THE EFFECTS OF THE 2008-2009 BUDGET CRISIS ON HEALTH CARE SERVICES FOR CHILDREN AGES ZERO TO FIVE

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THE EFFECTS OF THE 2008-2009 BUDGET CRISIS ON HEALTH CARE SERVICES FOR CHILDREN AGES ZERO TO FIVE

A Project

by

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Division of Social Work
Abstract

of

THE EFFECTS OF THE 2008-2009 BUDGET CRISIS ON HEALTH CARE SERVICES FOR CHILDREN AGES ZERO TO FIVE

by

Jennifer Dobbins

Statement of Problem

The California state budget crisis of 2008 required state legislators to make numerous fiscal cuts to public health care services. These services play an integral part in the development of children between the ages of zero and five years. The purpose of this study is to explore how state budget cuts have impacted the public health care services utilized by children ages zero to five in Sacramento County.

Sources of Data

The study was an exploratory study. The researcher conducted twelve face to face interviews with health care agency administrators and two with clients who utilize their services. Data was analyzed for prevalent themes related to the impact of budget cuts on services and programs, employees of the agencies, and the clientele.

Conclusions Reached

The findings from this study revealed that health care services for children ages zero to five years old have been minimally impacted by the 2008 economic crisis. On the other
hand, health care programs serving uninsured and underinsured adults have been
negatively impacted as a result of recent budget cuts in the state of California.

_______________________________, Committee Chair
Teiahsha Bankhead, Ph.D., L.C.S.W.

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Date
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Chapter 1

INTRODUCTION

As it came time to decide on a project topic, I was offered the opportunity to work with other students to conduct research regarding the effects of the current budget crisis on health care services. I knew the stock market crash that occurred in 2008 was an historic event, and the economic decline which followed was unlike any other recession experienced in the United States, particularly for the state of California. In fact, many experts had declared the state’s current economic situation was worse than it has been since the Great Depression (Center on Budget and Policy Priorities, 2009b; Center on Budget and Policy Priorities, 2010, States Deficit sec.; Center on Budget and Policy Priorities, 2010c; Baker, 2009, para. 2). For this reason, I was excited to embark on a project that would examine how this unique economic crisis was currently affecting the public.

As an undergraduate student, I studied health related sciences, and therefore have a strong interest in health care services and a particular passion for preventive care. As a social worker, I also place a high importance on ensuring that the more vulnerable populations in society are able to get their needs met. The combination of these interests led me to focus my research on the way in which health care services for our youngest members of society, children between the ages of zero and five years, are being impacted by the current 2008-2010 budget crisis in California.

Young children are a particularly vulnerable part of the population. They experience many developmental milestones during the first five years of life that help to
create the foundation for later development. Therefore, it is vitally important their health care needs are met in order for them to have a positive start in life and prevent unnecessary future challenges. Young children are also completely dependent on the adults around them to make certain their health care needs are met. For this reason, it is important to examine how the state and the county’s budgetary decisions are impacting the needs of this segment of the population during the current economic crisis. This information will provide social workers, legislatures and citizens with the information necessary to make responsible decisions in the way of health care for young children as the recession progresses.

Background of the Problem

California has had a history of budget debt (BBC, 2009, sec. 1). The state’s budget challenges stem from a combination of the state’s two-thirds vote requirement for the Legislature to pass a budget as well as pass taxes, various tax-cuts that have been made over the years, and the state’s reliance on ballot box budgeting (S. Graves, personal communication, February 24, 2010). In order to make ends meet, the Legislature has consistently remedied the state’s deficit with “one-time fix” solutions of borrowing money (California Budget Project [CBP], 2009f). However, when the stock market crashed in October of 2008 due to the housing market bust, the nation fell into a deep recession, leaving California without the ability to borrow its way out of its debt. Facing a $40 billion dollar deficit, the government was forced to temporarily increase taxes and make severe cuts to social services, including health care (California Budget Project, 2009f, p. 4, 7-8).
Despite the fact that education receives the majority of California’s general fund money (California Budget Project, 2009c, p. 1), Health and Human Services, which includes health care services, received the bulk of the spending cuts (California Budget Project, 2010, p. 13). Approximately 57 percent of the general fund is allocated to education services, while only 25 percent is allocated to health and human services (California Budget Project, 2010, p. 7). However, in 1988, California voters passed proposition 98, which sets a minimum funding guarantee for Kindergarten through twelfth grade education, community colleges and related services (California Budget Project, 2006, p. 1). This prevents legislatures from making deep cuts to these services. Health and human services do not have a similar funding guarantee, and because this area receives the second largest portion of general fund revenues, health care services are left vulnerable to cuts when the state is in need of money.

Over the past ten years, California has made great gains in creating a public health care system that covers children, ages zero to five, up to 300 percent of the Federal Poverty Level (FPL) (The California Endowment, 2008). In 1997, the federal government passed the State Children’s Health Insurance Plan, or SCHIP, which provided federal funding to extend public health programs for children eighteen years and under. With these funds, California developed the Healthy Families programs. Then, in 2001, Santa Clara began a pilot program known as Healthy Kids (The California Endowment, 2008). This program was designed to cover children whose families were between 200 and 300 percent of the poverty level and quickly expanded to 30 counties statewide (UCLA Center For Health Policy Research, 2009, p. 53). This health care
safety net has improved access to health care services, increased the consistent use of
doctor visits and flu shots, and increased the number of children who have consistent
coverage (Cummings, Lavarreda, Rice, & Brown, 2008). Due to the current budget
situation in California, the safety net which has been created is at risk of eroding. As the
need for public health care coverage is increasing because of job-loss and unemployment,
severe budget cuts are simultaneously being made to the very health care programs more
children and families need (Families USA, 2009, p. 2).

While these cuts are being made, changes in policy at the federal level have also
taken place. The American Recovery and Reconciliation Act (ARRA) was signed by
President Barack Obama with the purpose of supporting states financially and helping to
mediate the budget difficulties they are experiencing (Center on Budget and Policy
Priorities, 2009a). President Obama also signed the Children’s Health Insurance Plan
Reauthorization Act (CHIPRA), which not only allowed the original State Children’s
Health Insurance Plan (SCHIP) program to continue, but increased the number of eligible
children by raising the income eligibility requirement. These policies have come about
because of the economic crisis that has struck the nation, however, the question remains
whether they will be enough to salvage the children’s health care safety net as recession
progresses.

