CASE *Study*

BOULDER COUNTY HEALTHY KIDS

A Collaborative Community Approach to Public Health Insurance Enrollment for Children and Families

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INTRODUCTION

In the past decade, a number of national efforts have endeavored to increase enrollment of eligible children and families in public health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP).[1,2] Many states and local agencies passed legislation to make medical coverage available, yet enrolling the eligible but uninsured population continues to be a struggle.[2]

According to a recent report from the Colorado Health Institute, approximately 10% of Colorado's children were uninsured. Of those uninsured children, roughly 58% were identified as eligible but not enrolled (EBNE), totaling more than 78,000 children.[3] Despite the widespread commitment to combat the high EBNE rate, systemic barriers at the state, county and local levels persist. In response, foundations like The Colorado Trust have invested in community-based outreach efforts to improve the enrollment, retention and utilization of Medicaid and Child Health Plan Plus (CHP+), Colorado's state CHIP program.[4,5]

This case study highlights the work of one such effort: the Boulder County Healthy Kids initiative (Healthy Kids). Employing a unique network model of county government and community-based organization (CBO) coordination, Healthy Kids has successfully bridged the gap between the organizations targeting EBNE children and families, the county technicians who process Medicaid or CHP+ applications in the Colorado Benefits Management System (CBMS), and the health clinics that ultimately serve eligible clients. From 2008-2011, this county-CBO model has resulted in the enrollment of 6,556 kids and parents (4,535 were 18 or younger). We discuss Healthy Kids from its inception, the factors that have contributed to its success in addressing enrollment and retention barriers, and the challenges it continues to face in a time of individual- and state-level economic hardship.

HISTORY AND BACKGROUND

The Healthy Kids initiative was launched in 2008 as part of Boulder County's strategic plan to stabilize families through housing, food service, medical coverage and employment.

Healthy Kids was initially housed within the Boulder County Community Services Program. At that time, no coordinated plan existed for enrolling children in public health insurance. According to Jennifer Eads, the Special Projects Division Coordinator who created Healthy Kids, there were "big gaps" in access points and training for enrollment systems. To address these gaps, Christina Ostrom, then-Healthy Kids Program Manager (currently Family & Resident Support Services Division Manager), was able to tap into available Temporary Assistance for Needy Families (TANF) reserve dollars to fund

Healthy Kids, a program focusing solely on increasing outreach and enrollment efforts. In 2008, state policies regarding TANF surplus funds allowed counties to utilize excess TANF dollars to conduct outreach to TANF-eligible families – many of whom were also eligible for Medicaid. The TANF dollars also allowed Eads to hire Ostrom to help design, implement and eventually manage the program.

Anticipating that the TANF reserve funds would only sustain the project for its first year, Healthy Kids immediately began applying for external funding. At the end of 2008, it was awarded a three-year grant from The Colorado Trust, as part of the foundation's Expanding Outreach and Enrollment for Children and Youth program area, to develop and expand the Healthy Kids initiative. In 2009, Healthy Kids also received support from Caring for Colorado Foundation and The Colorado Health Foundation.

Healthy Kids was designed to be a collaborative, coordinated program that required engaging and actively involving community groups and leaders. Eads says, "For a public assistance program to be successful, it must be relevant to all key stakeholders and the community at large." As such, to understand community priorities and engage local leaders, Healthy Kids representatives met with community and county organizations – including public health, social services, local health clinics and United Way (one of the few community organizations providing enrollment services at the time) – to identify gaps in access points and training for enrollment services. Healthy Kids leveraged relationships with directors from these organizations and examined other models of outreach and enrollment around the country. They then developed a plan to complement other county-wide efforts for identifying, enrolling and retaining EBNE children and families, outlining four specific goals:

1. Become a Certified Application Assistance Site (CAAS) and eventually a Presumptive Eligibility (PE) site;
2. Engage local CBOs in their outreach and enrollment efforts;
3. Integrate program positions into the county to eliminate dependence on grant funding and encourage program sustainability; and
4. Take the burden of the enrollment process off clients as much as possible in order to facilitate successful enrollment and retention in a system that is often difficult to negotiate.

