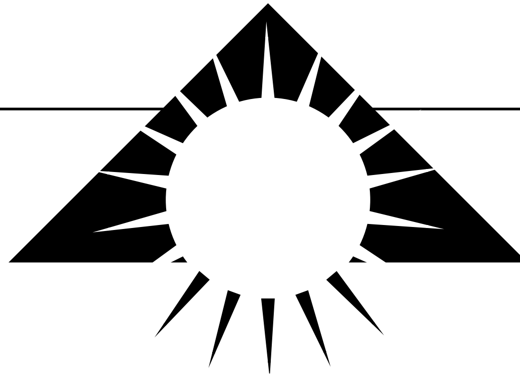

DC Family Policy Seminar

A community service project of Georgetown University

Sign 'em Up: Strategies to Enroll Eligible Children in DC Healthy Families

BACKGROUND BRIEFING REPORT

The DC Family Policy Seminar *provides District policymakers with accurate, relevant, nonpartisan, timely information and policy options concerning issues affecting children and families.*

A collaborative project of the Georgetown Public Policy Institute (GPPI) and its affiliate, the National Center for Education in Maternal and Child Health (NCEMCH). This briefing report and seminar is funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, under its cooperative agreement with NCEMCH (MCU-119301).

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BACKGROUND BRIEFING REPORT

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May 2, 2000

Abstract

The large number of uninsured children in this country is hardly a new issue, since health insurance has long been considered a powerful indicator of children's degree of access to and use of primary health care services. In order to decrease the number of uninsured children and the problems that arise from their lack of insurance, in 1997 Congress created the State Children's Health Insurance Program (SCHIP). SCHIP is the largest single expansion of health insurance coverage for children since the creation of Medicaid in 1965. SCHIP allocates $24 billion to states over a 5-year period to help them expand the availability of health insurance to uninsured children ages 18 and under. The District of Columbia's SCHIP program, DC Healthy Families, has targeted over 16,000 people for enrollment. While the program has successfully enrolled thousands of children and eligible adult family members, thousands more eligible children have not been identified and enrolled. (Eligible adults include pregnant women, parents, and relatives who are caretakers of eligible children.) It is reasonable to assume that the children already enrolled were easier for the program to identify and target.

This report begins with a description of SCHIP and a brief overview of DC Healthy Families. Next it discusses some of the barriers to identifying and enrolling children in DC Healthy Families and looks at several successful methods of expanding enrollment, including the use of community-based organizations (CBOs), school activities, and health care provider initiatives.

This report provides a brief introduction to the issue addressed by the DC Family Policy Seminar on May 2, 2000. The author thanks the numerous individuals in the District of Columbia government and in local and national organizations who contributed to the report. Special thanks are given to Kristine Kelty, Vince Hutchins, Mark Rom, Donna R. Morrison, and the staff of the National Center for Education in Maternal and Child Health for hosting this seminar, and to the staff of the Martin Luther King Memorial Library for providing space and technical assistance. This briefing report and seminar is funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, under its cooperative agreement with NCEMCH (MCU-199301).

Sign ’em Up: Strategies to Enroll Eligible Children in DC Healthy Families

This seminar is the 25th in a series designed to bring a family focus to policymaking. The panel features the following speakers:

- **Donna Cohen Ross**, Director of Outreach Center on Budget and Policy Priorities
- **Tina Cheatham**, Senior Policy Analyst for SCHIP outreach, Health Resources and Services Administration
- **Lynda Flowers**, formerly of DC Medical Assistance Administration
- **Kim L. E. Bell,** Project Director, DC Action for Children

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I. Introduction

The large number of uninsured children in this country is hardly a new issue, since health insurance has long been considered a powerful indicator of children's degree of access to and use of primary services.[1] Lack of insurance coverage negatively affects access to care for children with low incomes. According to a 1999 survey, 41 percent of parents of Medicaid-eligible but uninsured children postponed seeking medical care for their child because they could not afford it, but only 16 percent of parents of children enrolled in Medicaid did so.[2] Uninsured children's limited access to health care services increases the risk that they will contract potentially preventable illnesses. For example, the majority of uninsured children with asthma and one in three uninsured children with recurring ear infections do not see a primary health care professional. Many of these children are later hospitalized for acute asthma attacks that could have been prevented, or suffer permanent hearing loss from untreated ear infections.[3] A recent Kaiser Commission on Medicaid and the Uninsured found that parents of uninsured children are more likely than Medicaid-enrolled parents to fail to seek medical care for their child when they cannot afford it (45 percent vs. 23 percent), and to fail to fill a prescription for their child because they cannot afford to do so (26 percent vs. 13 percent).[2] In addition, lack of access to health care affects children before birth. Studies have shown that adequate prenatal care has long-term positive consequences for children's health and well-being.

Moreover, it is often argued that a public investment in health insurance for children may save taxpayer dollars because it will reduce the use of expensive hospital emergency rooms as regular sources of care. The state of Florida found that when insurance for children was subsidized, emergency room visits dropped by 70 percent in the areas affected by the subsidy, resulting in a savings to the state's taxpayers and consumers of $13 million in 1996.[3]

This report begins with a description of the State Children's Health Insurance Program (SCHIP) and a brief overview of the District of Columbia's SCHIP program, DC Healthy Families. Next it discusses some of the barriers to identifying and enrolling children in DC Healthy Families and looks at several successful methods of expanding enrollment, including the use of community-based organizations (CBOs), school activities, and health care provider initiatives. The report concludes with a brief discussion of the next challenge facing the District: ensuring that once children with low incomes are enrolled, they receive the care they need.

II. Overview of SCHIP

In order to decrease the number of uninsured children and the problems that arise as a result of their lack of insurance, in 1997 Congress created SCHIP, the largest single expansion of health insurance coverage for children since the creation of Medicaid in 1965. SCHIP allocates $24 billion to states over a 5-year period to help them expand the availability of health insurance to uninsured children ages 18 and under. The program builds on Medicaid, the federal-state health insurance program that covers approximately 36 million individuals with low incomes, including 18 million children.[4]

SCHIP aims to provide health insurance coverage to those children whose families do not qualify for Medicaid but are not offered private health insurance through their employer and cannot afford to purchase it on the market.[4] This is an important target population. Contrary to many of the stereotypes about uninsured children, in 1996 more than 90 percent lived in a home where at least one parent worked, and three in five lived in two-parent families.[3] In 1996, 70 percent of the Americans added to the ranks of the uninsured were children, and between 1989 and 1997 children lost private health insurance at twice the rate of adults.[3]