Statement of the Research Problem

Public children’s health care services play an important role in the early
development of low-income children. Studies have shown that children who receive
public health care services are more likely to access preventive care and are better
prepared for school than those who do not (Cummings, Lavarreda, Rice, & Brown, 2009, p. 411; UCLA Health Policy Research, 2008, p. 1). Since California’s economic crisis is so current, its effects on health care have not yet been studied. Information is needed to begin to understand how the budget cut decisions for the state’s health care programs are affecting the services provided to children between the ages of zero to five.

Purpose of the Study

The purpose of this study was to explore the effects of California’s current budget crisis on health care agencies serving children ages zero to five in Sacramento County. Representatives from health care agencies and clients served by these agencies were interviewed in order to determine how the recent budget cuts are affecting the agencies, the services they provide, and their clientele. A separate inventory for each unit of analysis, agencies and individuals, has been designed by the researchers with the aim of gaining a broader perspective of the effects of the current economic situation on health care services. This researcher focused on affects which impact health services for children zero to five years of age.

Theoretical Framework

Systems theory focuses on the resources available to families and communities as well as the way in which families and communities are able to effectively utilize these resources (Payne, 2005, p. 143). Ludwig von Bertalanffy described living systems as open system organisms (Nichols, 2007, p. 65). This means a system, which could be a family, an agency, a community, or a government, is constantly interacting with its environment, taking in and expelling information and resources. In other words, a family
or an agency is not only interacting with itself, as it would be in a closed system, but it is also working with, and influenced by, the larger community it is a part of.

When considering how the budget crisis in California is affecting health care for young children, one is looking at the interaction of many systems. The decisions of lawmakers with regard to the budget are influenced by the nation’s economy as well as the cost and spending of smaller communities within the state. In turn, these decisions affect the funding, and therefore the functioning, of health care programs throughout the state, including Sacramento County. The families and children who utilize these services are then impacted by these budgetary decisions. This interaction occurs in the other direction as well. When children are not able to access necessary health care services, their health and development suffer. This interrupts the family’s functioning. For example, parents might have to miss work in order to stay home with a sick child, or may seek out emergency health services when they are no longer eligible for health care programs. This can then impact the larger community system through increased taxes to cover rising emergency room costs. Community systems are in constant interaction with one another, which means the effects of California’s economic situation is being felt at micro, mezzo, and macro levels.

Definition of Terms

*Agency* – An organization, company, or bureau that provides some service for another. For the purpose of this study, agencies that provide a form of health care service will be examined.
Budget - An estimate, often itemized, of expected income and expense for a given period in the future. For the purpose of this study, the budget discussed is specific to the income and expenses for the state of California.


Health Care - The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.

Health Care Services – The specific work performed by health care professionals aimed at the preservation of the mental and physical well-being of members of the community. This study only looks at services offered within Sacramento County. In addition, only services which receive county or state funding are included in the study.

Public Health Insurance - Health care insurance which is funded by governments at the federal, state or local level (U.S. Census Bureau, 2009). It is intended to serve low-income individuals and families that cannot otherwise afford private health insurance. This study will specifically examine Medi-Cal, Healthy Families, and Healthy Kids programs.

Private Health Insurance – Health care insurance which is purchased by an individual from a private company (U.S. Census Bureau, 2009). Various health care coverage plans are offered for different prices and individuals are able to purchase a plan to suit their personal health needs.
Employer Based Health Insurance – Health care insurance that is provided for an employee by his or her employer or by a union (U.S. Census Bureau, 2009). The employer or union will cover a portion of the coverage cost and the employee pays the difference.

Children – An individual between the ages of zero and eighteen years.

Young Children – An individual between the ages of zero and five years.

Assumptions

This study assumes that all individuals, no matter economic status or age, have the right to access health care services. It is also assumed that children between the ages of zero and five years old are a particularly vulnerable population due to their reliance on adults and society to provide for their needs and due to the amount of development which occurs during this period of life.

Justification

Research has shown that consistent health care services play an important role in a child’s early development (UCLA Center For Health Policy Research, 2008, p. 1). In addition, it has been shown that children who have access to regular health care services are more likely to experience academic achievement (UCLA Center For Health Policy Research, 2008, p. 1). Based on this understanding, it is clear that the early development of children is being put at risk as California continues to make cuts to the health care safety net designed to protect children’s health.

As the recession progresses, state legislatures continue to make budgetary decisions that impact children’s health care programs, and thereby the health and future
potential of the state’s children. It is important for legislatures, social workers, and the public to be informed about how these programs are currently being impacted by the budget crisis so they can fight to maintain them in the future.

Limitations

While this study will provide information regarding how public health care programs for children are being impacted by the California budget crisis, it will face a few limitations. First, the study is limited to health care agencies in Sacramento County, therefore, the conclusions drawn from the findings cannot be generalized to the state as a whole. Second, the study is further limited by the time and number of researchers allotted to complete it. This constraint prevents researchers from gathering data from a larger sample of agency representatives and clients in Sacramento County. Third, researchers were restricted by the Sacramento County Review Board from conducting research within county run health care agencies, again limiting the sample size. Without these limitations to sample size, researchers would have been able to provide a more accurate representation of the actual impact of the current crisis on health care agencies and their clients in Sacramento County, California.

In addition, researchers only conducted interviews with health care agencies that were still in operation and with clients who currently have access to health care services. Agencies that have already been forced to close their doors due to the current crisis, and clients who have previously lost their health care coverage are not represented in this study.
Chapter 2

REVIEW OF THE LITERATURE

The state of California has found itself in the midst of one of the worst economic crises since the Great Depression. The state has experienced a $40 billion shortfall, one of the highest rates of unemployment in the nation, and been forced to make deep cuts to many of its state and county services. This crisis did not occur over night, however, but has been the combined result of past state decisions, which restricted revenues and increased spending, and the severe national recession.

In 1998, as the housing market began to improve, many Americans began investing in real estate because it could be purchased at a low cost (Leonhardt, 2008, n.d.). At the same time, Wall Street was making it easier for buyers to get loans, transforming the housing market from a local one which centered around banks to a global market where investors from almost anywhere could come together and lend money. Banks started to lend what are called sub-prime mortgages, which are loans offered to individuals with lower credit ratings (Leonhardt, 2008, n.d.). Due to the person’s lower rating, the loan is considered to be of higher risk, and therefore banks will charge a higher interest rate. Banks began splitting up these sub-prime mortgages, and bundling them into larger investments (Leonhardt, 2008, n.d.). This allowed lenders to invest small amounts of their own money bundled with larger amounts of home-owners money and be able to make a large profit. Since the people on Wall Street felt that the
housing prices nationwide had never fallen before, these high risk investments were considered worthwhile (Leonhardt, 2008, n.d.).

