



NIHCM  
FOUNDATION

## BRIGHT FUTURES and MANAGED CARE

# Action Brief

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### *Getting Kids Covered: How Are We Doing? How Can We Do Better?*

In 1997, the Clinton Administration and Congress collaborated to create the most significant expansion of health care coverage in 30 years. The Children's Health Insurance Program (CHIP) funded state coverage for children under age 19 with family incomes below 200% of the federal poverty level (FPL). The law, known as Title XXI of the Social Security Act, also provided funding to enroll all uninsured Medicaid-eligible children into the Medicaid program.

To share ideas and insights about outreach to and enrollment of uninsured children, NIHCM Foundation convened health plan managers, federal, state and local Medicaid and CHIP officials, outreach organizations and other child health experts for a forum on October 6, 1999. The forum was part of a series entitled "Bright Futures and Managed Care," which NIHCM Foundation is conducting under a cooperative agreement with the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau. This *Action Brief* summarizes key issues and discussion from the forum.

#### Keynote Speakers

**Jeanne M. Lambrew, PhD**, Senior Health Policy Analyst, National Economic Council, Executive Office of the President

**Thomas R. Hefty**, President, Chairman and CEO, Blue Cross & Blue Shield United of Wisconsin and United Services, Inc. (BCBSUW)

#### *The State of Children's Coverage*

The dream articulated three years ago has gone through a legislative and state approval process to cover close to 2 million children. According to Dr. Lambrew, enrollment and outreach is the next challenge. The Administration has provided funding, examples and guidance to states, including a joint application model

for integration of the Medicaid and CHIP programs.

**Focus of Outreach:** Because of the continuing problem with poor children who are eligible for Medicaid but not enrolled, outreach efforts are emphasizing Medicaid as well as CHIP. **The Administration has two goals: to educate families about the availability of CHIP and help them understand the importance of providing health care insurance for their children.** Fourteen agencies are involved in the federal interagency outreach task force, including the Departments of Education, Agriculture, Justice, Housing and Urban Development, and Treasury. HRSA and HCFA have provided over 140,000 posters to community health centers. **Dr. Lambrew stressed the importance of work with outside groups because families need to be surrounded with these messages - "on their cereal boxes, on TV, on the radio, in their electric bills" - to hear it multiple times so they will take action.**

**Collaboration is Key:** HCFA and HRSA have worked with the National Governor's Association to develop an 800 number. A family calling this number is routed to the appropriate state eligibility office. **Dr. Lambrew** concluded by discussing evaluation and how to replicate successful models in local communities.

***"If you don't look closely at variations in state performance, you cannot figure out how to design policy."***

**- Thomas Hefty**

**Mr. Hefty noted the confluence of school reform, welfare reform, and health care reform.** Welfare reform is tremendously popular in the upper Midwest, which traditionally has exhibited demographic differences from other parts of the U.S.: the country's lowest uninsured rate, the highest drop in welfare recipients, and the highest percentage of women employed in the workforce.

**Medicaid in Wisconsin:** In the last four years, 80,000 people have dropped off the Medicaid rolls, due in part to welfare reform. **Mr. Hefty expressed concern that although the state and health plans knew which parents and children were leaving welfare and thus in danger of losing Medicaid coverage, they were prohibited from contacting them, which effectively resulted in the enrollment loss.** Fortunately, the advent of CHIP resulted in reenrollment of 26,000 children. **“One lesson from outside the Beltway is to give the states with a good record [in taking care of the uninsured] more flexibility.”**

**Badger Care:** This Wisconsin program combines Medicaid and CHIP, and subsidizes families, not just children, having received federal approval for that effort. Families with incomes up to 200% FPL are eligible, and contributions are subject to a 3% cap of family income.

**Outreach Efforts through School Clinics:** BCBSUW has been working with 30 clinics in Milwaukee for the last three years to enroll and cover children. Because of issues concerning reproductive rights and school clinics, these efforts currently are only conducted at the elementary school level.