The provisions of SCHIP's enabling legislation, Title XXI of the Social Security Act, give states three options for expanding coverage: (1) designing a new children's health insurance program; (2) expanding the current Medicaid program; or (3) creating a combination program for children in families with incomes of up to 200 percent of the federal poverty level (FPL). States thus have flexibility in creating their programs, and, in addition, both Medicaid and SCHIP provisions allow for flexibility in determining eligibility levels. While some states cover children from families whose incomes are as high as 300 percent of the FPL, most state eligibility rules do not include coverage for those whose incomes are above 150 percent of the FPL. (The FPL for a family of four in 1998 was $16,450.) The SCHIP program provisions allow states to cover children in families whose incomes are above the Medicaid eligibility threshold but below 200 percent of the FPL. States that had previously provided coverage to children in families that had incomes above 150 percent of the FPL could expand the availability of coverage to children in families with incomes up to 50 percentage points higher than the previous income limit.[4]

III. DC Healthy Families

Description of the Program

The District of Columbia's SCHIP program, DC Healthy Families, was approved by the Health Care Financing Administration (HCFA) on September 17, 1998. The program, which began operations on October 1, 1998, is a Medicaid-expansion program that is jointly administered by the District's Department of Health (DOH), the Medical Assistance Administration, and the Department of Human Services Income Maintenance Administration (IMA).[5]

Before eligibility was expanded, the Medicaid program in the District provided free health insurance coverage to children under age 1 with family incomes at or below 185% of the FPL; children ages 1 through 5 with family incomes at or below 133% of the FPL; children ages 6 through 14 with family income at or below 100% of the FPL; and children ages 15 through 18 with family income at or below 50% of the FPL. As a result of the expansion, all children in the District of Columbia who live in families whose incomes are at or below 200 percent of the FPL are eligible for publicly funded health insurance at no cost to themselves.[6]

In addition, DC Healthy Families covers the parents and relative caregivers of eligible children, as well as pregnant women whose incomes are below 200 percent of the FPL.[5] As discussed previously, lack of access to health care can affect children before birth. Studies have shown that adequate prenatal care has positive long-term consequences for the health and well-being of both mothers and children. Ensuring that pregnant women receive adequate prenatal care is particularly important in the District of Columbia, which—despite improvements in the level of maternal and child health—still has some of the highest rates of infant mortality, low birthweight, and inadequate prenatal care, as compared to other cities of similar size. For example, of the women in the District who gave birth in 1987 (before the inception of DC Healthy Families), only 57.5 percent received adequate prenatal care. Of the women remaining, 25.1 percent received an intermediate level of care, and 17.4 percent received inadequate care.[7]

As previously mentioned, DC Healthy Families is a Medicaid expansion program. For funding purposes, the IMA tracks the differences in the federal matching rates (the portion of the program's cost paid for by the federal government) for DC Families and Medicaid. However, applicants and enrollees need not concern themselves with this issue, since all eligible applicants who have a gross income of below 200 percent of the FPL are automatically enrolled in DC Healthy Families. To enroll in DC Healthy Families, families must fill out an application that is submitted to the IMA, the agency responsible for determining eligibility.

Once accepted, a family remains eligible for 12 months. Enrollees receive assistance from the contract "enrollment broker" in selecting their HMO.[8] According to the District of Columbia DOH, at least 60 days before the end of the eligibility period enrollees receive a letter asking for information on any changes in their residency, income, and family size. These changes must be reported within 10 days after the letter is delivered in order for the family to maintain its eligibility for the program.[9]

Enrollment Statistics

As part of the process of approving DC Healthy Families, the DOH contracted with the Lewin Group to determine the number of children and adults who would be eligible for the program, and to come up with target numbers representing the numbers of persons expected to enroll. These target numbers are based on historical data and do not represent the total number of persons in each category.[10] Moreover, despite eligibility expansion and enrollment efforts, many children in the District of Columbia will continue to be without health insurance because (1) their family income exceeds 200 percent of the FPL, (2) they meet the income eligibility requirements but are undocumented aliens, or (3) they are eligible for DC Healthy Families but are not enrolled in the program.[6]

The three different target groups are (1) children who were previously eligible for Medicaid before the enrollment expansion on October 1, 1998; (2) children who are newly eligible because of expanded eligibility; and (3) newly eligible parents and pregnant women.[6] Table 1 shows the target numbers and the numbers of new enrollees.

These enrollment numbers represent 120% of the targeted population of previously eligible but unenrolled children, 48 percent of the targeted newly eligible children, and 86 percent of the targeted parents and pregnant women.[11]

While these numbers are encouraging, it is important to note that a higher percentage of the targeted number of parents and pregnant women—as compared to the percentage of the targeted number of children—have been enrolled in the program. Like many other states, the District is having trouble reaching newly eligible children.[1] Moreover, it is reasonable to assume that the children the program has succeeded in enrolling were more easily identified and targeted than the thousands of eligible children who remain unenrolled.

IV. Challenges to Identifying and Enrolling Children

There are several challenges associated with identifying and enrolling eligible children in both SCHIP and Medicaid. Many parents either do not know about the programs or do not know that their children qualify for the programs, or, if they do know that their children qualify, do not know how and where to enroll them. Research suggests that parents may not enroll eligible children because they want to avoid the "welfare" stigma that is often attached to publicly funded programs,

Table 1: Target Numbers for DC Healthy Families

	Target Numbers as of May 1998[6]	**Target Numbers as of June 1999[11]****	**Enrollees as of December 1999**
Previously eligible children	3,272	4,023	4,819
Newly eligible children	8,401*	5,601	2,674
Newly eligible adults	N/A	6,714	5,768

*This number represents the 6,672 uninsured children who are expected to enroll and the 1,729 children with private coverage who are expected to drop such coverage and enroll.

**Target numbers were reestimated following the program's initiation.

and also because the enrollment process is often difficult and inconvenient, particularly for non–native English speakers.[12]

According to the results of a 1999 Kaiser Commission on Medicaid and the Uninsured national survey, 58 percent of parents had not tried to enroll their child in Medicaid because they didn't think the child would qualify; 56 percent said they did not know where to apply; and 50 percent cited complex rules and forms as barriers to enrollment.[2] Others cited the enrollment office's limited hours and difficulties getting to the office. A survey of parents who had tried to enroll their children but did not complete the process revealed that the process was too complicated and confusing (62 percent). Other parents cited difficulties in obtaining all the required documentation (72 percent) and the overall bother of the enrollment process (66 percent) as important reasons for not completing the process.[2]

In sum, the major barriers to enrollment are lack of knowledge about SCHIP and Medicaid and their eligibility rules and, for those who do know about the programs, their negative perceptions of or experiences with the enrollment process.

