A Profile of Young Children in the Los Angeles Healthy Kids Program: Who Are They and What Are Their Experiences on the Program?

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EXECUTIVE SUMMARY

The Healthy Kids program of Los Angeles County provides insurance coverage to low income children who do not have access to other health insurance. This report is one of a series of reports being produced under the Healthy Kids program evaluation, which is designed to provide feedback to stakeholders on the progress of the initiative. First 5 LA contracts with The Urban Institute and its partners to conduct the evaluation.

The report provides an analysis of data from a survey—conducted by Mathematica Policy Research for the evaluation--of the parents of Healthy Kids children ages one to five. The key findings from the analysis of the survey are as follows:

Most Healthy Kids enrollees are age 3 to 5 and are in two-parent, Latino working families.

- Most of Healthy Kids parents have been in the U.S. for some time
- The majority of Healthy Kids families are very poor, with relatively low parental educational attainment.
- Most parents are Spanish speaking, suggesting a high need for culturally- and linguistically-appropriate services. Despite this general pattern, there is diversity among Healthy Kids, which should be taken into account when planning for the best way to target services. For example, it is possible that different Healthy Kids outreach approaches could succeed at enrolling increased numbers of certain types of children, such as more younger children or higher income children.
- While most Healthy Kids are in good health, a substantial proportion are not, according to several different measures. Special attention should be paid to health access for these vulnerable children, because of their fragile health status.
- Consistent with findings from the evaluation case study and focus groups, parents reported very positive experiences about the outreach, enrollment, and renewal processes for Healthy Kids.
- Healthy Kids is not substituting for employer-sponsored health insurance to any great degree, since few Healthy Kids enrollees have access to private insurance coverage.
- Emergency Medi-Cal plays an important role in providing financial access to health services for uninsured young children in Los Angeles County, and a large number of Healthy Kids enrollees retain Emergency Medi-Cal coverage after enrolling.

- Access to care for Healthy Kids enrollees is very good for many services, particularly preventive and primary care services, and the use of preventive care is high compared to national benchmarks. Almost all Healthy Kids enrollees have a usual source of care, and the location of the usual source of care was usually close to the child's home.

- Unmet need was very low for care for urgent health problems.

- Healthy Kids provides critical access to immunizations, and four and five year olds are still being caught up on their immunizations under the program. This shows that Healthy Kids has a public health effect broader than its own program's beneficiaries.

- In contrast to preventive care, the use of specialty services is lower than national benchmarks for SCHIP enrollees, and unmet need for specialty services is relatively high. Consistent with this finding, unmet need in general was higher for children with health problems.

- In spite of this generally positive picture of access to care, some parents had difficulty getting after-hours advice for health problems, when Healthy Kids parents needed to reach a doctor after the clinic was closed. In addition, a large share of parents who reported unmet need said that the main reason that they did not obtain care was that the clinic or doctors office was not open during times that were convenient.

- In spite of the generous coverage and low cost sharing under Healthy Kids, almost 30 percent of Healthy Kids enrollees reported that obtaining needed health care for their child was creating a financial burden for the families. Understanding the origin of these financial problems requires further study.

- Only about 2/3 of parents reported having a usual source of dental care for their child, which is much lower than for medical care. One major barrier is a lack of parent awareness about the importance of needing routine preventive dental care early in life, suggesting the need for more parent education. Further expanding the Healthy Kids network of dental providers will also help to provide adequate access to dental care to all enrollees.

- Parents reported relatively high rates of developmental screening for their young children under Healthy Kids, when compared to national benchmarks.

- However, relatively few parents reported being asked about, or receiving specific information about, their own concerns, particularly ones that require more time to discuss thoroughly and more cultural sensitivity during communication (e.g. child behavior and parent/child communication issues). This frequent lack of effective communication between health providers and parents, while consistent with national patterns, is an area where the Healthy Kids program could focus more effort.

- Consistent with the data collected in evaluation focus groups with parents, most parents are very satisfied with the quality of care in the Healthy Kids program. Still, some parents expressed their need for more time with their child's provider and for better communication around the child and family's needs.

One year from now a second survey report will provide results from the longitudinal follow-up with the same parents who provided the data reported here. This analysis will provide an assessment of the impact of the Healthy Kids program on a range of indicators such as access to care, use of services, developmental status, and health status. Until that time, we hope that this interim client survey analysis, while showing important accomplishments of the program to date, will also provide useful information for improving Healthy Kids as the program grows and develops.

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CHAPTER 1: BACKGROUND

In July 2003, a new program called Healthy Kids began in Los Angeles County, California. Los Angeles Healthy Kids has a goal of extending universal health insurance to children in families with incomes below 300 percent of the federal poverty level. To achieve the goal, Los Angeles used models from similar initiatives underway in several other California counties, but with several unique features. The key components of the program include:

- Intensive outreach and simplified enrollment assistance provided through a network of community-based organizations;
- A benefit package modeled after that of the Healthy Families program (California's SCHIP), that covers a comprehensive set of preventive, primary, and specialty care services, including dental and vision care;
- New insurance, "Healthy Kids," to cover uninsured children under 300 percent of the federal poverty level and not entitled to other public programs;
- Income-related premiums and copayments (families with incomes below 133 percent of poverty pay no premiums); and
- A "quality enhancement" initiative to improve the quality of behavioral health and developmental services in Los Angeles County.

The program is funded by a $0.50 tax on cigarettes and other tobacco products. These revenues—enacted through Proposition 10, a statewide ballot initiative—are earmarked to promote, support, and improve child development beginning in the prenatal period and through age five. The Los Angeles Proposition 10 Commission (called First 5 LA) administers these funds. In July 2002 the Commission voted to devote $100 million of its budget to create the Healthy Kids program. In addition, a key strategic partnership was formed between the County Department of Health Services (DHS), an agency that has extensive experience working with community-based organizations to conduct outreach and application assistance, and the not-for-profit health plan, LA Care, which possessed many years of experience serving more than

800,000 low-income county residents as the designated "local initiative" under Medi-Cal's managed care system. DHS oversees much of the program's outreach activities, and LA Care administers the Healthy Kids insurance product.

Soon after the creation of Healthy Kids, fundraising efforts by the Children's Health Initiative Coalition of Greater Los Angeles began. These efforts succeeded in raising an additional $86 million, permitting the county to expand Healthy Kids to all children through age 18 in May 2004. As of December 2005 there were 7,833 children ages 0-5 enrolled in Healthy Kids and 34,780 children ages 6-18[1].

The Healthy Kids Program Evaluation is designed to provide feedback to stakeholders on the progress of the initiative. First 5 LA contracts with The Urban Institute and its partners—the University of Southern California, the University of California at Los Angeles, Mathematica Policy Research, Inc., and Castillo & Associates—to conduct the evaluation, which is producing a series of reports. These are based on case studies of implementation; focus groups with parents; ongoing process monitoring (using secondary data sources); and (the subject of this report) a survey of parents of children enrolled in Healthy Kids. Funding comes from First 5 LA, and consequently the evaluation concerns primarily the Healthy Kids program for children ages 0-5.[2]

The evaluation began in May 2004 and several reports have been produced to date.[3] The analyses have revealed many of the successes and challenges of implementing Healthy Kids.

[1] Beginning in May 2005, the Los Angeles initiative—due to funding limitations and more rapid enrollment growth than initially anticipated—placed an indefinite "cap" of 35,000 enrollees ages 6-18.
[2] Beginning September 2004, The California Endowment provided additional funds to the evaluation to support process measurement related to the 6-18 population, an analysis of outreach efforts for older children, an analysis of the effect of Healthy Kids on Medi-Cal and Healthy Families enrollment, and a study of the program's effect on uninsurance among children in Los Angeles.
[3] See the following: Hill , Courtot, and Wada 2005; Hill et al., 2006; and Sommers et al. 2006 .

The following are among the key findings that emerged from the case study, focus group, and process monitoring evaluation components:

- Intensive, community-based outreach is succeeding in identifying families with uninsured children and providing them with helpful assistance in enrolling in appropriate insurance programs;
- Parents say that the program is providing them with highly valued comprehensive and affordable health insurance for their children;
- Recommendations for improvement include the need for a wider provider network (especially for dental and specialty providers) and for improved co-ordination between Healthy Kids and Medi-Cal.

This report provides an analysis of data from a survey of the parents of two types of Healthy Kids children ages one to five. The first group is those who were enrolled in the program shortly before their parents were interviewed (called "new" enrollees). The second group includes children who had been enrolled in Healthy Kids just over a year when their parents were interviewed (called "established" enrollees). Parents of new enrollees were interviewed about their recent experience with the enrollment process. They also were asked questions about their children's experience prior to enrollment in the Healthy Kids program.[4] Parents of established enrollees were interviewed about their experience with the renewal process and their child's experience on the program.

This report is organized to address the following major research questions:

- What are the demographic characteristics of children ages 1-5 who are enrolled in Healthy Kids?
- What is their health status?

[4] The data on the experience with access to care and had of services prior to enrollment are not included in this report; they will be used in next year's impact report.

- How do their parents perceive the enrollment and renewal processes for Healthy Kids?

- What are the opportunities for alternative public or private health care coverage for children enrolled in Healthy Kids and their parents?

- What are their parents' concerns about the developmental status of children enrolled in Healthy Kids, and what developmental screening and advice do children and their parents receive?

- What is the experience of Healthy Kids enrollees with respect to access to medical care, use of medical care services, and unmet need for medical care?

- What is the experience of Healthy Kids with respect to access to dental care, use of dental care services, and unmet need for dental care?

- How satisfied are parents with the Healthy Kids program, and how do they perceive the quality of services?

At the time of this writing, the second wave of the survey is in the field, during which the children interviewed in wave one are being re-interviewed. One year from now a second survey report will provide results from this longitudinal follow-up with parents. This analysis will provide an assessment of the impact of the Healthy Kids program on a range of indicators—such as access to care, use of services, developmental status, and health status in a subsequent report.

CHAPTER 2: METHODS

The Evaluation of the Los Angeles County Healthy Kids Initiative has multiple components, each addressing a range of evaluation questions and on different time schedules. One important component is the client survey analysis. The client survey analysis provides both an in-depth descriptive profile of the Healthy Kids population below age six, as well as an ability to assess the impact of the program on these children. While there is some overlap in the descriptive profile that the client survey analysis provides and that of the process monitoring task (such as the children's demographic characteristics and service use), the client survey analysis serves a unique role for the evaluation because it is the only evaluation component that is designed to answer questions such as whether the program improved access to care, increased health service use, or improved health or developmental status.

Survey

The client survey employs a longitudinal design, with the first wave of interviews having been conducted in 2005 (with associated data analyzed in this report), and a second wave of interviews with the same sample conducted one year later. This analysis of wave one data is primarily descriptive, while of both waves of data will be used to assess the program's impact next year.

Mathematica Policy Research (MPR) conducts the Healthy Kids client survey under sub-contract to the Urban Institute. Wave one data collection occurred in April through December, 2005. Wave two data collection is currently underway, beginning May 2006.

Sampling and Weighting. Project resources allowed for the completion of approximately 1000 interviews during wave one, half of which were with parents[5] of children

[5] The respondent could also be the child's guardian or other adult who knew about the child's health and health care. 92% of respondents were mothers and 7% were fathers.

who recently enrolled in Healthy Kids, and the remainder with parents of children who had been enrolled for a year. A sample of 1,430 children was drawn to achieve 1000 completed interviews, assuming a 70 percent response rate. An enrollment file from LA Care was used as the list for sample selection. The sample included children ages 12-72[6] months who either were newly enrolled in Healthy Kids during the months of March-July, 2005 (new enrollees) or who were enrolled during the months of March-July 2004 and thus were assumed to have been on the program for one year (established enrollees). Equal size samples (286) were drawn monthly for five months, with equal numbers of new and established enrollees.

We used two stage stratified random sampling within two primary strata, and one sub-stratum. The two primary strata were new enrollees and established enrollees. A sub-stratum within the established group separated children who completed the renewal process (who were over-sampled in order to have more up-to-date contact information) from those who had been enrolled more than a year but had not yet renewed their coverage.[7] In the first stage, families were sampled and then (if necessary) one eligible child was randomly selected per family.

Each child for whom an interview was completed was assigned a weight, according to his or her probability of selection into the sample and taking into account the complex sample design. The weight also included a non-response adjustment to account for non-response in the child's stratum.

Response Rate. The response rate was higher than anticipated. After excluding 168 sampled children who were ineligible for the survey[8], there were 1,262 sampled children; 1,087

[6] Infants were excluded because very few are enrolled in Healthy Kids, and because infant health care is very different from that of children ages 1-5. Children over 72 months old were excluded because First 5 LA (the primary funder of the evaluation) is concerned with health care for children under age 6.
[7] About 20% of the established children had been enrolled for over a year, but had not yet renewed their coverage.
[8] A brief screening interview determined if they were either the wrong age or were no longer enrolled in Healthy Kids.

interviews were successfully completed, for an overall response rate of 86 percent. The response rate among new enrollees (82 percent) was lower than among established enrollees (91 percent), in part because of more intensive follow-up among the established group as explained below.

The majority of non-response occurred because sampled families could not be located (9 percent of sampled families). These were families for whom the address and phone number, provided by LA Care was incorrect, and we were unable to locate them via electronic searching or in-person field locating methods. It is possible that some of these children were also ineligible (e.g. no longer residents of L.A. County and enrolled in Healthy Kids), but this could not be verified. A much smaller fraction of non-response occurred because families were never available to participate in the survey when we called them (1.6 percent of all sampled families). While there were only 12 overt refusals to participate in the survey, the parents who never responded to inquiries could be deemed "passive" refusals due to their continued unavailability to respond to our calls, letters and in-person visits over a seven-month field period.

Instrumentation. We designed the survey instrument to be similar to those used in the evaluations of the Healthy Kids programs of Santa Clara and San Mateo Counties, which were in turn comparable to the survey instrument used in the Congressionally Mandated Evaluation of the State Children's Health Insurance Program (Kenney, et al. 2005). In addition, we added a series of questions focusing on developmental issues for children age 0-5 from the Parent Evaluation of Developmental Status (PEDS) and the Promoting Healthy Development (PHD) Surveys. We drafted the questionnaire with a target interview length of 40 minutes. (The actual average length of administration was 36 minutes.) The instrument is attached as Appendix A. Building on these existing instruments allows us to compare results to prior surveys, which we do throughout the report.

Translation. The majority of interviews were conducted in Spanish (87 percent), followed by English (8 percent) and Korean (5 percent). Only 8 parents were not interviewed because they spoke a language that none of the interviewing staff spoke (such as Mandarin or Tagalog).

A native Spanish speaker, a certified translator, translated the survey into Spanish. The survey was then reviewed by a number of Spanish-speaking members of the research team who originate from various Latin-American countries, and by bilingual staff at LA Care. This resulted in minor revisions to the Spanish translation. There was no initial translation into Korean, but after learning that many parents spoke Korean, Korean-speaking interviewers translated the instrument into Korean and consistently applied the same translation for all interviews in Korean.