Eventually the housing prices stopped rising, and as they began to fall, investors began to realize their error. So many banks and investment firms worldwide had taken part in this housing boom that when the market began to decline, the negative effects were felt worldwide (Leonhardt, 2008, n.d.). Due to the way investments were bundled, with many small investments from various investors, each of the small losses turned into large losses for the banks, investment firms, and for the nation. As a result of the crashing market, Wall Street became increasingly strict about its investments, which in-turn caused smaller banks and investment firms to become more conservative as well. This made it difficult for even the strongest of borrowers to take out money, hurting the larger economy and creating a national recession (Leonhardt, 2008, n.d.).

The deteriorating housing market meant declining property-tax revenues in the state of California, which in turn resulted in lower than expected revenues for the state. (California Budget Project [CBP], 2009f). With lower than anticipated revenues, the state was required to spend more for services such as education and fire fighting (CBP, 2009f, p.14). This is because California uses property-tax revenues to pay for such services, and whatever costs cannot be covered with property-taxes are covered with General Fund dollars (CBP, 2009d). Therefore, as property-tax revenues decreased, General Fund expenditures increased. As well, the declining economy resulted in job-loss for many Californians, creating a larger than usual demand for public services and requiring the state to spend more than expected in this area (CBP, 2009f, p. 14 ). These
new demands for spending were combined with the state’s continued growth in population and inflation.

Since the year 2000, California’s population has increased by 4.4 million people, and in the single year of 2008, it grew by about 400,000 people (CBP, 2009f, p. 36). Along with an increase in population, the state has experienced a rise in inflation. Between the years 2000 and 2008, the state saw an increase in inflation of 25 percent (CBP, 2009f, p. 36). This growing inflation and resident census has resulted in an increased cost for goods and services, such as education, higher education, affordable health care for children, in-home care for seniors and the disabled and adoptions (CBP, 2009f, p. 39).

While the state’s spending has gradually been increasing, its revenues have simultaneously been decreasing. In 1978, the voters passed proposition 13, which placed a limit on state property-rate taxes, resulting in restrictions on future tax increases and thereby limiting state revenue (Kloberdanz, 2009, para. 5). In addition, tax cuts were put in place between 1993 and 2008, namely the reduction in Vehicle License Fees, that cost the state close to $12 billion during the 2008-2009 fiscal year (CBP, 2009f, p. 24). Voter approved bonds and earmarked spending has also limited policymakers’ ability to balance the budget (CBP, 2009f, p. 24).

Recently, the state has also seen a decrease in corporate income tax revenues, resulting in a decline of General Fund revenues. According the California Budget Project (2009), if corporations paid the same share of their profits in taxes as they did in 1981, collections would have been $8.4 billion higher (p. 27). As well, due to shifts in public
spending, state sales taxes have declined over time and the phasing out of federal estate
taxes will cost the state approximately $1.1 billion, also decreasing the state’s total
revenue (CBP, 2009f, p. 27).

California has been experiencing an imbalance in revenues and expenditures for
some time now (Legislative Analysts Office, 2004, sec. Major Budget Challenges Loom;
John W. Ellwood Goldman School of Public Policy, UC Berkeley, n.d.; Kloberdanz,
2009, para. 5), however, it has never resulted in the extreme budget crisis it is now
experiencing. In the past, the state relied on “deficit related borrowing” in order to
balance its budget, but with the current national recession, California has found itself in a
situation where, as Governor Arnold Schwarzenegger stated, “Our wallet is empty. Our
bank is closed. Our credit is dried up," leaving California in an economic state of
emergency (O’Leary 2009, para. 1).

Proposed Solutions

In order to begin to close the $40 billion deficit in California, the legislature
approved $12.5 billion dollars in state taxes and made various cuts to public services
(California Budget Project, 2009f, p. 4, 7-8). After passing a budget in February, 2009,
the state still had a $24 billion deficit to address. Governor Schwarzenegger’s proposed
solution was to hold a special election with the hope of gaining voter approval on six
initiatives which would increase taxes, allow state borrowing, and reallocate state funds
(Steinhauer, 2009a, para. 5). Despite the Governor’s efforts, California citizens did not
approve of his proposed solutions, and the only proposition to pass from the May 19,
2009 election was proposition 1F, which prevents salary increases for Legislators during
deficit years (Legislative Analyst’s Office, 2009). The failure to pass the other five measures left the state to find other means of balancing the budget and raising sufficient finances to run the day-to-day operations of the state by the start of the upcoming fiscal year, July 1, 2009 (O’Leary 2009, para. 3). In order to accomplish this, Governor Schwarzenegger began to propose deep cuts in education and social welfare spending.

Unfortunately there are no simple solutions to California’s current budget crisis. The state is out of money and will need to find ways to increase taxes as well as decrease spending in order to make ends meet. The federal stimulus package will help to close the budget gap, but it will not eliminate the problem. The latest budget agreement consisted of $15.6 billion in cuts, approximately $2.1 billion in borrowing, $3.9 billion in new revenues and about $2.7 billion in “accounting maneuvers”, or the shifting of finances (The New York Times, 2009, Overview section, para. 4). Even with this plan, state finance officials are estimating a budget deficit of about $7 billion for the current fiscal year, with the possibility of it growing to as much as $10 to $20 billion in the next fiscal year (Steinhauer, 2009, para. 3). Needless to say, the government still must find ways to reach a “lasting solution to the budget crisis” (CBP, 2009f, p. 67).