V. Ways to Simplify the Enrollment Process

Both researchers and practitioners have identified several ways to simplify the process of enrolling in Medicaid and SCHIP. Their suggestions include (1) simplifying and shortening the application forms; (2) eliminating asset tests; (3) using a single application for Medicaid and SCHIP; (4) accepting completed applications via mail or phone; and (5) establishing toll-free application-assistance hotlines. These methods are discussed in more detail below.

In the past some state Medicaid application forms were more than 20 pages long, which posed an insurmountable challenge for some families. Many states have made the enrollment process more manageable by eliminating unnecessary questions on the SCHIP and Medicaid application forms and by making certain that the questions are clear. One of the most effective methods of simplifying the process is to reduce the verification burden placed on families by eliminating the assets test used to determine eligibility for pregnant women and children. Under federal Medicaid laws (laws that also apply to Medicaid-expansion SCHIP programs), the only verification families must submit is proof of their child's immigration status, a requirement only applicable to noncitizens.[13] In addition, the entire process can be simplified if the states provide one application form for both programs. This helps both the applicants and the state, because it reduces paperwork.[14]

Allowing families to apply for SCHIP via mail or phone clearly simplifies the process for them. This option reduces transportation costs, does not require parents to miss work, and addresses many people's perception that there is a stigma attached to visiting a social service office. In addition, the fact that the forms can be filled out off site enables community groups to assist in distributing and collecting applications and to help potential enrollees fill out applications.[14]

Another strategy for making the enrollment process more manageable is to develop toll-free application-assistance hotlines. In its SCHIP literature, HRSA recommends that these hotlines be staffed beyond normal business hours. This may encourage the enrollment of higher-income, newly eligible children, since it is likely that their parents are employed. Many states already offer such hotlines, and help is available in several languages. In some states it is also possible to apply for SCHIP and Medicaid by telephone.[14]

VI. Community-Based Outreach Strategies

A simplified application procedure is of little use if potential enrollees are unaware of a program's existence. This is especially relevant for

SCHIP enrollment, as eligible parents may have no history of contact with the public system and often do not even consider publicly funded programs. An effective outreach strategy must therefore make people aware of the program. The strategy should also seek to address the stigma attached to welfare programs. As discussed previously, allowing mail-in applications is one option; another is to emphasize the program's identity as a stand-alone health insurance program for low-income, working families, separate from the welfare system.[12] Another frequently adopted strategy is to come up with a catchy name that suggests a program designed to keep children healthy, rather than a welfare program.[15]

The provisions of SCHIP legislation allow for flexible enrollment activities, and states are designing their own unique outreach programs to reflect their communities' needs. In addition to the general use of print and media campaigns and collaboration with agencies such as WIC, states are using CBOs for targeted enrollment activities. These activities, which target children who are historically more difficult to reach, include using community-based advocacy organizations, provider involvement, and school-based outreach activities. The activities are described in more detail below.

Community-Based Organizations

CBOs can play a significant role in disseminating information about SCHIP because they have existing relationships with eligible adults and children. Community organizations that could potentially be interested in becoming involved in an outreach campaign include community health clinics; child care centers; community action agencies; tenants associations; after-school centers; and programs that offer recreation, adult education, literacy classes, job training, food and shelter assistance, family counseling, and other services.[16]

States that have formed partnerships with community organizations report that they have been highly successful at enrolling eligible families in SCHIP. In an American Public Human Services survey, all 33 of the states that responded had formed multiple partnerships with groups working at the local and community level to review outreach materials, participate in focus groups and commissions to discuss strategies, and disseminate information. According to the survey, the partnership efforts cost the state very little and were effective at reaching targeted populations.[17]

Moreover, using CBOs makes available additional funding sources for outreach strategies, because some foundations providing funding may stipulate that a certain percentage must be used at the community level. One example of a foundation that provides funding for programs that encourage the involvement of CBOs is The Robert Wood Johnson Foundation. Its initiative, Covering Kids, is a national health access initiative for uninsured children with low incomes that aims to help increase the number of eligible children who benefit from health insurance coverage programs. The initiative awards 3-year grants to state-local coalitions working to identify and enroll eligible children. Each coalition receiving the funding must design a statewide program and pilot community-based initiatives. Although the lead organization must be a statewide agency, by requiring that at least half of all funds be used to support activities in the pilot communities, The Robert Wood Johnson Foundation ensures that Covering Kids work closely with neighborhood CBOs. In fact, it is through the program's community-based pilot projects that the foundation believes much of the work will be accomplished. There are many lessons to be learned from this approach.[18]

School-Based Outreach Activities

According to a recent U.S. General Accounting Office study, 69 percent of uninsured Medicaid-eligible children were either in school or had school-age siblings and therefore could be reached through school-based efforts. Since school professionals such

as teachers, social workers, and school-based health professionals are often the first to identify children's health concerns, it seems logical that school-based efforts could succeed.[19] In addition, parents often trust teachers and school officials and have faith in the information they provide.

In structuring school-based outreach activities, states should consider how to best involve teachers and administrators. One way to encourage them to become involved in enrolling eligible children in Medicaid and SCHIP is to stress the important link between children's health and their ability to learn and to behave appropriately in class. Some school-based health clinics are certified to receive Medicaid reimbursements, and it should be pointed out that helping students enroll in Medicaid and SCHIP can thus be in the school's financial interest. It is also important to avoid overwhelming school staff when requesting their involvement. In addition, school staff must be properly trained about the program and their role in enrolling children.[16]

One of the most effective ways to incorporate outreach activities in schools is to coordinate efforts with school calendars. For example, many states have coordinated outreach activities with mailings about school lunch programs, or have set up information booths during registration, report card pick-up days, and parent-teacher conference days.[16] Although states have found this practice very effective at increasing the numbers of applications and raising enrollment figures, some SCHIP and Medicaid coordinators point out that parents may have their hands full at these times and may be unwilling to fill out another form.[16]

Provider Involvement

Like schools, community health clinics and hospitals are excellent venues for distributing SCHIP program information. Physicians, nurses, therapists, medical social workers, pharmacists, and registration and billing office workers interact directly with patients and are often trusted advisors. Moreover, many families rarely think about needing health insurance until a child gets sick or hurt and needs care. At the same time, routine preventive care is virtually impossible to obtain without health insurance. Health professionals are in a good position to help families unravel this dilemma by emphasizing the importance of prevention and helping families obtain coverage for their children.[19]

One of the most basic ways to provide SCHIP information is to display posters and distribute flyers, brochures, and application forms in waiting areas, registration areas, lounges, and pharmacies. Health providers can help with outreach most effectively if everyone in the organization is aware of the program, since doctors and nurses are often too busy to talk about such issues with patients.

