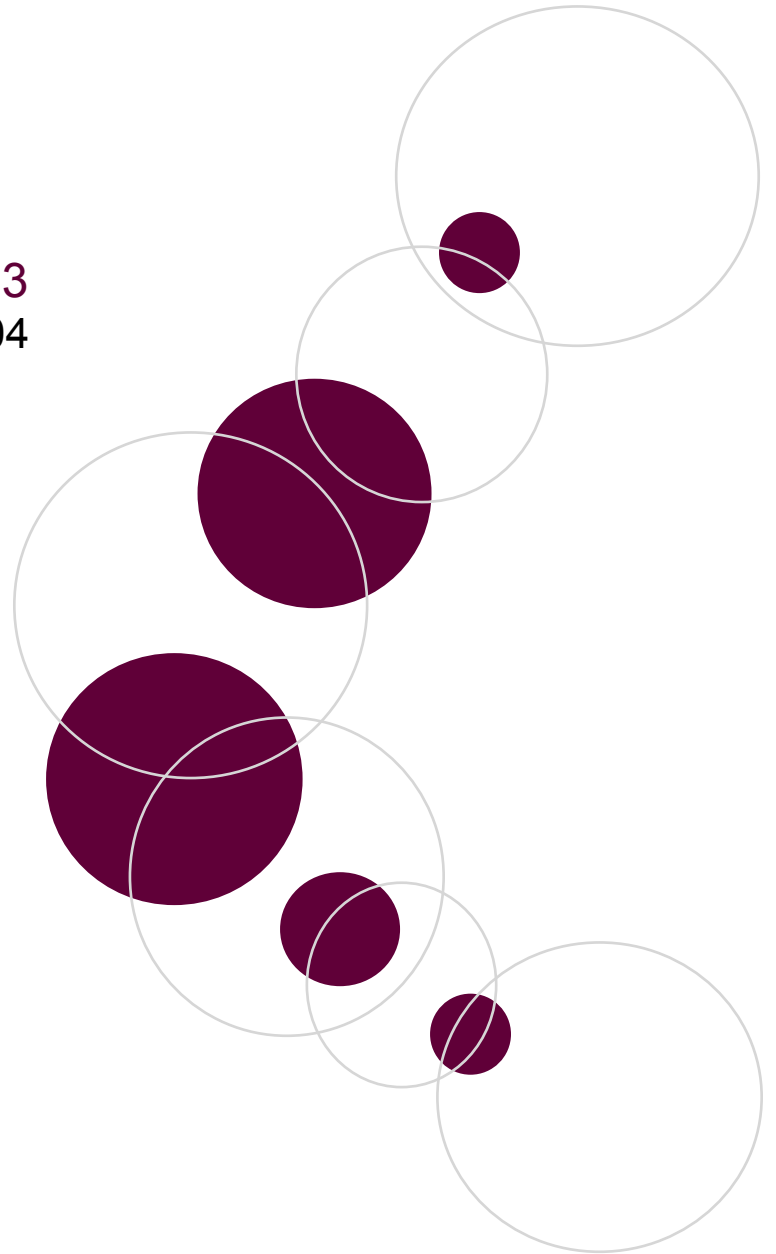


# CONSUMER EDUCATION A Link To Quality Improvement

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## Introduction

The Institute of Medicine (IOM) of the National Academies reports that 90 million American adults have trouble understanding and using health information. These individuals find it difficult to obtain, process, and understand the basic information and services needed to make decisions about their health<sup>1</sup>. Similarly, a study conducted by the Center for Studying Health System Change found that poor understanding extends to a consumer's inadequate knowledge of their own health plan, which contributes to the individual's dissatisfaction with their healthcare and ability to access it<sup>2</sup>.

As concluded by these studies, consumer education and health literacy have increasingly become significant components in addressing quality of care and health outcomes. According to the National Health Education Standards, health literacy allows consumers to “obtain, interpret, and understand basic health information and services.”<sup>3</sup> The goal of consumer education must be to increase health literacy. The need to improve consumers' understanding of health systems and healthcare cuts across all education levels, incomes, races, languages, and ages.