**Q & A: Mr. Hefty and Dr. Lambrew** discussed the marketing restrictions imposed on managed care plans, because of door-to-door direct marketing to beneficiaries and potentially abusive practices. **Mr. Hefty** contrasted outreach and generalized education and cited the need for a simplified application, follow-up assistance and phone processes. **The discussion also touched on the difficulties inherent in a system with both federal and state agency responsibility and which separates the administration of welfare reform from Medicaid.**

### ***What's Happened to Children's Coverage Since the Enactment of Welfare Reform and CHIP?***

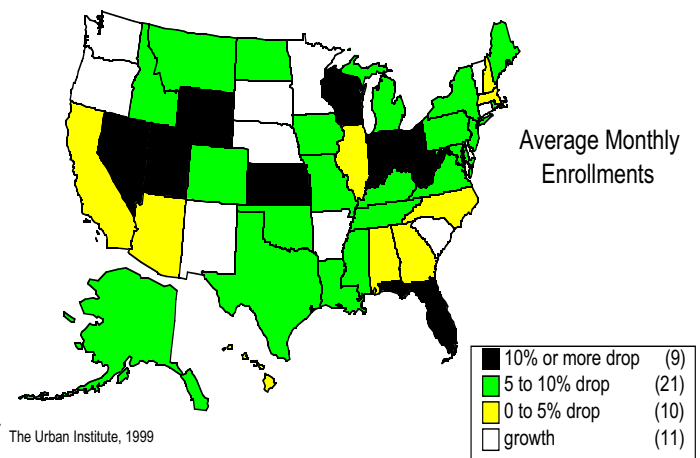
#### **Presenter**

**Leighton C. Ku, PhD**, Senior Research Associate,  
the Urban Institute

Since its peak, the number of people on welfare has fallen by nearly 50%. According to **Mr. Ku**, changes with caseloads began well before welfare reform,

because of state initiatives as well as a fairly strong economy. Between 1995 and 1997, Medicaid lost about one million people, a 3% reduction. The number of adults and children receiving Medicaid because of linkage with AFDC/TANF fell by about 25%. In contrast, the number in the non-cash categories increased.

Change in Medicaid Adults & Kids, 1995-97



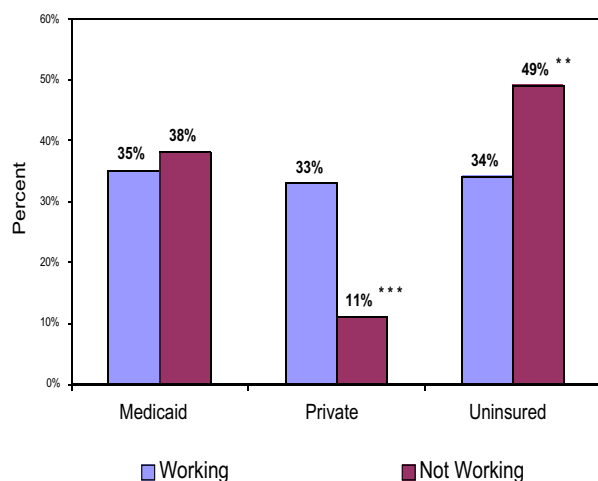
**A Common Misperception:** Outreach is often perceived as targeting people whose whereabouts are unknown. For those who have left welfare, their location is already known: **“their names, telephone numbers, and addresses are in welfare offices’ records.”**

**Coverage after Welfare:** The Urban Institute conducted a national survey to determine what happened to the insurance coverage of women who left welfare. At the beginning, about half kept Medicaid, but about six to 11 months later only 20% retained Medicaid. Private insurance never topped a third for this group.

Even when welfare leavers were working, only one-third of them received private insurance and one-third were uninsured. Forty percent said at some point during the prior year they could not pay their rent, mortgage, or utilities. Given these statistics, **“it is not surprising that health insurance is not their priority.”**

For many years, the erosion of private health insurance was driving the lack of insurance; by contrast, now it is the Medicaid problem. **For some groups, such as non-citizen immigrants, the problem is more severe. By 1997, about 60% were uninsured.**

## Health Insurance Coverage of Former Welfare Recipients by Employment Status (Women)



Source: Garrett & Holahan 1999

Regardless of the gains made through Medicaid, welfare reform, and CHIP coverage, the overarching issue remains the lack of affordable private health insurance. The second issue is the failure to redetermine Medicaid eligibility for people who are exiting welfare. This problem is the result of several factors: administrative difficulties, the lack of value placed upon coverage by the beneficiaries themselves, or their lack of effort to retain coverage. In addition, the practice of diversion, trying to prevent people from receiving welfare in the first place, or attempting to reduce their length of time, contributes to the decline in enrollment.

