"SCHOOL OUTREACH PILOT PROGRAM: LESSONS LEARNED FROM THE CHICAGO PUBLIC SCHOOLS" – MAY 25, 1999

HIGHLIGHTS OF THE TECHNICAL ADVISORY PANEL MEETING #7
(DISTRICT OF COLUMBIA, ILLINOIS, MICHIGAN, NEVADA, AND SOUTH CAROLINA)

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"School Outreach Pilot Program: Lessons Learned from the Chicago Public Schools (CPS)" - May 25, 1999 Highlights of the Technical Advisory Panel Meeting #7 (District of Columbia, Illinois, Michigan, Nevada, and South Carolina)

Opening Remarks

Mr. Marty Svolos, the Director of the Health Care Financing Administration's (HCFA) Division of Eligibility Enrollment and Outreach, Families and Children for the Center for State Medicaid and State Operations, opened the Technical Advisory Panel (TAP) meeting. He noted that outreach is a key aspect to enrolling eligible children into States' Children's Health Insurance Programs (CHIP)/Medicaid programs. Therefore, the Federal government and States must develop and implement effective outreach strategies that market and advertise CHIP. One way that the Federal government is assisting States is by sponsoring TAPs that focus upon priority issues identified by the States, such as the role schools can play in CHIP/Medicaid outreach. Schools are where there children are and, thus, are logical sites for States' outreach efforts. He noted that the program for this TAP focuses upon two major areas:

- Hearing first-hand from Illinois State representatives and Chicago Public Schools (CPS) personnel of the lessons learned from the outreach pilot project of the CPS; and
- Learning various facets of school-based outreach programs from the experience of other invited States-the **District of Columbia, Michigan, Nevada, and South Carolina**-as well as the insights from the education community and advocates on the necessary components of a comprehensive outreach program through schools.

Mr. Solvos then turned the meeting over to the co-chairs of the TAP, Dr. Lillian Gibbons, HCFA, and Ms. Carol Galaty, Health Resources and Services Administration (HRSA). Each of the co-chairs welcomed TAP participants (see **Attachment 1** for a listing of TAP attendees) and indicated their excitement at the significant progress States are making in the outreach arena, such as their use of schools for outreach and enrollment of eligible children into CHIP/Medicaid.

Lessons Learned from the Chicago Public Schools Pilot Program (with Questions and Answers Session)

Ms. Faith Covici, *Outreach Specialist with HCFA's Chicago Regional Office*, began the discussion by introducing the panel members: Ms. Juanita Martinez of the CPS; Ms. Denise Taylor of the CPS; and Ms. Beverly Hoffman of the Illinois Department of Public Aid. She then gave a short background history. The HCFA Chicago Regional Office, the CPS system, and the State of Illinois have been partners in the development and implementation of the CPS pilot project since early 1998. The CPS pilot project for outreach was highlighted in the White House Interagency Report, released in June 1998, describing its three goals:

- To use mapping strategies to target outreach strategies to identify uninsured children;

- To implement innovative outreach strategies in schools that other school districts can replicate; and
- To implement specific enrollment strategies.

The CPS pilot project has accomplished these goals through a variety of activities. Each of the panel representatives shared their experiences, with the many challenges and successes of implementing the CPS pilot project. The following provides highlights of the lessons learned and successes from this model.

Mapping Strategies/Data Issues

Ms. Juanita Martinez, *Administrator of the Health Services Management Program for CPS within Specialized Services*, discussed mapping strategies and data issues associated with the CPS pilot project.

- The CPS system had an enrollment of 430,000 children in 1998-1999, including a special needs population of approximately 55,000. One of the first issues addressed by the CPS system was the seeming lack of coordination between the free/reduced lunch program and Medicaid (KidCare[1]) databases that could be used effectively to target potentially eligible low-income children and their families.
  - Of the 430,000 enrolled children, approximately 84 percent received free/reduced lunches, in contrast to the 50 to 55 percent that were identified as enrolled in Medicaid. These percentages appeared to highlight an overlap between databases, enabling CPS to target children potentially eligible for but not enrolled in KidCare.
  - Illinois has an interagency agreement among the Departments of Education, Human Services (DHS), and Public Aid (DPA) that enable the CPS system and the Medicaid office to exchange data.
- The CPS system used mapping databases to geo-code demographic variables that highlighted geographic concentrations of the targeted populations. Armed with such information, the CPS pilot project was able to target its outreach campaigns to specific geographic areas and ethnic bases.

Application for Free/Reduced Meals

In a related effort, the CPS system, in cooperation with the State Department of Agriculture, amended the application for free/reduced meals.

- A section requesting the parent's signature to release information to other government agencies to determine eligibility for free or reduced health insurance was highlighted. The application was accompanied by a brightly colored flyer, created in English and Spanish, that

[1] Illinois refers to all of its public assistance health insurance programs for children and pregnant women as KidCare. The KidCare programs include: KidCare Assist Plan (Medicaid), KidCare Share Plan (low co-payment), KidCare Premium Plan (low monthly premium and low co-payment), KidCare Rebate Plan (reimbursement of part of the cost of health insurance), and KidCare Moms and Babies (Medicaid).

explained the procedure. The CPS system received 98,000 applications with sign-off to share information.

Presumptive Eligibility

Ms. Beverly Hoffman, *Public Service Administrator with the Illinois Department of Public Aid (DPA)*, discussed the State of Illinois' use of presumptive eligibility as "a carrot" to encourage eligible families to apply for KidCare.

- DPA conducted a pilot test to determine how well a modified version of the Medicaid presumptive eligibility of pregnant women would work with children. However, the number of responses from the families of presumptively eligible children was not encouraging.
  - The pilot test consisted of 150 children within the CPS system, of whom 52 were already enrolled into CHIP or Medicaid in early December 1998. The remaining 98 children were presumptively enrolled into Medicaid[2] for a 60 day period and the families were required by the State to submit a completed Medicaid application in order to receive continued benefits for a twelve month period. By the end of January 1999, the State had received completed applications for 8 children, which increased to a total of 17 by the end of February 1999.
- Dramatic changes have been made to the KidCare Program since the pilot project, including:
  - The application has been shortened to four pages;
  - DPA has partnered with KidCare Application Agents to help families fill out the applications and provide technical assistance payments for complete applications that result in new enrollment.
  - Enrollments in the program have increased from 26,345 to nearly 60,000;

Given the different landscape, DPA is working with CPS to consider a modified model enrollment project using the presumptive eligibility authorization. The State is confident that a better response would be received now, given the outreach efforts and work with community groups and KidCare Application Agents.

Report Card Pick Up Days

Ms. Denise Taylor, *Director of the CPS project Healthy Kids, Healthy Minds,*[3] discussed the Report Card Pick Up Days, an integral component of the CPS pilot project. With only a month of lead time to plan and organize the initial outreach initiative, CPS personnel optimistically hoped that thousands of children would enroll into KidCare during the November 4-5, 1998 period. However, the number of children enrolled into KidCare was less than expected (see below for actual results). Broad lessons learned from this experience included:

[2] Presumptive eligibility was used for enrollment into the Medicaid program only. The State decided not to use presumptive eligibility for CHIP because of its concern that families could unknowingly be placed into a situation of being responsible for co-payments and premiums.

[3] The *Healthy Kids, Healthy Minds* program works with 219,000 uninsured and under-insured children within the CPS system to provide linkages to other community groups and providers that offer free, or low-cost, health care services.

- Providing only a CHIP/Medicaid application is inadequate for effective outreach;
- Planning and organizing take more time than originally anticipated; and
- States should not try to do outreach alone or with just one group; rather, a variety of partnerships that reinforce the outreach message must be found.

With these broad lessons in mind, Ms. Taylor then described the various aspects of the CPS pilot project, including the results of school-based outreach/enrollment campaign on November 4-5, 1998 and April 14-15, 1999.

- **The CPS Pilot Program Structure**. The CPS pilot program has had top-level commitment from the beginning, including the support of Mr. Paul Vallas, the Chief Executive Officer of the CPS system.
  - ◊ The CPS system utilizes the "built-in" resource of professional groups on staff that have the expertise and sensitivity to assist families, including some 360 school nurses, 300 social workers, and 300 counselors placed in the system's 600 schools.
- **Why the Report Card Pick Up Days Were Chosen for the Initial Outreach Effort**. The CPS system viewed the Report Card Pick Up Days as an ideal opportunity to "kick-start" a public awareness campaign for KidCare by distributing literature and assisting enrollment in *every* school since the CPS system requires parents to physically enter the school and personally attend a teacher/parent conference to pick up their child's report card. Some of the CPS schools have a 90 to 95 percent parent participation rate.
- **Project Organization**. The CPS system consists of six regions, with each region having an Administrator and approximately 100 schools. CPS pilot project organizers met with each region to mobilize personnel and solicit "buy-in," including meetings with school principals, school nurses, social workers, and other allied health staff.
  - ◊ An inter-disciplinary Task Force was established at the CPS Central Office and met regularly. The Task Force used a team approach, with representation from key CPS departments. The Task Force was perceived as a vital component of the CPS pilot project.
- **Raising Awareness of the Initiative**. A diverse array of outreach activities occurred within a short time frame. These activities included, but were not limited to: reproducing and mailing KidCare applications[4] to targeted families' homes; creating flyers and information sheets about KidCare in six languages[5]; using an automatic calling system to remind parents of the Report Card Pick Up Days and the availability of assistance to enroll into KidCare; and advertising the outreach effort on ethnic radio stations, in newspapers, and at press conferences.