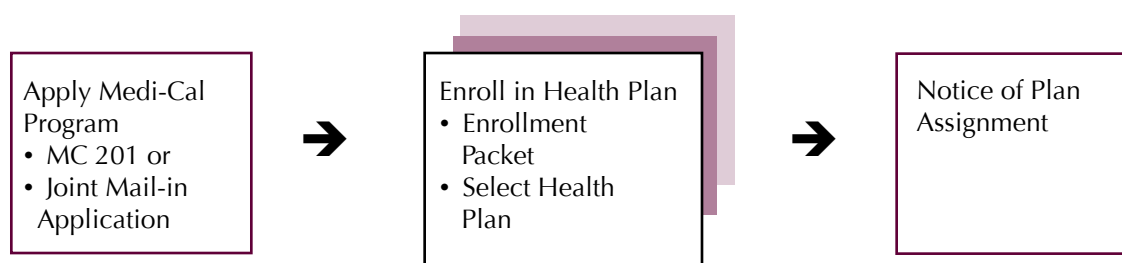
In the private sector, employers approach consumer education through their human resources or employee benefits programs, annual open enrollments, health plan literature, and health plan classes. However, in public health coverage programs, such as Medicaid, consumers rely primarily on the states and counties that administer the programs to help them understand how to access and utilize services as they enroll in healthcare coverage programs.

In California, 2.6 million consumers receive their healthcare through the Medi-Cal Managed Care program. While a state Medicaid waiver mandates enrollment in managed care for families with dependent children, the program also allows for voluntary enrollment. Under the Medi-Cal managed care system, consumers are expected to navigate an extremely complex process that includes selecting an appropriate health plan and/or doctor, deciphering the benefit package, and knowing how to effectively utilize benefits. Given that for many of these consumers this may be their first encounter with the concept of managed care and health plans, it is critical they have a clear understanding of the system from the beginning.

This Policy Brief is the third in a series focusing on quality improvement systems within Medicaid managed care programs. The Brief will explore different approaches and strategies utilized by California, other states, and other educational strategies to prepare consumers to navigate healthcare services. It will serve as a guide for California on how to enhance Medi-Cal managed care consumer education efforts, thus increasing health literacy and improving health status.

## California's Educational Methods

California educates consumers on access, utilization, and the Med-Cal managed care system largely through activities rooted in the enrollment process. Policymakers should begin to assess California's education model by examining this multiple step process and evaluating the function of enrollment in the Medi-Cal managed care system.



Consumers apply to Medi-Cal through their local county welfare agency or by completing a joint Healthy Families/Medi-Cal SCHIP mail-in application, often with the assistance of Certified Application Assistants (CAAs) in community-based organizations (CBOs). The enrollment process begins after the consumer is determined to be eligible for the program. The process is designed to give the consumer an opportunity to select a health plan, primary care physician, become familiar with their rights, benefits and how to access care in a managed care system.

Currently, 23 of California's 58 counties have a mandatory managed care system serving 2.6 million consumers. Medi-Cal managed care is delivered through one of three models: the County Organized Health System, the Geographic Managed Care model and the Two-Plan model. In all of California's mandatory managed care counties except San Diego, the state contracts with Maximus, a customer assistance broker, to facilitate enrollment and address most consumer education needs. Maximus' customer service system offers three ways to help consumers.

### (1) Trained Enrollment Assistants (EAs)

Enrollment assistants can be found in 13 counties. The number of EAs in each county depends on the number of Medi-Cal consumers in that county. There are about 118 full- or part-time EAs located at 128 sites in the 13 counties, with about half working in Los Angeles County. Between January 2002 and July 2003, EAs assisted 179,314 cases, representing 412,940 people making 436,641 health plan choices. Maximus' EAs operate in county welfare offices as well as at sites in the community providing assistance and conducting group orientations. Once determined to be eligible for the program, consumers are referred to a "Health Care Options" (HCO) orientation by their county eligibility worker and/or provided a schedule as part of the enrollment packet they receive in the mail. The EA staff help fill out enrollment forms, answer questions, facilitate orientation sessions, and handle other aspects of the enrollment process.