Because physicians often are respected members of the professional and business communities in which they practice, they can effectively encourage outreach activities. In many communities, physician associations have catalyzed outreach efforts with financial support for community groups or have encouraged their members to become involved in efforts undertaken at hospitals or clinics in which they work. For example, the Massachusetts Medical Society has mailed every physician in the state a poster with two brochures describing the availability of health insurance for children. They also sent physicians a Rolodex card containing the phone numbers needed to get more information, as well as a postcard they could mail back to the Medical Society to request additional materials. To enhance these efforts, the Medical Society recently launched a $60,000 outreach project aimed at publicizing the availability of free and low-cost health insurance in Massachusetts. The project will target all practicing physicians and their office staffs through training, one-on-one discussions, and dissemination of information.[19]

SCHIP can encourage provider involvement by emphasizing the potential benefits to providers, in addition to the benefits to the children, of encouraging children to enroll. Making sure children

have the insurance coverage for which they are eligible can bring financial resources into hospitals and clinics that may be hard-pressed to maintain quality care. Providers that have the capacity to hire staff or help finance outreach activities—either within their own hospitals or clinics or in conjunction with other CBOs—may view such activities as a way to help generate future revenues.[19]

VII. Model Programs

As previously discussed, numerous strategies can be implemented to improve outreach and increase enrollment. The following initiatives, which are based on coordination with CBOs, school employees, or health care providers, are working to enroll eligible children and parents in publicly funded health insurance programs.

DC Covering Kids: A Health Access Initiative

Funded by a $982,118 grant from The Robert Wood Johnson Foundation, DC Covering Kids: A Health Access Initiative was designed to complement the efforts of the District of Columbia DOH to identify and assist with health coverage preenrollment and enrollment activities for uninsured and underinsured children with low incomes in the District. DC Covering Kids is being implemented at both the citywide and the neighborhood level.[20]

At the citywide level, DC Covering Kids has partnered with government agencies, parent councils, and contractors.[10] Thus far, the initiative has used several city events to share information about publicly funded insurance programs. At the DC Safe Kids Coalition's "Safety Starts Here" conference, staff members used a workshop room to enroll people and increase awareness of the program. In addition, with the encouragement of DC Covering Kids, on Sunday, September 19, 1999, many churches made announcements during worship services about DC Healthy Families, and they also placed notices in their bulletins.[21]

At the neighborhood level the initiative has contracted with three nonprofit CBOs with proven records of success in outreach and advocacy to populations that are difficult to reach through mainstream efforts. These CBOs are The Far Southeast Family Strengthening Collaborative (a Healthy Families/Thriving Communities Collaborative), The Edgewood/Brookland Family Support Collaborative, and the Non Profit Clinic Consortium.

The Far Southeast Family Strengthening Collaborative, a Healthy Families/Thriving Communities Collaborative, is working with DC Covering Kids to reach hard-to-reach eligible families in the District's Ward 8, a federally designated Health Professional Shortage Area with the highest adolescent pregnancy rate and the second highest infant mortality rate in the city. The collaborative plans to implement a series of activities over the next 3 years that will seek to reach every eligible family in Ward 8. Thus far, staff have conducted outreach, education, and enrollment for DC Healthy Families at Anacostia Family Day, and they have worked on citywide projects.

The Edgewood/Brookland Family Support Collaborative, in conjunction with Mid Northeast and North Capitol collaboratives, is coordinating outreach and preenrollment efforts in Ward 5. Unlike Ward 8, which struggles to maintain a viable community, Ward 5 has a thriving civic culture, with strong resident and homeowner associations, parent-teacher groups, block clubs, and advisory neighborhood commissions. However, Ward 5 is also a federally designated Health Professional Shortage Area and has the highest infant mortality rate in the District. While Ward 5 has significant numbers of public and subsidized housing residents, and homeless families living in transitional shelters, it is also home to a substantial population of low- and moderate-income homeowners. Families in the latter group are likely to have children who are eligible for DC Healthy Families, and these families are the target of this outreach effort. Like the Far Southeast Family Strengthening

Collaborative, the CBOs in Ward 5 have taken advantage of neighborhood events, such as the EMS Fire Station Health Fair, to provide applications, assistance, and DC Healthy Families brochures to residents.

Non Profit Clinic Consortium is targeting the immigrant population of Wards 1 and 2 in Northwest Washington. In addition to the barriers discussed previously, immigrant populations often face additional difficulties as a result of language challenges and real or perceived risks of deportation as a consequence of applying for public benefits. Legal immigrants or U.S.-born citizen children of immigrants in the District who are probably eligible for DC Healthy Families or Medicaid but are not enrolled in either are the target population of this neighborhood project.[20]

New York City: The Student Health Outreach Project

CBOs in Northern Manhattan have partnered with the Children's Defense Fund–New York and Columbia University on The Student Health Outreach Project (SHOUT), a unique program that aims to reach out to uninsured children in the area. Columbia University graduate and undergraduate students are trained by Children's Defense Fund–New York's outreach staff on how to complete the new joint application for Medicaid and Child Health Plus, New York State's SCHIP program. Students also receive cultural sensitivity training in the appropriate screening procedures for immigrants and other populations with low incomes. Once trained, these student volunteers are placed in CBOs.

Through this program, many eligible uninsured children have received help enrolling in Medicaid and SCHIP. Students participating in SHOUT work in selected CBOs that serve populations that might qualify for either program. These student volunteers educate families about Medicaid and SCHIP, screen them for eligibility, and assist them during the enrollment process. Each student volunteer agrees to serve at least 2 hours a week in one specific CBO. As a result of this commitment, students and CBOs are a reliable and continuous source of information for families.

The goal of the SHOUT project is to enroll all eligible children in Northern Manhattan in Medicaid or Child Health Plus. The project strives to accomplish this goal by informing as many families as possible about the availability of free or low-cost health insurance. These efforts are carried out through an extensive public awareness campaign and by providing accessible enrollment sites manned by knowledgeable staff to offer families guidance through the application process.[22]

Escambia County, Alabama

Pediatrician Dr. Marsha Raulerson built on her relationship with the pharmaceutical company Wyeth Lederle to obtain a $10,000 grant to conduct an outreach project that targeted adolescents in Escambia County, AL. Dr. Raulerson identified seven of her adolescent patients who agreed to participate in SCHIP outreach efforts targeted to other adolescents in their county. A college student served as the director of the initiative and provided guidance for the adolescents.