[4] Illinois implemented CHIP in August of 1998. The State had difficulty providing the CPS system with enough applications quickly because of the newness of the program and because the CHIP applications were printed in color (as opposed to black and white text) requiring more time to print and produce.
[5] While the CPS system produced flyers and information sheets in six languages, the Illinois Medicaid program only accepts CHIP/Medicaid applications in English and Spanish. The intent of the CPS system was to inform families of the availability of KidCare for their children, as well as the steps needed to be taken to apply.

- ◊ Because the CPS system was the one of the few groups advertising KidCare, many individuals perceived KidCare as a CPS-sponsored program. For example, the CPS system received calls from families asking if their applications had been approved yet. From this experience, the CPS pilot project personnel noted the importance of building partnerships in order to minimize the public's confusion.

- **School Coordinators**. At the school-level, the CPS pilot personnel believed it important for each school principal to designate a coordinator to be a resident KidCare expert. The CPS pilot project provided each coordinator with a $100 stipend. Schools were required to make phones, photocopiers, and space available and to display posters/buttons to advertise the campaign.
  - ◊ States replicating the CPS outreach model should discuss with schools their expectations for the coordinator, emphasizing that the coordinator must have a daily presence in the school.

- **Training**. CPS personnel, with the Illinois DPA, conducted a massive training session in one week for approximately 2,000 volunteers. This training is being refined as the CPS pilot project matures and experience is gained. In fact, training is offered repeatedly to provide more advanced enrollment information, Individual Development Plan of Action (IDPA) updates, and opportunities for new staff to get on board.

- **Obstacles with School Staff**. At the school level, some staff initially reacted by saying that they already had enough to do; that they were not insurance agents; or, that they were unable to understand the twelve-page application themselves, let alone explain it to someone else. Another issue confronted was the concern of staff working with immigrant families that they would somehow unwittingly be placing a family member in jeopardy (the "public charge" issue). Each of these concerns are being addressed, in part by building a trusting relationship between the CPS pilot staff and the school staff and with the subsequent "public charge" clarification from the Immigration and Naturalization Service.

- **Results of the November 4-5, 1998 Report Card Pick-Up Days**. On November 4-5, 1998, the CPS pilot project mobilized over 2,000 school employees and volunteers in every school to assist families with KidCare enrollment. A 1-800 help line[6] (referred to as KidCare Central), with 30 phones, was implemented in CPS headquarters and staffed by CPS and DPA employees to answer callers' questions. While fewer children were enrolled into KidCare than anticipated, the CPS pilot project did "kick-start" the process of raising public awareness about the program.
  - ◊ Of the 219,000 eligible children for KidCare, approximately 4,600 applications, representing about 14,000 children, were received. Of the 4,600 received applications, only about 1,000 to 1,200 were approved for medical benefits. Reasons for the low approval rate included:
    - ➢ Some families did not fully complete the applications because they did not understand the 12-page form or the concept of health insurance;

[6] Phone calls to the 1-800 number increased by 50 percent during the November 4-5, 1998 period and remained at an increased level. This occurred again with the April 1999 Report Card Pick Up Days initiative.

- Some families signed and dated the applications before they were complete; and
- Some immigrant families, while submitting a completed application, withdrew their applications when the DPA sent letters requesting verification documentation of their immigrant status.

CPS Pilot Program Lessons from the State's Perspective

Experience gained from the CPS pilot program provided the following lessons that other States should consider:

- Once applications "hit the street," a State has no control over when they will be returned. Illinois is still receiving applications from the November 4-5, 1998 outreach/enrollment campaign.
- Illinois tracked applications through a number assigned to the CPS system and by color-coding the applications (gray).
  - Color-coding will not work since some schools make copies of the application.
  - Illinois assigned a single number to the CPS system as it would be difficult to track the specific performance results of 600 schools.
- Illinois received multiple applications per family, as their children attended different schools.
- States should staff appropriately in anticipation of an influx of applications. Illinois created a temporary central unit and trained staff, including staff from the outlying counties as back-up.
- Consequently, Illinois has implemented a permanent central unit/site to conduct KidCare eligibility, increasing uniformity in how applications are processed.
- Families' addresses can change frequently during the school year and many families do not have telephones, making it difficult to contact them for follow-up.
- Initially, Illinois had a 12-page application. However, based on input from providers and advocacy groups, the State learned that the application was daunting to eligible families. In response:
  - Illinois reorganized and shortened the application to three pages (front and back).
  - Illinois clarified that adults applying did not have to submit a social security number.

Changes for the April 1999 Report Card Pick Days

After a disappointing showing in the November Report Card Pick Up Days the lessons learned in November were applied and several major changes were made for the April 1999 Report Card Pick Up Days, including:

- The CPS system provided follow-up for the completion of the applications having learned that the dissemination of flyers and applications alone was inadequate.

- ◊ They implemented six regional centers where families can walk in to obtain assistance. They are working with community-based organizations (CBOs), providers, and faith communities to provide assistance to individuals for whom other sites are more comfortable or convenient.

- The CPS system hired personnel centrally to review every application received from the school-based coordinators for completeness and consistency (they do not determine eligibility). Incomplete applications are returned to the school-based coordinator or one of the six regional centers for follow-up.
  - ◊ From the middle of April to the end of May 1999, the central staff reviewed 3,000 applications. Some 80 percent were initially deemed incomplete. By the end of May 1999, 1,000 applications had been forwarded for eligibility determination.
- Outreach/enrollment assistance is being institutionalized in a number of ways. School staff who should have applications on-hand due to their frequent interaction with families are being identified. School staff should are encouraged to see involvement in KidCare outreach as part of their jobs. Schools are beginning to expand their outreach/enrollment assistance beyond the scope of the Report Card Pick Up Days to such activities as fall registration, summer school registration, health fairs, and PTA meetings.

Success Factors

Factors associated with the success of the CPS pilot project include:

- Supportive school principals are essential.
- Schools need to provide space, photocopiers, and phones.
- There needs to be adequate and repeated face-to-face time with parents before, during, and after the initial application.
- The CPS system is developing a model of the ideal school-based CHIP approach that moves beyond enrollment, such as forming a school committee that develops a healthy-school plan.

Closing Remarks

The panel concluded its discussion of the CPS pilot project with the following remarks:

- One of the most significant lessons learned from the November 1998 Report Card Pick Up Days is that conducting outreach and enrollment to eligible families for KidCare/Medicaid is an evolutionary process that requires an on-going effort to be successful. Eligible families must hear the KidCare message, regarding its availability and the opportunities to enroll, repeatedly from a variety of trusted sources. Aggressive outreach is needed, including multiple, sometimes extensive, face-to-face time with eligible families. Indeed, the CPS pilot project was better prepared for the April 1999 Report Card Pick Up Days through the implementation of a hotline, six regional centers, and a system for the review of applications for completeness and consistency. The CPS system, as more organizations and groups become involved in KidCare outreach and enrollment, continually forms partnerships to ensure eligible families enroll and use KidCare services.

- Since the Summer of 1998, the Federal government has played a role in the CPS pilot project by serving as a liaison to involve other Federal groups. For instance, HCFA's Chicago Regional Office has facilitated the training of numerous community builders from the Department of Housing and Urban Development who assisted during Report Card Pick Up Days.

Questions and Answers

A 'Q & A' session followed the CPS presentation. For ease of reference we have restated the questions and condensed the responses as follows.

Q: Where exactly have services been centralized, within the CPS system or within the DPA/DHS?

A: Both the CPS system and the State have centralized services. The CPS system centralized services within its headquarters in Chicago, which manages the CPS pilot project and receives the phone calls from parents and schools. The State also has implemented a centralized unit to conduct KidCare eligibility.

Q: Did the outreach activities of the CPS pilot project increase Medicaid enrollment?

A: KidCare enrollments are increasing, but not fast enough. However, from January 1998-September 1998, Medicaid enrollment has increased steadily. In addition, the CPS system, for the April 1999 Report Card Pick Up Days, provided schools with a database that included those children identified as having an end date for the Medicaid program so that KidCare outreach could be targeted to them.

Q: Are there any hidden costs States should be aware of when trying to replicate the CPS model?

A: Soft costs include the activities of CPS system staff, such as manning the phones, as well as donated services from partners, such as a grocery chain printing the KidCare number on 4,000,000 grocery bags. The bulk of the expense, however, was copying and distribution. States can manage the cost of copying applications and should avoid making too many copies since the application can change quickly.

Q: Are health providers now less reluctant to participate and how are outreach services actually delivered?

A: CPS personnel were surprised to find that providers lacked a basic understanding of the KidCare programs, which has been addressed over time through training and monitoring by DPA.

Q: How much coordination is there between the CPS pilot project and the Illinois Department of Public Health (DPH)?

A: From the beginning, DPH has been an active partner involved in the development and implementation of the CPS pilot project. CPS and DPH, as well as DPA and DPH, exchange information and collaborate in ensuring that a consistent message is conveyed.

Q: While materials have been translated in different languages, does the State have TTY lines for the hearing impaired?

A: The State's central office and field offices have TTY numbers and appropriate interpreters for sign language. The needs of the targeted population have also influenced what partnerships are developed; for example, volunteers fluent in sign language were placed in schools for the hearing impaired.

Guidance Implications for CHIP/Medicaid Outreach

State TAP participants were then asked to consider the CPS experience and their own experience to assess the potential for replicating aspects of the CPS pilot project. As a result, State TAP participants asked the following questions to assist them in clarifying school-based outreach strategies and initiatives they might consider:

Q: How does the division implementing the CPS pilot project keep other divisions informed, knowledgeable, and aware of its activities?