### (2) Call Center

The call center is available in 16 counties. Information about the call center is contained in the enrollment packet consumers receive in the mail following eligibility determination. In total, all 16 counties receive up to five million calls a year. However, it is not clear how many of these calls are from unique, first-time callers or how many calls end with an enrollment choice. The call center acts as a reference and referral system. Consumers call the 800 number to connect to an operator who assists them with the enrollment process and answers questions after the consumer gives their personal identification information.

### (3) Literature & Mailing System

Educational literature in the form of an enrollment packet is available in all counties whether they are mandatory managed care or not. Enrollment packets are usually mailed between 24 hours and 2 weeks from eligibility notification. They are also given out during the enrollment orientation sessions conducted by Maximus' EA staff. Enrollment packets contain educational literature to help the consumer choose a plan and provide other basic information on managed care. If the consumer has any questions, the packet refers them to their county's call center or to an orientation session.

All of these services are available in different languages and are designed to match the county's demographic profile and satisfy the threshold language requirements. Of these three methods, the literature and mailing system is the most heavily used. And, while there are opportunities to connect with consumers, most of the written materials are provided to consumers at the point of enrollment in Medi-Cal managed care. Table I shows the steps in the enrollment process and the types of information provided to consumers at various times. The process for the two-plan delivery model was selected given that the majority (2.41 million) of Medi-Cal consumers resides in counties with this model.

As outlined in Table I, once a consumer is notified that they are eligible for Medi-Cal, they receive information on selecting and enrolling in a managed care plan. Almost all the information a consumer needs regarding the enrollment process and managed care system is provided at this time. The packet can be  $\frac{1}{2}$  to  $\frac{3}{4}$  of an inch thick. It may contain the provider directory for each health plan along with the 27+ page, 8x11" booklet "My Medi-Cal Choice for Healthy Care: Health Care Options" and forms explaining the enrollment process and managed care system.

Consumers are expected to learn and retain all of this, including information that may relate to decisions made later, such as changing a plan or doctor, accessing prescriptions, or filing a complaint. Given the volume of information offered, consumers may become overwhelmed. They may not fully understand all the details, find themselves unable to make choices and become assigned or defaulted into a plan. For these consumers, the cost of not fully grasping the information can have consequences that impact quality of care. Therefore, it is necessary to examine consumers' knowledge of the Medi-Cal managed care system to determine the effectiveness of California's consumer education methods.

## Consumers' Understanding of California's Medi-Cal Managed Care System

To determine Medi-Cal managed care consumer education needs, we need to assess consumers' current understanding of how to navigate the system and make choices. Community Health Councils Inc. (CHC) conducted a survey in 2002 to measure the knowledge of Medi-Cal consumers. The survey showed that consumers who did not have English as their primary language were least likely to understand the enrollment packet and least likely to understand how managed care works. These consumers stated that missing critical information at the beginning of the process, such as clear step-by-step instructions for enrolling, hampered their ability to select a plan and navigate through the system. The survey also indicated that consumers need a better understanding of the services and benefits covered by Medi-Cal managed care.

In 2001, California's Department of Health Services (CDHS) created the California Enrollment Task Force to design a better enrollment process. Their examination and assessment of consumer needs were steps toward improving California's educational methods. The assessment led the Task Force to conduct a study on managed care default health plan selection. The study focused on individuals who were defaulted (automatically assigned) to health plans because they did not choose a plan within the timeframe given by their county. The Task Force determined that lack of knowledge about the Medi-Cal managed care system predisposes many consumers to default. Individuals who default do not seek as much help during the choice process nor do they use the materials in the enrollment packet. Consumers with limited literacy, including non-English speakers, are more likely to default. The Task Force suggested that these consumers should be targeted for assistance in the enrollment process.