The students began the outreach initiative by conducting focus groups with other adolescents in the county to identify their health care needs and desires. They also sponsored a number of receptions with local ministers and counselors to increase their awareness of SCHIP and to encourage them to spread the word about the program to other adolescents. The students collaborated with a local hospital to obtain names of patients ages 18 and under who were uninsured; they then attempted to reach these patients. (This information was released to the students with the understanding that the patient information would be used solely for SCHIP outreach efforts and that patients' confidentiality would not be compromised.) When hundreds of

student athletes were at school before the beginning of the school year for their mandatory physicals, the outreach volunteers were there to distribute program information.

The adolescents' efforts did not go unnoticed by community members. Local hospitals donated money to cover the cost of mailing information and also donated room space for meetings and receptions. The Alabama Medical Association donated funds to purchase tee shirts with information about the program printed on them. The students wore these tee shirts to school to increase their classmates' awareness of the program.

The outreach efforts headed by Dr. Raulerson appear to have been extremely successful. In one local hospital, the percentage of children and youth coming in without insurance dropped from 25 percent to 11 percent. The grant funds provided leverage for additional funds and support from area hospitals and other community groups.[23]

Kids Health 2001

Kids Health 2001, an all-out effort to get Seattle children enrolled in Medicaid, is using schools as the venue for its campaign. Family support workers are available in 65 elementary schools to help families obtain a range of benefits and services. Along with school nurses, they have been trained by the Washington Health Foundation's Child Health Access Program (CHAP) to assist families with Medicaid applications. To ensure adequate support for the outreach effort, the Washington Health Foundation has provided funding for four full-time family support workers and four full-time school nurses whose sole duty is to provide application assistance.

A series of school-based promotional activities has focused attention on the help available to parents. First, a letter from the school superintendent on the importance of health insurance for children was printed in nine different languages and mailed to 36,000 families. The letter encourages families to call their school's family support worker, the school nurse, or the CHAP telephone line for application assistance. The letter generated an overwhelming response. Each participating school also displays posters emphasizing the availability of ongoing application assistance. In addition, City Year Youth Corps workers are helping with outreach and application assistance at special events, and they are scheduled to receive pagers so that they will be able to respond to families within 24 hours.

Kids Health 2001 is also working to make application assistance a systematic part of the school routine. At kindergarten registration and school sports registration, families will be able to apply for health insurance for their children. Seattle schools have been experimenting with linking Medicaid application assistance to the school lunch program; by checking a box on the school lunch application, families can now grant the school permission to share their name and address with the Medicaid agency so that a Medicaid application can be mailed to them. Next year the school district is planning to pilot a new idea that takes the school lunch connection a step further. The school lunch application will be printed on a self-duplicating carbon form. By checking the appropriate box on the form, families will grant permission for a copy of the form, which includes family income information, to be mailed to the Medicaid agency for the purpose of determining income eligibility for coverage. The Medicaid agency will contact families to obtain any additional information they may need—such as the child's immigration status—to make a full eligibility determination.[16]

VIII. Policies to Increase Enrollment

In addition to using CBOs, provider clinics, and schools as potential sites from which to spread the word about SCHIP and Medicaid, states can increase enrollment in two other ways. The first is to establish "presumptive eligibility." The second is to increase the eligibility period for Medicaid and SCHIP. These two methods are explored in more detail below.

Presumptive Eligibility

Presumptive eligibility allows traditional Medicaid providers, WIC agencies, Head Start programs, and agencies that determine eligibility for subsidized child care to make eligibility determinations for the immediate enrollment of children who appear to meet the Medicaid and SCHIP income guidelines. This process can allow children to receive immediate health care coverage without waiting for a full eligibility determination to be completed. Families are required to complete a full application by the end of the month following the preliminary eligibility determination, but until final determination is made, a child is covered for Medicaid and SCHIP services.[14]

Twelve-Month Continuous Eligibility

Many families' income eligibility status changes frequently as a result of job changes or fluctuations in take-home pay. States have the option to provide individuals ages 18 and younger with up to 12 months of continuous eligibility after they are determined eligible, even if there is a change in the family's income, assets, or size. Under this option, Medicaid eligibility is granted for a period of up to 1 year, regardless of changes that may affect beneficiary circumstances.[14] This not only allows for more consistent enrollment but also minimizes the families' need to submit reports and reaffirm their eligibility at frequent intervals.[13]

IX. District Strategies

Enrollment Simplification

DC Healthy Families has already employed many of the strategies suggested above to simplify the enrollment process. Using input from residents and providers, the program has developed a three-page "short form" application for adults in a family with at least one child age 18 or younger, or children ages 20 and younger who are filling out the application on their own behalf. This form can be used to determine eligibility for DC Healthy Families.[24] Forms are available at public libraries, homeless shelters, schools, nonprofit and DC General–affiliated Public Benefit Corporation (PBC) clinics, pharmacies, grocery stores, the Capital Area Food Bank, Healthy Family/Thriving Communities Collaboratives, the Office of Tax and Revenue, the Bureau of Vital Statistics, the headquarters and field sites of the Department of Motor Vehicles and Office of Employment Services, and other organizations.[10] This "short form" has eliminated the asset test. Once enrolled, children remain enrolled for 12 months.

Assistance in completing the application is available between 8:00 a.m. and 4:45 p.m., Monday through Friday, through the (800) MOM-BABY hotline. In order to assist non–native English speakers, the hotline is staffed with operators who speak English, Spanish, Chinese, Vietnamese, or Korean. The hotline is also equipped to assist people with hearing impairments.[25]

Outreach Activities—Spreading the Word

Coordinating with schools extends beyond ensuring that charter schools, Catholic schools, and District of Columbia public schools do not run out of applications. DC Healthy Families has also collaborated with District of Columbia public schools to arrange activities on report card pick-up day. On three report card pick-up days, community volunteers set up information booths at more than 40 schools to distribute information about DC Healthy Families to parents who are picking up report cards. As a result of this strategy, which was launched in 1999, more than 1,000 families have applied for enrollment in DC Healthy Families.[25]

Like many other state programs, DC Healthy Families is conducting several public awareness campaigns. In February it launched DC Healthy Families 2000, a campaign that includes radio spots, print advertisements, a workplace initiative,

and corporate sponsorship opportunities. As part of this campaign, it sponsors Lights, Camera, Action!, a television script-writing contest. The contest encourages students ages 13 to 18 to write original television-commercial scripts that communicate the importance of keeping families healthy. The script(s) of the first-place winner(s) will air on local television (In Touch).