**Q & A:** Mr. Ku also discussed the public charge issue and the fact that CHIP statistics show large pockets of uninsured Hispanic children. He surmised that improvement in the coverage of immigrants will take a very long time because of their deep-seated fear of the Immigration and Naturalization Service (INS) and other government institutions.

### *Welfare Reform and Medicaid: What Are the Problems? How Are States Working to Overcome Them?*

#### Presenters

**Cindy Mann**, Senior Fellow, Center on Budget and Policy Priorities

**Ned Wollman**, Assistant Director, Office of Eligibility and Administration, Medical Care Policy Administration, Maryland Department of Health and Mental Hygiene

Ms. Mann cited two main points: (1) enrollment efforts should focus on the Medicaid program and the interactions between welfare and Medicaid; and (2) problems were predictable and are fixable. Title XXI gave states \$500 million to revamp their systems so that as families moved in and out of the TANF system, mechanisms would be in place to assure eligibility was properly determined. Ms. Mann pointed out that although many are excited about the potential of CHIP, “the number of children who are covered by Medicaid and who are projected to be covered by Medicaid is nearly ten times greater than the most optimistic projections for CHIP enrollment.”

**New Coverage Categories:** Each state must implement the delinking provision properly. In 1996, welfare reform delinked eligibility for cash assistance and Medicaid and set up a new separate eligibility category for families with children to replace AFDC. Therefore, families and individuals now fall into one of four categories: (1) people who are receiving cash assistance and also receive Medicaid; (2) people who apply for cash assistance and do not qualify who still need to be evaluated for Medicaid; (3) people losing cash assistance who must be properly evaluated for Medicaid; (4) and people who never entered the welfare system but potentially qualify for Medicaid.

Ms. Mann also suggested that states review their notices to beneficiaries, which can be confusing regarding the separation of Medicaid and TANF. Staff should walk through the application procedures in the welfare office, as a potential beneficiary.

HCFA is now doing a state-by-state assessment of eligibility and termination practices, to see whether corrective actions need to be taken, as well as to share some best practices. Problems include verification requirements which sometimes are more burdensome for TANF than Medicaid. The lack of paperwork for TANF may also affect the Medicaid application.

**Review of Systems:** At redetermination, Ms. Mann advised states to change the system so that a Medicaid beneficiary is not automatically disenrolled whenever cash assistance is closed. One of the most successful strategies states have implemented is to segregate applications in the computer system.

Ms. Mann’s final recommendation was to “view Medicaid as coverage for low-income families, parents

as well as children.” The “welfare leaver studies” show that people in states with family-based Medicaid coverage are more aware of the program as insurance for low-income families, and in fact, fewer people who leave welfare in those states actually lose Medicaid coverage.

**Mr. Wollman began by stating that Maryland has expanded its coverage to serve 58,000 children and pregnant women.** The Department of Health and Mental Hygiene administers the Medicaid program and also the Maryland Children’s Health Program (MCHIP). The Department of Human Resources is responsible for Medicaid eligibility, while MCHIP eligibility determination has been placed within the local health department. This not only simplifies the application process but also destigmatizes the program by removing welfare links. **Maryland has streamlined its application process with a simple three page mail-in form. No verification, assets test, or interview process are required.**

**Maryland’s First Step:** One of the major challenges is to make sure that welfare reform does not interfere with an individual’s ability to access Medicaid. The Client Automated Resources Eligibility System, CARES, is Maryland’s gigantic automated system which determines eligibility for all participants. Supervisors must review all cases being closed and denied through CARES, to ensure that the case was appropriately tested for Medicaid eligibility. The decision that a person does not qualify for temporary cash assistance (TCA) is reported to a central unit with subsequent review of that case for Medicaid eligibility. An automatic block was also created within the system. A case either denied or closed under TCA does not automatically trigger a closure for medical assistance.