A: Support and awareness for the CPS pilot project started at the staff level. Staff collected and analyzed data, documenting CPS students' unmet need for access to health care services and developed a plan to address those needs. CPS system divisions were kept informed through an inter-disciplinary Task Force.

Q: Does the CPS Free/Reduce Lunch Program Form ask about a student's health insurance status?

A: This information is requested on a parallel form, the Universal Student Health Consent Form, where parents' provide their consent for CPS to provide such services as immunizations and sports physicals. It is part of the packet of registration forms a parent receives at the beginning of the school year.

Q: Will other States have the ability to access Medicaid data as the CPS system has done?

A: There is an Interagency Agreement between the State Board of Education and the Illinois DPA/DHS that stipulates the exchange of data. Producing such data matches, however, may be a barrier for other States whose eligibility levels for the school lunch program are dissimilar or do not have such interagency agreements. One factor States should bear in mind is that CPS is a Medicaid provider.

Q: Did CPS or Illinois do any pre-testing of translated materials with cultural groups to assess their response and interpretation of the written materials?

A: There was no pre-testing of the Spanish version of materials. With the exception of Spanish, Illinois does not currently have adequate resources to support the continued maintenance of KidCare materials in other languages. Rather, Illinois is partnering with CBOs, coalitions, and advocacy groups to implement culturally appropriate outreach strategies, such as by translating materials and providing one-on-one assistance in a family's native language.

Using Television to Inform the Public of CHIP

Ms. Polly Sherard[7], *Marketing Executive for Special Projects at Channel 7-WJLA* in Washington, DC (an ABC affiliate), was in the audience and Dr. Gibbons invited her to share her experience in developing Public Service Announcements (PSAs) for CHIP. The following are highlights of her discussion.

- In 1998, Channel 7 worked with HCFA to develop a generic PSA that would *raise awareness* about the availability of CHIP in a manner so that any State could use it. English and Spanish versions were developed and aired in a number of cities across the country. These PSAs are available for any State to use. Another campaign, "Back to School," is being developed for airing in the Fall of 1999.
- As powerful as television is as a medium, to work successfully its use should be coordinated with State and local outreach efforts--television can be used to drive local goals and objectives rather than being a separate activity. For example, while parents are not in schools, they do watch television, listen to the radio, and read newspapers.
- Because there is limited television time available to air PSAs, it was necessary for Channel 7-WJLA to build partnerships/coalitions with other organizations that were willing to provide funds to purchase air time. For the District of Columbia, Maryland, and Virginia market, Channel 7-WJLA, with HCFA, successfully partnered with the National Office of the American Hospital Association, the National Office of the March of Dimes, and the National Capital Regional Office of the March of Dimes. Each of these organizations partnered with HCFA to fund air time for the CHIP PSAs in the Washington area, which includes several counties in Maryland, the District of Columbia, several counties in West Virginia, and all of Northern Virginia.
    - For the Fall of 1999 "Back to School" campaign, Channel 7 has received local commitments from a number of malls and grocery store chains, as well as a commitment from 16 local McDonald's owners/operators. The participating McDonald's are hosting in-store events during September 1999 where trained volunteers from health departments, social service organizations, and community groups will be available to help parents receive information and assistance with the enrollment process. Channel 7 will be running promotional spots that advertise "Back to School" related events sponsored by these organizations.
- PSAs developed for HCFA's "Insure Kids Now" campaign are available through the internet, at **www.insurekidsnow.gov/m_media.asp**.

Panel Session: National Overviews of CHIP School Outreach (with Questions and Answers Session)

Dr. Carol Cichowski, *Director of the Division of Special Education, Rehabilitation and Research Analysis in the Budget Service at the U.S. Department of Education* (DoEd) and co-

[7] Ms. Polly Sherard indicated her willingness to assist States, such as in how to change the trailers to be State-specific on the national PSAs for free, and can be reached by phone at 202-364-7925 or by e-mail at sherard@wjal.com.

chair of the DoEd's working outreach group for CHIP, served as the moderator and began by providing a brief synopsis on school-based CHIP outreach at the national level.

- The DoEd recognizes the relationship between children's access to quality health care services and their academic performance. In response they have created a proactive outreach plan that includes the education and involvement of employees, parents, teachers, and others on approaches to find and enroll eligible children into CHIP.[8] DoEd is also producing a resource for States of the "best" school-based child health outreach models that are available on its website, **www.ed.gov/offices/OUS/chip**.

Dr. Cichowski then introduced **Ms. Donna Cohen Ross**, *Director of Outreach at the Center on Budget and Policy Priorities.*[9] Ms. Cohen Ross began her presentation by commending the CPS outreach model and encouraged HCFA, States, and advocates to learn from this model and from the experiences of other States. Ms. Cohen Ross distributed copies of the Center of Budget and Policy Priorities' (the Center) outreach kit.[10] In addition to producing the outreach kit, Ms. Cohen Ross prepared a paper entitled "*How Schools Can Help to Enroll Children in Free and Low-Cost Health Insurance Program*" in April 1999. The following are highlights of Ms. Cohen Ross' presentation:

- There are a number of reasons why conducting child health outreach at schools is a logical idea: schools are where kids are;[11] school staff see the problems first-hand; schools may already provide health services; and schools are trusted institutions.
- Leadership is needed for school-based CHIP/Medicaid outreach to be successful; either a principal, superintendent, school nurse, or football coach—someone dedicated to the cause, with influence, that staff respect.
- Traditionally, the goal of outreach has focused on disseminating information to raise public awareness. The goals of outreach have shifted focus to achieving outcomes, specifically enrolling children into State CHIP/Medicaid programs, ensuring their use of services, and ensuring that they remain enrolled.

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[8] The DoEd, with ten other Federal agencies, is part of President Clinton's interagency working group to promote CHIP and inform eligible families about CHIP.

[9] The Center on Budget and Policy Priorities is a nonpartisan research organization and policy institute that conducts research and analysis on government policies and programs, with an emphasis on those affecting low- and moderate-income people. For example, the Center has conducted a survey of 50 States to learn about their outreach and enrollment practices, including what questions are asked on the application; what documents are needed for verification; and what they are paying for outreach/enrollment assistance.

[10] The Outreach Kit, *Free & Low-Cost Health Insurance: Children You Know are Missing Out,* was produced as part of the "Start Healthy, Stay Healthy" Campaign. The purpose of the outreach kit is to give organizations the tools to inform families about free and low-cost insurance for their children; assist families with application procedures; and follow through to ensure children get enrolled. The outreach tool packet contains: the outreach handbook; outreach materials; and an easy-to-use eligibility screening tool. The outreach kit is available through the Center's website (**www.cbpp.org**).

[11] According to a March 1998 report by the U.S. General Accounting Office (GAO), 69 percent of uninsured, Medicaid-eligible children were either in school or had school-aged siblings.

- States can provide important tools to CBOs, including schools, to conduct effective outreach and enrollment activities. For example, States can:
  - ◊ Simplify the CHIP/Medicaid application;
  - ◊ Minimize the number of documents required for application verification; and/or,
  - ◊ Permit CHIP/Medicaid applications to be submitted by mail.
- School staff who may be assisting families with health insurance are typically not experts in the area of CHIP/Medicaid eligibility or enrollment requirements. Consequently, forging partnerships among schools, health care providers (such as, hospital and community health centers), and child health eligibility agencies is critical. Such partnerships enable staff with CHIP/Medicaid knowledge to go on-site at schools to provide face-to-face assistance to families in completing their CHIP/Medicaid applications. Examples of such partnerships include:
  - ◊ In West Virginia, New River Health Association operates four school-based health centers (SBHCs). Staff at the SBHCs work closely with school personnel to provide assistance to targeted families in completing CHIP/Medicaid applications for their children. New River staff maintain a good working relationship with the local Medicaid office so they can troubleshoot if there are problems.
  - ◊ In Utah, State eligibility workers are outstationed to schools, where staff rotate among several sites to assist families in completing CHIP/Medicaid applications. A similar effort is underway in Minneapolis.
  - ◊ Nebraska is one of nine States to adopt the presumptive eligibility option for CHIP/Medicaid enrollment. While schools have not yet been given the "go-ahead" to make presumptive eligibility determinations, community health centers and local health departments have been authorized to do so and they are getting their foot in the schoolhouse door. For example, a staff member of Panhandle Community Services health center attended a parent information night at a local elementary school. The staff member was able to directly enroll children in Medicaid by assisting parents with a simple two-page form. In the presumptive eligibility process, if the child appears to qualify, the health center gives the parent a copy of the form that serves as a temporary enrollment card.
- Resources must be made available so that school staff can participate effectively. For example:
  - ◊ In Seattle, "family support workers" are available in 65 elementary schools to assist families in obtaining a range of health and social services. Private funds were solicited to increase the hours of several family support workers to work full-time in assisting families with their Medicaid applications.

Dr. Cichowski reiterated a point raised by Ms. Cohen Ross--if schools do not have the capacity to engage in follow-up activities, such as enrollment assistance, then it is critical that they partner with other public agencies or private organizations that are willing to assist in achieving the goal of enrolling eligible children into CHIP/Medicaid.