This research suggests that consumers, especially non-English speakers, need information on the basic functions of managed care, services, and benefits. The CHC survey showed consumers also need assistance with issues that come up after they are enrolled in a plan: solving problems, filing complaints, and changing plans and doctors. When consumers do not understand how to access or utilize services, they are more likely to suffer poor quality healthcare. Therefore, it is vital to the state's quality improvement system that the most effective consumer education methods are utilized.

**Table 1: Enrollment Process and Information Provided  
Two-Plan Delivery Model**

Step-by-Step Process		Information Provided
Initial introduction to program	DPSS, CBO, provider informs consumer on availability of healthcare coverage (no standardized method)	No information provided
Applies for Medi-Cal eligibility (single app/MC210)	May fill out application: In person at DPSS, <u>OR</u> With the help of/visiting CBO, <u>OR</u> Provider office/hospital, <u>OR</u> On their own/mail in their application	Actual application form that is filled out then either mailed back or submitted to DPSS
Notification by State	Letter from DPSS re: eligibility (4-6 weeks after they've applied)	Letter is sent with ID card to be used before consumer is enrolled in a plan
Enroll in MCMC Plan	Receive packet from Maximus	Booklets of provider directories in county Health Care Options Booklet* including: Table of contents; Enrollment/ disenrollment form & envelope; Instructions to fill out form; Health plan comparison chart; HCO presentation schedules; Important phone numbers; Exemption information; Guide/Q & A (explains MCMC, benefits, choosing plan, filling out form, how to use, file complaint, glossary of terms)
	Maximus HCO Presentation (optional) Eligibility workers refer consumers to presentations <u>OR</u> consumers read info from packet	HCO Presentations consists of: The Enrollment Process; Filling out the application; Reviewing the packet; Questions and Answers
	Packet asks consumers to choose plan/doctor for all family members and return form within 30 days	Enrollment/ disenrollment form
	Consumer may receive call from CBO/CAA to follow-up on submitting enrollment packet	CBO/CAA may conduct 30 day follow-up calls with those assisted in enrollment
	Receive 10-day reminder notice with default plan from Maximus to choose plan or be defaulted. Receive another reminder notice 10 days before deadline with default**	Letter from State/ Maximus
Notice of Plan Assignment	Receive letter & packet from health plan within first 7 days of enrollment	Welcome letter; Evidence Of Coverage; Health education flier; ID card
	Receive welcome call from health plan member services within 30 days of enrollment	Welcome into plan; Explanation of next steps; Answer questions
	May receive letter from doctor the first 30, 60, 90 days of eligibility	Letter requests member to make appointment within 120 days of selecting plan
	May receive letter from doctor within 90 days of their first medical visit	Letter requests member to schedule an initial health assessment

\*The enrollment packet was recently updated to be more comprehensive. The newest packet contains provider directories and a booklet with a cover letter. The booklet contains the same information as the older version, but it is all located within the booklet with no loose sheets. All this information is still given at the same time.

\*\*It is the consumer's responsibility to complete the enrollment form found in the enrollment packet and either return it to the presentation facilitator or mail it back within 30 days. If the consumer does not return their completed form, they are defaulted into a health plan by their county of residence.

## Highlights from Other Consumer Education Strategies

Since the mandatory roll-out of the managed care program, California has invested most of its energy and funding into improving educational literature. A media campaign was launched in the first years of mandatory enrollment, but California now relies heavily on printed materials for consumer education. Other states and counties continue to use different methods to outreach to their consumers. California can learn from these different strategies. Below are highlights of different educational methods used by state and county Medicaid programs.

### Literature

#### Minnesota

Minnesota's Department of Human Services publishes an award-winning booklet for health plan enrollment. The booklet is a 5x7", 22-page guide at an elementary reading level. It consists of color photographs, tables, color pages and 16-point-font text. Each section is introduced with a question. The guide explains the enrollment process and answers questions that may come up when enrolling.