**Mr. Wollman** described significant changes in the way Maryland’s system processes eligibility for Medicaid and also training to address the human element in the application process. **Long-term modifications will result in automatic testing in every coverage group in which a person or a family may be eligible.** Maryland is examining retroactive review of potential eligibility from the beginning of TANF implementation to the present. The state also has entered into a contract with the University of Maryland School of Social Work to contact all cases closed since January 1997. Finally, a toll-free hotline has been established to respond questions from the public.

**Q&A:** Ms. Mann concluded that the outreach and enrollment efforts of CHIP alone will not solve the problems. **The goal is to expand, not simply to net coverage for kids. Moreover, child health outreach will not reach the parents who still qualify for Medicaid coverage after leaving cash assistance.**

***Bridging the Gap from Welfare to Independence: Assuring that Health Coverage Continues***

**Presenters**

**Julia Taylor**, Executive Director/CEO YWCA of Greater Milwaukee, and YW Works

**Louise Brookins**, Executive Director of the Philadelphia Welfare Rights Organization, and the President/Director of Welfare Pride

**Ms. Taylor chronicled the genesis of the YWCA’s involvement in job training over 106 years ago.** The YWCA’s mission is to help women and their families become economically self-sufficient and to eliminate racism. YW Works is a unique, three-way partnership comprised of the YWCA, the Kaiser Group, a large employer in Waukesha, and CNR Health, a subsidiary of United Wisconsin Services (a Blue Cross Affiliate). Kaiser Group’s role is to assist with the employer linkage, while CNR helps with both the risk management and behavioral health components. **Milwaukee created one-stop centers about four years prior to welfare reform, creating a strong base for the program by providing some of the partnerships and resources necessary for people leaving welfare.**

The YWCA worked with the County to fund positions so that more eligibility workers could be hired more quickly. **Also co-funded was an “expediter” for urgent needs, such as providing food stamps or medical assistance immediately, rather than the usual three to five day wait.** In September 1997, Wisconsin Works (W-2), the jobs agency, had a case load of 2,500 participants on cash assistance. YW Works placed 1,000 people and is still in touch with these individuals.

***“Most of the people who left welfare have three times the income that they did before. But a lot of job churning is occurring as well.”***

**- Julia Taylor**

She portrayed the average participant: single mother of three children, predominantly African-American, with average educational level at tenth grade. Seventy-nine percent of the population is under 36. **The caseload also includes a higher number of married couples, people with younger children, and few with drivers' licenses and vehicles.**

**Services Available:** The program provides very intensive case management for alcohol and drug abuse, mental illness, and depression, with assessment and evaluation at the outset. The participants and medical personnel work with program staff to develop an employment plan; sometimes, the goal is to obtain counseling.

**Ongoing Case Management:** Early intervention may include home visits. A 24-hour hotline is also available for emergencies such as a domestic violence dispute, a fire, or a sick child. **“The program gives the new employee peace of mind to know that resources are available 24 hours a day.”**

**Ms. Brookins** described the origin of Philadelphia Welfare Rights in 1965; its tax-exempt arm, Welfare Pride, was formed in 1972 to sensitize, motivate, and train welfare recipients to work. **Ms. Brookins defused two common beliefs: welfare reform did not just come overnight, and states do have some options, but many states do not realize that.** Pennsylvania has lost thousands of medical assistance recipients, because many did not know that upon employment they are entitled to medical assistance for one year.

***“It saddens me that there are still many people out there not receiving the services they're eligible for, because no one is telling them, and they're not taking the time to find out.”***

**- Louise Brookins**

**Partnership to Reinstate:** Welfare Pride has partnered with Gateway, the Medicaid program of Highmark Blue Cross Blue Shield. Two to three weeks before members are terminated because of leaving welfare, a computer printout is generated by Gateway. Using this information, Welfare Pride contacts the individuals and determines whether they remain eligible for medical assistance.