Ms. Victoria Pulos, *Associate Director of Health Policy and CHIP at Families USA*[12] then discussed highlights from a paper entitled, *"Promising Ideas in Children's Health Insurance: Coordination with School Lunch Programs,"* produced by Families USA in May 1999.[13] However, she first noted that the United States Department of Agriculture (USDA) developed a new prototype cover letter for the National School Lunch Program (NSLP)[14] and four new prototype school meal application forms that were distributed to the States in the Fall of 1998.[15] These prototypes contained check-off boxes for parents wanting children's health insurance and were seen as a vehicle for simplifying processes and minimizing paperwork for both the agencies and families involved. Key highlights from her presentation are:

- **Why Coordinate the NSLP and CHIP/Medicaid?** One reason to coordinate the NSLP with CHIP/Medicaid is the similar income eligibility criteria between the two programs.
  - Under the NSLP, children with family incomes up to 130 percent of the FPL are eligible for the free lunch program. Most States have designed their CHIP and/or Medicaid program to cover children with family incomes at least up to 130 percent of FPL. Reduced price eligibility goes to 185 percent of FPL and many CHIP/Medicaid programs also go to this level.
- States can coordinate the dissemination and sharing of information to simplify families' enrollment into CHIP/Medicaid.
  - Disseminating Information. Enrolling into the NSLP involves distribution of a substantial amount of paperwork to convey information to households and obtain information regarding NSLP entitlement. This creates opportunities for CHIP/Medicaid to "piggy back" in disseminating information, such as including CHIP flyers with NSLP applications.
  - Sharing of Information. The USDA requires income eligibility questions on all school meal applications, including current household income amount and source. Thus, NSLP data can be used to target schools with a high NSLP participation rate for CHIP/Medicaid outreach.

[12] Families USA is a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health and long-term care for all Americans.

[13] Copies of "Promising Ideas in Children's Health Insurance: Coordination with School Lunch Programs" can be obtained from Families USA's website (**www.familiesusa.org**); this article offers a more complete discussion of the National School Lunch Program and the opportunities and pitfalls in coordinating NSLP with CHIP/Medicaid.

[14] NSLP was established over 50 years ago and is a widespread, national program that provides low-cost and free lunches to over 26 million children each day, over half of whom are receiving free lunches. It is available in about 99 percent of all public schools and many private schools. Local schools decide if they want to participate in the NSLP. The Food and Nutrition Service, an agency of USDA, administers NSLP. In most States, a State Department of Education oversees the program.

[15] The prototypes contain questions, in different formats, that permit families to waive confidentiality enabling information in the school meal application form to be shared with the State agency administering CHIP/Medicaid. What school lunch application is used is a local decision. Schools can design their own applications as long as they are approved by the State Department of Education and meet minimum criteria specified by USDA. The USDA also clarified its guidelines on disclosing information from school meal applications.

- ➢ School systems can notify the appropriate State child health agency of students who should be enrolled into CHIP/Medicaid. However, this requires prior consent of parents.

- Ms. Pulos' then highlighted some of the problems associated with coordinating the NSLP with CHIP/Medicaid:
  - ◊ Confidentiality Issue. Families must waive confidentiality to permit schools to share information from the school lunch application with the appropriate CHIP/Medicaid State agency.
  - ◊ How Income Is Counted/Definition of Households. The NSLP, CHIP, and Medicaid maintain different definitions of income eligibility. In general, a student lunch program counts more income than CHIP/Medicaid. If a student is eligible for free student lunches at 133 percent of the FPL, then that same student is more than likely eligible for a State's Medicaid program.
  - ◊ Need for Additional Required Information. Since the CHIP/Medicaid programs require more detailed information for eligibility than the school lunch program, the data can be used as a proxy to track children who are likely to be eligible for CHIP/Medicaid.
  - ◊ Citizenship/Immigration Status. CHIP/Medicaid is limited to citizens and qualified aliens, while NSLP has no such restrictions.
  - ◊ Third-Party Verification. The NSLP does not require third-party verification as part of the application process.

- **State Experiences on Coordinating NSLP and CHIP/Medicaid**. Some States have attempted to coordinate NSLP and children's health insurance programs, but no "ideal" model has yet been identified.
  - ◊ Colorado. The Colorado Child Health Plan, the precursor to Colorado's CHIP plan, used a shortened Medicaid application form, printed on the back of a brochure, for children receiving free and reduced-price meals. With the implementation of the State's CHIP, Child Health Plan Plus, use of the shortened application was discounted because of the State's need for more detailed income information. Information is still disseminated through the schools.
  - ◊ Washington. Many Washington schools use the check-in box on the NSLP forms, but have had problems relaying names from the schools to the Medicaid agency. Currently, the State of Washington is looking at different ways, under its RWJ Covering Kids grant, to improve the coordination of information between the Medicaid agency and school's lunch program.

In closing, Ms. Pulos noted that despite the pitfalls, coordination between the two programs is promising but challenging.

Dr. Cichowski then introduced **Ms. Debbie Somerville**, representing the *National Association of School Nurses*,[16] who discussed the roles of school nurses; the different school nurse models; and how school nurses can be key players in school-based child health outreach efforts.

- **Roles of School Nurses**. School nurses fulfill a range of roles, among which are:
  - Assessing and identifying the unmet health needs of children.
  - Providing or coordinating screenings including working with families to follow-up on screening failures, which is when they learn of a family's lack of health insurance or that the family is under-insured.
  - Providing emergency first-aid. In sending a child to a hospital to be treated, school nurses often find out from parents why their children's health care needs are unmet-a lack of health insurance or an inability to pay for the doctor's visit.
  - Coordinating and implementing treatment plans for chronic illnesses, such as tuberculosis and asthma. Because most school nurses do not provide such care directly, they link children with primary care providers. Again, through this role, school nurses can learn that a child does not have a regular primary care provider.
  - Perform clinic management in SBHCs. As the number of SBHCs grows, with care provided directly in the school, health insurance status is identified when SBHCs attempt to receive third-party reimbursement.
- **Models of How School Nursing is Delivered**. The model of how school nursing is delivered in a school district can impact the role school nurses take in school-based child health outreach efforts.
  - It is key to gain the support of the school nurse's employer. School nurses can be employed either by the health department or the school system, which has implications on the role school nurses will be play in outreach.
  - School nurses can be either full-time or part-time and can vary in the number of schools with which they work. A school nurse assigned to an entire school district would be only minimally available to anyone for outreach efforts.
  - Families rarely view the school nurse as a government employee, and so do not approach him/her with the stigma they associate with other government agencies and/or the school district. This enables the school nurse to work more freely with families.
  - School nurse services can also be provided through a contractual arrangement with a hospital or a managed care organization (MCO). As well as adding another entity to involve in the coordination of outreach efforts, there could be a conflict of interest.
- **How School Nurses Fit Into Child Health Outreach**. School nurses can contribute to school-based child health outreach efforts in the following ways:
  - By making referrals of children for enrollment into CHIP/Medicaid

[16] The National Association of School Nurses (NASN) was established in 1969 and provides a support network committed to providing quality health programs to the school community.

- ◊ By working with families to educate them on how to use the health care system and to understand the value of health care.
- ◊ By disseminating CHIP/Medicaid applications.
  - ➢ It may not effective to utilize school nurses in assisting families to complete a CHIP/Medicaid application because of the many duties and time constraints of nurses. A more effective model is for the school nurse to refer the family to an outreach work for assistance.

- ♦ The school nurse training should be comprehensive to enable school nurses to answer questions accurately and to refer appropriately.

Issues Raised During the Panel Session

The following issues were raised during the panel session:

- ♦ **Resources Available for Outreach**. States were reminded about the availability of Medicaid administrative matching funds that are available at the traditional and enhanced rates. There is a time limit on the use of these funds, and a number of States have used these funds effectively to do outreach.
- ♦ **Consistency of Roles of School Nurse Employed by Private Entities**. Ms. Somerville noted that there is not a lot of consistency in the roles of school nurses employed by private entities, which are typically contract-driven. In contracting with private entities for the provision of school nurse services, care must be taken to avoid potential conflicts of interest, such as when the school nurse is an employee of a MCO.
- ♦ **Cost Effectiveness**. Advocates in Texas determined that reducing missed school days due to health reasons would more than adequately fund the State's portion of CHIP for a maximum expansion. TAP participants were interested in obtaining Texas' methodology.

Overviews of Individual State Approaches to Involving Schools in CHIP/Medicaid Outreach Efforts

TAP participants from each of the invited States-**District of Columbia, Michigan, Nevada, and South Carolina**-gave an overview of how they use schools in their CHIP/Medicaid outreach approaches (see **Attachment 2**). Following the States' presentations, a brief general discussion was held to discuss any outstanding issues.

- ♦ **Targeted Outreach Efforts for Adolescents**. Attending States were asked if they were doing, or planned to do, any targeted outreach to adolescents:
  - ◊ **District of Columbia**. The District of Columbia is interested in working with HRSA to extend the role of student ambassadors to become trainers for other volunteers. The District of Columbia proactively partners with youth organizations and this Fall, is hoping to be involved with an evening basketball league through such activities as pep rallies and cheerleading contests. It was suggested that if the basketball games require a ticket, the District of Columbia could require attendees to bring a completed CHIP application in lieu of a ticket.

- ◊ **Michigan**. Michigan is considering developing two to three lessons plans focused upon CHIP to incorporate into its health education curriculum, as 90 percent of high school students take a semester of health education for graduation. One assignment could be to complete a CHIP application or find someone to assist in completing the application. Students could also produce posters and PSAs that explain the importance of health insurance.
- ◊ **Nevada**. Nevada is considering using its Boys and Girls Clubs and teen programs to develop CHIP posters as well as incorporating CHIP information into parenting classes.
- ◊ **South Carolina**. South Carolina is working with a local community to incorporate CHIP as a topic for discussion during the health issues segment of a weekly "Teen Talk" show aired on cable television.