Pre-testing. A pretest of the survey instrument was conducted to identify ways to improve the administration procedures, measure the length of the interview, test the flow and sequencing of questions, clarify question wording for the sample members, and clarify instructions for the interviewers. We pre-tested the instrument in March 2005 with a dozen respondents. After the pre-test, we removed a few questions to shorten the overall length and made minor modifications to the survey based on information obtained through monitoring by MPR staff and debriefings with interviewers.

Training and Administration. Interviewers received two days of training by the survey director. The training session lasted approximately 6 hours and covered the study design and population, as well as a question-by-question review of the instrument. All interviewers were bilingual, in either Spanish/English or Korean/English.

Before they were contacted, LA Care sent sampled families an endorsement letter. The letter introduced the study, identified the study sponsor and MPR, and explained that participation was voluntary and that the identities and responses of all participants would remain confidential. The letter offered families a $20 gift card for completing the survey and provided a toll-free number at MPR to call in case they had questions. Interviewers timed their first call to the families a few days after the letters were mailed.

The survey was conducted by telephone. Trained bilingual monitors listened to about 7 percent of survey introductions, call attempts, and survey interviews to ensure that interviewers read the survey introduction and questions verbatim, answered respondent questions thoroughly, and recorded answers accurately.

Locating. When interviewers learned that a telephone number was wrong or the telephone had been disconnected, the case was sent to a team of experienced locators for additional searching. The search used Lexis-Nexis, a personal database search company. These searches generated potential new telephone numbers and addresses. Sampled families who could not be located in this manner were mailed a slightly revised version of the endorsement letter to their last known address. It asked the family to call the toll-free number provided in the letter to learn more about the study and/or to participate.

After all intensive locating was complete, we used in-person field follow-up to contact 65 families. This intensive follow-up was designed to improve the response rate for the established enrollee stratum, so that it would be comparable to the new enrollee stratum. The three experienced field locators were native Spanish speakers living in three different parts of Los Angeles County. Field locators were assigned the cases that were nearest to their home. These locators went to the home address of sample members and provided them with cellular

telephones on which they contacted the MPR survey operations center. A trained interviewer then completed the interview by telephone (not in person by the field locator). Twenty additional interviews were completed in this manner.

Reference Period and Recall Period. Many survey questions asked about experiences (such as use of health services) during a fixed time period. For new enrollees this was the six months just prior to enrolling in Healthy Kids. For established enrollees this was the six months just prior to the interview.

Because it took time to locate and interview parents, there was a lag between the date of the child's enrollment in Healthy Kids and the interview (for new enrollees) and between the first year anniversary on Healthy Kids and the interview (for established enrollees)[9]. This means that the recall period for new enrollees was substantially longer than for established enrollees.

Data Preparation. Upon completion of data collection, survey and analysis staff reviewed data frequencies to verify that for each question the correct number of responses was reported and that the skip logic between questions was correctly executed. The survey director reviewed all text responses and back-coded any to prelisted choices where appropriate, or assigned new codes if responses were common enough to warrant the additions. Once the data were prepared, a file without personal identifiers was delivered to the Urban Institute for further analysis.

Analysis

We tabulated the data using SAS and STATA. Tables generally present weighted percentages as well as the raw total number of children in a particular analysis. While no

[9] The average time since enrollment at the time of the interview for new enrollees was 98 days (range 43-216) and since the one year anniversary for established enrollees was 101 days (range 42-261).

standard errors are provided in the tables, for simplicity of data presentation, any differences described in the text between groups within the Healthy Kids population are statistically significant[10]. Often we also compare Healthy Kids children to other groups for whom similar survey results are available nationally or in California. When there are no citations for the comparison statistics, they come from our original tabulations of the other data sets. Significance tests were not possible when comparing Healthy Kids client survey data to aggregate national data.

[10] Standard errors can be provided upon request.

CHAPTER 3: DEMOGRAPHIC CHARACTERISTICS OF HEALTHY KIDS

The client survey provides a rich source of information with which to develop a profile of the Healthy Kids population. This chapter describes the demographic characteristics of children enrolled in Healthy Kids who are ages 1 to 5.

Survey Results

Table 3.1 provides some basic statistics describing the demographic characteristics of young children enrolled in Healthy Kids for about one year (established enrollees)[11]. As shown, Healthy Kids serves primarily low-income, non-citizen, Latino children. While their parents have high employment rates, most have low educational attainment.

There are equal numbers of boys and girls enrolled in the program and most children are of pre-school age (between three and five years). Since younger children and infants are more likely to be born in the United States and therefore qualify for other programs based on their citizenship status, the vast majority of Healthy Kids enrollees are non-citizens (93.6 percent).

Most families of Healthy Kids enrollees have been in Los Angeles County for a substantial period of time. About 40 percent of parents of Healthy Kid enrollees have lived in L.A. County between three and five years, and fully 20.3 percent have lived in L.A. County for more than five years. (Since many of these long-term residents have children under age five born outside of the U.S., this suggests that there is movement between the US and their country of origin.)

[11] Data for new enrollees are not discussed but share a similar demographic profile as established members with a few exceptions. The main differences are that established enrollees are older and their parents have been in L.A. County somewhat longer.

Table 3.1:
Demographic Characteristics of Healthy Kids Enrollees

	Percentage
Age	
1	2.4
2	11.3
3	19.4
4	31.2
5	35.8
Gender	
Male	49.9
Female	50.1
Years in L.A. County (parents)	
<1-3	38.3
3-5	41.1
5+	20.7
Level of Poverty (% of FPL)	
<100	84.8
100-199	14.2
200-299	1.1
Parental educational attainment	
Less than high school	52.2
High school graduate	20.7
Any college or training	27.1
Citizenship	
Citizen	6.4
Non-citizen	93.6
Parent has spouse/adult partner in household	
Yes	83.5
No	16.5
Employment of either parent	
Full-time	72.4
Part-time	20.3
Unemployed	7.3
Race/ethnicity	
Latino	87.5
Asian, not Latino	10.9
Other, not Latino	1.6
N	**535**

Healthy Kids are almost all very poor, with the large majority in families below 100 percent of the federal poverty level (84.8 percent). In addition, just over half of Healthy Kids children have parents who have not graduated from high school. Still, a substantial number (about a fifth) are high school graduates, and over a fourth have some college or training beyond high school.

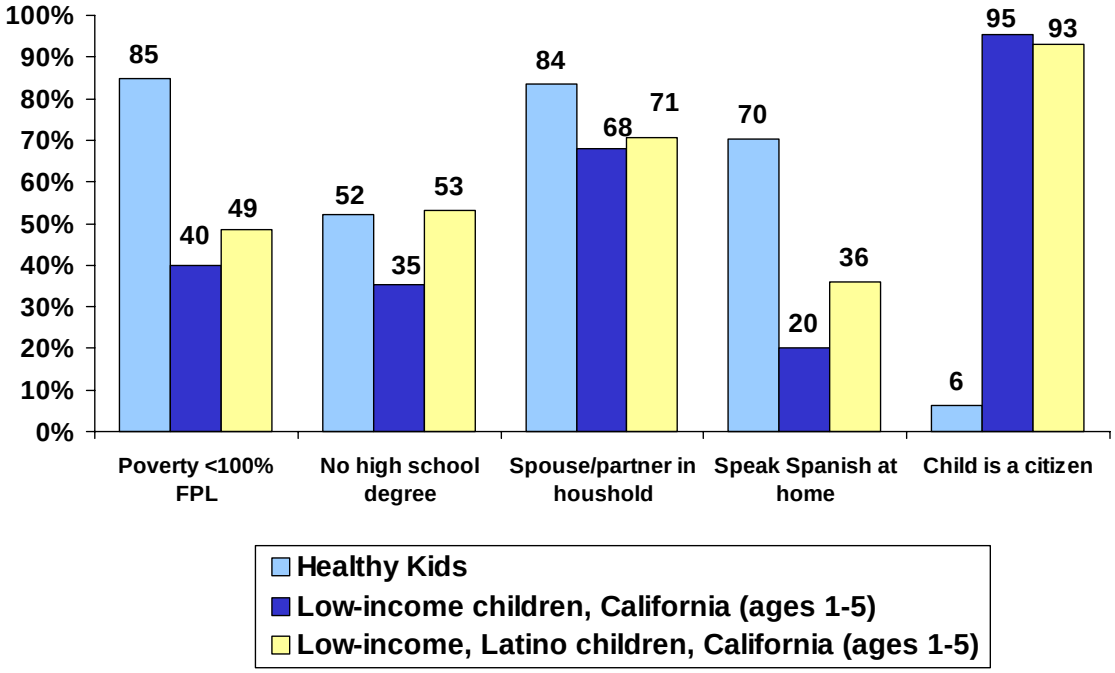
In contrast to the majority of poor children nationally, who live in single-parent families, Healthy Kids children mostly live in households with either two married parents or parents who are partners (83.5 percent). In addition, the large majority of Healthy Kids enrollees have at least one working parent. Fully 72.4 percent have at least one parent who works full-time and another 20.3 percent have a parent who works part-time.

The ethnic background of children served by Healthy Kids is predominately Latino (87.5 percent), with 10.9 percent identifying as Asian (predominantly Korean). Corresponding to the high proportion of Latino children, most Healthy Kids families speak only Spanish at home (70.4 percent). However, there are a substantial number of bi-lingual families, with almost 20 percent speaking two languages at home (data not shown).

There are both similarities and differences between Healthy Kids enrollees and other low-income children in California[12], as demonstrated in Figure 3.1. A clear difference is the disproportionate percentage of Healthy Kids who live below 100 percent of the poverty line (84.8 percent) compared to all low-income and low-income Latino children ages 1 to 5 in California (39.8 and 48.6), according to the California Health Interview Survey of 2003 (CHIS, 2003). On the other hand, with respect to parental educational attainment, Healthy Kids parents appear similar to the parents of low-income Latino children statewide.

[12] Defined as children in families with income below 300% of the federal poverty level.

Figure 3.1 Healthy Kids Basic Demographics In Comparison to Other Lower-Income Children In California



Source: California data from the California Health Interview Survey (2003)
Note: Low income is below 300% of the Federal Poverty Level.

There are no directly comparable statewide data concerning family composition. While the measures are not identical, Healthy Kids appear to be more likely to reside in intact families than other low income Latino children statewide.

Another distinct difference between Healthy Kids enrollees and low-income Californian children the proportion who speak Spanish at home (70.4 percent). Statewide, the number of low-income, Latino families who speak Spanish in the home is much lower (35.9 percent).

CHAPTER 4: HEALTH STATUS

Most young children are in good health and need primarily regular preventive care. However, most children also experience episodic illnesses, and some children are chronically in poorer health than their peers.

In national surveys, immigrant children have been shown to be in generally poorer health than other children (Huang, et al, 2006), although the evidence is mixed with immigrant children faring better on some measures and worse on others (Hernandez and Charney, 1998). Studying the health status of very young children (such as those studied here) is challenging because some of the measures that are typically used (such as days lost from school) do not apply. Also, some underlying conditions (such as mental health problems) may not yet be evident. Finally, a telephone survey, such as the survey of Healthy Kids parents reported here, elicits only a parent's impression of their child's health and is not validated by a clinical diagnosis.

Client Survey Questions

Keeping in mind these caveats, we asked the following questions to develop a profile of the health status of those Healthy Kids who had been on the program for about one year (the established enrollees):

- In general would you say your child's health is excellent, very good, good, fair, or poor?
- Does he/she currently have any physical, behavioral, or mental conditions that limit or prevent his/her ability to do childhood activities usual for his/her age?
- Has a doctor or other health care professional ever said that your child has asthma?
- In the past month has your child had any of the following: an accident such as a bad fall or broken bone; a very high fever; or any other condition that concerned you a great deal?
- Does your child have trouble seeing (even with glasses)?

- During the past 12 months, has your child had a toothache, cavity, blackened or spotted teeth, or any other dental problem that caused you concern?
- Thinking back to the first year of your child's life, would you say that his/her health was better, worse, or the same as other infants?

Survey Results

Table 4.1 shows the health status results for Healthy Kids enrollees by age. Because there were few one and two year olds in the sample (since there are few in the Healthy Kids program), we grouped children ages 1-3 for analysis.

The first measure, perceived health status, is used around the world and for all age groups as a measure of general health. Parents usually report on their perception of the child's health, as is done here. While almost half of the parents reported their child to be in excellent or very good health, 16.3 percent said that the child was in fair or poor health (almost all being "fair"). Certainly these parents have some concerns about their child's health, and these are likely the children who need regular health services beyond routine preventive care.

Among the different age groups, four year olds are in somewhat better perceived health than the children in the other age groups, a pattern that is also evident for activity limitations. For example, only 12.2 percent of the four years olds were reported to be in fair/poor health by their parents, compared to 19.1 percent of 1-3 year olds and 17.3 percent of 5 year olds.

The percentage of Healthy Kids enrollees in fair/poor health is higher than for children nationally. For example, the National Survey of Children's Health found that 7.1 percent of Latino children ages 1-5 on Medicaid were in fair/poor health; the percentage is lower for non-Latino children and for non-Medicaid children. However, the percentage was about the same for children ages 0-5 in the San Mateo County Healthy Kids program (14.0 percent), and is even

lower than reported in the Los Angeles County health survey for publicly insured Latino children (25.9 percent).

Table 4.1: Health Status by Age
Healthy Kids Enrollees (ages 1-5)

	Percentage			
	Age 1-3	**Age 4**	**Age 5**	**Total**
Perceived health status				
Excellent/Very Good	41.7	45.3	50.5	46.0
Good	39.2	42.5	32.2	37.7
Fair/Poor	19.1	12.2	17.3	16.3
Activity limitations	4.1	3.3	7.2	4.9
Diagnosed with asthma	8.9	7.4	7.8	8.1
Trouble seeing	3.1	4.7	4.9	4.2
Dental problem	30.6	47.8	50.2	43.0
Health worse than others in infancy?	8.3	9.6	12.5	10.2
Urgent condition In past month:				
Accident	5.2	3.2	5.5	4.7
High fever	17.6	12.6	12.9	14.4
Any health condition that worried parent a great deal	32.6	26.3	30.1	29.7
N	**180**	**161**	**193**	**534**

One thing that likely affects these comparisons is acculturation bias in the reporting of perceived health status. A study of children in first, second, and third generation Mexican-American households found that 23.9 percent of first generation children ages 0-5 were reported by their parents to be in fair/poor health, while only 16.8 percent of second generation and 6.8 percent of third generation children of those ages were reported to be in fair/poor health. Among the same children, third generation children were actually more likely to have active infection

during physical examinations, indicating that they had a higher rate of illness (Hernandez and Charney, 1998). There is also a possible translation bias in reporting this measure, since in national surveys Latino parents who take a survey in Spanish report higher rates of fair/poor health than those who take the survey in English.

