at the state level to determine whether Medi-Cal and Healthy Families enrollment is associated with more appropriate use of health care services by children.**

  The state has an obligation to understand the effectiveness of these efforts in improving access to health care and health outcomes among low- and moderate-income children. The California HealthCare Foundation recently awarded grants to research organizations throughout the state to measure access to health care for children enrolled in these programs. Preliminary results are expected by the end of 2002.

- **The lack of sufficient and sustainable funding presents a major challenge for local organizations involved in these activities.**

  Although multiple sources of funding are potentially available from federal, state, local, and private sources, the competition for outreach funds is intense**.** Organizations that receive contracts from the state face lengthy delays in finalizing contracts and receiving payments. Financial uncertainty can cause institutional instability, which leads to high turnover among staff and the loss of institutional knowledge.

- **Due to high turnover rates among certified application assistants, local programs have implemented continuous training programs.**

To a large extent, Medi-Cal and Healthy Families rely on CAAs to help families complete and submit applications. Nearly two-thirds (61 percent) of Healthy Families applications were completed with assistance. Thus, CAAs play an important role in a decentralized enrollment system. However, due to low pay, long hours, and the uncertainty of future funding, the turnover is very high among CAAs. Many programs are conducting ongoing training programs to maintain a consistent supply of trained workers. Despite these efforts, programs report that they have a difficult time filling vacant outreach positions.

Appendix A: List of Organizations Interviewed

Table A1: List of Organizations Interviewed

Project or Program Name	County	Target Population (Race/Ethnicity and Location)	Type of Program
Coalition of Orange County Community Clinics	Orange	Predominantly Latino Urban	Clinics
La Clinica Salud Del Pueblo	Imperial	Latino Rural	Clinic
Partners for Community Access (PCA)	San Diego	Predominantly Latino Urban	Clinics
United Indian Health and Services	Humboldt	American Indian Rural	Clinic
Bakersfield City School District	Kern	Predominantly Latino Rural	Schools
Health Access Through Schools (HATS)	San Diego	Predominantly Latino Urban	Schools
The Health Trust	Santa Clara	Latino Urban	Schools
Los Angeles County Department of Health Services	Los Angeles	Multi-ethnic Urban	Schools, Health Facilities, CBOs
Pasadena Department of Public Health	Los Angeles	Multi-ethnic Urban	Schools
Korean Health Education and Information Resource Center	Los Angeles, Riverside, Orange, San Bernardino	Korean Urban	CBO
Lao Family Center of Fresno	Fresno	Laotian Rural	CBO
San Mateo County General Hospitals and Clinics	San Mateo	Multi-ethnic Urban	CBOs
SAY San Diego	San Diego	Predominantly Latino Urban	CBO
California Rural Indian Health Board	Statewide	American Indian Rural	Collaborative
Community Health Councils, Inc.	Del Norte, Humboldt, Lake, Los Angeles, San Diego, and Trinity	African American/Latino Urban and Rural	Collaborative
Consumers Union	Los Angeles, Kern, Santa Clara	Urban and Rural	Collaborative
San Diego Kids Health Assurance Network (SD-KHAN)	San Diego	Urban and Rural	Collaborative

Notes

1. E. Richard Brown, Jennifer Kincheloe, and Hongjian Yu. "Health Insurance Coverage of Californians Improved in 1999—but 6.8 Million Remained Uninsured." UCLA Center for Health Policy Research. Los Angeles, CA. February 2001.

2. Brown, Kincheloe, and Yu. February 2001.

3. E. Richard Brown, Ninez Ponce, and Thomas Rice. *The State of Health Insurance in California: Recent Trends and Future Prospects.* UCLA Center for Health Policy Research. Los Angeles, CA. March 2001.

4. Halfon, Inkelas, DuPlessis, Newacheck. March/April, 1999.

5. Medi-Cal Policy Institute. April 2001.

6. Medi-Cal Policy Institute. April 2001.

7. California Health and Human Services Agency, Department of Health Services and Managed Risk Medical Insurance Board. *Report on Streamlining Application and Enrollment for the Healthy Families Program and Medi-Cal for Children.* Sacramento, CA. June 2001.

8. The 2001-02 state budget provides $1.3 million to support the statewide implementation of the Health-e-App project.

9. California Health and Human Services Agency, June 2001.

10. 100 Percent Campaign. "Express Lane Eligibility: How California Can Enroll Large Numbers of Uninsured Children in Medi-Cal and Healthy Families." Santa Monica, CA. February 2000.

11. California Health and Human Services Agency. June 2001.

12. Governor Gray Davis. "Highlights from the 2002-2003 Governor's Budget." Sacramento, CA. January 2002.

13. Child and Adolescent Services Research Center. *Evaluation of Outreach and Education Campaign for Healthy Families Program and Medi-Cal for Children: Final Report.* March 2001.

14. 100 Percent Campaign. "Community Voices: Medi-Cal/Healthy Families and Community Outreach: Promising Progress and Directions for Change." Report #6, March 2001.

15. 100 Percent Campaign. March 2001.

16. Department of Health Services. "Healthy Families/Medi-Cal for Children Outreach: Request for Application." Sacramento, CA. March 2001.

17. Department of Health Services. March 2001.

18. More information about potential strategies to establish a school-based outreach program can be found in Healthy Kids Healthy Schools. *Healthy Kids Make Better Learners: A Guide to School-Based Enrollment in State-Sponsored Health Insurance Programs.* San Francisco, CA: Consumers Union. November 2001.

19. Halfon, Inkelas, DuPlessis, and Newacheck. March/April 1999.

20. Child and Adolescent Services Research Center. March 2001.

21. Child and Adolescent Services Research Center. March 2001.

22. Child and Adolescent Services Research Center. March 2001.

23. Personal communication with Anna Diaz, DHS School Connections Program, September 10, 2001.

24. The Community Health Council, Inc. is conducting research to understand the low participation rates among African Americans in Healthy Families in Los Angeles County. This trend mirrors data at the state level.

25. Brown, Ponce, and Rice. March 2001.

26. County of Los Angeles Department of Public Social Services. "We've Got You Covered-Los Angeles County." Los Angeles County, 2000.

27. Agency for Healthcare Research and Quality. "Children's Health 1996: MEPS Chart Book Number 1." Agency for Healthcare Research and Quality. Washington, DC. 2001.

28. Child Trends. "School Readiness: Health Communities Get Children Ready for Schools and Schools Ready for Children." August 2000.

29. Insure the Uninsured Project. *Trends in Health Financing and Coverage in California 1996-2001.* Santa Monica, CA. January 2002.

30. MRMIB. "Retention in the Healthy Families Program," which can be found online at www.mrmib.ca.gov/MRMIB/Healthy Families/Retention.

31. In this report, "unavoidable" is defined by MRMIB as (1) applicant request, (2) child reached 19 years of age, (3) Immigration documents were not provided within 30 days, or (4) child was determined not to be eligible at AER.

32. National Governors' Association. "Retention and Reenrollment in SCHIP and Medicaid." Washington, DC. 2001.

33. Child and Adolescent Services Research Center. March 2001.

34. Department of Health Services. “Third Annual Report to the State Legislature.” Sacramento, CA. 2001.

35. Child and Adolescent Services Research Center. March 2001.

36. Department of Health Services. 2001.

37. Many other counties such as Solano, Santa Clara, San Francisco, Orange, Kern, and Contra Costa have developed collaborative networks to stimulate enrollment in Medi-Cal and Healthy Families. These programs have been described elsewhere.

38. Child and Adolescent Services Research Center. March 2001.