Closing Remarks

In closing, the co-chairs of the TAP, Dr. Gibbons and Ms. Galaty, thanked participants for sharing their experiences with using schools as part of States' CHIP/Medicaid outreach. They encouraged States to use HCFA's Outreach Strategy Corner, **www.hcfa.gov/initi/outreach**, as a forum to submit and exchange ideas, experiences, and lessons learned. The information from this TAP, once finalized, will be available on HCFA's website. In addition, HCFA Regional Offices will receive a copy of the videotaped proceedings that States may use as a training tool. Both HCFA and HRSA look forward to continuing effective partnerships with States and assisting them to be successful with their CHIP/Medicaid outreach efforts.

ATTACHMENT 1
PARTICIPANTS OF TAP #7

"School Outreach Pilot Program:
Lessons Learned from the Chicago Public Schools"
HCFA Central Office, Baltimore, Maryland
May 25, 1999
(Based upon Sign –In Sheets)

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ATTACHMENT 2
"INDIVIDUAL STATE APPROACHES TO INVOLVING SCHOOLS IN CHIP/MEDICAID OUTREACH EFFORTS: DISTRICT OF COLUMBIA, MICHIGAN, NEVADA, AND SOUTH CAROLINA

This attachment provides summaries of each invited State's presentation on its use of the State's school system to conduct CHIP/Medicaid outreach and enrollment. States with experience in using the school system for CHIP/Medicaid outreach and enrollment were requested to address the following broad topics during their presentations, as applicable:

- Approaching the school system;
- Method for targeting schools for involvement;
- Number of schools the State is working with;
- Materials distributed to schools and families;
- Outreach activities/enrollment assistance conducted with schools;
- Evaluation efforts;
- Future outreach plans with schools; and,
- The challenges and successes associated with partnering with schools for outreach.

States that were not currently using the school system, or were in the beginning stages of establishing a relationship with the school system, were requested to discuss the State's vision for using schools for CHIP/Medicaid outreach and enrollment. All States, regardless of experience, were requested to consider what, if any, aspects of the Chicago Public Schools (CPS) experience they would consider implementing.

The summaries of State presentations are provided in alphabetical order.

District of Columbia

(Ms. Lynda Flowers, Ms. Twana Jones-Fortune, Ms. Billie Shepperd, and Ms. Linda Wright)

Ms. Lynda Flowers, Project Officer of the District of Columbia's Healthy Families (DCHF) Program with the Department of Health, discussed the outreach strategies of DCHF, focusing upon its partnership with schools. The District of Columbia team also included Ms. Twana Jones-Fortune, Coordinator for the Mom-Baby helpline; Ms. Billie Shepperd, School Health Liaison with the Office of Maternal and Child Health, Department of Health; and Ms. Linda Wright, Program Director, HIV/AIDs Education Program, District of Columbia Public Schools. Ms. Artencia Hawkins-Bell, Project Director at Birch and Davis Associates, Inc., the District of Columbia's CHIP outreach contractor, was also available to answer any questions.

Current Status of DC Healthy Family Implementation. With its CHIP funds, DC expanded eligibility for its existing Medicaid program under a plan called DC Healthy Families (DCHF), implemented October 1, 1998. DCHF offers coverage to children under age 19, as well as to

their parents/legal guardians, with family incomes at or below 200 percent of the Federal Poverty Level (FPL) who meet the eligibility requirements. DCHF also covers all pregnant women with family incomes up to 200 percent of the FPL. Children eligible for DCHF are offered the same benefit package as DC's Medicaid plan and benefits are delivered through managed care organizations (MCOs) under a 1915(b) waiver. Behavioral health and long-term services are carved out and reimbursed on a fee-for-service basis. Families enrolled in DCHF are not subjected to cost sharing.

To apply for DCHF, an applicant must submit a completed two-page user-friendly application, available in English and Spanish, with one month's proof of income, a copy of his/her social security card, and proof of DC residency. DCHF applications are available in sites throughout the city, as well as on-line. Applicants can call the helpline (1-800-MOM-BABY), where staff are available to assist applicants with completing the application between the hours of 7:45 a.m. to 4:30 p.m., Monday through Friday.

DCHF's General Outreach Approach. With the assistance of an outreach contractor, DC has developed a comprehensive outreach plan to target all uninsured children in the city. The DCHF outreach plan incorporates two primary principles: to promote a citywide effort and to utilize and build upon partnerships (a "win-win" situation). The DCHF program has successfully created partnerships throughout the District with various companies, organizations, and faith-based groups, to promote and educate communities about DCHF; a few examples of DCHF partnerships include:

- **DC Chamber of Commerce.** Through the DC Chamber of Commerce, the DCHF program is forming key partnerships with businesses; for example, the Washington Gas Company sent DCHF information with June 1999 gas bills and area grocery chains (Safeway and Giant) and drug stores (CVS and RiteAid) display applications on their pharmacy counters.
- **DC Hotel Association.** The DC Hotel Association includes DCHF information in its newsletter. DCHF has formed a partnership with Marriott Hotels whereby Marriott includes a DCHF application in its new employee packets, as well as involving DCHF as part of the graduation ceremonies of welfare-to-work training programs.
  - ◊ TAP participants were enthusiastic about DC's targeting school settings that parents attend to distribute CHIP materials; States should also consider using its Temporary and Needy Families Assistance (TANF) outreach funds for this type of CHIP outreach.
- **Day Care Centers.** Day care center staff attending DCHF training, in return, receive credit towards their mandatory licensure; staff from over 300 of the 600 DC day care centers have been involved in this effort.
- **Other Government Agencies.** The Department of Housing and Urban Development has a project to set up neighborhood computer centers in DC neighborhoods; as part of residents' training on how to use a computer, they access the DCHF application on-line. DC has the goal of making DCHF applications available at each of its public agencies.

The DCHF program enters into new partnerships every day.

Approaching the School System. After establishing several successful partnerships with businesses and organizations, DC decided to approach the DC Public School system to become involved in DCHF outreach. By creating the school partnership, DC wanted to heighten awareness of DCHF in all schools; to build an ongoing partnership with all schools; to develop effective outreach efforts that have a long-term impact; and to enroll all eligible children. In order to initiate the process, DCHF staff met with the DC Public School's Chief Health Officer in November 1998 to discuss partnership opportunities and in December 1998 the Deputy Superintendent of Auxiliary Services approved the partnership with DCHF. DC then developed a comprehensive DCHF school-based outreach plan that was approved immediately by the Chief Health Officer.

Method for Targeting Schools. Through a partnership with the DC Public School System, DC targeted each of the public schools to be involved in DCHF outreach. DC did not target private schools as part of its outreach initiative as staff thought few children would be eligible; like other States, the children DC believes should be targeted for DCHF enrollment are older and have, in all probability, aged-out of its Medicaid program.[17]

Number of Schools the State is Working With. DC, during the 1998-1999 school year, worked with each of DC's 146 public schools, representing an estimated 71,000 children. For the 1999-2000 school year, DC will be extending all its DCHF school-based outreach activities to DC's catholic schools, representing 5,000 children, at the request of the Archdiocese of Washington, and DC's chartered schools, representing an estimated 2,600 children.

Materials Distributed to Schools and Families. DC distributes the following DCHF materials to schools: DCHF applications and collection boxes (typically located in the principal's office), flyers, and posters. DC has used focus groups of residents, parents, and representatives of DC's immigrant communities to review and obtain feedback that improves the DCHF application.

Outreach Activities/Enrollment Assistance Conducted with Schools. DC's DCHF outreach plan with the school system includes on-going training, enrollment events, and participation at school events. Highlights of outreach activities include:

- The Chief School Health Officer, in January 1999, conducted a half-day DCHF training session for representatives from each of the superintendent's offices at the elementary, junior and senior high school levels. Using a "train-the-trainer" concept, the goal was to educate the school representatives, who in turn were charged with training the teachers, counselors, and principals at each school.
- The DCHF/DC Public Schools partnership was launched during the "DCHF Enrollment Week," the second reporting card period of parent/teacher conferences during the week of February 8-12, 1999. A multi-pronged approach was used to inform schools and parents of the event.

[17] At the time DC implemented DCHF, the Medicaid program had a 91 percent enrollment rate of eligible individuals.

- ◊ Letters were sent to each principal informing them of the event. Principals were encouraged to have their staff attend one of the DCHF community training sessions to enable them to offer on-site enrollment assistance to parents. Each school received a DCHF package of materials (including flyers, posters, applications, and collection boxes) for use during "DCHF Enrollment Week."
- ◊ A kick-off press conference was held with Mayor Anthony Williams, at which time a poster and poetry contest, "The Importance of Keeping Families Healthy,[18]" was launched.
  - ➢ Over 100 entries were submitted by elementary and middle school students from 9 area public schools and 26 winners were selected. Prizes included gift certificates to local retailers and the two top winners in each category received a "victory lunch" at Planet Hollywood with Mayor Anthony Williams.
  - ➢ The posters and poems were made into a traveling art show, with stints at the Mayor's Office, the Children's Museum, and the Smithsonian, as a way to build momentum to involve more schools.
- ◊ Parents received a letter, with a DCHF brochure, encouraging them to complete a DCHF application at the school and to call the 1-800 helpline if they had any questions.
  - ➢ DCHF recruited a local television channel, Fox, to run announcements a week prior to "DCHF Enrollment Week" to raise parents' awareness. The announcements generated a lot of calls to the helpline and a number of parents, during the parent/teacher conference for their child, requested a DCHF application.