To accomplish these goals, Healthy Kids identified and invested efforts in three areas:

1. **Outreach:** According to feedback from county and community partners, many EBNE children were not being effectively targeted. By working with community organizations such as social service providers, schools and health clinics, they hoped to "catch" more EBNE children and families, and build the capacity of these organizations to identify and enroll them.
2. **Enrollment:** Aware of many systemic challenges with processing Medicaid and CHP+ applications at the county and state level, Healthy Kids wanted to help address and solve these issues by building relationships with county and state officials in charge of the public benefits system.
3. **Utilization:** Enrolling children would not necessarily lead to better health unless children and families had a medical home in which they could use their benefits. Healthy Kids determined that teaming with Medicaid and CHP+ providers to accommodate an influx of new patients was essential to completing the cycle of enrollment.

IDENTIFYING EBNE CHILDREN AND FAMILIES

In 2008, almost 30% of children living in Boulder County were eligible for either Medicaid or CHP+, but were uninsured.[6] Although a few community organizations had received funds to specifically target the EBNE population and assist with enrollment, many of these efforts were uncoordinated. As such, when Healthy Kids began, it sought out other organizations that were either providing some level of assistance, or might be able to help reach EBNE children and families.

ENGAGING LOCAL CBOs

Realizing that local CBOs were often the first point of contact for families in need, Healthy Kids decided to build off of these organizations' existing relationships with the community as a key strategy to identify and engage EBNE families. It also recognized that many of these organizations could provide enrollment assistance onsite. Ostrom explains: "We cast a wide net when we approached potential community partners. We looked for organizations that provided services and had direct access to families and children. We were able to partner with 12 organizations right off the bat."

MARKETING DIRECTLY TO LOCAL RESIDENTS AND BUSINESSES

In addition to forming partnerships with local CBOs, Healthy Kids realized that engaging EBNE families in the community required direct marketing. Consequently, it began an aggressive outreach campaign that included attending community events and engaging local businesses, schools and health clinics as referral partners. Both strategies required marketing materials outlining the scope of its services. Notably, Healthy Kids was careful to avoid using government jargon and terms that can stigmatize – such as "Medicaid" or "public health insurance" – instead describing its services as medical coverage and health care utilization assistance.

In its first year, Healthy Kids promoted the program to more than 100 local businesses, with frequent participation in community events and health fairs. While this approach appeared successful, Healthy Kids continually evaluated its efforts and refined its strategies. For example, it learned that having its own booth at community events did not engage attendees; however, when Healthy Kids partnered with an organization providing a health-related service – such as free vision, dental or general health screenings – it reached far more people. As well, having a representative available who could fill out applications with clients receiving these services greatly diminished the likelihood of losing them.

Recognizing that many assistance calls came directly from clients trying to use their insurance at pharmacies, Healthy Kids also tried to partner with local pharmacies. However, many pharmacies did not see the need for promoting public health insurance enrollment because they often provide their own discount plans for low-income customers. Nevertheless, Healthy Kids plans to continue engaging pharmacies. According to Ostrom, "It's going to take finding the one person that gets excited by the idea for it to take off. Developing a personal relationship is key and we haven't been able to do that yet." Healthy Kids believes that health insurance is superior to a discount plan, and its goal is to discuss this with pharmacies so uninsured customers can access the variety of services available through health insurance.

DEVELOPING PARTNERSHIPS WITH SCHOOLS AND CLINICS

Another strategy to strengthen community partnerships and enhance outreach and enrollment assistance was to place enrollment technicians in two school districts and two local health clinics. This strategy entailed:

- Providing enrollment assistance onsite
- Engaging schools in promoting public health insurance (e.g., by incorporating outreach at special events, enlisting high school coaches and promoting accessibility using the school district website)
- Obtaining and using free and reduced lunch data (only when parents or guardians give consent) to identify children who may be eligible for public health insurance.