As the state’s deficit continues to increase, causing it to make significant cuts to public service programs, the public’s need for these programs has also increased (CBP, 2009f, p. 21). For example, the number of families receiving CalWORKs increased by 15 percent, however, the financial support from the General Fund for the 2009-10 budget plan remained virtually the same as the year before (Legislative Analyst’s Office, 2009b, p. 50). This was because the budget plan contained approximately $700 million in
budget reductions and the state was expecting an increase in federal assistance from the American Recovery and Reinvestment Act (ARRA). In addition, the number of Californian’s enrolled in the Medi-Cal program between June 2007 and June 2008 rose by 2.0 percent, compared to an increase of 0.3 percent the year prior (CBP, 2008a, p. 9). Despite the continued increase in enrollment, Medi-Cal expenditures decreased by $1,148 million between the 2007-2008 and 2008-2009 fiscal years, and again by $1,978 million between the 2008-2009 and 2009-2010 fiscal years (Legislative Analyst’s Office, 2009b, p. 36). Similarly, the Healthy Families program, which serves the health care needs of low-income children, received a decrease of 42 percent, or $166 million less of General fund dollars. However, the number of children enrolled in the Healthy Families Program increased by 5.5 percent during the year 2008, following an 8.3% increase the year before, leaving the program to try and gather additional funding from philanthropic and other outside organizations (Legislative Analyst’s Office, 2009b, p. 41).

Public health care services, such as Medi-Cal and Healthy Families were designed to insure low-income families and children could receive necessary medical care. Unfortunately, due to the economic situation of California, the services provided by these programs are being cut back. In fact, Healthy Families has been at risk of being eliminated altogether (CBP, 2009c, p. 16). This puts many children and families in danger of losing the health care coverage they need.

Public Health Insurance for Children Ages Zero to Five

MEDICAID

Authorized under Title XIX of the Social Security Act in 1965, Medicaid is a means-tested public assistance program offering health insurance for low-income
individuals and families (Blau, 2007). While the federal government has set up the general guidelines for the program, and funds between fifty to eighty percent of the program in most states, each state has the liberty to determine the specific requirements of its program (Blau, 2007, p. 393; Department of Health and Human Services [DHHS], 2005, p. 1). For instance, in order to receive federal funding, each state must provide health care coverage to the majority of individuals who receive federally assisted income payments such as Social Security Income (SSI), infants born to Medicaid eligible pregnant women, families with children who meet certain requirements under Temporary Aid to Needy Families (TANF), and to children under the age of six and pregnant women whose income is at or below 133% of the Federal Poverty Level (FPL), as well as a few other specific categories of people (U.S. Department of Health and Human Services, 2005). However, outside of these mandated groups, each state is allowed to establish its own eligibility requirements based on income and need (DHHS, 2005, p. 1).

In the state of California, the Medicaid program is referred to as Medi-Cal. The program started in 1966 and has been serving low-income Californians with health care services since. The program is free to eligible participants, there is no waiting period to apply and applications are generally handled by county welfare offices (Kincheloe, Frates, & Brown, 2007, p. 850). The program is funded by both the state and the federal government equally, and it has expanded its eligibility requirements to include: families with children, seniors, persons with disabilities, youth in care, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS (Department of Health Care Services, 2007). With regard to the Medi-Cal program for
children, the benefit package is designed specifically to address their medical needs (Dubay, Gyer, Mann, & Odeh, 2007, p. 278). The program requires children to be provided with regular health, dental, hearing and vision screenings as well as any other care that is deemed medically necessary (Dubay et al., 2007, p. 278).

Before 1997, Medicaid was the only public health insurance program available to children ages five and younger. However, because of social and economic changes, child poverty rates began to rise during the 1980s and into the 1990s, causing the nation to see the need to expand its public health care coverage for children (Cunningham & Kirby, 2004, p. 27). These trends resulted in the passing of the State Children’s Health Insurance Plan (SCHIP) in 1997 (Cunningham & Kirby, 2004, p. 27).

*State Children’s Health Insurance Program*

SCHIP is a federally funded program which provided states with additional funding in order to expand their public health care program to children from families with higher incomes (The California Endowment, 2008, p. 2). The program targeted the children whose families earned too much money to be eligible for Medicaid, but did not earn enough to be able to afford private health insurance (Dubay et al., 2007, p. 370). Each state was allowed the flexibility to either use its federal funds to directly expand its current Medicaid program, or to create a new program that would work along side its already existing Medicaid program while coordinating enrollment between the two programs (Dubay et al., 2007, p. 370). With the addition of SCHIP, each state made efforts to streamline its enrollment process in order to make it more user friendly and
create various outreach programs to try to enroll greater numbers of eligible children into either Medicaid or SCHIP (Dubay et al., 2007, p. 371).

The state of California decided to use its additional SCHIP funding to develop a new program, which it calls Healthy Families (The California Endowment, 2008, p. 2). This program combines both public and private funds in order to expand coverage to a population of children not previously covered by Medi-Cal. The new program covers families who earn up to 250 percent of the federal poverty level (The California Endowment, 2008, p. 2). Unlike the Medi-Cal benefit package, the SCHIP program more closely mimics a private sector benefit package (Dubay et al., 2007, p. 378). While some programs offer a comprehensive package, most are more restricted, providing limited mental health, speech and physical therapy, and dental care (Dubay et al., 2007, p. 378). Many programs operate under a medical necessity standard which does not reflect the fact that children have different needs than adults (Georgetown University Health Policy Institute, 2005, p. 3). Other differences from Medi-Cal found in the Healthy Families program are: it requires the payment of a monthly premium, parents of Healthy Family children are not eligible for the program, it “locks out” children with employer-based coverage within three months of applying for coverage, and applications are processed by a centralized, state-level agency, creating statewide uniformity (Kincheloe et al., 2007, p. 850). Despite having a less comprehensive program, Healthy Families now covers an additional 858,000 children in California, an increase of 32 percent from the number of children covered in March 2003 (The California Endowment, 2008, p. 3).
While the creation of Healthy Families expanded the number of children receiving health care coverage in California, the state realized there were still many children who were living above 250 percent of the FPL, however they were not covered by private or employer based coverage (The California Endowment, 2008, p. 2). In the late 1990s, efforts were made to insure this population of children were able to receive some form of health care coverage. Santa Clara County was the first county to create a Children’s Health Initiative (CHI), later known as the Healthy Kids Insurance Program (The California Endowment, 2008). The program was created in 2001 as a pilot program in Santa Clara County and expanded to a total of 30 counties, including Sacramento.