Results of the School-Based DCHF Outreach. DC received 800 completed DCHF applications as a result of its outreach partnership with DC's public schools, with approximately half of the applications being approved for DCHF coverage. DC uses a coding system to track the source of applications.

Future Outreach Plans with Schools. The DCHF partnership with DC's schools is ongoing, with new strategies constantly being implemented. Upcoming plans include:

- ♦ Attending Back-to-School meetings, held in the summer of 1999, with principals, teachers, counselors and social workers to prepare them for the beginning of the school year.
- ♦ Developing a monthly DCHF newsletter for school principals.
- ♦ Disseminating information in Back-to-School packages that families receive at the beginning of the school year.
- ♦ Developing DCHF enrollment activities around specific events, such as school assemblies, school award ceremonies, sporting events, and extracurricular activities (for example, the annual Fall Gospel Choir Explosion Weekend that features choirs from DC's junior and senior high schools).

[18] CVS pharmacy and MedStar Health sponsored the poster/poetry contest.

- Developing a pool of trained volunteers, from local sororities/fraternities and community-based programs, such as the DC Law Project, that can provide DCHF enrollment assistance during targeted school events.
  - At the TAP, DC representatives came up with the following ideas:
    - Giving health school seniors community service credit for becoming trained as "educators" of the DCHF program within their schools and communities; and,
    - Incorporating DCHF training as part of a teacher's annual 15 hours of in-service training to be certified.
- Creating a School Ambassador Program to place adult volunteers at each DC school to promote DCHF and to assist families in completing the application.
- Expanding the Student Ambassador Program to additional sites, as well as providing additional training and supervision to current Student Ambassadors that enables them to distribute DCHF information in targeted areas in the community and at all school events.

Successes and Challenges of School Partnership. Creating a partnership with the schools has proved to be a success. Within the first six months of the program, 77,339 students and their parents were educated about DCHF. Schools continue to advocate the DCHF program on their own by hosting enrollment events and incorporating DCHF in regular school activities and special events. Additional successes include:

- The support and participation from the Mayor's office;
- Positive media coverage of DCHF enrollment events; and,
- "Win-win" partnerships with corporate sponsors, such as CVS pharmacy and MedStar Health's sponsorship of the "The Importance of Keeping Families Healthy" poster and poetry contest and the businesses that donated prizes.

At the same time, there have been a number of challenges, including:

- Some of DC's Parent Teacher Associations were initially less responsive than anticipated.
- Some principals did not initially disseminate the DCHF materials.
- The departure of two key advocates from the DC Public School System.
- The intensive amount of labor needed to coordinate the dissemination process with schools, including distributing a massive amount of materials.

Issues and Questions Raised During the Presentation. The following issues/questions were raised during the District of Columbia's presentation, presented in a 'Q&A' format:

Q: ***How does DC fund the DCHF expansion that covers the parents and legal guardians of eligible children?***

A: DC has a 30/70 match with the Federal government. The DC City Council appropriated the funds, the 30 percent of the match, to cover expanding DCHF coverage to the parents and legal guardians of eligible children.

Q: ***What is the response rate for mail-in applications?***

A: DC indicated that, in general, the mail-in application response rate is good. Applicants are encouraged to contact DC's helpline, 1-800-MOM-BABY, if they need assistance; the helpline is a key component of DCHF outreach. Ms. Jones-Fortune noted that DC is also getting an excellent response rate from males calling the helpline to apply for their families. Twice a week, the helpline forwards a mailing list to the DCHF outreach contractor of individuals requesting an application. Helpline staff then follow-up with these individuals to ensure that they have received an application and to answer any questions. DC is planning to conduct a satisfaction survey with a random sample of individuals who have called the helpline with questions about DCHF.

Q: ***Do schools make copies of the DCHF application?***

A: Although there was an initial problem with some schools making copies of the DCHF application, the DCHF program strongly discourages schools from doing so. As part of the DCHF training for schools, DCHF staff stress the pitfalls associated with copying, such as inadvertently deleting the instruction sheet and/or the DCHF mailing address on the back of the application. Schools are also reassured that DC has an adequate supply of DCHF applications to accommodate their needs.

Q: ***Has DC considered purchasing media time as part of DCHF outreach?***

A: DC rarely makes direct purchases of media time, having learned from past experience that television, in general, does not reach the targeted audience. DC works closely with its corporate sponsors and MCO partners to promote DCHF. For instance, CVS pharmacy, a key DCHF sponsor, has hosted two radio store tours, where a local radio station broadcasts live from the CVS parking lot; local dignitaries stop by; prizes are given out; and DCHF volunteers are available to assist families.

Michigan

(Ms. Patricia Nichols, Ms. Jacqueline Tallman, and Ms. Alfredine Wiley)

Ms. Jacqueline Tallman, Program Development Consultant and Oral Health Program Coordinator, in the Division of Family and Community Health within the Michigan Department of Community Health, discussed Michigan's overall CHIP outreach approach, focusing upon the role of schools. The Michigan team also included Ms. Patricia Nichols, Deputy Director, Curriculum Development and School Health Programs within the Michigan Department of Education, and Ms. Alfredine Wiley, Guidance and Counseling Administrator for the Detroit Public Schools.

Current Implementation Status for MIChild. MIChild is the name of Michigan's program to provide health care coverage to previously uninsured children in the State. A dual application is used, although MIChild is run as a separate program from Healthy Kids (Medicaid). MIChild covers children with family incomes between 150 and 200 percent of the FPL; Healthy Kids covers children with family incomes up to 150 percent of the FPL, as well as pregnant women and children up to age one with family incomes up to 185 percent of the FPL. MIChild charges a $5 monthly premium per family, regardless of the number of children in the family, and has no deductibles or co-payments.

Approaching the School System. Michigan is approaching the school system as part of its three-pronged approach for MIChild outreach.

1. At the ***State*** level, a multi-media campaign (radio, television, newspaper) is used to raise public awareness.
2. At the ***State*** and ***Regional*** levels, over 130 associations, organizations, and advocacy groups that target children's well being were requested to take an active part in outreach to families with children who are eligible for MIChild through a letter sent by the Governor.
3. At the ***local*** level, 76 multipurpose collaborative bodies (MPCBs)[19] were provided a total of $1.3 million in grants[20] to develop and implement a local plan of outreach to families with children eligible for MIChild that compliments the State's multi-media campaign.

How Michigan involved schools in MIChild outreach activities is discussed below.

Method for Targeting Schools. Michigan is currently working with all schools to promote MIChild. Many of the MPCBs have involved schools as part of the local outreach initiatives and each of the MPCBs have received MIChild training. The community partners are implementing a wide spectrum of creative outreach strategies, "as what plays in the Motor City (Detroit) may not play elsewhere in the State" and include the following types of activities:

[19] A MPCB is a multi-purpose group with representation from all the relevant agencies within a community, such as social services, health services, criminal justice services, and education services.
[20] This is one time funding only.

- Community training
- Local publications
- Sporting events
- Cultural events
- Payroll check inserts
- Parenting classes
- School activities
- Health fairs
- Local television and radio talk shows
- Kindergarten roundup
- Support groups

An example of the community training was the arranging of a videoconference on MIChild training through a hospital system, as an in-kind contribution, that occurred in eight sites across the State. Individuals from the community, including agencies, MPCB affiliated organizations, schools, churches, advocates, were invited to attend. The videoconference provided general information on the MIChild program and basic instructions for completing a MIChild application. Michigan has formed a speaker bureau to conduct MIChild outreach presentations, as well as creating standardized slide presentations that individuals can use.

Number of Schools the State is Working With. Michigan is working with each Title I[21] and non-Title I school in the State, as well as non-public schools.

Materials Distributed to Schools and Families. Michigan distributed the following materials as part of the 1998-1999 academic year:

- At the beginning of the 1998-1999 academic year, Michigan sent MIChild applications to all children attending Title I schools and an informational MIChild brochure to all children attending non-Title I schools.
- Schools were specifically targeted through a letter sent in August 1998 to each building administrator by the State Department of Education with suggestions of how schools could help children have access to quality health care by proactively helping eligible families complete and mail-in a MIChild application. Suggestions included, but were not limited to:
  - Have school staff devise a plan of how they would have each eligible family from the school complete a MIChild application;
  - Distribute the application and/or brochures to ALL children as parents that are not eligible may give the information to neighbors or relatives who qualify.
  - Have teachers stress the importance of children taking MIChild information home and having parents read it.
  - Keep additional brochures available to distribute to parents as they come to school for meetings, to volunteer in the school, to drop off a child, or to replace a lost brochure.
  - Partner with the local health department and county Family Independence Agency in conducting school-based outreach.
  - Incorporate information about MIChild into school health curriculum.

[21] Title I is the largest Elementary and Secondary Education Act (ESEA) program. Under Title I, Federal funds are distributed based on the number of poor of children in a school rather than on academic achievement scores.

- ◊ Make MIChild a focus at PTA meetings during the school year.

Outreach Activities/Enrollment Assistance Conducted with Schools. The schools in Michigan, in 1998-1999, served as a mechanism for informing families of the availability of MIChild for their children (suggested outreach activities schools could perform were outlined above). Michigan is also working closely to train school nurses, school social workers, and school counselors to become MIChild resources within the school setting for families. Training focuses not only on the MIChild program but also on how to talk to parents one-on-one so that they have children insured (the educational component of outreach).