#### Alabama

Alabama revised its Medicaid educational materials in the past five years. The state has always been sensitive to literacy, but in the past two years Alabama also addressed concerns with non-English speakers and different dialects in foreign languages. Changes in the state's population make-up prompted Alabama to conduct extensive studies to identify needs within communities. The resulting modifications include language preferences that address translations of literature, dialect and cultural preferences. In addition, Alabama found that some consumers are illiterate in their native language so the state has included more visuals in English and other-language literature.

#### Massachusetts

The Massachusetts Medicaid (MassHealth) program provides consumers with an Enrollment Guide booklet. Resembling California's guide in style, it differs in format and layout. MassHealth's guide employs more visuals, including photographs and pictures, to demonstrate enrollment steps. Photographs introduce each section. The guide uses a layout and fonts that are appealing to the eye, using a large font, spacing, and color. MassHealth's enrollment form is attached to the introductory/cover letter; it is not a part of the enrollment booklet, as is California's. The enrollment form and cover letter feature pictures that help illustrate the steps a consumer takes. Easy-to-access information, including a comparison of the plans and benefits, are located in separate sheets in a side pocket at the front of the booklet next to the table of contents.

### Media Campaigns

#### Pennsylvania

In 2001, Pennsylvania Medicaid initiated its Public Information Campaign (PIC) in the Lehigh/Capital zone (central counties of Pennsylvania). PIC was designed to help increase public awareness of the HealthChoices Program during its implementation phase and encouraged consumers to enroll immediately. The campaign employed various strategies, all of which stressed the importance of making a choice of doctors and health plans. The strategies are listed below.

- A toll free number that connected the consumer to an enrollment call center
- Pre-enrollment brochures mailed to consumers in color envelopes with the HealthChoices logo and the toll free number
- Posters with the pre-enrollment brochure and the toll free number displayed in every county assistance office
- 60- and 30-second television commercials, in English and Spanish, that showed the pre-enrollment brochures and the toll free number
- Radio play messages that spoke about the pre-enrollment brochures and gave the toll free number
- Enrollment specialists assigned to every county assistance office
- Smart Phone without buttons that connected the consumer directly to the call center if the enrollment specialist was busy or unavailable.

In the first two weeks of the implementation phase, enrollments in the Lehigh/Capital zone were 244% higher than in the first two weeks of implementation in the southwest zone, which had not used television ads or color envelopes. The number of calls received by the enrollment call center in the Lehigh/Capital zone was 21,977, compared to 4,930 in the southwest zone for a similar time period, or an increase of 445%. Because there has not been a Health Choices Program expansion in Pennsylvania since 2001, the PIC campaign has not been repeated.

### Presentations and Orientations

#### San Diego County

CDHS contracts with San Diego County to administer outreach, education, presentations, orientations and other enrollment activities in San Diego. A consumer is required to apply for any public assistance services in person at one of the nine offices located within the county. Once eligible, a consumer must attend a mandatory orientation to explain their rights and responsibilities. For new Medi-Cal enrollees, an additional presentation is provided by county staff immediately after this initial presentation. This orientation informs Medi-Cal enrollees of their choices, their rights and how to access services through a managed healthcare system. Presentations are also provided at additional locations, such as Women, Infants and Children (WIC) nutrition sites, health fairs, and community centers. County enrollment counselors have access to an on-line provider supported by the participating health plans to assist consumers in choosing a Primary Care Provider (PCP). The presentations include a video, questions and answers, and individual time with the enrollment counselor. In addition, these presentations are conducted in San Diego County's four threshold languages (English, Spanish, Vietnamese, and Arabic). About 90% of consumers fill out their enrollment form at the presentation, while the remainder take the form home to fill out on their own and then mail it in separately or bring it to an enrollment site for overnight mailing to Maximus.

## Minnesota

Minnesota's Medicaid program also had success with an enrollment process based on orientations and presentations over a mail-in process. In 2001, Minnesota's Medicaid urged consumers to attend an orientation much like San Diego's today. The result was a decreasing default rate of 19-20%. Unfortunately, due to budget constraints, Minnesota was unable to continue funding this methodology and the rate has increased to 26%.