_Healthy Kids_

Healthy Kids was designed as a way to decrease the number of children in California who did not have health care coverage. The program provides coverage to children whose families earn between 250 and 300 percent of the Federal Poverty Level and to undocumented children (UCLA Center For Health Policy Research, 2009, p. 53). In 2007, more than 86,000 children were enrolled in a Healthy Kids program, however, due to funding shortages, most programs have enrollment caps and are therefore not able to enroll all children who are eligible for Healthy Kids, leaving another 20,000 California children on waiting lists (UCLA Center For Health Policy Research, 2009, p. 53).

Healthy Kids programs not only help to cover children who are not eligible for Medi-Cal or Healthy Families, but the program also increases the number of children enrolled in these programs. Counties with a Healthy Kids program have shown to enroll 90.5 percent of eligible children in Medi-Cal or Healthy Families while counties that do
not have a Healthy Kids program only enroll 87.5 percent of their eligible children in these programs (UCLA Center For Health Policy Research, 2009, p. 53).

By increasing children’s access to health care, not only are children more likely to lead healthy lives, they are given a better opportunity for building a foundation for further success in life. It has been found that children who have public health care coverage are more likely to receive preventative care, make their well-child visits, get flu shots, and have access to prescription drugs (Cummings, Lavarreda, Rice, & Brown, 2009, p. 411). They are also 12 to 25 percent more likely to have seen a dentist in the past six months (California Health Care Foundation, 2008, p. 11). Considering the fact children experience rapid development both physically and emotionally during their first few years of life, it is particularly important they have access to the above services (UCLA Center For Health Policy Research, 2008, p. 1). Access to care is not only crucial for a child’s normal development, it has a significant role in a child’s academic achievement. According to UCLA Health Policy Research (2008), healthy children are more prepared to learn and concentrate and develop the necessary skills to be able to achieve in school (p. 1).

*Progress Made in Children’s Health Care*

Since SCHIP became a law in 1997, a great deal of progress has been made to ensure more children are able to access health care coverage. From 1997 to 2005, the number of uninsured children in the nation has dropped from 22.3 percent to 14.9 percent and in the state of California alone, the number of uninsured children dropped 25 percent between 2001 and 2005 (Dubay et.al., 2007, p. 370). Between the years 2003 and 2008,
Medi-Cal increased its coverage of children by six percent and Healthy Families increased the number of children it covers by 32 percent (The California Endowment, 2008, p. 3). Due to the increased safety net provided to children through the Medi-Cal and Healthy Families programs, children now have a much lower uninsured rate than adults (UCLA Center For Health Policy Research, 2008a, p. 2). Together, these two programs have cut the rate uninsured, low-income children by a third, and most of this gain can be attributed to Medicaid, which covers approximately eight of ten publicly covered children (Dubay et al., 2007, p 378). Efforts made to streamline the enrollment process and to increase outreach efforts have played a vital role in the increased number of children with health care coverage (Dubay et al., 2007, p. 375).

While California has made great strides in ensuring more children are able to receive health care coverage, large numbers of children continue to go without it every year. At the time of the 2007 California Health Interview Survey, 683,000 children remained uninsured (UCLA Center For Health Policy Research, 2009, p. 62). To make matters worse, more than a quarter of these children were eligible for Healthy Families, almost one-third were eligible for Medi-Cal and approximately 33 percent were eligible for their local Healthy Kids program (UCLA Center For Health Policy Research, 2009, p. 62). In fact, if all eligible but uninsured children were enrolled in either Medi-Cal or Healthy Families, 385,000 fewer children would be uninsured in California.

With regard to the Healthy Kids program, if all eligible but uninsured children were to become enrolled, an additional 155,000 children would have health care coverage. The challenge with this program though, unlike either Medi-Cal or Healthy
Families, is the program itself does not receive sufficient funds to meet the demands of all eligible children. As of 2007, the Healthy Kids program was only able to meet about 39 percent of the total need for coverage, resulting in long waitlists of eligible children (Center for Community Health Studies, 2007, p. 1). Despite increased outreach and enrollment efforts, it is clear more needs to be done in order to ensure all of California’s eligible children are receiving the health care coverage available to them. However, in light of the many fiscal challenges facing the state, it is becoming questionable as to whether California will even be able to maintain the gains it had made in the past five to ten years. Fortunately, the federal government has recognized the difficulties facing California, and many other states, and decided to intervene in a way which will help support the state, and its children, through this difficult economic time.

Federal Policy Changes That Benefit California’s Health Care For Children

The recession has resulted in states experiencing a steep decline in tax revenues and requiring them to make deep cuts to social services in an effort to balance their budgets (Center on Budget and Policy Priorities, 2010b). However, even after raising taxes and making cuts in health care, education, human services, public safety and more (California Budget Project, 2009c), the states were still unable to meet their budget requirements (Center on Budget and Policy Priorities, 2010b). Realizing the states were not going to be able to meet their budgetary demands, the federal government intervened, providing them with additional funds and service supports with the aim of preventing further debilitating service reductions and increases in taxes (Center on Budget and
Policy Priorities, 2009b). This federal assistance came in the form of the economic stimulus package.

*American Recovery and Reinvestment Act*

On February 17, 2009, a mere 14 months after the national recession began (State Policy and Politics, 2009, para. 6), President Obama signed into action the American Recovery and Reinvestment Act (ARRA) in order to begin increasing employment and bolstering the economy (Center on Budget and Policy Priorities, 2009a). The ARRA, also known as the economic stimulus package, provided provisions for low and moderate-income families as well as to states that were facing severe budget shortfalls. In order to increase spending, and thereby increase state revenues, the ARRA provided families with financial benefits and increased tax-refunds (Center on Budget and Policy Priorities, 2009a). In addition, the Obama administration included various provisions within the stimulus package design to preserve much needed state and local services (Center on Budget and Policy Priorities, 2009a).

One of the largest portions of the federal fiscal relief went to federal matching for state Medicaid programs (Legislative Analyst’s Office, 2009a, p. 18). The ARRA increased the federal match for state Medicaid programs by 6.2 percent, starting retroactively on October 1, 2010 and continuing for a 27 month period, or until December 31, 2010 (Legislative Analyst’s Office, 2009a, p. 18; The California Endowment, 2009, p. 6). There is an additional provision which reduces the state’s costs based on the state’s unemployment rate. If the most recent three-month period unemployment rate exceeds the lowest average monthly unemployment rate for any three-month period after January
1, 2006 by 1.5 percent, then the state will receive a 61.6% federal match for Medicaid. For California, this results in $11.2 billion over three fiscal years. The state intends to use this money to fund projected budget deficits and program cuts in the Medi-Cal program (The California Endowment, 2009, p. 7).