Ms. Wiley noted that during 1998-1999 academic year, the Detroit Public School system has had every resource coordination team receive MIChild training, with 260 of the 263 trained as of mid-May 1999. Each resource coordination team is multi-disciplinary, including representation from social workers, psychologists, special education, and a school administrator. In acknowledgement of the fact than any initiative needs strong leadership to succeed, the presence of the school administrator, such as a school principal, was mandatory; if the school administrator was absent, the team was sent home. In addition, the Detroit Public School system has implemented 20 constellations and recently hired approximately 20 nurses, 40 social workers, 20 psychologists, and some counselors. For the 1999-2000 academic school year, the goal of the Detroit Public School system is to ensure that every public school has a team of MIChild resources available to them.

MIChild Evaluation Efforts. Michigan felt that the initial volume of submitted MIChild applications was low. To determine factors associated with awareness and source of MIChild information, Michigan contracted with a public research company to conduct a telephone survey of 700 persons who received the MIChild application—350 who had applied and 350 who did not. Guiding that research was the following list of objectives:

- ♦ Identify the resources that have been effective at promoting the awareness of MIChild (Where did you hear about MIChild?), and which resources would be best to use in the future.
- ♦ Identify the key issues and constraints that might impact the success of the MIChild program (Why didn't you return an application?).
  - ◊ Identify the similarities and differences between applicants and non-applicants (such as, who are they demographically?).
- ♦ What difficulties were experienced with the application and its subsequent processing?
- ♦ Is the monthly fee for MIChild burdensome or affordable?

<u>Initial Results</u>. The *effectiveness* of different outreach strategies for increasing awareness about MIChild, as ranked by the survey respondents (Table 1.1), and the *source* of the survey respondent's information (Table 1.2) has assisted the State in formulating its strategic plan for MIChild outreach. From both tables, it can be seen that **schools play a key role in information gathering and assistance for both applicants and non-applicants.**

Table 1.1: Most Effective Methods for Increasing Awareness (As recommended by interviewees)

Method	Applicant Percentage	Non-Applicant Percentage
Television Ad	53%	46%
Brochure	33%	33%
Direct Mail	32%	35%
Local health department	32%	28%
School/University	30%	25%
Clinic/Hospital	29%	36%

Table 1.2: Source of Awareness

Method	Applicant Percentage	Non-Applicant Percentage
Television Ad	41%	49%
Relative/Friend/Co-Worker	17%	16%
School/University	16%	15%
Brochure	10%	5%
Direct Mail	7%	5%
Radio Ad	6%	7%

An interesting finding from the survey was that while respondents liked the idea of a mail-in application, they felt uncomfortable about sending personal information to a post office box in Lansing, Michigan (the capital of the State). Therefore, one of the biggest outreach efforts for the State in the coming year will be word-of-mouth and peer interaction to motivate families with eligible children to apply.

Issues and Questions Raised During the Presentation. No issues or questions were raised during the Michigan presentation.

Nevada

(Ms. Diana Taylor, Ms. Lisa Taylor, and Ms. Judy Wright)

Ms. Lisa Taylor, Eligibility Certification Specialist/Marketing and Outreach Assistant for Nevada's Child Health Insurance Program (CHIP), Nevada Check Up, briefly described Nevada Check Up, Nevada's CHIP approach, and how schools throughout the State are an integral component of outreach. The Nevada team also included Ms. Diana Taylor, Administrative Specialist in the Health Services Department of the Clark County School District in Las Vegas, Nevada and Ms. Judy Wright, Bureau Chief for Family Health Services within the Nevada State Health Division.

Current Implementation Status of Nevada Check Up. With its CHIP funds, Nevada implemented Nevada Check Up, a separate health insurance plan, on October 1, 1998. Nevada Check Up provides health care coverage to children ages 0 to 18, as of the date of the application, in families with an annual gross income at or below 200 percent of the FPL who meet the eligibility criteria.[22] Children enrolled in Nevada Check Up are offered the same benefit package as Nevada's Medicaid program, with benefits delivered through MCOs and other State qualified health care organizations or fee-for-service depending on the area.

A family can apply for the program by completing a one-page application,[23] attaching the necessary documents,[24] and mailing back the application. Coverage begins on the first day of the month following the receipt of the enrollment form and premium. Enrollment is monthly and a person's eligibility continues through September 30, 1999, with the next annual enrollment period, October 1, 1999. If the applicant appears to be income eligible for Medicaid, Nevada Check Up will provisionally enroll the applicant in Nevada Check Up while Medicaid eligibility is being determined. If the applicant does qualify for Medicaid, he or she will be disenrolled from Nevada Check Up.

Approaching the School System. Nevada initially intended to implement Nevada Check Up on July 1, 1998 (although it was subsequently delayed until October 1, 1998). In order to meet such an ambitious timeframe, Nevada Check Up staff recognized the need for its initial marketing and outreach initiative to involve the State's school districts. In January of 1998, Nevada Check Up staff contacted the 17 school districts via the statewide superintendents meeting. The Superintendents were enthuastic and agreed to help facilitate a mass mailing of 300,000 applications by providing information on their student populations, such as the number of students enrolled and the number of students who spoke English or Spanish. This mass distribution proved to be very successful and, as a result, many schools districts invited the State

[22] Nevada's Medicaid program covers children up to age 6 with family incomes up to 133 percent of the FPL and children age 6 and older born on or after October 1, 1983 with family incomes up to 100 percent of the FPL.
[23] The Medicaid application is longer and is used to determine eligibility for each of Nevada's public assistance programs, including Temporary Assistance to Needy Families (TANF) and food stamps.
[24] Two most current pay stubs and, if self employed, two most current tax returns.

to conduct training sessions and presentations to educate faculty about the Nevada Check Up program.

Method for Targeting Schools. All schools in Nevada's 17 school districts were targeted for outreach and were sent Nevada Check Up applications. Nevada then targeted the School Nurses Association, providing training sessions to school nurses statewide through quarterly meetings in the north (Reno), the south (Las Vegas), and rural areas (remaining 15 school districts). The training emphasized the role schools nurses could take: having families understand the importance of preventive care.

Number of Schools the State is Working With. The State is working with each of the 17 school districts in Nevada, 15 of which are deemed rural.

Materials Distributed to Schools and Families. As noted above, 300,000 Nevada Check Up applications, in English and Spanish, were disseminated through the schools.

Outreach Activities/Enrollment Assistance Conducted by the Schools. School nurses have been key in providing Nevada Check Up information to families, as well as enrollment assistance. Several of the school nurses are bilingual, which has been instrumental in getting information out to Hispanic families and their children. At the same time, some school nurses, while enthuastic about Nevada Check Up, can be assigned to multiple schools and do not have a lot of time available to assist families.

Because Nevada has no school-based health centers, school-level health services may not be readily available to families. In response, the Nevada Check Up program has also partnered with Family Resources Centers,[25] which are places families can go to obtain information about services available to them within their communities. The Family Resources Centers identify families with children eligible for Nevada Check Up, and provide them with assistance in completing a Nevada Check Up or Medicaid application.

Evaluation Efforts. Since implementation, Nevada has tracked how applicants heard about Nevada Check Up. **The most often cited source of information is schools, with a 37 percent** response rate (followed by friend/relative at 13 percent and media at 12 percent).

Future Outreach Activities. While the school district remains a focal point, Nevada has plans to expand its Nevada Check-Up school-based outreach approach through several activities, including:

- Marketing Nevada Check Up through the State's free and reduced lunch program in all 17 school districts for the 1999-2000 school year. To increase Nevada Check Up enrollment, Nevada Check Up staff, working with the State Department of Education, designed a waiver in both English and Spanish for parents to sign to authorize the release of information to Nevada Check Up. The waiver will be attached to the free and reduced lunch application. An inter-local agreement permits the exchange of information. The Nevada Check Up program

[25] Family Resource Centers are only available in the northern region of the State.

will pay for the cost of the printing costs and the distribution to all of the schools; the State Department of Education will distribute the information to families. Several Nevada schools operate year around and have already begun to distribute materials to new students registering, consequently the Nevada Check Up program has already begun to receive signed waivers. This effort targets an estimated 266,000 eligible children in Nevada.

- Targeting school registration, including kindergarten and new students, through a referral form that parents sign to release information to Nevada Check Up; this is an important strategy as Clark County's population is increasing by 4,000 families a month.
- Running two themed promotions:
  - "Get Physical With Nevada Check Up." The State is working with the Athletic Departments to include a Nevada Check Up application in materials (many children must have physicals, or health insurance, before participating in extracurricular activities).
  - "Nevada Check Up's Picture of Good Health." The State has received a grant to work with community-based organizations to provide an incentive for families: if they fill out a Nevada Check Up application then they receive a voucher for school pictures.
- Becoming involved in targeted school events, such as back to school nights and parent teacher conferences.
- Training a school's homeless advocate[26] to provide assistance to families in completing a Nevada Check Up or Medicaid application.
- Coordinating with Nevada's WIC program; on a pilot basis, individuals visiting certain WIC offices are given a Nevada Check Up brochure that includes a tear-off postcard that they can use to self-refer themselves to Nevada Check Up.

Challenges to School-Based Outreach. One barrier Nevada encountered with its school-based outreach approach was that the distribution of applications did not always occur in a timely manner. Some parents indicated that they had never received the application from their child while other parents submitted several applications, one for each child in school.

Another barrier, identified during the course of the TAP, is the need for school staff to coordinate their outreach efforts using a team approach. Ms. Diana Taylor, with the Clark County School District, noted that Nevada Check Up information "trickled down" from the State superintendents to the school nurses, bypassing school principals. As a consequence, the school nurses currently "own" the Nevada Check Up program within a school. There is now recognition that each school needs to take a team approach, that includes the involvement of the school principal, the person who "runs the show." In this manner, the team takes ownership for assisting families to enroll into Nevada Check Up. It was also noted that a school's secretary, who often serves as a central point of contact for families, should probably be involved in the outreach effort.