Moving to other measures of health status, Table 4.2 shows that very few parents report that their child's activity is limited by their health (only about 5 percent, higher in five year olds). This is the same rate as reported in the San Mateo County Healthy Kids program for this age group. About 8 percent of parents report their child had been diagnosed with asthma, a rate that was fairly constant across the age groups and similar to the rate for children nationally of that age. However, the rate is somewhat lower than observed in San Mateo County (11 percent) and among Latino children state wide according to the California Health Interview Survey (9.5 percent). As a possible measure of underlying chronic health problems, about 10 percent of parents said that their child's health in infancy was worse than other infants.

While only a small proportion of young children appear to have chronic health conditions, the prevalence of acute conditions potentially requiring medical attention is much higher. As shown in the table, 29.7 percent of parents reported that their child had a health condition (such as an injury from an accident or a high fever) in the past month that worried them a great deal.

In addition to this evidence of the prevalence of medical problems, 4.2 percent of children were reported to have trouble seeing and fully 43.0 percent were reported to have had a dental problem that concerned the parent in the past 12 months. Perhaps not surprisingly, the rates of dental and vision problems increased as children aged, suggesting the importance of addressing these problems as children approach school age.

Table 4.2:
Selected Health Status Indicators
By Perceived Health Status, Healthy Kids Enrollees (Ages 1-5)

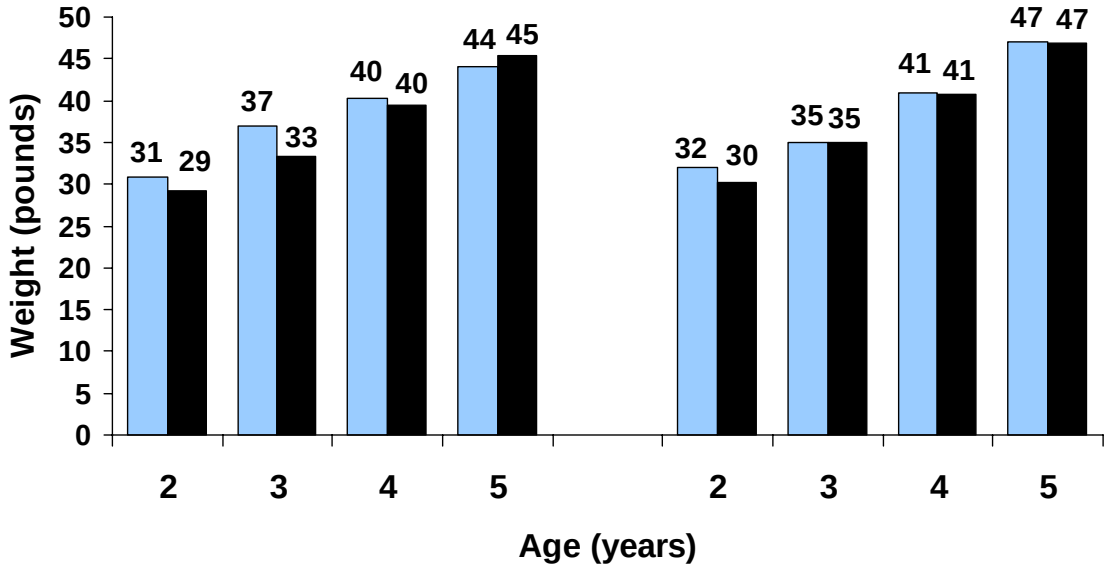
	Perceived Health Status			
	Percentage			
	Excellent/ Very Good	Good	Fair/ Poor	All Children
Health Status Indicator				
Percent with any activity limitation	2.9	4.5	13.3	4.9
Percent in worse health than others in infancy	5.4	10.9	22.7	10.2
Percent with Urgent condition in last month	21.2	30.9	51.6	29.7
N	**248**	**200**	**86**	**534**

Given the concerns regarding possible bias in the reporting of perceived health status, we compared other measures of health status to this overarching measure (Table 4.2). Reassuringly, there is substantial consistency across various health status measures. The children reported to be in fair/poor health were consistently more likely to have activity limitations (13.3 percent), have been in worse health than others in infancy (22.7 percent), or to have had an urgent health condition in the past month (51.6 percent). These rates compare to rates of 2.9 percent, 5.4 percent, and 21.2 percent respectively for children reported to be in excellent or very good health.

Childhood obesity is a major public health problem in the U.S., and low-income children and Latino children are more often obese than other children (Krebs et al. 2003; Ogden et al. 2006). We investigated whether Healthy Kids children were more or less overweight than their peers nationally. Figure 4.1 shows the weights for Healthy Kids enrollees, as reported by their

parents, compared to data from the National Health and Nutrition Examination Survey (NHANES). As shown, Healthy Kids are very similar to children of the same age and gender nationally.[13] Consequently it appears that these primarily recent immigrant children are no more overweight than all U.S. children. Still it will be important to build on this generally good picture by preventing increased obesity as children remain in the country and adopt American eating habits.

Figure 4.1: Weight of Healthy Kids Children Compared to National Average



Source: NHANES for national data (2002)

[13] It is important to note that the NHANES data are from a physical examination and the Healthy Kids data are from parent reports.

CHAPTER 5: PARENT IMPRESSIONS OF HEALTHY KIDS ENROLLMENT AND RENEWAL

One of the major challenges facing the Healthy Kids program is identifying uninsured children, matching them with their appropriate health insurance program, helping them complete an application for the program, and encouraging them to renew their coverage at the appropriate time. Potential hurdles include the difficulty of finding families (many of whom are undocumented and wary of all government programs), and overcoming various barriers to enrollment such as complicated paperwork or stigma.

With these potential obstacles in mind, Healthy Kids incorporated many proven methods for easing the application and renewal process with the aim of boosting enrollment and renewal rates. Largely modeled after similar strategies implemented a few years earlier for the new Healthy Families program, these Healthy Kids outreach/enrollment efforts included:

- Advertising campaigns in culturally relevant media outlets
- Extensive community-based outreach and enrollment assistance with application and renewal
- Twelve months of continuous enrollment
- Contacting families to encourage renewal
- Renewal forms that are easy to complete (for example, "pre-populated" with existing information for correction)

This chapter first describes these strategies in more depth, drawing on material gathered during the evaluation site visit (Hill, Courtot, and Wada 2005), and then assesses the enrollment and renewal experience from the parents' perspective, using data from the client survey.

Healthy Kids Enrollment and Renewal Process. In order to achieve high rates of enrollment, especially for low-income and vulnerable children, the Los Angeles Healthy Kids Program decided to use an intensive community-based outreach and enrollment strategy, building on the previous success of Healthy Families and Medi-Cal outreach for children in the

late 1990s. The stakeholders felt that such an approach would gain the trust needed to overcome potential barriers to enrollment, such as concerns about immigration status.

The Los Angeles Department of Health Services and the California Endowment contract with 15 and 16 community-based organizations, respectively, to carry out enrollment activities which include: talking to families about the availability of Healthy Kids, Healthy Families, and Medi-Cal, as well as insurance options for adults; assisting families with filing the original and renewal applications; and providing troubleshooting for application/renewal problems. At the time of application, the application assistor also helps the family choose a primary care provider. If a family does not make a choice on the application, LA Care staff contacts the family in order to help them make a choice.

All new enrollees are required to apply using the help of an application assistor (usually a worker from a community-based organization). The application assistors are based in a variety of settings for maximum coverage in the county, including within different public service settings. In some neighborhoods, targeted outreach is conducted by volunteers (called "promotoras") who contact families door-to-door. This holistic approach to outreach and enrollment emphasizes that there is "something for everyone" in a family.

During evaluation focus groups, parents said that this community outreach gained their trust and alleviated their fears about "public charge." [14] These strategies, combined with the availability of application materials in Spanish, led to almost unanimous agreement that the enrollment process was easy (Hill et al. 2006).

As with enrollment, the renewal process was designed to be simple with the goal of increasing retention rates. LA Care and a program integration workshop developed a semi-

[14] Parents may be concerned that enrolling their child in a public program would make them a "public charge" and affect their ability to become a U.S. citizen.

passive renewal process modeled on other programs, such as Healthy Families. As a result, Healthy Kids enrollees receive 12 months of continuous enrollment, regardless of a change in their income. As the renewal date approaches, families are sent a renewal form (45 to 60 days before the completion of 12 months of enrollment), which is pre-printed with the information they previously submitted when enrolling in the program. Families are required to check that the information is still correct, notify LA Care of any changes, and mail back the form to establish ongoing eligibility. LA Care also conducts at least three follow-up calls to ensure successful completion and gives non-respondents 30 days notice before children are disenrolled from the plan. Application assistors are again available to families; however, in contrast to enrollment they are not required to certify the application form. Healthy Kids achieved a retention rate of 70.2 percent during the first year of the program, surpassing the First 5 LA retention goal of 60 percent (Hill, Courtot, Wada 2005).

To complement this community outreach/enrollment program, First 5 LA advertised the availability of Healthy Kids through a media and public information campaign that included press releases, press conferences, use of local ethnic TV and radio stations, and distributing print materials to community-based organizations. These outreach/enrollment and media activities were apparently successful at identifying and enrolling children, since by December 2005, 7,833 children aged 0 to 5 were enrolled in Healthy Kids (Sommers et al. 2006), surpassing the First 5 LA enrollment objective of half of the estimated 14,000 eligible children.

Client Survey Questions

In the client survey, in order to assess how parents felt about their experience with enrollment, the following questions were asked of new enrollee parents:

- How did you hear about Healthy Kids?

- Where did you apply for Healthy Kids?

- How easy or difficult did you find the application process? Was it very easy, somewhat easy, somewhat difficult, very difficult?

- Once your child was enrolled in Healthy Kids, did you choose (his/her) doctor or health care provider, or was one selected for you by the health plan? (Options included, respondent choose doctor/ health plan chose doctor)

- (If the respondent chose the doctor) How did you pick your child's doctor or health care provider? (Options included, child or family already seeing doctor/ recommended by someone respondent trusts/ respondent chose for a list given by the health plan)

- (If the health plan chose a doctor, or the respondent chose a doctor from the health plan's list) Were you satisfied or dissatisfied with the way the doctor or health care provider was selected?

Two questions were asked of established enrollee parents who had completed the renewal process for their child:

- How easy or difficult was the renewal process? Was it very easy, somewhat easy, somewhat difficult, very difficult?

- Did you need help from an application assistor with the renewal process? (Yes/no)

Survey Results

Application Process. As Table 5.1 shows, parents heard about Healthy Kids from diverse sources, suggesting that efforts to reach them through a variety of mechanisms and in a variety of places succeeded. A high percentage of parents heard about the program at a clinic, hospital, or emergency room (31.2 percent) and an even higher percentage enrolled there (52.6 percent). Word of mouth from a friend or family member was another important mechanism by which parents discovered Healthy Kids, with 22.9 percent of parents learning about the program that way.

Table 5.1: How Parents Heard About Healthy Kids And Where They Applied

	Percentage	
	How the parent heard about Healthy Kids	**Place of application**
Health clinic/Hospital/ER	31.2	52.6
Friend or family	22.9	-
School	11.9	9.4
Over the phone	-	16.5
WIC site	6.4	4.5
County/social services	3.4	4.3
TV or radio	3.4	-
More than one place	12.0	-
Other place	3.9	4.9
N	**544**	**533**

Almost 12 percent of parents heard about Healthy Kids at a school, and 9.4 percent applied there, which suggests both the importance of outreach to kindergarten and preschool children and that older siblings in school act as a conduit for information for younger siblings. Only a small proportion of parents heard about Healthy Kids via radio or television commercials (3.4 percent). Parents participating in focus groups recommended expanding such advertising (Hill et al. 2006). Twelve percent heard about Healthy Kids in more than one place. By examining verbal responses of the 3.9 percent who answered "other place", we found they had a wide variety of information sources, such as community-based organizations, work, and public spaces such as parks, emphasizing the diversity of outreach approaches.

These findings concerning where parents heard about Healthy Kids and the location of application are similar to those of this evaluation's process monitoring reports (Sommers et al. 2006) and those for Healthy Kids programs in San Mateo and Santa Clara counties. In those counties, clinics, hospitals, and the emergency rooms were also places where most Healthy Kids enrollees learned about and applied for the program. For San Mateo County, 34.0 percent of applicants heard about Healthy Kids at clinics and 65.5 percent applied there (Howell et al. 2005), and in Santa Clara County these figures were 26.6 percent and 68.0 percent respectively (Hughes 2006). Additionally, in SCHIP programs across 10 states, health care providers were cited as the most important source of information about the program (Kenney et al. 2005). Focus groups with parents of Los Angeles Healthy Kids enrollees also confirmed that clinic outreach is very important mechanism both for informing parents about the program and for enrolling children.

Table 5.2 shows that Healthy Kids efforts to simplify the application process appear to be successful, since fully 94 percent of parents found the enrollment process either very or somewhat easy. There were no significant differences by ethnicity or income (data not shown). The percentage of parents finding the Healthy Kids application process either easy or very easy is almost identical to the rate in San Mateo County (Howell et al. 2005) and the percentage for recent enrollees in the SCHIP programs of ten states (Kenney et al. 2005). However, more SCHIP parents reported enrollment as very easy (65 percent) than in LA County (49.7 percent).

Table 5.2: Ease of Application and Renewal

	Percentage	
	Enrollment	**Renewal**
Very easy	49.7	52.9
Somewhat easy	44.1	40.3
Somewhat difficult	6.1	6.2
Very difficult	0.2	0.6
N	**541**	**387**

Note: Data for the enrollment process came from new enrollee parents and data for the renewal process came from established enrollee parents.

As mentioned, as part of the application process a parent may select their preferred primary care provider. If they do not choose one, the health plan will contact them later about this to assist them. Table 5.3 shows who chose the doctor when families enrolled, how respondents made their decision if they were responsible for choosing the doctor, and how satisfied parents were if the health plan chose the doctor on their behalf. Half indicated they chose a doctor themselves (49.1 percent). For those who chose a doctor themselves, 38.4 percent remained with their existing doctor, 18.0 percent chose a doctor who was recommended to them, and most of the rest chose a doctor from the health plan's list (42.1 percent).

Table 5.3: Choosing A Doctor On Enrollment

	Percentage
Who chose child's doctor?	
Health plan chose doctor	50.9
Respondent chose doctor	49.1
If respondent chose doctor, how?	
Already seeing doctor	38.4
Recommended by a friend/ family member	18.0
Chosen from a list given by the health plan	42.1
Other	1.5
How satisfied by how health plan chose doctor?	
Satisfied	88.1
Dissatisfied	11.9
N	**532**

On the other hand, half the parents thought the health plan chose a doctor on their behalf (50.9 percent). It could be that parents responded that the plan chose the doctor when they received advice from the plan, or when a list from the plan was used to choose the doctor. In any case, having the plan "choose" their doctor was satisfactory for most parents (88.1 percent).

As Table 5.2 indicates, established enrollee parents experience with the renewal process was equally positive to that of the enrollment process. An almost identical proportion (52.9 percent) found that renewing their children's Healthy Kids enrollment was very easy. Focus groups supported this conclusion, with participants largely stating that the renewal process was easy, quick, and that the help they received was very useful (Hill et al. 2006). Slightly more than a quarter of parents used application assistors for renewal (26.3 percent, data not shown).