X. The Next Challenge: Ensuring Access to Health Care

This briefing report provides an overview of DC Healthy Families, current enrollment figures, and strategies to help enroll all eligible District children in the publicly funded health insurance program. However, identifying and enrolling children are only the first steps in ensuring that they have access to quality health care. The next challenge facing DC Healthy Families is ensuring that there are enough easily accessible health professionals to serve children enrolled in the programs. This is a tremendous challenge in the District of Columbia, where many residents lack adequate access to primary health care, despite the fact that the number of primary care physicians (PCPs) per capita in the District is among the highest in the nation. The PCPs are unevenly distributed throughout the city, and not all of them accept Medicaid. A 1995 Mayor's Blue Ribbon Panel on Health Care Reform Implementation reported that more affluent parts of the city have over three times the number of PCPs found in poorer neighborhoods. Moreover, many neighborhoods in the District are federally designated Health Professional Shortage Areas.[26] Nearly all of these areas are also likely to experience heavier service use in the future, because of the increased numbers of people with low incomes who now have insurance and thus can take advantage of available health care.

It is important that all children receive the health care they need, including preventive care and prenatal care. Healthy children learn better in school and are less likely to pass diseases on to other children. The District faces numerous challenges in ensuring that its children receive necessary health care. Identifying and enrolling all eligible children in DC Healthy Families is a good first step.

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Appendix A

District Resources

Columbia Heights/Shaw Family Support Collaborative
Contact: Marian Urquilla
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Washington, DC 20009
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Fax: (202) 518-6742

The Columbia Heights/Shaw Family Support Collaborative (CH/S FSC) is a comprehensive, neighborhood-based child abuse and neglect prevention effort. Founded in 1996, the collaborative works in partnership with seven other neighborhood collaboratives throughout the city and brings together public and private service providers, residents, and community associations to create a continuum of child welfare and family support services in Northwest Washington, DC. The mission of CH/S FSC is to build a prevention-based family support network in the Columbia Heights and Shaw neighborhoods.

DC Action for Children
Contact: Susie Cambria, Public Policy Analyst
1616 P Street, N.W., Suite 420
Washington, DC 20036
Phone: (202) 234-9404
Fax: (202) 234-9108
Web site: http://www.dckids.org

DC Action for Children (DC ACT) is an independent nonprofit, multi-issue advocacy organization dedicated to improving conditions for children and families in Washington, DC. DC ACT gathers and publishes accurate information, oversees legislative and administrative decisions, holds government officials accountable, organizes coalitions, and works to mobilize a citywide constituency for children.

DC Covering Kids: A Health Access Initiative
Contact: Kim L. E. Bell, Project Director
DC Action for Children
1616 P Street, N.W., Suite 420
Washington, DC 20036
Phone: (202) 234-9404
Fax: (202) 234-9108
E-mail: kimbell@dckids.org

The Robert Wood Johnson Foundation has awarded a grant to the Community Foundation of the National Capital Region to implement DC Covering Kids: A Health Access Initiative. DC Action for Children is acting as an agent to the Community Foundation in implementing the initiative. DC Covering Kids will complement the efforts of the District of Columbia in identifying children and enrolling them in health coverage programs. DC Covering Kids will be implemented at both the citywide and the neighborhood level.

DC Healthy Families
645 H Street, N.E.
Washington, DC 20002
Phone: (800) MOM-BABY
Web site: http://www.dchealth.com/dchf

DC Healthy Families is a Medicaid expansion program that provides free health insurance to families with children ages 18 and younger. DC Healthy Families covers children, adolescents ages 18 and younger who live alone, pregnant women, and parents. DC Healthy Families is part of the State Children's Health Insurance Program, a national initiative whose purpose is to ensure that every child has access to health care. DC Healthy Families is funded by the District of Columbia and the federal government and is administered by the Department of Health, Medical Assistance Administration; the

Department of Human Services, Income Maintenance Administration; the Office of Maternal and Child Health; and the outreach contractor, Birch and Davis Associates, Inc.

Edgewood/Brookland Family Support Collaborative—Beacon House

Contact: Louvenia Williams
1345 Saratoga Avenue, N.E., Suite 1
Washington, DC 20018
Phone: (202) 832-9400
Fax: (202) 832-9456

The Edgewood/Brookland Family Support Collaborative (E/BFSC) is a community-based network of organizations and residents working together to promote environments that support the growth and development of youth, families, individuals, and communities. E/BFSC's mission is to create an infrastructure that supports and strengthens all the members of the community, both individually and collectively. Working from a strengths-based focus and through the service efforts of residents and other community stakeholders, the collaborative strives to ensure that the community is thriving.

Far Southeast Family Strengthening Collaborative

Contact: Joy Smith, Director
2401 Martin Luther King Jr. Avenue, S.E., Suite 205
Washington, DC 20020
Phone: (202) 889-1474
Fax: (202) 889-2213

The Far Southeast Family Strengthening Collaborative is a partnership of residents, agencies, and institutions in the Far Southeast community that have come together to create a healthy socioeconomic environment through which every child and family has opportunities to achieve their maximum potential and to lead a productive life. Its goal is to develop a plan to better coordinate services to children, youth, and families in Far Southeast. As a participant in DC Covering Kids: A Health Access Initiative, over the next 3 years the collaborative plans to implement a series of activities that will help it reach every eligible family in the District of Columbia's Ward 8.

Mid-Northeast Collaborative

Contact: Isadore Lane
1310 Florida Avenue, N.E.
Washington, DC 20002
Phone: (202) 399-6195
Fax: (202) 399-9120

The mission of the Mid-Northeast Collaborative is to regain the family through the development of a community-based model and the identification of available resources. The collaborative hopes to reduce child abuse and neglect in the mid-Northeast section of the District of Columbia by building and strengthening collaborative efforts using government, private, and community resources.

North Capitol Healthy Families/Thriving Communities Collaborative

Contact: Sheila Strain
1190 First Place, N.W.
Washington, DC 20001
Phone: (202) 898-1800

The North Capitol Collaborative seeks to protect children, strengthen families, and build community resources to sustain a healthy, safe, and vibrant community. The collaborative works with area churches, schools, businesses, and individuals to accomplish its goals of building community capacity by improving the economic, social, and spiritual environment in the North Capitol area. The North Capitol Collaborative partnership with the Child and Family Services Administration (CFSA) is an innovative community strengths-based model for the delivery of family support and preservation services.

South Washington/West of the River Family Strengthening Collaborative

Contact: Samuel Tramel
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Washington, DC 20003
Phone: (202) 543-3535
Fax: (202) 543-3668

The mission of the South Washington/West of the River Family Strengthening Collaborative is to build a healthy community by creating a local network of community-based, family-centered, and supportive resources. Using this network to promote the emotional, social, physical, and economic stability of children, youth, and families, the collaborative strives to create a community through which every child and family in South Washington has opportunities to achieve their maximum potential and lead a productive life.