Presently, the school districts and clinics provide an office for each of the enrollment technicians. Further, as county employees, the technicians have dual access to relevant school and/or medical documents (required for eligibility) – a critical entry point to otherwise difficult-to-reach student and

patient populations. School-based outreach technicians conduct application assistance at any school in the district and are available on-call. They are also engaged in outreach and enrollment year-round through summer and other vacation periods. Ostrom reports that nearly half (42%) of the individuals enrolled through Healthy Kids' school-based technicians were completely new to public benefits.

Similar to their school-based counterparts, the clinic technicians enroll patients in health insurance, working closely with families to obtain required documents in order to streamline the eligibility process. The technicians also troubleshoot at least 30 cases each month – for example, correcting CHP+ Health Maintenance Organization (HMO) enrollment issues with the CHP+ vendor and/or collaborating with other counties to address problems with existing cases. One clinic reports that having an onsite technician has provided increased efficiency to its billing processes.

Healthy Kids' outreach efforts continually evolve. Says Ostrom, "You have to keep looking for creative ways to reach families. Eventually the demographic of people who attend community health fairs know you exist, so you have to look for other populations and consider how to best reach them."

LESSONS LEARNED: REACHING EBNE CHILDREN AND FAMILIES

- Develop a strategic and comprehensive marketing campaign.
- Engage local businesses as referral partners.
- Maximize reach by partnering with community organizations.
- Partner with service providers at community events and health fairs.
- Continue to re-evaluate outreach strategies and marketing efforts.
- Building relationships with businesses or pharmacies takes persistence. Sometimes finding a committed individual within an organization is key to a successful partnership.

BREAKING DOWN ENROLLMENT BARRIERS

In Colorado, as with many states across the country, the economic downturn has meant more applications for public benefits and less funding for counties;[1,2] Boulder County is no exception. According to Ostrom, in 2010 the county experienced a 40% increase in health insurance applications with no increase in staff. The burden placed on county technicians, as they are asked to process more applications without additional support and processing times inevitably increase, is heavy.

While the slow processing times – more than 45 days in some cases – are a huge enrollment barrier, they were not the only challenge that Healthy Kids initially faced in getting families enrolled. Following up on submitted applications and resolving enrollment issues also consumed staff time. If Healthy Kids wanted to succeed in its outreach strategies, it needed assurance that clients would be successfully and quickly enrolled.

BUILDING INTERNAL CAPACITY

Recognizing the burden faced by county technicians, Healthy Kids opted to submit its – as well as its community partners' – client applications to Affiliated Computer Services (ACS), the private vendor contracted to accommodate the statewide backlog of public health insurance applications. Unfortunately, ACS also struggled with the heavy processing load and Healthy Kids began seeing an increase in erroneously denied applications. In fact, Healthy Kids estimated it was spending 85% of the workday remedying these errors, including tracking down lost applications and resolving enrollment issues. For example, to check on the status of an application, Healthy Kids staff had to call a 1-800 ACS number and wait on hold until a technician could field their inquiry. Because Healthy Kids could only inquire about three applications at a time, multiple calls were frequently required, and as their caseload grew, following up on existing applications through ACS became untenable.

In a move that Eads calls "unprecedented," Healthy Kids requested, advocated for and was ultimately granted read-only access to the CBMS. Having the ability to look up clients' application statuses on their own, rather than relying on external entities, was helpful and saved time. For example, staff learned that many of the applications denied by ACS were due to simple typos in the application or missing documents. As a result, Healthy Kids negotiated a process with ACS whereby it could appeal a denial without a signed letter from the client. This agreement gave Healthy Kids a stronger position to advocate on behalf of its clients and shortened the appeal process, resulting in faster enrollment.