CHAPTER 6: INSURANCE COVERAGE PATTERNS AMONG FAMILIES WITH HEALTHY KIDS ENROLLEES

Two key policy questions are whether Healthy Kids is serving children who would otherwise lack comprehensive insurance coverage, and whether the program might be substituting for coverage that could be provided through parents' employers. In response to this concern, the Healthy Kids program, like the Healthy Families program, requires that children not have employer-sponsored insurance during the three months prior to enrolling. In addition, families with incomes above 150 percent of the Federal Poverty Level are required to pay premiums of between $4 and $6 per month, depending on the family's income.

Data from the Los Angeles County Health Survey of 2003 showed that only a small share of non-citizen children in LA county had employer-sponsored insurance coverage prior to the launch of Healthy Kids program. In addition, because most of the children in similar programs targeted at undocumented children in San Mateo and Santa Clara counties did not have access to employer-sponsored coverage, we expected that few Healthy Kids enrollees in Los Angeles would have access to employer-sponsored insurance coverage.

This analysis examines the extent to which Healthy Kids enrollees have access to employer-sponsored insurance (ESI). We first assess the share of Healthy Kids enrollees who had ESI prior to enrolling in Healthy Kids and whether ESI coverage is available to and potentially affordable for them. We also examine coverage patterns for the parents as well as the siblings of the children who are enrolled in the Healthy Kids program.

Client Survey Questions

The analysis is based on survey questions to parents of new enrollees about the child's health insurance coverage just before enrolling in Healthy Kids and the health insurance coverage of parents and siblings. Parents were asked the specific type of coverage their child

had in the period prior to enrolling in Healthy Kids, including whether the child had Medi-Cal (regular or Emergency), Healthy Families, employer-sponsored coverage, private non-group coverage, or any other type of coverage. We asked parents if they or their spouse had health insurance coverage. If so, we asked what type of coverage they had; whether they or their spouse had an employer that offered insurance coverage to dependents; and whether the employer contributed something toward the premium for dependent coverage. These questions were used to assess whether the family had access to affordable ESI for the child, using a methodology adapted from the congressionally mandated evaluation of SCHIP (Kenney et al. 2005) and the evaluation of the San Mateo Healthy Kids program (Howell et al. 2005). We also asked how many of the child's siblings were uninsured and how many were covered by Medi-Cal or Healthy Families.

Survey Results

Figure 6.1 shows the insurance status of children just prior to enrolling in Healthy Kids.[15] Parents could report more than one form of insurance, so a hierarchy was used to categorize the children into mutually exclusive groups. All children that had any ESI (regardless of any other coverage) were categorized as having ESI, followed by Medi-Cal/Healthy Families, Emergency Medi-Cal, other coverage, and fully uninsured. Children who were reported to have only coverage under the Child Health and Disability Program, clinic/hospital-based coverage, or no coverage were classified as being uninsured.

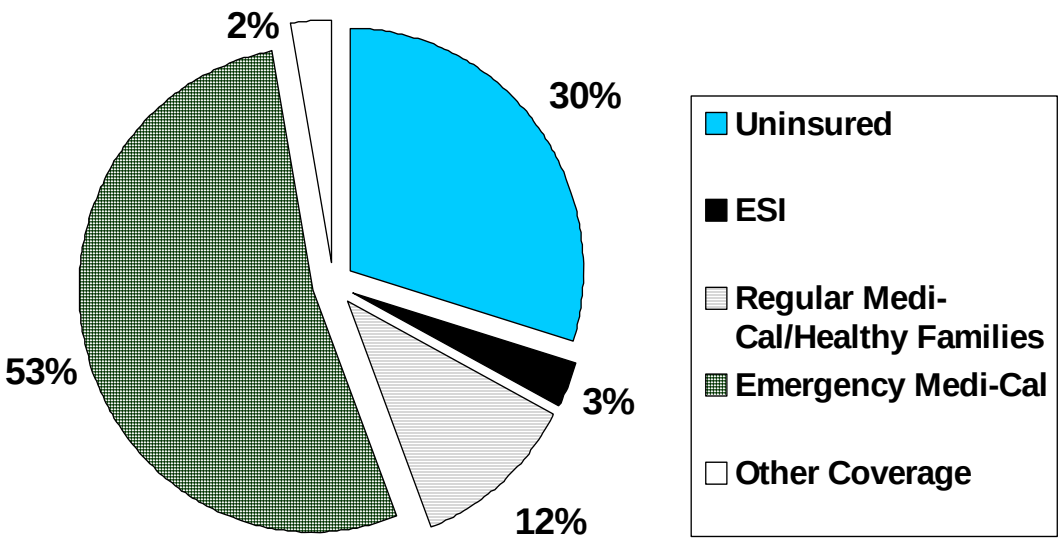
About 10 percent of children were reported to have more than one type of coverage prior to enrolling in Healthy Kids. It was especially common for Emergency Medi-Cal to be reported in tandem with another type of coverage. Fully 16 percent of the children with Emergency

[15] These estimates are based on information from new enrollees. The results for established enrollees are very similar.

Medi-Cal were reported to have another source of coverage. However, the only children in the figure shown to be Emergency Medi-Cal are those with no other form of coverage.

Just 3 percent of Healthy Kids enrollees had employer-sponsored coverage just before they enrolled in the program. Thus very few parents dropped ESI coverage in order to enroll their children. In addition, over 80 percent of Healthy Kids enrollees lacked comprehensive health insurance coverage prior to enrolling; 30 percent had no health insurance coverage whatsoever and 53 percent only had Emergency Medi-Cal. The remainder had either regular Medi-Cal/Healthy Families (12 percent) or some other type of coverage (3 percent).

Figure 6.1: Insurance Status Prior to Enrolling in the Healthy Kids Program



Fifty-three percent were reported to have had Emergency Medi-Cal alone, and another 10 percent had Emergency Medi-Cal in combination with some other type of coverage (data not shown). The proportion of children with Emergency Medi-Cal prior to enrolling is two to three

times higher than the rates reported in San Mateo and Santa Clara Counties for the same age group, and over half of the children had been on Emergency Medi-Cal for more than six months. In addition, a third of the recent and 46 percent of the established enrollees who had Emergency Medi-Cal coverage just prior to enrolling still had this coverage at the time of the interview (data not shown). The findings concerning Emergency Medi-Cal are consistent with information gathered during evaluation focus groups. A large proportion of parents in the focus groups reported that they had and continued to use Emergency Medi-Cal, even after enrolling in Healthy Kids (Hill et al., 2006).

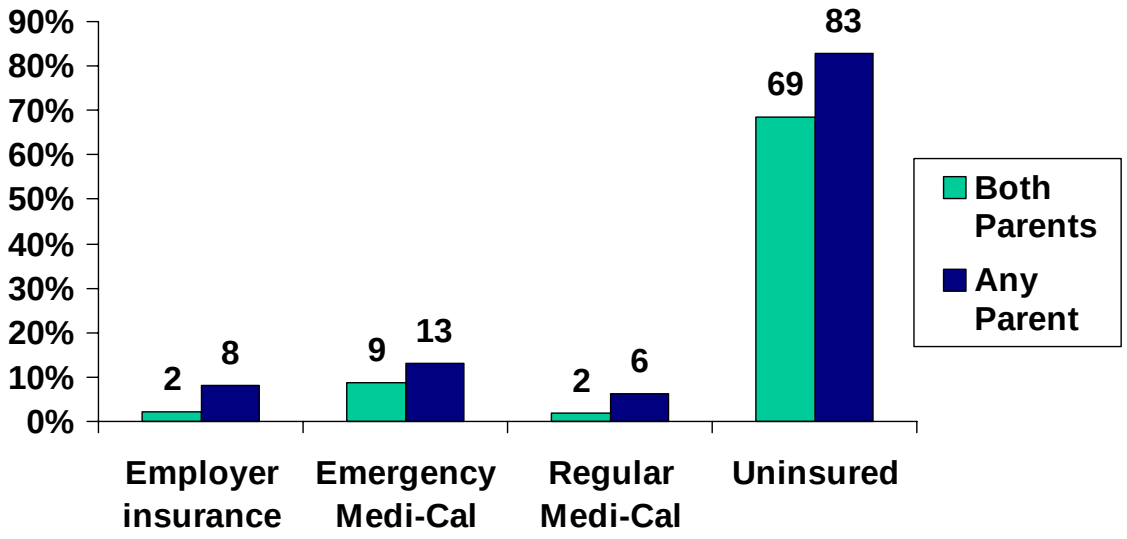
The vast majority of Healthy Kids enrollees have no access to ESI coverage whatsoever, let alone access to coverage that is affordable, which explains why so few children had ESI prior to enrolling in the program (Table 6.1). For example, only 9.9 percent of parents of Healthy Kids enrollees have an offer of employer-sponsored coverage. Among those parents, about half work for employers that subsidize the premium for dependent coverage, but only 2.9 percent have a parent who is covered under that policy, indicating that the employer policy is affordable to the family.

Table 6.1: Access to Employer-Sponsored Coverage Among Healthy Kids Enrollees

	Percentage
Parent has an offer of dependent coverage through employer	9.9
Parent has an offer of dependent coverage and employer pays some or all of premium	5.4
Parent has offer of dependent coverage, employer pays some or all of premium, and parent has employer-sponsored coverage themselves	2.9

Parent Coverage. This low access to ESI and to insurance coverage generally within Healthy Kids families translates into high rates of uninsurance among parents (Figure 6.2). Fully 82.9 percent of Healthy Kids enrollees have at least one parent who lacked health insurance coverage at the time of the survey, and just 8.1 percent have a parent with ESI. Emergency Medi-Cal is the single largest category of coverage reported for parents, with 13.1 percent of Healthy Kids enrollees having at least one parent with Emergency Medi-Cal coverage.

Figure 6.2: Insurance Status Of Healthy Kids Enrollees' Parents



Source: 2005 Survey of LA Healthy Kids Enrollees

Sibling Coverage. Having children in the family with different forms of coverage may cause difficulties for parents dealing with different administrative rules and renewal processes, or different provider networks. As shown in Table 6.2, many Healthy Kids enrollees do have siblings who are enrolled in other public health insurance programs. Among the new enrollees

with siblings (about 70 percent of enrollees), 15.8 percent had one or more siblings enrolled in Healthy Families and 24.9 percent had one or more siblings enrolled in Medi-Cal. (The rates are higher for established enrollees—data not shown.) While most siblings do have some form of health insurance, 11 percent of the new enrollees had at least one sibling who was uninsured. (The rate was almost identical for established enrollees.)

Table 6.2: Coverage Patterns Among the Siblings of Healthy Kids Enrollees

Healthy Kids Enrollees With One Or More Siblings	**Percentage**
At least one sibling enrolled in Medi-Cal	24.9
At least one sibling enrolled in Healthy Families	15.8
At least one sibling uninsured	16.0
N	**365**
All Healthy Kids Enrollees	**Percentage**
At least one sibling enrolled in Medi-Cal	17.1
At least one sibling enrolled in Healthy Families	10.8
At least one sibling uninsured	11.0
N	**538**

CHAPTER 7: ACCESS TO AND USE OF MEDICAL CARE

The primary goal of the Healthy Kids program is to improve access to health care for previously uninsured children and therefore increase their use of needed health services. Having a usual source of care is considered a necessary component of continuous primary care and therefore is a key indicator of access (Starfield 1992). Studies have shown that immigrant children are significantly less likely to have a usual source of care than other children (Huang et al. 2006). We would expect that most Healthy Kids children would have a usual source of care, since part of the enrollment process into the program includes the selection of the child's primary care provider. Having a usual source of care should further be reflected in the child's use of services ("realized access"). The American Academy of Pediatrics recommends that one year olds receive two preventive visits a year and that two to five year olds receive such a visit annually.

In addition to requiring routine primary and preventive care, most young children have periodic episodic illnesses that requires a physician visit, and some have chronic conditions that need frequent monitoring and treatment. The case study interviews and parent focus groups (Hill, Courtot, and Wada 2005) both suggested that access to primary care was very good under Healthy Kids, and that access to specialty care was generally good, but could be improved for some children, especially those with special health care needs. For example, the Healthy Kids program took several steps that are likely to improve access to care for enrollees (Hill, et al., 2006). The benefit package is broad, according to those interviewed, as is the network of providers who accept Healthy Kids enrollees. Program developers deliberately chose a health plan with such a broad network (LA Care) to administer Healthy Kids. At the same time as providing access to private providers, the network also includes many safety net providers with

experience serving low income Latino families. Over 1400 primary care providers participate as well as 2343 specialists and 45 hospitals.

Client Survey Questions

We examine both perceived and realized access to care for children enrolled in the Healthy Kids program for about a year (the established enrollees). We asked parents the following four types of questions:

- *Usual Source of Care*: Do you have a particular place that your child usually goes to if he/she is sick or you need advice about his/her health? (For parents who reported a usual source of care, several additional questions were asked specifically about the usual source of care, such as: Do you have one person you think of as your child's personal doctor or nurse?)

- *Use of Services*: During the past six months, how many times did your child go to a hospital emergency room? Was he/she admitted and had to stay overnight in the hospital? How many different times did your child stay overnight in the hospital? How many times did your child see a doctor or any other health care professional such as a physician assistant or nurse? Did he/she see a doctor or health professional for preventive care, such as a check-up, well-child visit, shots, or physical examination? Did your child get any shots? Did your child see a specialist? Did your child go to an eye doctor, optometrist, or optician for an eye exam?

- *Unmet Need:* During the last 6 months was there any time that your child needed to see a doctor or other health care professional for preventive care such as a well-child visit, checkup or physical examination but did not go? Needed to see a specialist but did not go? Needed care by a specialist and it had to be delayed? Needed to see a doctor other health professional because of an illness, accident, or injury but did not go? Needed an eye exam and it had to be delayed? Needed a prescription drug but did not get it?

- *Ability to Meet Health Needs:* During the past six months, how confident were you that your child could get health care if he/she needed it? How often did your child's health care needs create financial difficulties?

To provide a context for the interpretation of results for Healthy Kids enrollees, we provide in the text some measures for established enrollee 0 to 5 year olds from the Congressionally Mandated SCHIP Evaluation, which used virtually the same survey instrument with an identical reference period (Kenney, et al. 2005).

It is important to recognize that the SCHIP population differs from Healthy Kids enrollees in several important ways that could affect access to care. For example, SCHIP enrollees live in families with higher incomes, and almost all are citizens. As a result, one might expect access and use to be better for the SCHIP population than for the Healthy Kids population.

One additional source of information on use of services reported here comes from survey data linked to the Health Plan Employer Data and Information Set (HEDIS), which has data from medical records on the number of Healthy Kids two year olds who were up-to-date on their immunizations. While the number of children who could be linked was very small (31 children), the results provide some qualitative information on immunization levels for that age group.