The stimulus package also makes amendments to the Consolidated Omnibus Budget Reconciliation Act (COBRA), which provides continued health care coverage to workers who have been laid off of their jobs (The California Endowment, 2009, p. 7). The bill provides a 65% subsidy to COBRA coverage for up to nine months for workers and their families who have been laid off between September 1, 2008 and December 31, 2009. This will potentially stop the shift from employer based health coverage to Medi-Cal and Healthy Families in California, thereby minimizing state expenditures (The California Endowment, 2009, p. 7).

While the ARRA helps to mitigate the negative effects of the recession on Medicaid, it does not contain any provisions to directly support the State Children’s Health Insurance Program (SCHIP). Rather, the program received support through its reauthorization in March, 2009. SCHIP was originally passed to provide states with funding for ten years, which meant the program needed to be reauthorized in 2007. Due to the program’s great success, Congress proposed legislation that would expand the program, allowing it to meet the needs of approximately 4 million additional children who would otherwise remain uninsured (Center on Budget and Policy Priorities, 2007). President Bush vetoed the bill, however, stating the proposed legislation was “a step toward government-run health care” (Levey, 2009, para. 2). The bill was reauthorized, as
written, for an additional two years (Center on Budget and Policy Priorities, 2007, now providing the Obama Administration the opportunity to provide health care coverage to a greater number of children.

*Children’s Health Insurance Program Reauthorization Act*

On February 13 2009, President Obama signed the Children’s Health Insurance Program Reauthorization Act (CHIPRA) (The California Endowment, 2009, p. 4). The passing of this bill increased the federal allotment received by states over the next four and a half years by revising the formula for distributing funds (The California Endowment, 2009, p. 4). The formula for distribution was modified in order to target the states that are actually enrolling children into their programs. The projected allotment for California during the 2009 fiscal year is $1.5 billion. This is an 85% increase when compared to the amount received with the prior law (The California Endowment, 2009, p. 4).

CHIPRA also increases the family income level of eligible children in order to cover children from families with higher income levels. For children whose parents earn up to 300% of the FPL, the federal government will provide two-thirds of the funds. For children whose families earn over 300% of the FPL, the federal government will pay the Medicaid match rate as designated by the American Recovery and Reinvestment Act (The California Endowment, 2009, p. 4). However, in order for California to participate in these new changes, it needed to pass legislation allowing the state government to pay its share, which would equate to approximately $20 million in fiscal year 2010 and $89.5 million over the next four years.
CHIPRA not only expands opportunities for outreach and enrollment in public health care coverage programs, but also provides a performance bonus to states that can enroll more children than are currently enrolled in their Medicaid and CHIP programs. California has already simplified its enrollment process, and will therefore likely meet the requirements for the performance bonus. The challenge will be meeting the enrollment target levels in Medi-Cal in order to receive the funds. Children’s Health Initiatives, or Healthy Kids programs, play an important role in increasing Medi-Cal enrollment, and should they meet the target, the state could restore its funding, permitting it to increase its outreach and enrollment (The California Endowment, 2009, p. 5).

In addition, CHIPRA provides new flexibility and tools are provided to implement Express Lane Eligibility. Express Lane Eligibility is “the use of data held by other government agencies to identify individuals who may be eligible for Medicaid or SCHIP, evaluate their eligibility for health insurance and enroll them or renew their coverage, as appropriate” (The Children’s Partnership, 2005, para. 1). Under CHIPRA, California can now rely on data findings from an Express Lane agency to determine simplified eligibility determinations (Public Law, 2009, sec. 203). California has already approved multiple Express Lane Eligibility programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the National School Lunch Program, Food Stamps, etc., but many of these programs have not been funded or fully implemented due to budget constraints. This new provision within CHIPRA should help to lessen these constraints. (The California Endowment, 2009, p. 5).
The provision of dental coverage opportunities to CHIP recipients are being required by states under the new law. The state of California already offers dental coverage as part of its Healthy Families program, but it may need to remove the current cap on dental services in order to be in compliance with the new CHIPRA regulations (The California Endowment, 2009, p. 6). If this does not occur, the state might not receive the revenues for which it is eligible.

As shown above, the ARRA and the CHIPRA provide states with much needed assistance to their public health care programs. The question is whether or not this support will be enough to allow states to cover the continually increasing number of unemployed and uninsured residents (UC Berkeley Center For Labor Research and Education, 2009, p. 3). In addition, will it be enough to ensure that California’s children are able to receive the health care coverage they need to have a healthier start in life?

The Effects of California’s Budget Crisis on Health Care for Children

Children’s Health Care Coverage

While the state government is trying to determine how to best handle the large budget shortfall, the state of California continues to feel the effects of both the national recession and the state’s budget crisis. The combination has resulted in two years of job loss that erased four years of prior employment gains, leaving California with a more severe decline in job losses than it has experienced in previous recessions (California Budget Project [CBP], 2009e, p. 5). In fact, California’s unemployment rate hit a high of 12.2 percent in August 2009, making it one of the states with the highest rate of unemployment in the nation (Calvan, 2009, para. 14). Not only is the rate one of the
highest in the nation, but it has risen faster than any other unemployment rate in the
history of comparable recorded data (CBP, 2009e, p. 5). Making matters worse, the
California Budget Project (CBP) also reported that one in four unemployed workers has
been jobless for a minimum of six months in July 2009, once again, the highest level ever
recorded.

As for the workers who still have jobs, they are experiencing lower wages than
before the economic crisis began (CBP, 2009e, p. 10). The CBP reported that the
average earnings for a worker exactly in the middle of the distribution curve have
declined by 0.5 percent (CBP, 2009e, p. 10). As well, due to the poor economy, many
companies are cutting back workers hours in order to cut their costs. This also causes
workers to take home smaller paychecks (CBP, 2009e, p. 10).

According to the Kaiser Family Foundation (2008), a one percent increase in
unemployment would increase the number of uninsured by 1.1 million (p. 5). Whether
families lose their employer based insurance due to being laid off, or the loss of income
prevents them from continuing to pay premiums for private insurance, the end result
remains the same: more and more families are finding themselves in the ranks of the
uninsured. In fact, California, which was at one time considered to be a leader in health
care coverage, now has an estimated 6.6 million people without health care insurance
(Calvan, 2009, para. 15). This puts California as the state that has the largest number of
people without insurance, and the trends are only getting worse (California Health Care
Foundation, 2009, p. 2). The percentage of working-aged adults who did not have any
form of health care coverage rose from 23.8 percent last year to 24.4 percent this year,
and the percentage of adults who did not visit a doctor because they said they could not afford it rose from 22.7 percent last year to 23.8 this year (Calvan, 2009, para. 16-7).