But that wasn't enough. Being able to submit appeals without a client signature only solved a small part of the problem as staff still needed to work with processing technicians at ACS or the county to resolve issues. Ostrom points out, "We were still beholden to the vendor. We could see what was happening and that was an enormous help, but there was nothing we could do about it." They were still spending a lot of time on the phone with technicians, who themselves didn't have the extra time to field numerous inquiries from Healthy Kids.

It became clear that Healthy Kids needed to build its own enrollment team if it was going to enroll clients faster. Building this team did not mean bypassing county technicians or creating redundant systems; it meant figuring out a way for Healthy Kids to reduce the burden on county technicians as much as possible. Its solution was to fund an in-house, part-time enrollment technician to process all applications funneled through Healthy Kids, enabling application issue resolution without having to call the county or ACS. Eads and Ostrom view this as one of the hallmark accomplishments of the program. Eads says, "A large part of the success of Healthy Kids is our partnership with the county. It works because they see us and our community partners as supporting their work rather than just creating more work for technicians." When the new technician came on board, Healthy Kids moved from Boulder County Community Services to Housing and Human Services; it made sense to bring the Healthy Kids team into the same hallway as the county technicians to pool resources and share best practices.

CREATING A COMPLETE ENROLLMENT TEAM

While having an enrollment technician on staff expedited the enrollment process for Healthy Kids, other inefficiencies existed. For example, Healthy Communities – a state-funded program that assigns caseworkers to help parents utilize the public health insurance benefits for their children – was housed in a different county department. The resulting lack of coordination between Healthy Communities and Healthy Kids caused redundancy. Accordingly, Healthy Kids negotiated the transfer of the Healthy Communities program (1.5 FTE) to the Healthy Kids program, allowing more efficient case management and another funded position.

The final step toward a complete enrollment team was creating a position for an imaging technician. This position was critical because in Boulder County all paper documentation is scanned into a system (FileNet) so that technicians can search for and retrieve documents. This imaging process must be

completed in addition to entering applications into CBMS. Imaging is inherently time-consuming, and waiting for the backlogged administrative staff to image documents would often delay applications for weeks.

By the end of 2011, the Healthy Kids team consisted of a director; three support staff to field client calls, provide application assistance and support community partners; one technician to process applications; one imaging technician; and a program coordinator. Healthy Kids estimates that its team is able to process most applications within 15-20 days and expedited applications on the same day, versus the more typical turnaround of 45 days or longer.

LESSONS LEARNED: IDENTIFYING AND OVERCOMING ENROLLMENT BARRIERS

- Every county's enrollment process is different: Healthy Kids identified inefficiencies specific to its county and worked with other county directors to mitigate them.
- Support and align county efforts, don't duplicate them.
- Staff support all aspects of enrollment: CBO partners, application assistance, utilization and retention.

SUPPORTING LOCAL COMMUNITY PARTNERS

Although Healthy Kids directly assists clients with the enrollment process, it also supports the enrollment efforts of community outreach partners. One of the most widely offered services Healthy Kids provides is training and informational updates for CBO staff on the process of applying for health insurance. Each organization receives an initial CAAS training on assisting clients with applications and certifying documents. Healthy Kids staff provide a refresher training at least once a year or at the request of the CBO, such as when there is staff turnover.

Healthy Kids also disseminates information about policy changes related to eligibility and enrollment so assistance providers are current with changing eligibility requirements. Ostrom emphasizes the importance of this regular contact, "Once you've created a partnership with a community organization, you can never stop engaging them. You must provide consistent, ongoing training, be aware of turnover and occasionally attend staff meetings to reiterate the importance of outreach and enrollment." But like most components of the Healthy Kids program, the relationship with community partners has evolved over time via continual evaluation.

ONE MODEL DOES NOT FIT ALL

Originally, Healthy Kids envisioned a model in which community partners would complete applications, and Healthy Kids staff would assist with enrollment and provide case management to the client after their application was submitted. While this process worked well for some partners, one model did not fit all. Healthy Kids' community partners are a diverse group with different missions and organizational models, and varying experience with public health insurance enrollment and utilization. It made more sense for the partners to incorporate outreach and enrollment into their organizations in a way that worked best for them, and for Healthy Kids to tailor their support to each CBO's program model.