Survey Results

Usual Source of Care. Table 7.1 presents the availability of a usual source of care for Healthy Kids enrollees, as well as several characteristics of the usual source of care for those that have one. A high percentage of parents, 91.7 percent, reported their child had a usual source of care, and another 2.2 percent reported a usual source of care that was an emergency room. Only 6.1 percent reported having no usual source of care for their child, which is not surprising since selecting a primary care provider is part of the Healthy Kids application process.

Among those with a usual source of care, only 24.4 percent reported that the usual source of care was a private doctor's office, while 75.0 percent reported that the usual source of care was a clinic. This contrasts sharply with the profile of providers that are usual sources of care for SCHIP enrollees, for whom 66 percent of parents cited a private doctor's office as the usual source of care. Among the 31 children with no usual source of care, 9 parents said that the reason

for not having one was that their child seldom or never got sick, 6 cited not knowing where to go, and 5 said that care cost too much or they didn't have insurance (data not shown).

Table 7.1: Access to Care for Healthy Kids Enrollees

	Percentage
Child has usual source of care	
Yes	91.7
No: Report ER as usual source	2.2
No	6.1
N	**523**
Type of usual source of care[a]	
Private doctor's office	24.4
Clinic or health center	75.0
Other type of place	0.6
N	**493**
Travel time to usual source of care[a]	
Less than 30 minutes	70.0
30 minutes to an hour	21.7
One hour or more	7.4
N	**493**
Does child have personal doctor/nurse?[a]	
Yes	66.8
N	**491**
Needed advice when the usual source of care was closed[a]	
Yes	28.2
N	**492**
Was able to reach a doctor when usual source of care was closed[b]	
Yes	53.2
N	**135**

[a] For those with a usual source of care
[b] For those who needed advice when the usual source of care was closed

The process monitoring reports using data from LA Care (Sommers et al. 2006) have indicated that the proportion of Healthy Kids enrollees with private providers is higher than suggested by the survey data. While we are unsure of the source of this discrepancy, it is possible that many of the private doctors in the health plan data base practice in either for-profit or not-for-profit clinics. Another possibility is that some children have a private physician assigned a primary care provider, but actually more regularly attend a clinic for care.

Parents of most Healthy Kids enrollees (70.0 percent) reported that their child's usual source of care was conveniently located within 30 minutes of their home. However, 21.7 percent lived 30 minutes to an hour from it, and another 7.4 percent lived an hour or more away. Young SCHIP enrollees had somewhat better geographic access, with 83 percent being less than 30 minutes away from their usual source of care.

Among those with a usual source of care, parents were asked whether their child had a personal doctor or nurse who knew their child and was familiar with the child's history. About two-thirds of parents said yes, contrasting with 74.8 percent of parents of young SCHIP enrollees.

In spite of this generally positive picture of access to care, some parents had difficulty getting after-hours advice for health problems. Approximately 28 percent of parents of Healthy Kids enrollees sought health care advice when the usual source of care was closed, and of those only 53.2 percent were able to reach a health professional to talk about their child's problem.

Use of Services. Table 7.2 shows the rate of doctor and other health professional and specialist visits; emergency room visits; overnight hospital stays; vision services; preventive care visits; and shots[16]. Use of each of these types of services is shown by age and by whether the

[16] Dental care use is discussed in the following chapter.

child was in good health or had health problems. Over 75 percent of Healthy Kids enrollees saw a doctor or other health professional in the six months prior to the survey, but a substantial proportion, 23.6 percent, had no visits in the time period. An additional 23.2 percent had just one visit. At the same time, 34.1 percent had 2 to 3 visits, and 22.3 percent and 19.0 percent had four or more visits, showing that some Healthy Kids children were heavy users of medical care. As additional evidence of health problems, 11.4 percent of Healthy Kids enrollees saw a specialist in the six months prior to the survey. Differences in the rate and number of doctor and specialist visits were not statistically significant either by age or by health status, which may be due to the small sample sizes in the age and poor health status groups.

Table 7.2: Use of Health Care Services in the Past Six Months

	Total	Age (years)			Health Status	
		1-3	4	5	Good	With health problems[1]
Any doctor visit	76.4	73.6	77.1	78.5	74.8	81.0
Number of doctor visits						
0	23.6	26.4	22.9	21.5	25.2	19.0
1	23.2	20.3	23.8	25.5	24.7	19.0
2-3	34.1	30.8	36.3	35.3	33.5	35.9
4	19.0	22.3	17.0	17.8	16.6	26.1
Any specialist visit	11.4	9.1	13.2	11.9	11.7	10.5
Any emergency room visit	22.5	27.4	21.0	19.3	19.5	31.4
Any hospital stay	3.3	4.3	0.7	4.1	1.9	6.9
Any preventive care visit	70.5	66.4	71.3	73.6	69.3	73.9
Any shots	59.2	60.4	62.7	55.0	59.1	59.5
Any vision screening	8.2	7.4	7.3	9.3	7.6	9.9
N	**535**	**181**	**161**	**193**	**402**	**133**

[1] Children with health problems were defined as those who were reported to be in fair or poor health, those who were in worse health in infancy, and those who had a condition that limited their activities.

The likelihood of Healthy Kids enrollees having any doctor visit was quite similar to that of SCHIP enrollees ages 0 to 5 (75.2 percent). However the Healthy Kids rate of specialist visits is lower than for SCHIP (17.2 percent). Consequently, the data suggest that Healthy Kids enrollees have adequate access to primary care but that there are potential access problems for specialty care, especially for the Healthy Kids children who are in poor health.

Twenty-two percent of Healthy Kids established enrollees had an emergency room visit in the prior 6 months, with 1 to 3 year olds being more likely to have an emergency room visit than five year olds (27.4 percent versus 19.3 percent respectively). Moreover, children with health problems were much more likely to have an emergency room visit (31.4 percent) than children in good health (19.5 percent). While the use of the emergency room by Healthy Kids enrollees might seem high, the overall rate (22.5 percent) is quite similar to the rate for SCHIP enrollees ages 0 to 5 (24.3 percent).

The rate of overnight hospital stays was 3.3 percent in the six months prior to the survey. As expected, children with health problems had significantly higher rates of hospitalization (6.9 percent) than children in good health (1.9 percent). The much lower rate for 4 year olds relative to 1 to 3 and 5 year olds was consistent with parent reports that 4 year olds were in better health than the other two age groups, as shown in Chapter 4. The Healthy Kids hospitalization rate is comparable to that of SCHIP enrollees ages 0 to 5, of whom 5.1 percent were hospitalized.

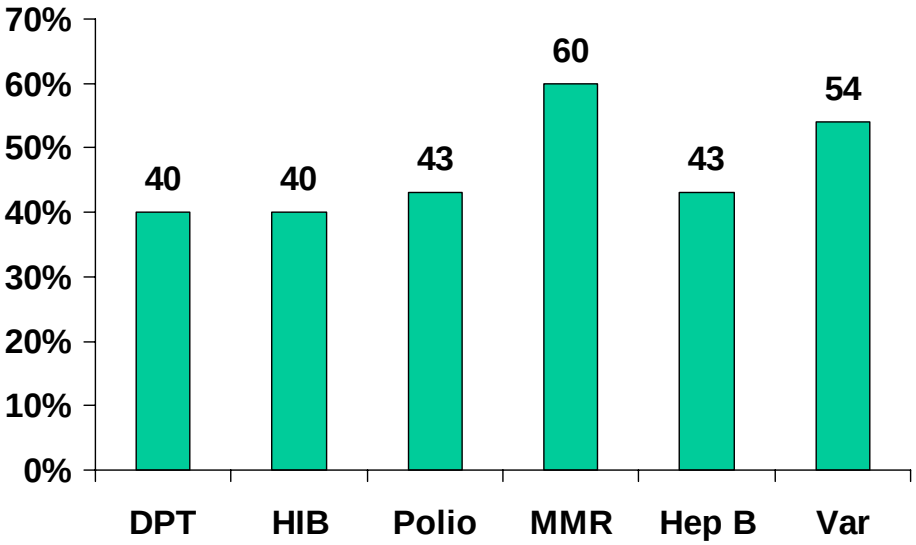
The table show rates of use of three types of preventive services: having a preventive doctor visit; receiving a shot or vaccination; and having a vision check up or eye exam. Fully, 70.5 percent of Healthy Kids enrollees had a preventive care visit in the previous six months, higher than the rate for SCHIP enrollees ages 0 to 5 (57.1 percent). Fifty-nine percent of enrollees received a shot or vaccination, and 8.2 percent received a vision check up. There were

no significant differences with respect to age or health status in any of the preventive care measures.

It seems surprising that such a high proportion of children had shots, since most are older than the ages when immunizations are received routinely. However, it is possible that the older children are still getting caught up on their immunizations. As further evidence for this, Figure 7.1 shows results from the linkage of HEDIS data linked to client survey data. For the 31 two year olds whose data could be linked, the figure shows the percent who were up-to-date on their immunizations. The data show that the health plan faces a challenge in achieving full immunization coverage for newly arrived immigrant children. Only 40 to 60 percent of these two year olds were up-to-date, depending on the type of immunization. This is in contrast to the 83 percent of all U.S. children who were up-to-date on all immunizations at the same age in 2004 (U.S Department of Health and Human Services/CDC, 2005). The highest immunization rates (Measles, Mumps, Rubella and Varicella) were those that require only one "catch up" shot to be up-to-date.

Most of these two year olds arrived in the U.S. only recently (having been born abroad), and it is very possible that infants in the countries of their birth do not receive the same range of immunizations that are recommended by the American Academy of Pediatrics and used as HEDIS standards (www.cdc.gov/nip/acip). The fact that the proportion of Healthy Kids receiving shots is the same for 4 year olds as for 1 to 3 year olds (Table 7.2) suggests that enrollment in the program is leading to catch-up in the immunizations schedule all the way through early childhood, and thus potentially protecting the public health of all children in Los Angeles County.

Figure 7.1: Percent of Healthy Kids Two-Year Olds Up-to-Date on Immunizations by Type



Note: DPT = Diphtheria, Tetanus, Pertussis; HIB = Haemophilus, Influenza, Type B; Hep B = Hepatitis B; Var = Varicella

Unmet Need. Data on unmet need in the six months prior to the survey are shown in Table 7.3, with separate estimates by age and health status of the child. Access to urgently needed medical care is good for Healthy Kids enrollees. Only a very small percentage of Healthy Kids parents reported needing care for their child's illness or injury but not getting it (2.5 percent), although the rate was higher for children with health problems (4.3 percent). There were no significant age differences by age.

However, there were higher rates of unmet need for preventive care. Twelve percent of Healthy Kids enrollees needed preventive care but did not obtain it. This varied significantly by age and by health status with 4 year olds and children in good health being less likely to experience unmet need for preventive care. In theory, the need for preventive care should not vary by health status, so the higher perceived level of unmet need for children with health

problems is surprising. Perhaps the parents of these children are too busy getting other types of care for their child (for example, some parents reported that they could not take their child because he or she was sick) or perhaps they are generally more anxious about their child's health needs.

Table 7.3: Healthy Kids Unmet Need in the Past 6 Months

	Total	Age (years)			Health Status	
		1-3	4	5	Good	With health problems[1]
	Percentage					
Needed doctor visit for illness/injury but did not go	2.5	3.4	1.7	2.5	1.9	4.3
Needed preventive visit but did not go	12.5	15.4	7.8	13.8	9.6	20.7
Needed specialist visit						
But did not go	6.0	7.3	3.5	7.0	4.6	10.2
But delayed care	5.4	6.3	4.7	5.0	3.3	11.4
Needed vision care visit but delayed care	0.8	0.4	1.4	0.9	0.8	1.2
Needed prescription drugs but did not get them	3.3	5.4	1.7	2.8	2.4	5.8
N	**535**	**181**	**161**	**193**	**402**	**133**

[1] Children with health problems were defined as those who were reported to be in fair or poor health, those who were in worse health in infancy, or those who had a condition that limited their activities.

Among the small number of parents (66) who reported an unmet need for preventive care, their reasons for having an unmet need fell into several categories: parent information issues such as believing the provider did not accept their insurance or not knowing where to go (3.5 percent); transportation issues (11.3 percent); access issues such as not being able to schedule an appointment soon enough or not getting approval from the plan (18.5 percent); cost

issues (16.4 percent); missed appointments (23.3 percent); or other (26.9 percent). Among those specifying other reasons, about half were miscellaneous access barriers (data not shown).

Six percent of parents said that they needed specialist care for their child but did not go, and another 5.4 percent said that they needed specialist care for their child but delayed the care. Not surprisingly, the rate of unmet need was higher for children with health problems than for children in good health. Ten percent of children with health problems did not get needed specialist care, and 11.4 percent delayed such care. This compares to 4.6 percent of children in good health not getting needed specialist care and 3.3 percent delaying needed care. There were no significant differences in unmet need for specialist care by age.

The combined rate of unmet need for specialist care (6.4 percent of children either did not have needed specialist care or delayed it) is substantially higher than the combined rate for SCHIP enrollees ages 0 to 5 (2.8 percent). When considered as a share of those who needed specialist care, this combined rate of unmet need was 58.2 percent.[17] These findings of a high rate of unmet need for specialist care are consistent with the relatively low use rates reported in Table 7.2, especially for children with health problems, suggesting potential access problems for specialist care for Healthy Kids enrollees.

Very few parents reported delaying vision care for their children (less than one percent). In addition, few children who needed prescription medicines were unable to get them (3.3 percent) which is similar to that of the SCHIP enrollees ages 0 to 5 (5.5 percent).

Ability to Meet Child's Health Care Needs. As a final indicator of access to care, the survey assessed parents' level of concern about meeting their child's health care needs (Table 7.4). First, parents were asked how confident they were they could meet their child's health care

[17] This percentage is computed by dividing the number of children whose parents reported unmet need for specialty care by the number of children who either had specialty care or had an unmet need for it.

needs, and 88.9 percent said that they were very or somewhat confident. This varied by the health status of the child. Among parents of children in good health, 91.2 percent were very or somewhat confident in getting needed care, in contrast to only 82.2 percent of parents of children with health problems.

Table 7.4: Ability to Meet Child's Health Care Needs

	Total	Age (years)			Health Status	
		1-3	4	5	Good	With health problems[1]
	Percentage					
Very confident or somewhat confident in getting needed care	88.9	87.2	87.0	92.2	91.2	82.2
Child's health care created little to no financial difficulty for family	68.3	66.9	74.3	64.5	70.8	61.1
N	**535**	**181**	**161**	**193**	**402**	**133**

[1] Children with health problems were defined as those who were reported to be in fair or poor health, those who were in worse health in infancy, or those who had a condition that limited their activities.

In addition, most parents (68.3 percent) reported that meeting their child's health care needs created little or no financial difficulty for them, with 61.1 percent of children with health problems facing little or no difficulty (a significant difference from children in good health). Consequently, in spite of the low cost sharing for Healthy Kids services, a substantial portion of parents perceived some financial difficulty. These financial difficulties could be attributed to lost wages when parents take their children to the doctor, co-payments for children with high rates of service use, or more general anxiety among parents about the potential costs should their child become very ill.