## **Phone Enrollment & Other Methods**

### New York

New York State's Medicaid managed care enrollment process varies from county to county, as it does in most states. New York City, where the majority of the state's Medicaid recipients reside, has employed many methods for educating and enrollment. As in California, consumers may enroll by completing an application on their own or with the assistance of enrollment broker staff members (NY also contracts with Maximus). Additionally, consumers may get enrollment help from health plan marketers and through their call center. The call center serves not only as a counseling and referral service, but also as an enrollment specialist. Consumers are able to phone the call center and enroll in a health plan without filling out a form. Very pleased with the phone enrollment option, New York City's auto-assignment/default rates are steady and are about as low as they have been in the program.

### Pennsylvania

After implementing managed care in the southeast zone of Pennsylvania (Philadelphia and surrounding counties), the state's Department of Public Welfare found consumers sometimes confused by the new program. Pennsylvania formed an advisory group to review lessons learned and to develop new strategies to transition the remaining counties into managed care. The advisory group served as an ongoing forum for consumers to express their opinions on the HealthChoices program. Changes implemented included using the call center to enroll in health plans instead of referring consumers to their enrollment packet or an orientation session. The call center script was revised so the specialist would initiate the conversation with the consumer by asking them to identify their current doctor or health facility. The specialist then helped the caller choose a plan that included their existing provider. Educational materials were revised to be more reader-friendly. The revisions proved successful and Pennsylvania continues to use the revised scripts and literature in all HealthChoices zones. Default rates for Pennsylvania decreased from an initial 35% in the southeast zone and 22% in southwest zone to 17% statewide.

As demonstrated with the states and counties above, various educational models are currently being exercised and have proved successful. Although many models use reading materials, they also incorporate other methods to inform their consumers. Based on these findings, California should consider ways to enhance their education strategies to meet the needs of their Medi-Cal population.

## **Areas for Improving California's Educational Method**

As the studies have indicated, understanding the Medi-Cal managed care health system can be difficult for a diverse population that speaks different languages and has different learning styles. In order to increase health literacy, experts suggest that consumers need to understand the basics of the system, learn how to use the system, and know why it is important for them to do so. While California's enrollment materials may provide this basic information, the format and context in which this information is provided may diminish its effectiveness.

Although California contracts with Maximus to conduct orientations and to maintain a call-in information center, the enrollment packet is the only educational material that reaches every consumer. California relies too heavily on this single method to educate and prepare the consumer to effectively utilize their managed care program. Existing systems such as the phone center and orientation program are under-utilized. In contrast, the state contracts with Maximus to process SCHIP Healthy Families applications. An automatic calling system has been developed to initiate contact with families to resolve issues regarding incomplete applications and other benchmarks. Furthermore, the curriculum and materials used in the HCO presentation by Maximus are not available to CBOs that could otherwise assist families in understanding how the system works and what to expect.

In a state as diverse as California, it is important to address both the cultural and literacy (general and health) needs of the Medi-Cal managed care population to ensure appropriate and timely use of healthcare services. 67% of adults in the Medi-Cal population in California did not complete high school<sup>4</sup>. While the state has addressed the issue in part by translating printed material in multiple languages and adapting the information to a 6<sup>th</sup> grade reading level, the issues of health literacy and culture go beyond translation and reading level. Research has demonstrated that individuals learn through different mediums and in a social context.

CDHS recently responded to the needs of its consumers by reformatting the enrollment literature. Current enrollment literature attempts to give consumers the knowledge to navigate through the Medi-Cal managed care system; however, the material is presented only at the point of enrollment. Medi-Cal consumers must interface with county eligibility workers and/or CAAs from CBOs, intake and office personnel at community clinics, hospitals and doctors offices at various times throughout the application and enrollment period. However, little if any information is provided about the relationship between managed care health plans and the Medi-Cal program other than at the enrollment process. Information regarding "what is managed care," "what are your Medi-Cal benefits" and "how to choose a health plan" is combined in one mailing with the instructions and forms that have to be completed and returned in order to enroll in the program.