For example, Boulder Nurse Midwives, which accepts some Medicaid patients, doesn't see enough uninsured patients to make becoming a CAAS reasonable. However, it does have to confirm coverage for patients and often needs to resolve billing issues – tasks that are time-consuming and inefficient. Boulder Nurse Midwives refers all patients who need enrollment or reenrollment assistance, as well as those experiencing problems with their Medicaid coverage, to Healthy Kids. In return, Healthy Kids helps verify coverage and provides enrollment dates and specific plan coverage information.

Other partners, such as Emergency Family Assistance Association (EFAA), GENESIS and its partner organization GENESISTER, have similar working relationships with Healthy Kids. They evaluate their clients for eligibility and provide enrollment assistance. Prior to partnering with Healthy Kids, EFAA would refer eligible families to the county for enrollment services. GENESIS and GENESISTER would provide application assistance, but couldn't verify documents. A large part of enrollment assistance consisted of troubleshooting problems that clients had with their coverage. While they all now provide full CAAS services, EFAA will refer clients with unusual circumstances to Healthy Kids for application assistance beyond their level of expertise. GENESIS and GENESISTER are comfortable working through difficult application scenarios, but rely on Healthy Kids to handle post-submission enrollment issues. Jody Scanlon, program director for GENESIS and GENESISTER, says this relationship has allowed them to do more for their clients. "Assisting with the application definitely takes more time than it used to because we're completing the application, verifying documents and helping obtain documents when that's necessary," she says. "But because Healthy Kids has taken over troubleshooting Medicaid problems, our overall workload in that area is actually less. This relationship has really empowered us to do more for our families."

Spotlight: GENESIS

Some of Healthy Kids' community partners already provided outreach and enrollment support. For example, the GENESIS program offers a myriad of support to teen parents and their families. Providing health insurance enrollment assistance was a necessary part of their case management for pregnant teens. Prior to partnering with Healthy Kids, caseworkers at GENESIS helped clients fill out applications and tried to troubleshoot problems with Medicaid. These efforts were often time-consuming and resulted in incomplete applications because caseworkers could not verify documents. By partnering, Healthy Kids could help GENESIS and other organizations provide quicker and more comprehensive application assistance.

INCENTIVES

Asking nonprofit organizations that often have limited resources and staff to incorporate a new service into their model is no easy task. To encourage and compensate community partners for time spent providing application assistance, Healthy Kids initially provided a $25 incentive for each completed application. However, some organizations were producing such a high volume of applications that Healthy Kids instead helped fund the staff positions responsible for providing application assistance. This allowed each organization to work within its own capacity and still be compensated for additional work.

The significance of the incentive is different for each organization. Elizabeth Graham Freedman, director of programs for EFAA, points out that no individual service offering is a burden. Multiple services, however – particularly when they are not specifically funded – can drain an organization because each one takes additional time to implement, manage and modify; incentives help offset that burden. GENESIS and GENESISTER also value the incentives, but would continue to provide application assistance, regardless.

FINDING THE RIGHT FIT

Connecting with EBNE families through community organizations makes sense. But Healthy Kids learned quickly that selecting and engaging CBOs as application assistance sites isn't easy. Even if an organization seems like the perfect fit for an outreach and enrollment program, it may have neither the capacity or view it as complementary to its mission. And, while some organizations value outreach and enrollment as crucial to helping families become stable, their programs can sometimes hinge on the efforts of one dedicated employee. If that employee leaves, the program can fall apart.

For Healthy Kids, finding the right community outreach partners was hit-and-miss. Early on, it partnered with several organizations that never delivered any health insurance applications. Eventually, Healthy Kids severed the formal relationship with these organizations and they were no longer considered part of the Healthy Kids network. "When recruiting CBO partners, don't pressure anyone to participate," Ostrom advises. "Just because the type of organization makes perfect sense as a CAAS doesn't mean it will work. If you have to push them, they likely won't do the work in the long run."