Although these numbers represent adults, the effects trickle down to children. Based on data collected from the CHIS, low-income, uninsured parents are three times as likely to have uninsured children (UCLA Center For Health Policy Research, 2009, p. 61). This means as parents are losing their health insurance, it is a likely their children are also losing their coverage. While public health insurance programs are available to children, even when their parents do not qualify, many parents are unaware of this because they have never before had to rely on public programs.

While many families are not enrolling in the Medicaid program, many other families are. Analysis done by the Kaiser Family Foundation (2008) found that with every percentage rise in national unemployment, there is an increase in Medicaid and SCHIP enrollment of one million (p. 5). This increased enrollment does not come without an additional cost to the state, however. At a 10 percent unemployment rate, the increased enrollment in Medicaid and SCHIP would cause a cost increase of $18.6 billion, with the states share being eight billion dollars (Kaiser Family Foundation, 2009, p.ii). Considering California’s unemployment is at 12.2 percent (Calvan, 2009, para. 14), the cost to the state would be greater than this estimate. While the assistance from the federal government has helped prevent more severe cuts to the program, program reductions continue to be necessary in California.
Children’s Health Care Programs

California’s state government approved budget agreements in February and July of 2009 with the hope of balancing the state’s budget and ending the current budget shortfall. Unfortunately, in an attempt to accomplish this task, many cuts and policy changes were made that had significant impacts on health care programs affecting children ages zero to five (California Budget Project, 2009c, p. 16; California Budget Project, 2009a, p. 14-15).

At the end of both budget deals, no public health care program was left untouched. The effects felt by Medi-Cal were as follows: ten optional services to Medi-Cal were eliminated, including dental services for the majority of adults (California Budget Project, 2009a, p. 17). Payments to both public and private safety-net hospitals were cut by ten percent and the “cost of doing business” increase for the county operation of Medi-Cal services was suspended (California Budget Project, 2009a, p. 17). In addition, the Governor used a line-item veto to cut state funding to the county operation of Medi-Cal. The July agreement also assumed state savings due to obtaining federal funds and unspecified reductions. In total, assuming the state receives all of its anticipated federal funding, California is looking at saving about $1.6 billion after making the above changes to Medi-Cal (California Budget Project, 2009a, p. 17).

With regard to Healthy Families, it initially appeared the program was not going to be affected by budgetary reductions following the reauthorization of the Children’s Health Insurance Plan, which allowed approximately 900,000 California children to keep their health care coverage (Healthy Families, 2009, para. 2). It also allowed thousands
more children to gain access to health care otherwise not available to them. In total, the funds from this law will equate to two-thirds of the money needed to run the Healthy Families Program in California and would provide four and a half years of continued stability for the program (Healthy Families, 2009, para. 3). “Due to the recent economic downturn the Healthy Families Program has experienced record-high monthly enrollment into the program. For every dollar in Healthy Families Program costs California receives .65 cents; the state puts up .35 cents. The reauthorization will allow California children access to comprehensive health, dental and vision care that is so crucial for their healthy growth and development” (Healthy Families, 2009, para. 4).

However, when the state legislature had to look at the budget again in July, the program was at risk of being eliminated altogether in order to decrease continued state costs. The Governor used a line-item veto of $50 million dollars and the Legislature reduced the program’s funding by $124 million, creating a $196 deficit for the program (California Budget Project, 2009a, p. 14). As a result, the Managed Risk Medical Insurance Board (MRMIB) ordered an enrollment freeze and a waitlist of approximately 90,000 children was created (California Budget Project, 2009a, p. 14). Freezing the enrollment would not be enough, however, because the program was also going to have to drop more than 650,000 children from the Healthy Families program between November 2009 and June 2010. Fortunately, with the help of legislation passed by Assemblywoman Karen Bass, the CHIPRA, a sizeable contribution from the First 5 Commission and cost shifting, the Healthy Families Program was saved (California Budget Project, 2009a, p. 15).
On September 22, 2009, Governor Arnold Schwarzenegger signed AB 1422, which imposes a tax of 2.35 percent on Medi-Cal Managed Care plans, resulting in the raising of an estimated $97 million in 2009-10 for Healthy Families (California Budget Project, 2009a, p. 15). Along side AB 1422 was the support of the First 5 Commission in the form of $81.4 million (California Budget Project, 2009a, p. 15). Even with the money raised from these two sources, the program was still short $17.5 million (California Budget Project, 2009a, p. 15). To close this gap, costs were shifted to families. Premiums and co-pays have been increased for some services and access to higher cost dental plans has been restricted for the first two years a child is in the program (California Budget Project, 2009a, p. 14). While the cost shifting is not ideal, it allows the program to continue operating, eliminating the need to drop children’s coverage and re-opening enrollment to more uninsured children in the state of California.

Many steps have been taken by the federal, state and local governments, as well as community organizations in order to maintain the current health care safety net for children. The federal government passed the American Recovery and Reinvestment Act which contains provisions designed to assist states in continuing their Medicaid programs while saving money to use toward balancing their budgets (Center on Budget and Policy Priorities, 2009b). The Children’s Health Insurance Program Reauthorization Act was signed by President Obama in order to continue and expand the existing SCHIP program (The California Endowment, 2009, p. 4). Governor Schwarzenegger passed legislation increasing taxes and organizations such as the First 5 Commission have donated millions of dollars to preserve the Healthy Families program in order to ensure children continue
to receive health care coverage despite the economic hardship facing the state at this time (California Budget Project, 2009a, p. 15). However, because the economic crisis is so current, there is little understanding of whether these efforts have been enough to not only protect public health care coverage in California, but to handle the increasing numbers of eligible individuals.