Welfare case workers are supposed to refer individuals not eligible for medical assistance to CHIP; sometimes this does not happen. **A mail-in process does not always**

**work; many of the former recipients were not reading the letters, because of their disdain for the welfare office.** So Welfare Pride decided to educate the community; the organization is uniquely positioned to assume this role, because it is not government funded.

Welfare Pride does not market, or specify which managed care plan should be chosen, but instead discusses questions an applicant should ask before enrolling. The process has identified 5,000 families and placed them back on medical assistance with Gateway. **Because of limitations on communications from managed care programs, Ms. Brookins recommended that health plans consider entering into arrangements with other organizations;** then, if beneficiaries are being terminated inappropriately, some other entity can contact them.

**Ms. Brookins** believes that the employment of former welfare recipients is the key to Welfare Pride's success. **“People listen to their peers,” she said. “We went across the State of Pennsylvania and knocked on doors. We went into the projects and pulled people out of bed. They got enrolled.”**

### *Effective Public/Private Collaborations to Find and Enroll Uninsured Kids: What Are the Key Ingredients of Success?*

#### **Presenters**

**Lillian K. Gibbons, RN, DrPH,** Senior Advisor, Children's Health Care Programs, Health Care Financing Administration

**Michael Perry,** Vice President and Partner, Lake Snell Perry & Associates

**Kurt Snodgrass, MS,** Oklahoma Health Care Authority

**Randy Revelle,** Vice President, Washington State Hospital Association

**Dr. Gibbons** gave an update on CHIP, indicating that almost all states and territories have an operational plan and many states are submitting amendments. She noted that it is an exciting time for the field of outreach, because more people are enrolling in Medicaid as a byproduct of CHIP activities. HCFA and the Department of Health and Human Services are concentrating on five priority areas

for 2000: **(1) Enhance enrollment in Medicaid as well as CHIP; (2) Develop a national campaign to promote health coverage and preventive services; (3) Promote special focus on enrollment of children from immigrant families; (4) Improve retention and simplify the redetermination processes in CHIP and Medicaid; and (5) Institutionalize school-based outreach.**

Mr. Perry described his work with the Kaiser Family Foundation to conduct focus groups of white, Hispanic, and Chinese parents. Participants were low-income parents with uninsured children in California, with family income of 133% FPL. **The goal was to find out why children were not enrolled in the Medi-Cal program, California's version of Medicaid** (see *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children*, which can be found at [www.kff.org](http://www.kff.org)). Issues raised by those groups, including eligibility and enrollment, prompted Kaiser to fund a national study with additional focus groups in three states and a survey of approximately 2,900 low-income parents (see *Medicaid and Children: Overcoming Barriers to Enrollment*, which can also be found at [www.kff.org](http://www.kff.org)). Included were parents who have successfully enrolled children in Medicaid to determine differences between those parents on the program versus those parents who still have uninsured children.

**Focus Group Results and Relationship to Survey:** The survey disputed the stereotype of the Medicaid recipient as an unemployed single mother. **Instead, working families and two parent families were prevalent.** Most of the parents of uninsured children had actually been on Medicaid and their children had also been enrolled at some point. **“The main reason parents of uninsured children do not have insurance for their children is the lack of affordability.”** Although they have access to care when their child is sick, they lag behind the parents of Medicaid enrolled children in terms of well care visits.

**Families without Prior Medicaid Experience:** Such parents have no connection to the social welfare system, and thus are much harder to reach. Because many work, they often assume their income is too high. These parents attach a stigma to Medicaid because of its connection to welfare.

**Criticisms of Medicaid:** Eligibility criteria is very confusing, especially because family income fluctuates. Parents complain about enrollment and reenrollment

processes, which they describe as burdensome, overly invasive, lengthy and inconvenient. **They also talk about unpleasant personal treatment, not only by enrollment officers, but also by medical professionals and others who know that they are Medicaid recipients.** Parents lack awareness that Medicaid eligibility focuses on the individual child as a unit, rather than the family. **Therefore, many did not know that one child in the family could qualify for Medicaid, while another child may not because of the child's age or birth outside the US.** An overwhelming number believe that Medicaid has time limits.