LESSONS LEARNED: DEVELOPING COMMUNITY PARTNERS

- Don't pressure organizations to partner.
- Stay visible: continue to engage CBO partners, providing training and resources regularly.
- Provide incentives to help sustain partnerships.
- Let partners decide what they can realistically accomplish along the outreach and enrollment service continuum, and support their needs.

CREATING A CLIENT-CENTERED MODEL

Few would describe the process of applying for public health insurance as easy. Often the families who qualify are trying to negotiate several urgent needs, such as feeding their families or finding housing, along with long-term and preventive services like health insurance.[7,8] These competing needs can lower the priority of obtaining health insurance and other long-term or preventive services. Healthy Kids staff understood the need to work in every way possible to take the burden of enrollment off the client.

TAKING THE BURDEN OFF THE CLIENT IMMEDIATELY

Healthy Kids realized that giving pamphlets or general information about its program to potential clients rarely resulted in follow-up from the client. Instead, Healthy Kids instituted a direct-referral model with community partners. Rather than distributing a stack of brochures for businesses to hand out to potential clients, staff members leave a single pamphlet at partnering organizations with a stack of referral sheets. The pamphlet provides staff at these organizations with vital information about the Healthy Kids program so they can accurately promote its services to families. Potential clients can fill out a referral sheet for the organization to pass on to Healthy Kids. This allows Healthy Kids to initiate a direct connection with EBNE families. Staff believe this strategy has both increased its enrollment numbers and decreased the upfront effort necessary for clients who are often consumed with more pressing responsibilities.

MINIMIZING APPOINTMENT TIME

When clients had to show up for multiple appointments to complete their applications, Healthy Kids staff often saw a huge drop-off. Not only did missed appointments result in fewer submitted applications, it became time-consuming and inefficient for Healthy Kids staff. Consequently, they set up processes designed to minimize appointment times for families. For example, a Healthy Kids staff member now completes as much of the application as possible during the first phone call with a new client. Clients then only need to bring in documents, review the application and sign it – turning a potential 45-minute appointment into a 5-minute errand.

FINANCIAL ASSISTANCE

A common barrier for many EBNE families is the out-of-pocket expense for required documentation, such as birth certificates, or the CHP+ enrollment fee. In response, for example, Healthy Kids utilizes grant funds to order birth certificates online. All documents are sent to the Healthy Kids office so they can be immediately submitted with the application. In the event that Healthy Kids cannot obtain documents for clients, it provides the financial assistance and resources necessary so clients can obtain them on their own. Not only do these shortcuts expedite the application process, they also help clients obtain documents to make later redetermination quick and seamless. Although Healthy Kids anticipated needing funds for documentation, the number of CHP+ enrollees who could not afford the one-time, $25 per person or $35 per family enrollment fee was surprising; so Healthy Kids reallocated more than $10,000 from other parts of its budget to eliminate this barrier. Now that enrollment fees have increased to $75 for one child and $105 for two or more, it is even more critical that staff check in with families to ensure they are able to afford the fee.

MAKING A LASTING IMPACT: INCREASED ENROLLMENT, RETENTION AND UTILIZATION OF BENEFITS

Since 2008, the Boulder County Healthy Kids initiative has enrolled 4,535 children and 2,021 adults in Medicaid or CHP+. A large part of its success is due to the development of partnerships with key local organizations. It collaborated with other county agencies to support the overburdened county enrollment technicians and streamline client assistance; Healthy Kids also collaborated with many community partners that have, in turn, built trusting relationships with EBNE children and families.

By involving multiple partners, all of the organizations were able to maintain their trusted relationships with clients while sharing the burden of the enrollment process with Healthy Kids. This allows the community partners to focus on their strengths and refer cases to Healthy Kids when the needs of the family exceed the capacity of the organization. While many tout the success and competence of the Healthy Kids staff, they attribute a great deal of their success to collaborative efforts with other organizations.