CHAPTER 8: ACCESS TO DENTAL CARE

Dental care is the most prevalent unmet need and dental caries the most prevalent infectious disease among children (Newacheck et al. 2000). Even among young children, cavities, both filled and unfilled, are more prevalent in poor children than non-poor children, in Hispanic relative to white children, and in children of parents with low-educational attainment (Edelstein 2002). Moreover, young children in families with low incomes and with parents of low educational attainment are less likely to have dental insurance and to visit a dentist than children in higher income families with more educated parents. While an immediate problem in young children, cavities in primary teeth are also associated with cavities in permanent teeth in youth, adolescence, and adulthood. Moreover, children with dental problems lose 52 million school hours annually and poor children are at greater risk for missing school because of dental problems. (Mouradian et al. 2002). The American Academy of Pediatrics recommends the establishment of a dental home by age one and that dental visits occur every six months starting at age one in order to assess risk, develop and implement a prevention plan, provide anticipatory guidance and education, and provide needed dental services (American Academy of Pediatrics 2003).

As with primary care, the Los Angeles Healthy Kids program has taken special steps to assist parents in establishing a usual source of dental care for their children. The program contracts with Safeguard Dental—which has a network of 1500 dentists to serve Healthy Kids children, and assists parents with selecting a dental care provider as part of the enrollment process. The network for dental providers is almost identical to the Healthy Families network, and is broader than that available to Medi-Cal children (Hill, et al. 2005).

Client Survey Questions

To examine the extent of access to dental care for established enrollees ages 2 to 5[18], we asked parents the following questions:

- *Usual Source of Dental Care:* Do you have a dentist's office or clinic that your child usually goes to if he/she needs to see a dentist or a dental hygienist for a checkup, to get his/her teeth cleaned or for another dental procedure? If not, what is the main reason your child did not have a usual place of dental care?

- *Use of Dental Care:* Children who had a visit to a doctor or other health professional in the past six months were asked: During the past six months did your child go to a dentist or dental hygienist for a checkup or to get his/her teeth cleaned? How about for a dental procedure such as having a cavity filled or a tooth pulled? Has your child ever gone to a dentist or dental hygienist for a checkup or any other reason? [19]

- *Unmet Need for Dental Care:* During the past six months, was there a time that your child needed to go to a dentist or dental hygienist but did not go? What was the reason the child did not see a dentist or dental hygienist when needed? During the past six months, was there any time that your child needed dental care and it had to be delayed? What was the reason the dental care for your child had to be delayed?

As in the previous chapter, we present data on the established enrollees and in some cases provide data from the Congressionally Mandated SCHIP Evaluation on 3 to 5 year olds as a benchmark (Kenney, et al. 2005). We conduct the analyses of use of and unmet need for dental services separately by single year of age of the child and by whether their parent reported that they had concerns about the child's teeth in the past 12 months (a measure of dental health status).

Survey Results

Usual Source of Dental Care. Sixty-six percent of Healthy Kids parents reported their child had a usual source of dental care (Table 8.1). Conversely, 1/3 of enrollees in this age group had none. The rate of having a usual source of dental care among SCHIP enrollees ages 3 to 5

[18] One year olds were excluded.

was somewhat higher at 71 percent, which could reflect either greater access or the somewhat higher ages of the SCHIP enrollees.

Table 8.1: Usual Source of Dental Care

	Percentage
Usual source of dental care	66.4
N	**519**
Reasons for no usual source of care	
Parent Education and Information	59.3
Do not believe child needs a dentist	25.3
Child seldom has a tooth problem	7.1
New to the area	1.3
Do not know where to go	25.6
Access issues	9.7
Costs too much/insurance issues	9.9
Transportation problems	1.2
Other	19.9
N	**169**

Among those who did not report having a usual source of dental care, a large share of parents, almost 60 percent, cited as their main reasons problems that could be characterized as lack of parent information. These reasons included: parents not believing that the child needs a dentist (25.3 percent); that the child seldom or never has a tooth problem (7.1 percent); that they were new to the area (1.3 percent); or that they did not know where to go (25.6 percent). These

[19] Ideally, these questions would have been asked of all children. Unfortunately, a skip pattern error meant that these questions were only asked of children who had had a health professional visit in the last six months. This is approximately ¾ of established enrollees in the survey (see Table 7.2).

findings illustrate the need for more education of Healthy Kids parents regarding the importance of preventive dental visits and about how to find a dental provider that participates in Healthy Kids. Another 9.7 percent of parents cited access issues such as being unable to find a dentist that accepts the plan or a dentist that speaks their language, or that the hours are not convenient; 9.9 percent cited that the costs are too high or that they just changed insurance; 1.2 percent cited transportation problems; and 19.9 percent cited other reasons.

These findings are consistent with results from parent focus groups. While in the parent focus groups most parents reported satisfaction with dental care (and that it is a highly valued program benefit), some parents reported difficulty finding an accessible provider (Hill, Courtot, and Wada 2006).

Use of Services. Questions regarding the use of dental services were only asked of the ¾ of children who had seen a doctor or other health professional in the past six months. Among these children, 40.8 percent had a dental checkup and 58.2 percent had ever seen a dentist in their lifetime (Table 8.2). The proportion having a dental check up in the past six months was somewhat higher for SCHIP enrollees (49.1 percent), a small difference that may be due to the older average age of the SCHIP enrollees. The rate of use of dental care for these young children compares favorably with national rates, since only 35.0 percent of 2 to 4 year olds in the U.S. had any type of dental visit in the past year in 2004 (Bloom and Dey 2006). As evidence that Healthy Kids is improving dental health status, fully 24.5 percent of enrollees had a dental procedure within the past six months.

The use of dental services varied by age of the child with 2 year olds being the least likely to have had a preventive visit or a procedure in the past six months, and with 4 and 5 year olds being the most likely. Similarly, enrollees whose parents reported that they had dental

problems were more likely to have both types of dental visits and to have had a visit in their lifetime than those without dental problems.

Table 8.2: Use of Dental Services in the Past Six Months

Service Use	Total	Age (years)				Dental Health Status	
		2	3	4	5	No problems	Dental problems[1]
	Percentage						
Visit for check-up	40.8	10.3	30.9	48.2	45.8	29.2	55.1
Visit for dental procedures	24.5	7.4	19.2	29.8	27.6	7.7	45.2
Ever gone to the dentist	58.2	26.5	38.8	69.3	67.7	44.8	74.9
N	392	41	79	121	149	301	218

Note: Use of dental care is available only for children whose parents reported their child received a medical visit.

[1] Children with dental problems are those whose parents reported their child had a dental problem that caused them concern in the past 12 months.

Table 8.3: Unmet Need for Dental Care

Service Use	Total	Age (years)				Dental health status	
		2	3	4	5	No problems	Dental problems[1]
		Percentage					
Needed dental care but							
Did not go	15.4	10.1	14.1	15.0	18.6	5.4	28.6
Delayed care	13.3	5.4	8.4	19.5	13.2	3.4	26.6
N	**520**	**58**	**108**	**161**	**193**	**301**	**218**

[1] Children with dental problems are those whose parents reported their child had a dental problem that caused them concern in the past 12 months.

Unmet Need for Dental Care. Table 8.3 presents data on unmet need for dental care. Fifteen percent of Healthy Kids enrollees ages 2 to 5 needed dental care but did not go. The proportion that needed care but did not go did not vary significantly by age. The percentage that delayed care was similarly high (13.3 percent), with four and five year olds more likely to have a delay.

Children with dental problems were much more likely to have unmet need than those without dental problems. For example, 28.6 percent versus 5.4 percent, respectively, did not go to the dentist when needed. Consistent with a higher rate not getting needed dental care, 26.6 percent of children with dental problems reported delaying dental care, while only 3.4 percent of those with no problems reported a delay.

When the two measures of unmet need are combined for an overall measure of unmet dental care need, fully 21.7 percent of enrollees ages 2 to 5 needed dental care and either did not go or delayed care. This is higher than any of the medical services studied. Moreover, it is higher than for comparable estimates for SCHIP enrollees ages 3 to 5 of whom only 11.2 percent either did not go or delayed needed dental care.

Parents responses to a question about the main reason that needed dental care was either not received or delayed were grouped into the following categories: parental information issues such as the place did not accept their insurance or they did not know where to go; transportation issues; access issues such as they could not schedule an appointment soon enough or they did not get approval from the plan; missed appointments; or other issues. Using this classification, the reasons for not receiving needed dental care were: parent information issues (17.9 percent); transportation problems (11.4 percent); access issues (23.3 percent); cost (16 percent), missed appointments (10.8 percent); and other reasons (20.6 percent). Among those who delayed needed care, the reasons were similar: parent information (8 percent); transportation problems

(12.2 percent); access issues (25.8 percent), cost (8.9 percent), missed appointments (11.9 percent); and other reasons (31 percent). The majority of “other” issues were miscellaneous access issues (data not shown).

CHAPTER 9: CHILD DEVELOPMENT

According to experts, good health care for young children should include a component during routine preventive care that assesses and addresses a child's healthy development, including parents' concerns about development (Green and Palfrey, 2002). The health provider should observe the child's physical and emotional development, ask the parent about their observations and concerns, and counsel the parent through a process often called "anticipatory guidance". Developmental screening and education in preventive care can increase parent satisfaction with care, improve early identification of problems, and help parents with positive development-promoting activities such as reading to their child regularly (Regalado and Halfon, 2001; Minkovitz et al., 2003; Halfon and Inkelas, 2003). Eliciting parent concerns during well child visits is useful for shaping guidance to meet the parent's needs and for identifying issues early.

Some of those interviewed as part of the evaluation case study indicated a concern about the adequacy of developmental screening and referrals (Hill, et al. 2005). To enhance the extent to which parent concerns are addressed, First 5 L.A. recently launched the Early Developmental Screening and Intervention strategic partnership, designed to enhance systems of care that support early identification of problems and the promotion of young children's development.

Because of First 5's strong interest in developmental services, the evaluation of Healthy Kids examines the developmental concerns of Healthy Kids parents and several indicators of the quality of developmental care. Questions in the client survey are drawn from other surveys that address this issue, including the Promoting Healthy Development Survey (PHDS) developed by the national Child and Adolescent Health Measurement Initiative (Bethell, et al. 2001), and an adaptation of the clinical Parents Evaluation of Developmental Services (PEDS) (Glascoe 2002). National surveys that have incorporated similar questions, such as the National Survey of Early

Childhood Health in 2000 (Halfon and Olson, 2004) and the National Survey of Children's Health in 2003 (U.S. Department of Health and Human Services/HRSA 2005), provide some benchmark comparisons for the experience of Healthy Kids enrollees.

Client Survey Questions

The survey questions on this topic fall into three categories: parental concerns about their child's development; the developmental assessment process and the extent to which it addressed the parent's concerns; and the type of anticipatory guidance the parent received.

Developmental Concerns. The child development concerns questions include the following:

- Are you concerned a lot, a little, or not at all about any of the following:
  - How your child talks and makes speech sounds?
  - How he/she understands what you say?
  - How he/she uses his/her hands and fingers to do things?
  - How he/she uses his/her arms and legs?
  - How he/she behaves?
  - How he/she gets along with others?
  - How he/she is learning to do things for himself/herself?
  - Your child's feelings and moods?
  - Whether your child can do what other children his/her age can do?

- As a follow-up question, parents were asked more generally whether they had any concern about their child's learning, development, or behavior (not just for the specific items on the above list).

Developmental Assessment. Several questions were asked to determine the types of developmental assessments that providers were doing, including whether they assessed and addressed parents' concerns. The basic developmental assessment question was:

- During the past six months did your child's doctors or other health providers ever tell you that they were doing what doctors call a "developmental assessment" or a test of your child's development?

Recognizing that parents might not understand the term "developmental assessment" or have been told that it was happening, we asked two follow-up questions asked about (1) whether the health provider ever had the child roll over, pick up small objects, stack blocks, throw a ball, or recognize different colors, or (2) whether the provider asked the parent whether the child did any of those things.

To determine whether providers were assessing and addressing parents' specific concerns, we asked whether, in the past six months, a health provider asked them about their concerns. Also, when a parent had reported one or more developmental concerns, they were asked whether their provider gave them specific information to address those concerns. When they reported that the provider did not, they were asked if they would have wanted their provider to provide that information.

Anticipatory Guidance. To evaluate whether parents were receiving appropriate anticipatory guidance, we asked whether, in the past six months, the health provider talked to the parent about:

- Things you can do to help your child grow and learn
- The kinds of behaviors you expect to see as your child gets older
- Food/feeding issues
- Toilet training
- Words and phrases the child uses/understands
- How the child is learning to get along with other children
- Guidance and discipline techniques
- Dangerous situations, places, and objects
- How to make the house safe

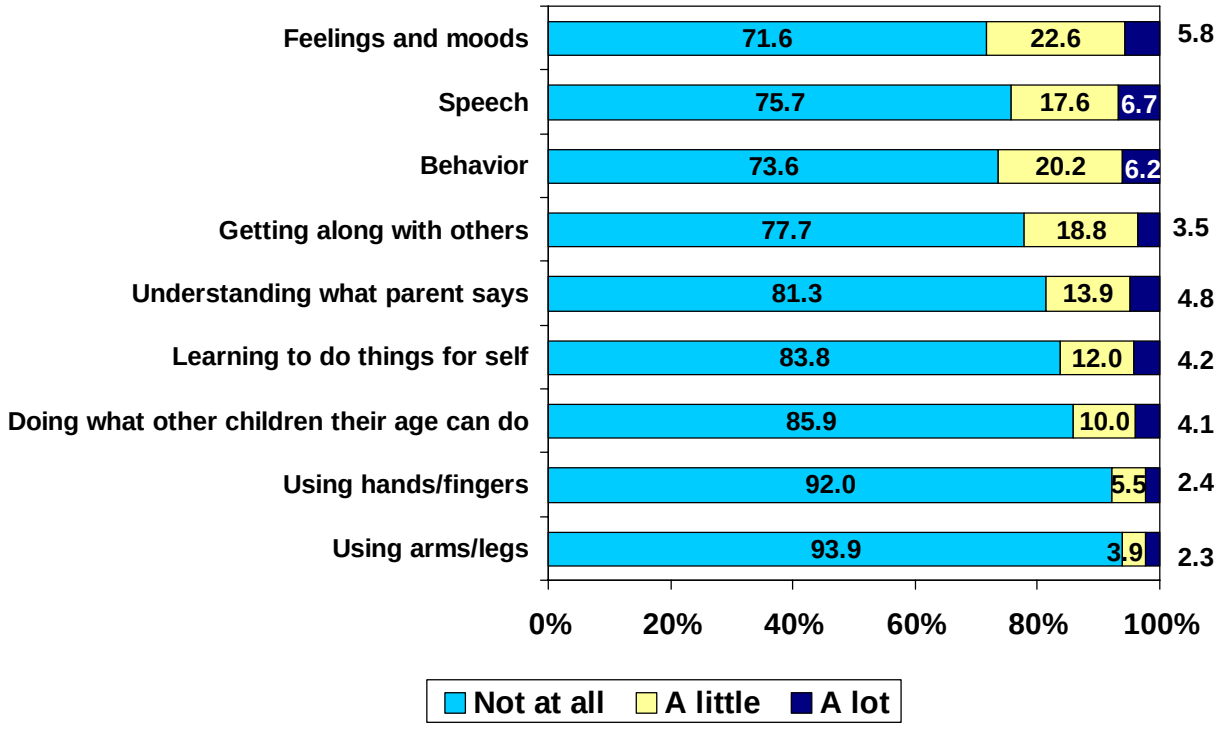
- The importance of reading with their child
- Child care

When a parent said “no” to any of the choices, they were asked a follow-up question about whether they wished the provider had talked to them about the specific topic.