To enhance consumer education, California should also consider strategies utilized by other programs that have worked with hard-to-reach populations and educated low literacy populations on complex topics. For example, the UC Labor Occupation Health Program, a community outreach program, educates diverse populations with literature consisting of visuals, such as maps, drawings, and photographs. In addition to these materials, they hold classes to better articulate the information. California's current enrollment booklet is dense and contains few white spaces or visual images with which the reader can identify. The consumer must be able to navigate the enrollment process first in order to receive

assistance through either the help line or an HCO presentation. There is no basic information available for distribution and use in the community other than the HCO enrollment booklet. The Wellness Guide, a guidebook used for health education, provides a model. The guide is distributed to trusted community organizations and hard-to-reach communities. It focuses on empowerment within the community so that consumers can advocate for themselves and take a role in their own health. The Center that distributes the guide teaches community organizations how to use and distribute the guide and the community organizations then instruct consumers.

While educational literature dominates how states inform their Medicaid consumers, other strategies should be considered. These include public awareness campaigns, one-on-one counseling, classes, telephone assistance, the active use of CBOs, videos, home visits, computer software, and attendance at community events<sup>5</sup>. While we commend their efforts to address consumer education, CDHS must explore other opportunities to provide this critical information and enhance their educational methods as part of an overall quality improvement plan.

### **Recommendations for Improving Medi-Cal Managed Care Consumer Education**

The Medi-Cal Task Force and others proposed several steps California can take to improve the content and format of their enrollment materials and thus their consumer education program. To build a comprehensive program, the state will need to expand its educational strategy beyond the existing enrollment process. By helping consumers become informed and educated, we can support their decision making, encourage them to become active participants in their healthcare, and improve their overall health status.

#### **Immediate Steps to Enhance California's Consumer Education Model**

Incorporate Consumer Education in the State's Quality Improvement Strategy: Link consumer education strategies to the state's overall quality improvement strategy. The state should conduct a comprehensive evaluation of consumer education efforts and examine data impacted by consumer knowledge of the system. A review of why consumers default may expose some consumer education needs. Consumer satisfaction data should be used to assess their understanding of the system and identify more creative and efficient ways to educate consumers. Once identified, current and potential educational methods should be tested through periodic field focus groups to evaluate their effectiveness.

Information Distribution Approaches: Establish a system that reinforces and staggers the dissemination of information in order to avoid information overload at any one time. For example, basic information linking Medi-Cal and managed care should be provided at the time of application and at the time of enrollment. Six months into their enrollment, consumers should receive a second notice that reiterates the options of changing doctors and plans, filing grievances, and describes benefits.

Reading Materials: Strengthen the use of written materials by reviewing and testing them for translation, improved terminology, cultural content and dialects. The state should revisit recommendations made by organizations undertaking similar efforts. At the very least, layouts should be upgraded to include a format that is easier on the eye, with clearer fonts, colors, and more visuals that include photographs and pictures. The final product should include consumer-friendly information that tells consumers how to take control of their own healthcare and provides a clear step-by-step account of the enrollment process.

Call Center: Strengthen the call center by making it more accessible and easier to use. Medi-Cal outreach and media strategy should promote the 800 number. Instead of being used for referrals or a source of forms and applications, the call center should be actively engaged in helping consumers make enrollment choices, file complaints, choose a doctor, assist with healthcare, and answer questions. A system similar to the Healthy Families automated phone system should be developed to initiate phone assistance and remind families of the need to respond to the enrollment packet.

Enhanced Human Assistance and Interaction: Expand consumer assistance and education through enhanced human interaction. Counseling, whether through mandatory orientation sessions or one-on-one sessions, should be built into the eligibility and enrollment process. Counselors should explain why it is important for consumers to choose their health plan, to learn how to use the literature, and maneuver through the system. Sub-contracts could be established with CBOs and CAAs, who already have contact with consumers, to conduct presentations, one-on-one counseling and/or provide information at the time of application assistance and routine follow-ups.