FINANCIAL SUSTAINABILITY

As mentioned previously, the Healthy Kids initiative began in 2008 with TANF reserved funds and a grant from The Colorado Trust. During 2009, it received funding from The Colorado Health Foundation and Caring for Colorado.

However, given that Healthy Kids was offering an essential service, its goal from the beginning was to incorporate the program systematically into the county's budget; and by the end of 2011, the county was providing in-kind funding for Healthy Kids' director and technician positions. Moving Healthy Communities to the Healthy Kids further streamlined services for Medicaid and CHP+ eligible families. That said, while the county funds an additional case manager position for Healthy Communities,

Healthy Kids is not sure it can be completely county-funded in this economic climate. Eads says, "Foundation funding is still crucial for programs like Healthy Kids, particularly until the economy improves or the state has more money to allocate to such programs."

SUSTAINING QUALITY OF SERVICE

While financial sustainability is necessary for Healthy Kids to continue in the years to come, it is equally important to maintain the quality and efficiency of services by attracting and retaining high quality staff. Some nonprofit organizations "pinch pennies" when it comes to staff salaries; Healthy Kids, on the other hand, adopts a "get-what-you-pay-for" mentality. Staff turnover has been low, reducing the amount of time and money required to train new employees. In the last year, Healthy Kids expanded the program, adding new staff to support streamlined services and troubleshooting assistance for the entire county caseload. Given the large number of Spanish-speaking clients, it has also been critical to maintain a high percentage of bilingual staff (currently, 86% of Healthy Kids staff are bilingual).

Healthy Kids continually engages community organizations in order to understand how needs change and evolve, constantly adapting to serve the community effectively. It maintains its partnerships and nourishes an ongoing community dialogue.

CONCLUSION

The Boulder County Healthy Kids initiative is not a model of success because it has solved all of the challenges of helping children and families obtain medical coverage. Certainly, as economic circumstances, state policies and community needs continue to change, so too do the challenges that Healthy Kids and other organizations face in providing outreach and enrollment services. Rather, what makes Healthy Kids noteworthy is its ability to develop a system in which key players collaboratively identify and address their ongoing challenges. By building relationships with county directors, enrollment technicians, case managers at CBOs and individual clients, Healthy Kids has tackled some of the biggest enrollment barriers, creating an infrastructure that children and families in Boulder County can rely on for streamlined assistance in applying for public health insurance coverage.

ENDNOTES

1 *Outreach Strategies for Medicaid and SCHIP: An Overview of Effective Strategies and Activities.* Denver, CO: Kaiser Communication on Medicaid and the Uninsured: 2006.

2 Wielawski IM. In: Isaacs SL, Colby DC, eds. *To Improve Health and Health Care.* The Robert Wood Johnson Foundation Anthology, Volume XII. Princeton, NJ: Jossey-Bass; 2009: Chapter 3.

3 *Colorado Children's Health Insurance Status: 2011 Update.* Denver, CO: Colorado Health Institute: 2011.

4 Moody S, Arenales A. *A Case Management Approach to Medicaid and CHP+ Enrollment: Recommendations for Colorado's Investment in Medicaid and CHP+ Outreach.* Denver, CO: Covering Kids and Families: August 2008.

5 Chung P, Cavender TA, Main D. *Trusted Hands: The Role of Community-based Organizations in Enrolling Children in Public Health Insurance Programs.* Denver, CO: The Colorado Trust: February 2010.

6 *2008 Kids Count in Colorado Annual Report.* Denver, CO: Colorado Children's Campaign: 2008.

7 Kushel MB, Gupta R, Gee L, Haas JS. Housing Instability and Food Insecurity as Barriers to Health Care Among Low-income Americans. *Journal of General Internal Medicine.* 2005: 21:(1):71-77.

8 Long SK. *Hardship among the Uninsured: Choosing among Food, Housing, and Health Insurance.* Washington, DC: The Urban Institute. 2003: Series B, No. B-54.

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