Survey Results

Parental Concerns. Figure 9.1 shows the level of parent concerns about different aspects of young children’s development. The most prevalent concerns centered on both the child’s emotions and behaviors and on communication with the child (either the child’s speech or their ability to understand what the parent says). A quarter of parents expressed being “a lot” or “a little” concerned about feelings/moods, speech, or behavior.

Figure 9.1: Parental Concern About Their Child’s Development



The level and type of concerns expressed by Healthy Kids parents is slightly higher than levels of concerns reported by parents nationally and in California. For example, 26.4 percent of Healthy Kids parents are concerned "a little" or "a lot" about their child's behavior, in contrast to 20 percent of parents of children of the same age nationally and 20 percent of parents of Latino children in low-income households in California.

A scoring method from the clinical and survey version of the PEDS (Bethell et al. 2001; Bethell et al. 2002) uses the reported parental concerns to categorize children according to their potential developmental risk. Certain questions, such as speech, are weighted more heavily as indicators of potential risk. We used this scale to classify children enrolled in Healthy Kids according to potential developmental risk (high, medium, low, or none), with results shown by age in Table 9.1. Thirteen percent of children had a "high" level of risk (according to their parents' reported concerns about development), with the level of concern highest for five year olds. This may be because communication (i.e. children's expressive language) is weighted heavily in the scaling, and parents expectations about their child's speech may increase as they approach school age.

The table further shows that, while over 55.1 percent of parents had at least one concern of some type about their child's development, only 27.8 percent reported that their health care provider asked about their concerns within the past 6 months. About one-quarter (25.6) with concerns said their provider gave them information to address their specific concerns. These levels are lower than rates from national surveys and reflect both national and California differences between parents of Latino children in low-income households and other children. For example, according to the National Survey of Children's Health in 2003, 40.7 percent of all parents of children in this age group were asked about their developmental concerns; however

only 29.1 percent of Latino low income children (below 300 percent of poverty) were asked about them, a rate similar to that for Los Angeles Healthy Kids. In addition, reflecting parents' desire for greater parent-provider communication about their child's development, most parents who did not receive information from their providers about their specific concerns said they wished they had (76.6 percent). The patterns described above for the whole population are similar across the three age groups shown in the table (ages 1-3, 4, and 5) reflecting the importance of addressing concerns at all ages.

Table 9.1:
Level of Parental Concern and Discussion of Concerns with Provider, By Age

	Percentage			
Developmental risk level	**Age 1-3**	**Age 4**	**Age 5**	**Total**
High	10.1	9.8	18.3	13.0
Moderate	16.9	15.8	15.2	15.9
Low	26.5	22.0	24.1	24.3
None	46.5	52.4	42.4	46.8
Any concerns*	55.2	49.3	60.0	55.1
Provider asked about concerns**	30.8	21.9	30.0	27.8
If concerned, provider gave information that addressed concern**	26.9	24.6	25.2	25.6
If provider did not give information, wish they had**	83.9	69.7	75.4	76.6
N	179	161	193	533

* Reflects all parents who reported one or more specific concerns currently as well as those reporting any developmental concern in the past 6 months.
** In past 6 months.

Table 9.2 shows whether parents reported that their child received a developmental assessment within the past six months, as indicated by a positive response to any three of the developmental assessment questions. These parental reports are shown according to the child's age, the level of development risk, and the child's type of usual source of care. As shown, about 60 percent of parents of children in Healthy Kids recalled a developmental assessment. This rate of developmental assessment for Healthy Kids is relatively high. Only 52 percent of parents of children ages 19 to 35 months nationally recalled an assessment within the past 12 months, according to the National Survey of Early Childhood Health in 2000[20]. On the other hand, as shown in the table, the rate does not vary much by age or parental concern levels, so it appears that assessments are not necessarily triggered by the questions parents ask or the concerns they express in routine visits.

One reason the rate of developmental screening appears higher in Healthy Kids compared to the available national data may be due to the types of usual sources of care where many children are seen. As shown earlier in Chapter 7, a large majority of parents reported that their child's usual source of care was a clinic. As Table 9.2 shows, a much higher percentage of parents of children who usually use clinics reported their child had a developmental assessment (67.2) than other parents (47.3). During the evaluation site visit of November, 2004, several respondents suggested that children in Healthy Kids have better opportunities for developmental screening, because more of them are seen in safety net clinics where such screening may be more routine (Hill, Courtot, and Wada, 2005). Given the lack of national benchmarks and the difficulty in measuring assessment services using parent reports, more research is needed on this important topic.

[20] There are some differences in the way the rate is measured in this survey and in other surveys. For example, parents in the national survey were not asked whether the doctor asked about the child's developmental behaviors.

Table 9.2: Recall of Developmental Assessment by Age, Level of Parental Concern, and Type of Usual Source of Care

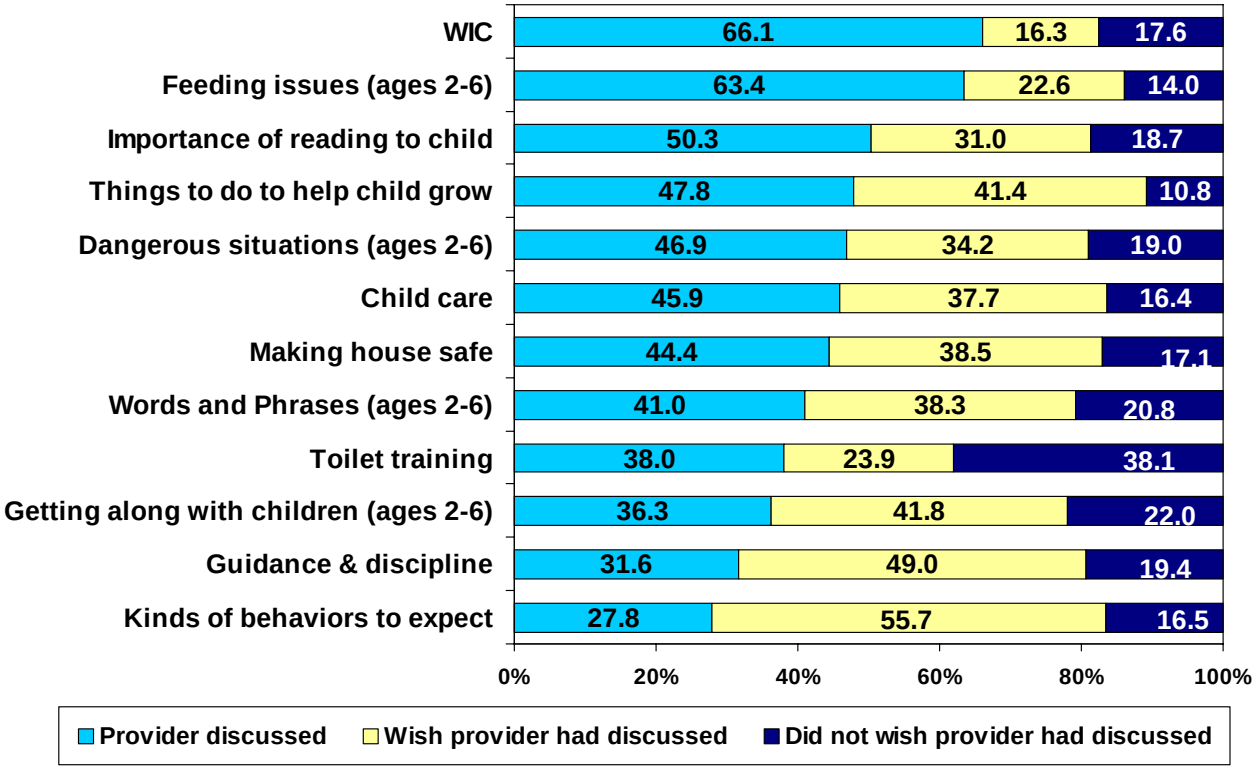
	Percentage reporting developmental assessment in past 6 months
Age	
1-3	56.8
4	62.8
5	64.6
N	**527**
Parental concern	
High	64.2
Moderate	62.9
Low	61.0
None	60.5
N	**527**
Usual source of care	
Clinic	67.2
Other	47.3
N	**496**

Figure 9.2 shows the percentage of parents who reported that they received anticipatory guidance on a range of topics, and (when they reported they did not have such guidance) the proportion saying they wished they had received it. Guidance concerning feeding (including the availability of WIC) was the most prevalent topic on which parents reported receiving guidance (66.1 percent) along with guidance or other feeding issues (63.4 percent). However, guidance concerning other topics was less common, and there were many topics for which more than a third of parents said they had received no guidance but wished they had. Many of these reflected

(such as recognizing colors), rather than specifically observing the behavior.

behavioral concerns, including a need for guidance about the kinds of behaviors to expect, guidance and discipline, and how to help the child get along with other children.

Figure 9.2: Anticipatory Guidance



These higher rates of interest in, but lack of discussion about, children's behavior are consistent with the higher rates of behavioral concerns discussed above. Other needs for guidance, also consistent with concerns expressed above, relate to speech and ways that the parent can help the child learn. Finally, many parents said they needed more guidance around safety issues (e.g. making the house safe and dealing with dangerous situations) and childcare. These patterns in the level of anticipatory guidance are generally lower than, and the level of interest in topics that have not been discussed is generally higher than, reported in the National

Survey of Early Childhood Health, although that survey interviewed parents of younger children on average than those in the Healthy Kids program (Olson, et al., 2004). Still, the pattern in the types of topics which parents wanted covered is very similar to the national pattern.

CHAPTER 10: PARENT'S PERCEPTION OF QUALITY OF CARE

There are many dimensions of quality of care for children. Since a child is dependent on their parent's willingness to bring them for care regularly, a parent's perception of care quality, while subjective, is one extremely important dimension of quality (Beal et al., 2004). For example, a parent's report on the level of communication with their child's health provider is an important indicator that information is flowing well between the provider and the parent, in order to diagnose problems and assure follow-up after the visit and to maintain or improve the child's health (Halfon, et al, 2004).

In interviews during the evaluation site visit of November, 2004 and in focus groups with parents in April and May of 2005, both advocates and parents indicated generally high levels of satisfaction with the services provided under Healthy Kids. None of the advocates reported serious problems with services, and parents uniformly said they would recommend Healthy Kids to their friends (Hill, Courtot, and Wada, 2005; Hill, et al., 2006).

Client Survey Questions

In the evaluation's client survey several questions assessed the parent's satisfaction with the quality of their child's health care and about the level of communication with their child's health care provider. These were in addition to those questions that focused specifically on communication about child development issues, discussed in the previous chapter.

Satisfaction with Quality of Care:

- How satisfied were you with the quality of health care your child received in the past six months? (Very satisfied/Somewhat satisfied/Somewhat dissatisfied/Very dissatisfied)
- How satisfied were you with the amount of time you spent with providers at your usual source of care (Very satisfied/Somewhat satisfied/Somewhat dissatisfied/Very dissatisfied)?
- Would you recommend your usual source of care to family and friends? (Yes/No)

Questions Concerning Quality of Communication with Provider (choices were Never/Sometimes/Usually/Always):

- How often did your child's provider:
  - Take time to understand the needs of your child?
  - Take time to understand you and your family and how you prefer to raise your child?
  - Talk to you about issues in your community that may affect the health of your child?

- Specifically at the usual source of care:
  - How often did your provider explain things in a way that you could understand?
  - How often did your provider speak a language you understand well?
  - How often did you have difficulty communicating with the provider because of a language problem?
  - How often did your provider treat you with courtesy and respect?

Survey Results

Table 10.1 shows three overall measures of parent satisfaction with the quality of care, which was generally very positive. Over 90 percent of parents of all three age groups (one-to-three year olds, four year olds, and five year olds) felt either very or somewhat satisfied with the quality of their children's care. Slightly fewer, but still over 85 percent, were very or somewhat satisfied with the amount of time spent with their provider at their usual source of care, and a similar percentage would recommend their usual source of care to family and friends. While satisfaction levels were high across all age groups, parents of younger children were less likely to be very satisfied than parents of older children. These satisfaction levels are similar to those in the San Mateo County Healthy Kids program, where 44.9 percent of parents reported being very

satisfied with the amount of time spent with their provider, corresponding to 46.3 percent for Los Angeles Healthy Kids.

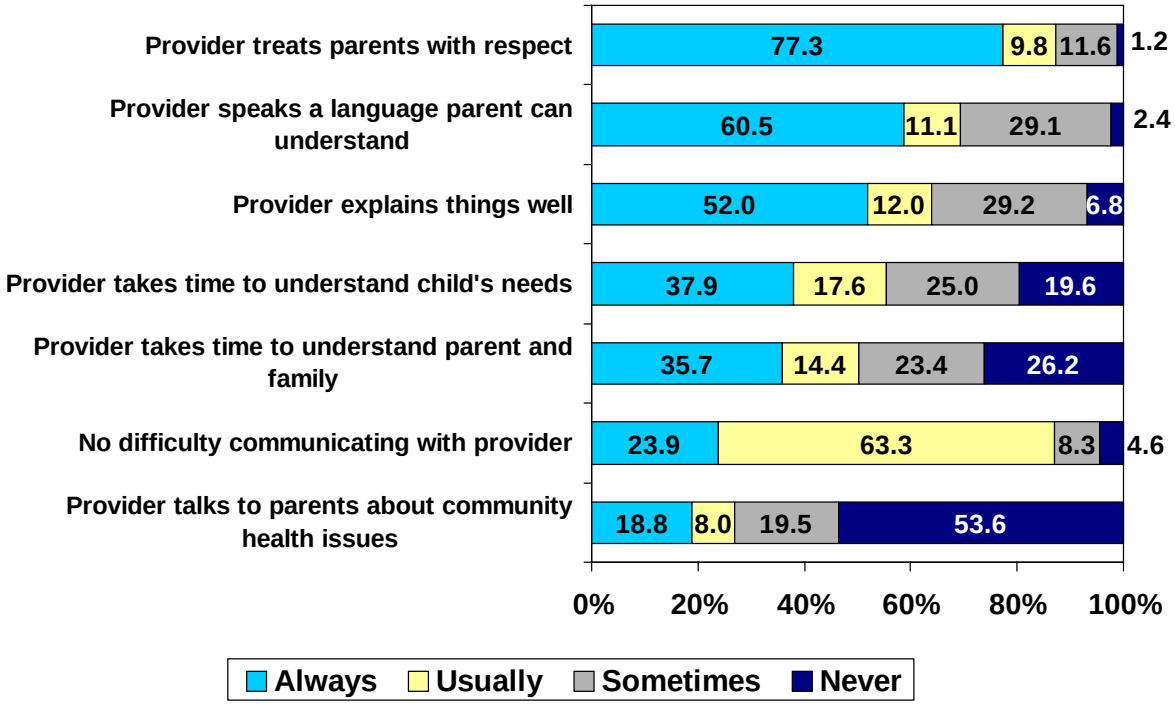
Table 10.1: Parents' Satisfaction with Quality of Care

	Age			
	1-3	**4**	**5**	**Total**
	Percentage			
Satisfaction with quality of care				
Very satisfied	56.9	67.6	65.3	63.2
Somewhat satisfied	37.4	25.2	32.1	31.7
Somewhat dissatisfied	4.2	5.6	2.7	4.1
Very dissatisfied	1.5	1.5	0	1.1
N	**79**	**159**	**191**	**529**
Satisfaction with amount of time spent with providers at usual source of care				
Very satisfied	43.9	41.9	51.9	46.3
Somewhat satisfied	38.7	44.6	39.2	40.6
Somewhat dissatisfied	15.4	9.1	8.9	11.1
Very dissatisfied	2.0	4.4	0	2.1
N	**169**	**144**	**185**	**498**
Would recommend usual source of care to family and friends	88.5	87.5	92.7	89.7
N	**169**	**144**	**185**	**498**

Figure 10.1 shows specific indicators of parent satisfaction with communication with their child's health provider. The very large majority of parents felt they were treated with courtesy and respect by their child's health provider at levels that correspond to the high overall satisfaction levels reported above. In addition, a majority reported few language barriers,

another very positive finding which is consistent with the findings from focus groups (Hill et al., 2006). Still, there appear to be some communication issues, in addition to those discussed in Chapter 9 concerning child development communication. For example, only about a third of parents reported that providers always take time to understand the needs of their child. A similar percentage reported that the provider always took time to understand the parent and family.