**A Universal Finding:** In the focus groups, the enrollment process is perceived as a barrier because it requires individuals to spend so much time at welfare or social services offices, which are only open during business hours. **“Enrollment by phone and enrollment by mail have a lot of appeal,”** said Mr. Perry. They do not want home visits, mainly for security reasons. Another suggestion is to extend office hours and open on weekends. **The families feel that they never have the opportunity to ask questions and have a conversation with someone about enrollment.**

**Findings from Hispanic and Chinese participants:** Spanish speakers still do not have enough information translated in their language and find that no one is able to answer their questions about enrollment. The group also raised concerns about how enrollment will affect their immigration status. **The survey showed that Spanish speaking Hispanics in particular were most positive about the Medicaid program.** Other perceived flaws include that doctors are not as good because they are reimbursed at lower levels.

**Knowledge about Medicaid:** Most people had personal experience through friends, neighbors, and family members on the program. Consequently, families have access to a huge amount of information and misinformation. **The focus groups and survey support the concept of using different outreach strategies for those families with prior Medicaid experience versus those families without such history.** Personal contact is critical, even if only over the phone. **Schools were mentioned as a place parents want to get information and enroll in Medicaid.**

Mr. Snodgrass outlined Oklahoma's outreach initiatives. The state used Title XXI funds to enhance its Medicaid model, with approximately 20,000 children

eligible for coverage. **The eligible population is now more diverse, in terms of socioeconomic status, education level, perceptions, and biases about health care and accessing primary and preventive health care services.**

**Progressive Steps:** Oklahoma decided in 1997 to eliminate the face-to-face interview, especially for applicants with higher income levels. The application became available through county office health departments, WIC offices, public libraries, schools, and through the mail by calling an 800 number. Eliminating the asset test reduced the application from 17 pages to two. The program modified the termination process, to generate a notice to the appropriate Medicaid worker, to contact the client about reapplication. Since no face-to-face is required, the case worker can mail the application for income verification. **Oklahoma has gone a step further by instituting income declaration. Although a controversial move, Mr. Snodgrass noted that because the uninsured rate is so high, it is unlikely that people will lie about income.**

**Target for Outreach:** When Oklahomans were surveyed about how they had heard about Medicaid, the majority named family and friends as their sources. **Therefore, the state has retooled most of its efforts to target not just the potential eligibles, but also their families.** The program has tried to remove the welfare stigma. For example, the materials do not reference Medicaid. **Mr. Snodgrass** described the outreach effort as a collaboration with the Departments of Health Services (DHS), and Education, The Commission on Children and Youth, the Caring Program for Children, Blue Cross Blue Shield, and the Robert Wood Johnson Foundation.

***“Early on we felt, if you build it they will come. That’s not true. Multiple factors affect a client’s or recipient’s or prospective recipient’s decision to enroll: social class, culture, reference groups such as churches, and primarily family.”***

**- Kurt Snodgrass**

**Media Promotion:** The Oklahoma Health Care Authority has parlayed a \$50,000 contract with the Oklahoma Association of Broadcasters into \$450,000 worth of air time for public service announcements. Other media-related efforts include slides in most theaters, and statewide newspaper advertising, with some full-page ads

in minority and immigrant papers.

**Selling the Soap:** Someone needs to actually place applications in the hands of the target population, so DHS allocated 47 workers solely for outreach: 80% in the field, and 20% in office helping mainstream eligibility and certifying applications. The state’s objectives included not only identification and enrollment of eligibles, but also retention. Enrollment is now 243,000 in managed care programs, which is directly attributable to work done at the local level.

**Mr. Revelle described the kids.health.2001.campaign operating in Seattle and King County.** Washington has provided coverage for families with income up to 200% FPL since 1993. The campaign has recognized about 30 potential barriers to enrollment, including the identification of parents or guardians and making them aware that free health insurance is available for their children. Another is linguistics; in the Seattle public schools alone, almost 100 languages are spoken.

**Five Primary Strategies: (1) Do your homework; (2) Work through the schools; (3) Use an information and enrollment hotline; (4) Rely on trusted advocates; and (5) Implement system improvements.** One homework tactic consists of working with a marketing firm for the design and implementation of a communications plan.