Appendix B

National Resources

Association of State and Territorial Health Officials
Contact: Christa Singleton, Senior Project Coordinator
1275 K Street, N.W., Suite 800
Washington, DC 20005
Phone: (202) 371-9090
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Web site: http://www.astho.org

The Association of State and Territorial Health Officials (ASTHO) is a nonprofit public health organization that represents the leaders of state and territorial health agencies. ASTHO serves as a primary information resource to state health agencies on a wide range of issues, including HIV/AIDS, immunizations, tobacco-use control, primary care, maternal and child health, and the environment. ASTHO is engaged in a variety of legislative, scientific, educational, and programmatic issues and activities on behalf of public health. Policy committee areas include (1) access to care, (2) environmental health, (3) infectious disease, (4) prevention, and (5) public health information and infrastructure.

ASTHO's Access Policy Committee assesses policy and programmatic issues related to access to health services, particularly for vulnerable and at-risk populations. The committee's focus includes the integration of public health in managed care and the restructuring of Medicaid. The committee provides ongoing oversight for the Primary Care and Maternal and Child Health (MCH) cooperative agreement projects, funded by the Health Services and Resources Administration's (HRSA) Bureau of Primary Health Care (BPHC) and Maternal and Child Health Bureau (MCHB), and for a new human genetics policy project funded by the Centers for Disease Control and Prevention's Office of Genetics and Disease Prevention. Specific priorities addressed by project activities include the implementation of the new State Children's Health Insurance Program; the changing roles of public health and managed care; the impact of welfare reform on public health and access; the transition of Medicaid populations to managed care systems; the viability of the nation's safety-net providers; and the challenges and opportunities of not-for-profit health system conversions.

Center on Budget and Policy Priorities
Start Healthy, Stay Healthy Campaign
Contact: Donna Cohen Ross, Outreach Director
820 First Street, N.E., Suite 510
Washington, DC 20002
Phone: (202) 408-1080
Fax: (202) 408-1056
E-mail: shsh@cbpp.org
Web site: http://www.cbpp.org

The Center on Budget and Policy Priorities (CBPC) is a nonpartisan research organization and policy institute that conducts research and analysis on a range of government policies and programs, with an emphasis on those affecting people with low and moderate incomes. The center promotes better public understanding of the impact of federal and state spending policies and programs primarily affecting families and individuals with low and moderate incomes. Areas of research include national poverty trends, tax policy, housing affordability, effectiveness of funding for social programs, hunger and nutrition issues, unemployment, minimum wage, and state budget and tax policies. The center specializes in research and analysis oriented toward policy decisions that policy-

makers face at both federal and state levels. It examines data and research findings and produces analyses designed to be accessible to public officials, other nonprofit organizations, and the media. The center operates two outreach campaigns to help working poor families receive two key benefits for which they are eligible: the earned income tax credit and health care coverage for children through Medicaid or other state child health insurance programs.

Since 1994, the center's national Start Healthy, Stay Healthy outreach campaign has enlisted a wide array of community-based organizations, health and human services providers, advocacy groups, program administrators, and others to identify children from working families with low incomes who may be eligible for free or low-cost health insurance programs. The campaign also promotes coordination between newly enacted state child health programs and Medicaid to ensure that children receive coverage.

Children's Defense Fund

Contact: Jeannette O'Connor, SCHIP Implementation Coordinator
25 E Street, N.W.
Washington, DC 20001
Phone: (202) 662-3551
Fax: (202) 662-3560
E-mail: cdfhealth@childrensdefense.org
Web site: http://www.childrensdefense.org

The mission of the Children's Defense Fund (CDF) is to ensure every child a healthy start, a head start, a fair start, a safe start, and a moral start in life, and successful passage to adulthood with the help of caring families and communities. CDF provides a voice for all the children of America who cannot vote, lobby, or speak for themselves. CDF pays particular attention to the needs of minority children and children who have disabilities or who live in families with low incomes. CDF educates the nation about the needs of children and encourages preventive activities that can help them avoid becoming ill, getting into trouble, dropping out of school, or suffering family breakdown. CDF has also made available regular information updates via e-mail. Topics covered include best practices for outreach and enrollment; uninsured children; maternal and child health; immunizations; and Medicaid. Types of information include descriptions of successful outreach and enrollment strategies and how they can be implemented in local communities; national and state data; descriptions of proposed or adopted federal and state legislation; and reviews of developments in state and local child health policy and in public health literature.

Families USA Foundation

Contact: Vicki Pulos, Associate Director of Health Policy
1334 G Street, N.W., Suite 300
Washington, DC 20005
Phone: (202) 628-3030
Fax: (202) 347-2417
E-mail: info@familiesusa.org
Web site: http://www.familiesusa.org

Families USA Foundation is a national nonprofit, nonpartisan organization dedicated to the achievement of high-quality, affordable health and long-term care for all Americans. Families USA produces health policy reports describing the problems facing health care consumers and outlining steps to solve them. It also conducts public information campaigns about the concerns of health care consumers; serves as a consumer clearinghouse for information about the health care system; and provides training and technical assistance to state- and community-based organizations as they address critical health care problems in their communities and state capitals. Families USA also issues reports and other materials on health care and long term care for use by consumer organizations, policymakers, the media, and state-based coalitions working on health care and long-term care reform.

Health Care Financing Administration
Contact: Mary Kahn, HCFA Public Affairs
200 Independence Avenue, S.W., Suite 303D
Washington, DC 20201
Phone: (202) 690-6145
Fax: (202) 690-7159
E-mail: CHIPinquiry@hcfa.gov
Web site: http://www.hcfa.gov

The Health Care Financing Administration (HCFA) is the federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). HCFA manages SCHIP, the $24 billion health insurance portion of the Children's Health Initiative. HCFA works closely with the states, Congress, the Health Resources and Services Administration, and other federal agencies to implement the program, define its parameters, and approve individual state plans to insure children at the earliest possible date. HCFA's Web site contains SCHIP information that includes state-by-state contact information; an SCHIP state plan status map; a database of each state plan; copies of the initial SCHIP legislation; suggestions on ways to simplify and clarify application, enrollment, and eligibility requirements; ways to meet the health care needs of immigrant children; examples of and options for successful outreach and enrollment activities; and information on coverage and immunization under Title XXI and the Vaccines for Children (VFC) program.