[26] Many of Nevada's schools have a homeless advocate who assists homeless families.

Issues and Questions Raised During the Presentation. The following issues/questions were raised during Nevada's presentation, presented in a 'Q&A' format:

Q: ***Does Nevada know if it, like other States, has a declining Medicaid enrollment?***

A: Nevada indicated that Medicaid enrollment has been increasing, in part because of Nevada Check Up referrals. Nevada includes Nevada Check Up information and an application with Medicaid denial and termination letters.

Q: ***Using WIC Data to Target Eligible Individuals.***

A: Nevada has a large immigrant population that is spread across the State. Michigan suggested that Nevada could use its WIC database to identify families eligible for Nevada Check Up. Michigan, because its WIC program has a higher income eligibility than Medicaid, used its WIC database to identify those families on WIC but not on Medicaid; once identified, Michigan did a direct mailing of MIChild information to them. South Carolina noted its WIC data are not always accurate as staff do not enter into the database whether or not a family is on Medicaid.

South Carolina

(Ms. Beth Harmon, Ms. Debbie Hanna, and Ms. Cherry Whiten)

Ms. Beth Harmon, Outreach Coordinator with the Department of Health and Human Services presented South Carolina's experience to date incorporating schools into its CHIP/Medicaid outreach approach. The South Carolina team also included Ms. Debbie Hanna, Coordinator of Student Support Services for the Charleston County School District, and Ms. Cherry Whiten, District Director of Social Work for Appalachia I Public Health District for the South Carolina Department of Health and Environmental Control (DHEC).

Current Status of Partners for Healthy Children Implementation. Implemented in August of 1997 (even before CHIP legislation), South Carolina expanded eligibility for its existing Medicaid program under a plan called "Partners for Healthy Children" (PHC). PHC offers coverage to children ages 1 to 5 with family incomes between 133 and 150 percent of the FPL; to children ages 6 to 13 with family incomes between 100 to 150 percent of the FPL; and, to children ages 13 through 18 with family incomes between 50 to 150 percent of the FPL. As a result, older children were now eligible for the same benefits as their younger siblings. PHC enrollees are offered the same benefit package as South Carolina's Medicaid plan and benefits are delivered by the same health care delivery system.

Approaching the School System. The Department of Health and Human Services (DHHS) believes that the only way to successfully reach the uninsured children in South Carolina is to "meet the people where they live." With this vision in mind, DHHS officials identified the school system as a natural partner for identifying eligible children for PHC enrollment. Since 1997, South Carolina has worked with every school to promote PHC through the following activities:

- 1997--Year One. At the beginning of the school year, DHHS sent letters and applications to Superintendents' offices throughout the State. The letter requested that the Superintendents' office distribute the PHC applications to all schools in their district. The intent behind this effort was for every child, regardless of socioeconomic status, to receive an application.
  - During the first year of the program, approximately 33 percent (9,455) of all applications submitted (28,945) were due to the school-based outreach effort.
- 1998--Year Two. In the second year, school principals were the primary targets and recipients of applications, which were accompanied by a letter from the Director of DHHS. As in year one, the letter carried the message that every child should receive an application. In addition, other key school staff members were included in the 1998 outreach strategy, including:
  - The Athletic Director's Association sent a letter, with PHC applications, to all Athletic Directors in the State encouraging them to communicate the importance of having adolescents share the application with their families.

- ◊ The newsletters of the School Nurses Association and School Guidance Counselors contained information about PHC and the availability of applications through a school's office.
- ◊ Outreach efforts from the second year proved successful. Over 10,000 more applications were submitted than in 1997, an indication that some families had been missed during the previous year.

Method for Targeting Schools. All schools in South Carolina were targeted for PHC outreach activities and sent the State's most effective marketing tool-the PHC application.

Number of Schools the State is Working With. South Carolina is currently working with all schools in South Carolina to promote PHC to school staff and parents alike.

Materials Distributed to Schools and Families. As noted above, PHC applications and posters, developed by DHHS staff, are mailed directly to a school's principal. While the school principal serves as the initial contact, front-line school staff frequently assume in-school responsibility for PHC program coordination. Each school distributes PHC applications differently; typically, PHC applications are distributed to children at the beginning of the school year as part of the VIP (Very Important Papers) packet of required paperwork families must complete. In fact some families submitted a completed PHC application, writing on the application "I do not think my child is eligible" just because it was included with the VIP packet. In addition, school nurses distribute PHC applications during school events, such as report card distribution and health fairs.

Outreach Activities/Enrollment Assistance Offered. Several of South Carolina's school districts have been creative in their PHC outreach approach, including:

- ♦ In Charleston, Department of Social Services (DSS) staff share information about PHC with health educators and during health classes.
- ♦ Through corporate partnerships, schools offer incentives (such as pizza parties) to individual classes that return the most PHC applications.
- ♦ In Kershaw county, a hospital paid children $5.00 for each completed PHC application they brought back to school.
- ♦ PHC applications were used as an English assignment in school-students received an "A" if they returned a completed application to school.

The State, in its effort to target families for outreach, have also gone beyond the school grounds:

- ◊ Stock car races in the State are a popular family event. In an effort to go to where the families are, DHEC staff decided to set up PHC tables at the gates to the raceway. While this was worth trying, it proved to be unsuccessful. It was believed that families were probably not in the "right" frame of mind to consider health insurance for their children.

DHEC staff are also working the local offices of temporary employment agencies and small business to have them provide PHC information to their employees.

Enrollment Assistance. In 1998, DHHS contracted with DHEC to promote PHC in communities. DHEC staff, usually outreach workers from local health departments, have developed close working relationships with many of the school districts to participate in the delivery of PHC applications, as well as to provide assistance to families in completing a PHC application. If no one is available for enrollment assistance on-site at the school, the State offers a toll-free number for families to call with questions. Also, local DSS offices are equipped to assist families.

PHC enrollment assistance available in some school districts includes:

- School nurses have been trained by DHEC about the benefits of PHC and know to refer families to DHEC for assistance in completing a PHC application or selecting a medical home; school nurses also play a role in the dispersal of PHC applications.
- DHEC and DHSS staff have made PHC presentations at PTA meetings, health education classes, and health fairs.
- DHEC staff have been stationed at schools during registration and health fairs to assist families in understanding the PHC program and completing the PHC application.

Evaluation Efforts. In 1997, PHC evaluated its school-based outreach approach by color coding the applications "yellow school bus." However, this proved difficult to administer. The current PHC application instead includes the question "Where did you get this application?" Some schools stamp the applications while others do not.

Future Plans for Outreach. For the 1999-2000 school year, DHHS will continue its partnership with the schools with the goal of having every child take a PHC application home. Outreach activities to be conducted include:

- A Fact Sheet, to be attached to the school principal's letter, has been developed to assist front line school staff in answering common questions asked by parents, including referring parents to the State's toll free PHC helpline. The flyer also includes a PHC income chart, which South Carolina recently modified to include income disregards.
- DHEC staff will visit principals at the beginning of the school year to field their questions.
- PHC applications will be sent to school principals to distribute to families with eligible children.
- DHEC and/or DHHS staff will provide PHC information and application assistance, and be present at school events.
- DHEC staff will continue to provide training to school nurses and counselors.

Successes and Challenges of School Partnership. Schools are one of South Carolina's most successful outreach approaches and the successes associated with using the school system include:

- The audience is captive.
- Every child receives an application, not just those thought to be eligible.
- The cost of outreach is low.

At the same time there are challenges, including:

- Parents may never receive the application.
- Non-school aged children are not targeted.

An overall challenge for South Carolina in conducting PHC outreach, regardless of whether schools are used, is that many middle class families do not perceive themselves as eligible and "pride" often prevents them from hearing otherwise. South Carolina is cognizant that some families will need to hear the message about the availability of PHC health care services for their children repeatedly before they may act.

Issues and Questions Raised During the Overview. The following issues/questions were raised during South Carolina's presentation, presented in a 'Q & A' format:

Q: ***Where do parents call with questions, the school or the State?***

A: Parents do call individual schools with questions, which is why DHHS is developing a PHC fact sheet that will address common questions asked by families. The fact sheet will also encourage the school to refer families to the PHC toll-free phone number. Ms. Hanna noted that within the Charleston school district, principals are accountable for academic achievement of their students-this is the "hook" to get them involved in PHC outreach efforts as healthy children come to school better prepared to learn more faster. Parents call the statewide toll-free number most of the time. It is listed throughout the application and is provided to the staff at schools.

Q: ***How has Partners for Healthy Children used the media in its outreach approach?***

A: To date, South Carolina has not relied on the media to promote PHC, noting that the largest cost associated with PHC is printing the applications. The State uses a "grass-roots" approach to outreach that has been effective, with one of the most successful outreach methods being "word-of-mouth." The State wants family members and friends to remain the principle channel of communication and recruitment. With more than 88,000 enrolled children to date, the State does not feel the need to use billboards to advertise PHC.

Q: ***What impact has the question of Public Charge had on outreach efforts?***

A: South Carolina is committed to targeting immigrants for enrollment into PHC; the State estimates that, over the next several years, its immigrant population will grow six times. South Carolina has experienced a negative impact due to the public charge issue in terms of building collaborative partnerships to outreach to immigrant families. Some potential partners are reluctant to proffer their full support to PHC because the public charge issue

remains a potential threat to their clientele. It is hoped that the May 25, 1999 Federal regulations that clarified the public charge issue will assist in resolving this issue.