**Campaigns should create effective messages and a common vision.** One message is the immediate goal to insure every young person under age 19 by the year 2001. Another is the campaign name, kids.health.2001, and the motto, “all our children deserve health care.”

**Other Ideas:** **The best way to secure an enrollment is to connect a parent or guardian with a trusted advocate, when the parent or guardian is thinking about a health-related issue during an “enrollable moment.”** Also, rely on the schools; the campaign recently sent out with kids in their backpacks more than 48,000 letters, customized in 10 languages and signed by the superintendent of schools, the mayor of Seattle, and Mr. Revelle. This method was more successful than sending letters through the mail. The school strategy has produced about 37% of total enrollments.

The eligibility, enrollment, and client advocacy hotline is called CHAP, the Community Health Access Program, and at 48%, is the single largest source of enrollments. **“The focus group which has been through the process**

praised the CHAP operators to the sky,” Mr. Revelle said. Staff are not only well-informed and friendly, but also good at follow-up by being persistent and persuasive.

**Friend-to-Friend, Face-to-Face Contact:** Use a variety of outreach and enrollment workers. For example, a City Year Health Team of ten young adults reaches out to enroll teenagers and others through youth programs, community events, and neighborhood events. Although 70% of uninsured young people are Caucasian, minority children are disproportionately represented. Therefore, the campaign is funding outreach and enrollment workers from the local health department who target Spanish-speaking and African-American communities.

**“Outreach is hard work. When I started, somebody asked me how many people we could enroll a month per outreach worker, and I said probably about 100. It turns out it is about 15.”**

**- Randy Revelle**

**Final Words of Wisdom:** Coordinate statewide Medicaid outreach with the application for the National School Lunch Program. Most kids eligible for a free or reduced lunch are also eligible for Medicaid. Mr. Revelle concluded with two pieces of advice: “first, the only way to get anything done is to do it; and second, remember children may be only one-third of our population, but they are 100 percent of our future.”

**Q & A:** The panel discussed the various perspectives presented from families about door-to-door enrollment. Mr. Perry surmised that the contradictory comments reflected concerns about a visit from an enrollment officer or government worker. In contrast, people may be more receptive to someone in the community they know, either a recognized advocate or friend.

### **Bright Futures Update**

#### **Presenters**

**Eileen M. Clark**, Assistant Project Director, Bright Futures, Georgetown University’s National Center for Education in Maternal and Child Health (NCEMCH)

**Mary Brecht Carpenter**, NCEMCH

Ms. Clark began by stating that while others were

ensuring that children were enrolling in health insurance programs, the Bright Futures staff has been working hard to ensure the development of guidelines to provide quality preventive health care for children once they are enrolled. NCEMCH has been producing four major Bright Futures publications simultaneously. These include the second edition of the Bright Futures guidelines and three in the Bright Futures In Practice series, focusing on nutrition, physical activity, and mental health.

**NCEMCH has collaborated with the American Academy of Pediatrics, the American Association of Dentistry and other national professional organizations to ensure that the second edition included the latest preventive health care guidelines for children.** Additions start in the infancy section, which now contains more information regarding car safety, addressing the proper use and installation of safety seats. In the middle childhood sections, the book encourages more physical activity as well as safety measures for biking and skating.

**The 2nd edition contains the new immunization schedule, as well as the latest screening guidelines for hypertension, hyperlipidemia, blood lead levels, iron deficiency, anemia and hearing, new charts on tooth eruptions, sexual maturity ratings, and sexually transmitted diseases.** See the Bright Futures web site at [www.brightfutures.org](http://www.brightfutures.org) for additional information.

**Ms. Carpenter** reflected on other aspects of NCEMCH’s work, including outreach to kids, particularly with the advent of the CHIP program. They created a publication called “Successful Outreach Strategies, Ten Programs that Link Children to Health Services.” NCEMCH also publishes a series called MCH Program Interchange, including one on outreach. Information on children’s health insurance can be found on NCEMCH’s web site at [www.ncemch.org](http://www.ncemch.org).

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