Health Resources and Services Administration
Contact: Marcia Brand, Special Assistant
Office of the Administrator
5600 Fishers Lane, Room 14-15
Rockville, MD 20857
Phone: (301) 443-4619
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E-mail: Mbrand@HRSA.DHHS.GOV
Web site: http://www.hrsa.dhhs.gov/childhealth/

The Health Resources and Services Administration (HRSA) is the federal government's health care "access agency." HRSA is building systems of care in partnership with communities to ensure that children and families receive comprehensive, quality service. HRSA manages SCHIP outreach, the establishment and maintenance of Health Homes, and public health intervention through the expansion of community-based providers. HRSA's "Child Health" Web site offers a compendium of outreach models; information on the agency's child health programs; a list of SCHIP experts at the Department of Health and Human Services; a database of key state child health resources that is searchable by state; examples of four programs through which HRSA is helping states and communities develop workable solutions to local health care challenges; and "Facts about Uninsured Children."

National Center for Education in Maternal and Child Health
Contact: Rochelle Mayer, Director
2000 15th Street, North, Suite 701
Arlington, VA 22201-2617
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Web site: http://www.ncemch.org

The National Center for Education in Maternal and Child Health (NCEMCH) provides national leadership to the maternal and child health community in three key areas of program development, policy analysis and education, and state-of-the-art knowledge to improve the health and well-being of the nation's children and families. NCEMCH provides information services to professionals and the public on maternal and child health; disseminates information on available materials, programs, and research; and conducts conferences and workshops.

National Conference of State Legislatures

Contact: Rhonda Gonzalez
444 North Capitol Street, N.W., Suite 515
Washington, DC 20001
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Fax: (202) 737-1069
E-mail: info@NCSL.org
Web site: http://www.ncsl.org

The National Conference of State Legislatures is a bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states and its commonwealths and territories. The conference is a source for research, publications, consulting services, meetings, and seminars. NCSL's mission is to improve the quality and effectiveness of state legislatures; foster interstate communication and cooperation; and ensure that legislatures have a strong, cohesive voice in the federal system. NCSL's health care program provides information services on a wide range of health policy issues via publications, meetings, seminars, Web pages, technical assistance, and responses to requests for specific information.

National Governors' Association

Contact: Emily Cornell, Policy Analyst
Hall of States
444 North Capitol Street, N.W., Suite 267
Washington, DC 20001
Phone: (202) 624-5300
Fax: (202) 624-5313
Web site: http://www.nga.org

The National Governors' Association (NGA) is the association of governors of the 50 states and U.S territories. NGA serves as a vehicle through which governors influence the development and implementation of national policy and apply creative leadership solutions to state problems. Through NGA, governors identify priority issues and deal collectively with issues of public policy and governance at both the national and the state levels. The association's mission is to provide a forum for governors to exchange views and experiences among themselves; assistance in solving state-focused problems; information on state innovations and practices; and a bipartisan forum for governors to establish, influence, and implement policy on national issues. The Health Policy Studies Division of NGA's Center for Best Practices sponsors numerous activities and services for governors and their staff to support and assist state efforts to implement Title XXI.

About the DC Family Policy Seminars

The DC Family Policy Seminar (DC FPS) is a collaborative project of the Georgetown University Graduate Public Policy Institute (GPPI) and its affiliate, the National Center for Education in Maternal and Child Health (NCEMCH). The mission of the DC FPS is to provide District policymakers with accurate, relevant, nonpartisan, timely information and policy options concerning issues affecting children and families.

The DC Family Policy Seminar is coordinated by Vince Hutchins, Project Director, National Center for Education in Maternal and Child Health, 2000 15th Street, North, Suite 701, Arlington, VA 22201-2617.

To receive additional information about the DC Family Policy Seminar, or to request copies of the following briefing reports or highlights, please visit the DC FPS Web site at http://www.ncemch.org/dcfps, or contact Kristine Kelty at (703) 524-7802 or via e-mail at dcfps@ncemch.org.

The following list represents the twenty-four seminars DC FPS has sponsored since 1993:

- *Reconnecting DC Families: Involving Low-Income Fathers in the Lives of Their Children.* February 2000.
- *Do School-Based Mental Health Services Make Sense?* November 1999.
- *Out-of-School Time Activities: Can Programs Help Families and Can Families Help Programs?* May 1999.
- *Quality Housing for All: Family and Community-Led Initiatives.* February 1999.
- *Educating with Peers: Others Do—Should You?* November 1998.
- *Saving Our Schools: Would Vouchers Create New Solutions or New Problems?* April 1998.
- *Finding Families: DC's Foster Family Deficit.* February 1998.
- *Building the Future: Strategies to Serve Immigrant Families in the District.* October 1997.
- *Diverting Our Children from Crime: Family-Centered, Community-Based Strategies for Prevention.* May 1997.
- *The Child Care Crisis in the District of Columbia: Can (or Should) Businesses Fill the Gap?* March 1997.
- *Feeding Our Families: Community Food Security in the District of Columbia.* November 1996.
- *Keeping Our Kids Safe: Preventing Injury in DC Public Schools.* September 1996.
- *Fundraising for Family-Centered Organizations in the District.* July 1996.
- *Strengthening Families: Parenting Programs and Policies in the District.* April 1996.
- *Transitioning from Welfare-to-Work in the District: A Family-Centered Perspective.* February 1996.
- *Helping Families and Schools Get It Done: Mentoring Interventions in the District.* November 1995.
- *Caring for Our Children: Meeting the Needs of Low-Income, Working Families in the District.* September 1995.
- *Families That Play Together: Recreation and Leisure in the District.* July 1995.
- *HIV/AIDS: Helping Families Cope.* April 1995.
- *Substance Abuse Prevention and Treatment Programs: A Family Approach.* February 1995.
- *Family-Friendly Welfare Reform: Using Welfare Policies to Strengthen the Family.* November 1994.
- *Preventing Family Violence.* September 1994.
- *Preventing Adolescent Violence.* May 1994.
- *Preventing Teen Pregnancies.* December 1993.

Example: Children should be brought up to respect their parents. I had a very good upbringing. Raise. To take care of a person (or an animal or plant) until they are completely grown. Example: Her parents raised her very well as she is now a very kind and considerate young woman. Child Development.Â Example: The child comes from a very dysfunctional family. The father was violent and is now in prison and the mother has a drugs problem. Emotional Security. To feel happy and secure from having enough love, acceptance and respect. Example: The most important factor leading to a fulfilled and happy life for a child is emotional security. Well-adjusted. All children and youth have the right to happy and healthy lives and deserve access to effective care to prevent or treat any mental health problems that they may develop. However, there is a tremendous amount of unmet need, and health disparities are particularly pronounced for children and youth living in low-income communities, ethnic minority youth or those with special needs. How Many Children Have Mental Health Disorders?Â Family â€" e.g., parent education on the needs of children at each stage of development. School â€" e.g., strategies for teachers for effective classroom management. Community â€" e.g., violence prevention programs administered through community/recreational centers or churches.