#### **Steps to Expand California's Educational Methods**

Public Service Media Campaigns: Develop public service announcements that maintain a consistent outreach effort emphasizing the importance of health plan choice and using the same slogan, materials, and logos to "brand" the program. To support such campaigns, consider partnering with foundations or others undertaking similar efforts. Past campaigns in California should be reviewed and evaluated to determine their effectiveness and how they can be improved.

Additional Human Interactions: Establish new methods to connect with hard-to-reach populations by contacting consumers through follow-up phone calls to answer questions, especially to those consumers who have not responded to mailings. The state should support the efforts of CBOs that already interact with the community in this capacity.

Development of Training Curriculum: Develop and distribute informational materials that can be used within the community by county welfare offices, CBOs, clinics, WIC offices, schools and other points of contact. The HCO presentation curriculum can be adapted for use by community organizations in conducting presentations and assisting clients one-on-one.

Computer Software and Videos: Develop basic video and audio programs that can be reused and that, at the very least, explain the fundamentals and key terms of managed care. These instruments can be utilized by CBOs, clinics, and other organizations that serve consumers with low literacy.

Classes: Create consumer-friendly educational classes within community settings that offer the opportunity for consumers to interact with someone who will explain managed care in colloquial terms.

Education Partnership: Collaborate with health plans, CBOs, foundations to maintain a health education dialogue with the consumer. Ensure that the information is useful and relevant to consumers and complements the State's education strategies. Consider partnering to pilot test one of the recommended consumer education strategies given above.

## Interviews

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RAND Health. Consumers and Health Care Quality Information: Need, Availability, Utility. Oakland: California HealthCare Foundation Quality Initiative, October 2001.

## Additional Information and Resources Used

### State & County Websites

California: [www.dhs.ca.gov](http://www.dhs.ca.gov) Minnesota: [www.dhs.state.mn.us](http://www.dhs.state.mn.us)  
New York: [www.health.state.ny.us](http://www.health.state.ny.us) Pennsylvania: [www.health.state.pa.us](http://www.health.state.pa.us)  
Massachusetts: [www.state.ma.us/dma](http://www.state.ma.us/dma) San Diego County: [www.co.san-diego.ca.us](http://www.co.san-diego.ca.us)

### Additional Websites

California HealthCare Foundation: [www.chcf.org](http://www.chcf.org)  
California Health Interview Survey: [www.chis.ucla.edu](http://www.chis.ucla.edu)  
Center for Community Wellness: The Wellness Guide:  
<http://www.ucwellness.org/publications.html>  
Centers for Medicare & Medicaid Services: <http://cms.hhs.gov>  
Council of State Governments: [www.csg.org](http://www.csg.org)  
Institute of Medicine of the National Academies: [www.iom.edu](http://www.iom.edu)  
Health Affairs: The Policy Journal of the Health Sphere: [www.healthaffairs.org](http://www.healthaffairs.org)  
Labor Health Occupational Health Program: <http://ist-socrates.berkeley.edu/~lohpf/>

## Credits

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[Footnotes]

<sup>1</sup> Guide to Health Literacy: A Prescription to End Confusion, April 2004

<sup>2</sup> "Do Consumers Know How Their Health Plan Works?" Journal Health Affairs, March-April 2001

<sup>3</sup> Committee on National Health Education Standards, 1995

<sup>4</sup> 2001 California Health Interview Survey data

<sup>5</sup> Educating Medicaid Beneficiaries about Managed Care: Approaches in 13 Cities. New York: The Commonwealth Fund, May 2000

## ABOUT COMMUNITY HEALTH COUNCILS, INC.

Community Health Councils is a non-profit, community-based health promotion, advocacy and policy organization. Established in 1992, CHC's mission is to improve health and increase access to quality healthcare for uninsured, economically-disadvantaged, and underserved populations. The Medi-Cal Managed Care Quality Initiative Project increases public accountability and consumer involvement in Medi-Cal Managed Care programs. The Project works to increase consumers' awareness and enhance consumer and patient organizations' involvement in healthcare quality issues. This brief is the third in a series that highlights quality of care and consumer education issues as part of CHC's commitment to improving California's Medi-Cal Managed Care quality assurance systems.

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