Figure 10.1: Parental Assessment of Provider Communication



These results are similar to those for the San Mateo Healthy Kids program. For example, in San Mateo 77.2 percent of parents reported the child's provider always treated them with courtesy (almost identical to the L.A. rate, 77.3 percent), while only 50.2 percent said the provider always explained things well (corresponding to 52.0 percent in L.A.). However,

language barriers appear to be lower in Los Angeles. While only 51.2 percent of San Mateo parents said their doctor always spoke their language, the percentage in Los Angeles was higher, 60.5 percent.

CHAPTER 11: CONCLUSIONS

This analysis of wave one of the Los Angeles Healthy Kids client survey provides a rich portrait of the youngest children (ages 1 to 5) served by the program, as well as information on their families and their experience on the program. This chapter provides some of the highlights from the analysis, as well as some conclusions concerning the implications of the findings for the Healthy Kids program.

Demographics and Health Status. Most Healthy Kids enrollees in the age group included in the survey are aged 3 to 5 and are in two-parent, Latino working families. In addition, most parents have been in the U.S. for some time, even if most children were born abroad, suggesting migration back and forth to the home country. The majority of families are poor, with relatively low parental educational attainment. In addition, most parents are Spanish speaking, suggesting a high need for culturally- and linguistically-appropriate services for Healthy Kids families.

Despite this general pattern, there is considerable variety. Many Healthy Kids live in Asian families and many have parents with substantial education. This diversity should be taken into account when planning for the best way to target services. Since there is adequate premium financing for children ages 0-5, it is possible that different Healthy Kids outreach approaches could succeed at enrolling increased numbers of certain types of children, such as more younger children, higher income children, or children from other ethnic groups.

While most Healthy Kids children are in excellent or good health, a substantial proportion is not, according to several different measures. Special attention should be paid to health access for these vulnerable children, because of their fragile health status.

Outreach, Enrollment, and Renewal. Parents reported very positive experiences about the outreach, enrollment, and renewal processes for Healthy Kids. Parents heard about the

program and enrolled their children in multiple ways and places, with clinics in particular playing a key role. This suggests that having diverse outreach/enrollment settings is effective. The vast majority of enrollees applied for and renewed their Healthy Kids membership without difficulty, which also suggests success with program design efforts to simplify these processes. It is important to consider, however, that these findings could be biased, since they include only interviews with parents who successfully completed the application or renewal process for their children. Still, while it is not possible to know whom the program is failing to reach, focus group discussions with parents reveal that barriers to application have in large part been overcome by the design of the application process in LA County.

Insurance Coverage. Healthy Kids is not substituting for employer-sponsored health insurance to any great degree, since few Healthy Kids enrollees have access to private insurance coverage despite the fact that almost all have parents who work. In addition, most of their parents are uninsured, and their siblings are either uninsured or have coverage from Healthy Kids or another public program. This means that "crowd out" of private insurance does not appear to be a problem for Healthy Kids.

The client survey analysis revealed that Emergency Medi-Cal plays an important role in providing financial access to some (but not all) health services for uninsured young children in Los Angeles County. In addition to coverage by Emergency Medi-Cal before enrolling, we found that a large number of Healthy Kids enrollees retain Emergency Medi-Cal coverage after enrolling in Healthy Kids.

Medical Access and Use. Access to care for Healthy Kids enrollees is quite good for many services, particularly preventive and primary care services. As evidence of this, almost all Healthy Kids enrollees have a usual source of care, and unmet need for care is low for urgent

health problems. Healthy Kids children's use of most medical services also appears to be good since it is similar to that in the SCHIP program for most services, even though SCHIP children have higher incomes. The use of preventive care appears to be particularly good for these young children. It is very important that the older children in this 1-5 year age group are still being caught up on their immunizations, showing that the program has a public health effect broader than its own program's beneficiaries.

However, there are a few areas where access to care could be improved. First, the use of specialty services is lower than that of SCHIP enrollees and unmet need for those services is high. Consistent with this finding, unmet need in general was higher for children with health problems.

Two other areas warrant mention. While only a small share of Health Kids enrollees had parents who needed to reach a doctor after the clinic was closed, only about half of those who tried were able to talk to a health professional. In addition, a large share of parents who reported unmet need said that the main reason that they did not obtain needed care was that the clinic or doctors office was not open during times that were convenient. Together these findings suggest that Healthy Kids enrollees may need greater access to clinic and doctor offices in the evenings and on the weekends.

Finally, almost 30 percent of Healthy Kids enrollees and almost 40 percent of Healthy Kids enrollees who have a health problem had parents who reported that obtaining needed health care for their children was creating financial burdens for the families. So while the co-payments required for enrollees may be nominal, for some families they are high either because their income is very low, their child has a special health care need, or both. Greater understanding of

the financial issues facing these families might make a difference in access to care for their children.

Dental Access and Use. Access to dental care is critical to young children's oral health. The analyses presented in this report reveal some barriers to obtaining recommended dental care for Healthy Kids enrollees. For example, only about 2/3 of parents reported having a usual source of dental care for their child.

One major barrier to access is a lack of parent awareness--particularly for parents of 2 and 3 year olds--about the importance of having a usual source of dental care and routine preventive visits every six months after infancy. Outreach and education are needed to inform parents about the importance of beginning dental care in the early years.

Another barrier to obtaining dental care appears to be limited access to dental providers for some parents, since a large share of parents who reported having unmet dental care needs cited access or cost issues as their main barriers to obtaining care. Expanding the Healthy Kids network of dental providers will help to provide adequate access to dental care to all enrollees.

Child Development and Parent Satisfaction. Several portions of the survey assessed the level of developmental screening and anticipatory guidance being provided to Healthy Kids and their parents, and the level of parent satisfaction with that process as well as other aspects of care. Parents reported relatively high rates of developmental screening and of discussion of certain topics, such as their child's nutrition. However, relatively few parents reported being asked about, or receiving specific information about, their own concerns. The types of parental concerns that are not being addressed as frequently are ones that require more time to discuss thoroughly and more cultural sensitivity during communication (e.g. child behavior and parent/child communication issues).

Shaping well child visits to address these types of parent concerns is very challenging in a busy clinic or private provider's office. This frequent lack of effective communication between health providers and parents, while consistent with national patterns, is an area where the Healthy Kids program could focus more effort, and is consistent with the new initiative by First 5 to foster such communication.

As with parent concerns about child development, the overall picture of parental satisfaction with quality of care is generally very positive, but there appear to be some areas for improvement. Again, the areas of concern are often the parents' perceived need for more time with the provider and for better communication around the child and family's needs.

Next Steps for the Client Survey Analysis. One year from now a second survey report will provide results from the longitudinal follow-up with the same parents who provided the data reported here. This analysis will provide an assessment of the impact of the Healthy Kids program on a range of indicators such as access to care, use of services, developmental status, and health status. Until that time, this interim client survey analysis shows important accomplishments of the program to date, and provides some useful information for improving Healthy Kids as the program grows and develops.

REFERENCES

American Academy of Pediatric Dentistry. 2003. "Oral Health Risk Assessment Timing and Establishment of Dental Home." *Pediatrics* 111(5): 1113-1116.

Beal, Anne C., John Patrick, Denise Dougherty, Tanisha Jorsling, Jeanelle Kam, James Perrin, and Heath Palmer. 2004. "Quality Measures for Children's Health Care." *Pediatrics* Vol.113: 199-209.

Bethell, Christina, Colleen Peck, and Edward Schor. 2001. "Assessing Health System Provision of Well-Child Care: The Promoting Healthy Development Survey." *Pediatrics* Vol. 107:1084-1093.

Bethell, Christina, Colleen Peck, Melinda Abrams, Neal Halfon, Harvinder Sareen, and Karen Scott Collins. 2002. *Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid*. New York: The Commonwealth Fund.

Bloom, Barbara, and Achintya Dey. 2006. "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2004." Hyattsville, MD: National Center for Health Statistics. *Vital Health Stat* 10(227).

Edelstein, Burton. 2002. "Disparities in Oral Health and Access to Care: Findings of National Surveys." *Ambulatory Pediatrics* 2(2 Supplement): 141-147.

Glascoe, Frances P. 2002. *Collaborating with Parents: Using Parents' Evaluation of Developmental Status (PEDS) to Detect and Address Developmental and Behavioral Problems*. Nashville, TN: Ellsworth & Vandermeer Press LLC.

Green, Morris and Judith S. Palfrey (Eds.). 2002. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd ed., rev.)*. Arlington, VA: National Center for Education in Maternal and Child Health.

Halfon, Neal and Moira Inkles. 2003. "Optimizing the Health and Development of Children." *JAMA* Vol.290: 3136-3138.

Halfon, Neal and Lynn M. Olson. 2004. "Introduction: Results From a New National Survey of Children's Health." *Pediatrics* Vol.113: 1895-1898.

Hernandez, Donald J. and Evan Charney (Eds.). 1998. *From Generation to Generation: The Health and Well-Being of Children in Immigrant Families*. Washington D.C.: National Academy Press.

Hill, Ian, Brigette Courtot, and Eriko Wada. 2005. *A Healthy Start for the Los Angeles Healthy Kids Program. Findings from the First Evaluation Case Study*. Prepared for First 5 LA and The California Endowment.

Hill Ian, Brigette Courtot, Patricia Barreto, Eriko Wada, and Enrique Castillo. 2006. *What Do Parents Say about the Los Angeles Healthy Kids Program? Findings from the First Evaluation Focus Groups.* Prepared for First 5 LA.

Howell, Embry, Dana Hughes, Genevieve Kenney, Jennifer Sullivan, and Jamie Rubenstein. 2005. *Evaluation of the San Mateo County Children's Health Initiative: Second Annual Report.* Prepared for San Mateo County Children's Health Coalition.

Huang, Jennifer Z., Stella M. Yu, and Rebecca Ledsky. 2006. "Health Status and Health Service Access and Use Among Children in U.S Immigrant Families." *American Journal of Public Health* Vol.96: 634-640.

Hughes, Dana. 2006. "Santa Clara Children's Health Initiative Outreach and Enrollment Efforts Are Effective and Helpful to Parents." *In Brief* No.3. Washington D.C: Mathematica Policy Research, Inc and The Urban Institute.

Kenney, Genevieve, Christopher Trenholm, Lisa Dubay, Myoung Kim, Lorenzo Moreno, Jamie Rubenstein, Anna Sommers, and Stephen Zuckerman. 2005. *The Experiences of SCHIP Enrollees and Disenrollees in Ten States: Findings from the Congressionally Mandated SCHIP Evaluation. Final Report*. Mathematica Policy Research, Inc. and The Urban Institute.

Krebs, Nancy F., Robert D. Baker, Frank R. Greer, Melvin B. Heyman, Tom Jaksic, Fima Lifshitz, and Marc S. Jacobson. 2003. "Policy Statement for the Prevention of Pediatric Overweight and Obesity." *Pediatrics* 112: 424-430.

Minkovitz, Cynthia. 2003. "A Practice-Based Intervention to Enhance Quality of Care in the First 3 Years of Life. The Healthy Steps for Young Children Program." *JAMA* Vol.290: 3081-3091.

Mouradian, Wendy E., Elizabeth Wehr, James J. Crall. 2000. "Disparities in Children's Oral Health and Access to Dental Care." *Journal of the American Medical Association* 284(20): 2625-2631.

Newacheck, Paul W., Dana C. Hughes, Yun-Yi Hung, Sabrina Wong, and Jeffrey J. Stoddard. "The Unmet Health Needs of America's Children." *Pediatrics* 105(4): 989-997.

Ogden, Cynthia L, Carroll, Margaret D., Curtin, Lester R., McDowell, Margaret A., Tabak, Carolyn J., Flegal, Katherine M. 2006. "Prevalence of Overweight and Obesity in the United States, 1999-2004**."** *JAMA* 295: 1549-1555.

Olson, Lynn M., Moira Inkles, Neal Halfon, Mark A. Schuster, Karen G O'Connor, and Ritesh Mistry. 2004. "Overview of the Content of Health Supervision for Young Children: Reports from Parents and Pediatricians." *Pediatrics* Vol.113: 1907-1916.

Regaldo, Michael and Neal Halfon. 2001. “Primary Care Services Promoting Optimal Child Development From birth to Age 3 Years.” *The Archives of Pediatrics and Adolescent Medicine* Vol.155: 1311-1322.

Sommers, Anna, Eriko Wada, Moira Inkelas, Joshua McFeeters, and Ian Hill. 2006. *Los Angeles Healthy Kids Evaluation Semi-Annual Process Monitoring Report: Third and Fourth Quarters 2005*. Prepared for First 5 LA and The California Endowment.

Starfield, Barbara. 1992. *Primary Care: Concept, Evaluation, and Policy*. New York: Oxford University Press.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. 2005. *The National Survey of Children's Health 2003*. Rockville, Maryland: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. 2005. *Health, United States, 2005: 83 (data for year 2004), table 77.* http://www.cdc.gov/nchs/fastats/immunize.htm (accessed July 10, 2006).

APPENDIX A: SURVEY INSTRUMENT