Current Research

According to the Center on Budget and Policy Priorities (2010b), state budget deficits are likely to remain as big as they currently are, or bigger, throughout the upcoming year (p. 1). Continued budget shortfalls mean states will continue to have to make cuts to public services. California legislators have already begun to consider how they will work to balance the 2010-2011 budget. Initial proposals are planning to reduce Medi-Cal eligibility to the lowest limit allowed by federal guidelines (Health Access, 2010, p. 1). This would equate to approximately 250,000 Californian’s losing their health care coverage starting January 1, 2011, the day after the current stimulus package expires (Health Access, 2010, p. 1). In addition, the current proposal is once again considering the complete elimination of the Healthy Families program, resulting in 874,762 children losing their health care coverage (Health Access, 2010, p. 1). It is unknown at this point whether the federal government will extend the deadline for the ARRA, which would prevent California from making reductions in services this severe. Either way, California will still need to find ways to decrease its budget shortfall, and health care services are likely to find themselves on the chopping block (Health Access, 2010, p. 1).
In addition, unemployment is expected to remain at high levels beyond the completion of 2010 (Center on Budget and Policy Priorities, 2010b, p. 4). When considering findings by the Kaiser Family Foundation (2008), which state that a one percent increase in unemployment results in an increase of 1.1 million uninsured individuals (p. 5), it can be expected California’s rate of uninsured will also remain at high levels beyond 2010. With unemployment rates remaining high, the state’s increased demand for Medi-Cal and Healthy Families will remain high as well (Center on Budget and Policy Priorities, 2010b, p. 4).

Continued budget deficits, as well as the high unemployment, present great concern about the status of health care coverage for children. Clearly, the possibility of eliminating the Healthy Families program is problematic when it comes to providing children with public health care. Last year, the First 5 Commission was able to step in and provide the funds necessary to preserve the program, but it is unlikely that program will be able to do the same this coming fiscal year (Knutson, 2009, para. 10). This is because the Commission used almost half of its savings, which took approximately 10 years to accumulate, to preserve the program last year (Knutson, 2009, para. 10). The elimination of this program would automatically leave close to 900,000 children without access to health care insurance (Health Access, 2010, p. 1).

Even if the Healthy Families program remains unaffected after the 2010-2011 budget decision, the possibility of further reducing Medi-Cal services, or worse, decreasing Medi-Cal eligibility, more adults will be without health care coverage. Both of these situations could result in larger numbers of uninsured children based on the
understanding that children with uninsured parents are three times more likely to be without health care coverage, even when they are eligible (UCLA Center For Health Policy Research, 2009, p. 61). Combine this with continued high unemployment, which, as stated above, results in higher levels of uninsured adults, greater numbers of children would be at risk of not receiving the health care services they need.

Little research has been done to examine how health care agencies and the individuals who access their services have been affected by recent budget decisions. What is known is health care coverage plays an important role in providing young children with a strong foundation upon which to build later success in life (Cummings, Lavarreda, Rice, & Brown, 2008, p. 1). When children have consistent coverage, they are more likely to receive preventative care, see the dentist and are better prepared for school (Cummings, Lavarreda, Rice, & Brown, 2008, p. 1; California Health Care Foundation, 2008, p. 11; UCLA Health Policy Research, 2008, p. 1). This care is particularly important considering the rapid development children undergo both physically and emotionally during their first few years of life (UCLA Center For Health Policy Research, 2008, p. 1).

As policy makers move forward with decisions to balance the 2010-2011 budget, it is important for them to understand how citizens have been affected by recent budget cuts. In order for them to make informed decisions, they must be educated on how their choices are affecting the population. For this to happen, research must be conducted which looks at the direct impact of the current recession on health care agencies and the individuals who access these services.
Chapter 3

METHODS

The national recession, combined with California’s budget debt have created an economic crisis in the state. In order to manage this crisis, the federal government passed the American Recovery and Reinvestment Act, which provided states with funds so they could begin to balance their budgets without having to make severe cuts to their public services. Despite the assistance from the federal government, California has had to make reductions in many of its service areas, health care being one of these services. This study seeks to determine how the 2008-2009 economic budget crisis has affected health care for children ages zero to five in Sacramento County.

To determine the effects of the state deficit on children’s health care, researchers performed a qualitative study. Health care agencies in the county were selected through a stratified method of sampling. Administrators of these agencies, as well as clients who utilize these services, were interviewed in order to discover how services have been affected by budget cuts. Data was then analyzed to ascertain how health care for children ages zero to five has been impacted in Sacramento County, California.

Design

This was an exploratory study which utilized qualitative data. The purpose of the study was to determine how the current economic crisis has affected public health care for children ages zero to five in Sacramento County. The researcher interviewed representatives from health care agencies and the clients who accessed these services. The data was gathered using a questionnaire designed by the researcher.
Sample

The participants of this study were representatives from health care agencies in Sacramento County and the clients who utilized services at these agencies. For the purpose of this study, only the agencies that received county or state funding were included. Data was collected from agencies that provide any of the following services for children ages zero to five: general health care, dental care, vision care, or resources to obtain these services. Data was also collected from clients who access the above-mentioned services.

Sample Selection

A sample of 45 agencies was derived from the Community Services Directory, Sacramento using a stratified method of sampling. Researchers chose every other agency, starting from the first agency listed on the published list of health agencies, and made contact via telephone to determine if the agency fit the inclusion criteria of providing health care services and receiving county and/or state funding. The list contained a total of 51 agencies. Researchers contacted every other agency on the list. Once all agencies were contacted, and interviews were arranged, researchers ceased contacting agencies on the list. Researchers requested to carry out an interview with the director, or an administrator referred by the director, who had knowledge of how the agency operated. Upon completion of the interview, researchers asked the director, or appointed administrator, to refer them to two clients who would be willing to be interviewed for a client perspective. The study contained 12 agency and 2 individual participants.
No inducements were offered.

Instrument

Two interview inventories were used in this study: one for agency representatives and one for individual clients. The inventory for agency representatives contained a total of thirty-nine questions. Eleven questions were general questions about the agency, eight questions were about the services provided to children ages zero to five, eleven questions were regarding services provided to women, and nine questions were about services for undocumented clients. (Please refer to Appendix B.)

The interview inventory for individuals contained a total of twenty-six questions. Six questions regarding the participant’s experience with services for children ages zero to five, five questions regarding the participant’s experience with services for women, seven questions about the participant’s experience with services for undocumented clients, and eight demographic questions. (Please refer to Appendix C.)

The interview presented no risk of harm or discomfort to agency representatives and a minimal risk for individuals.

Measurement

The inventory designed for health care agency administrators utilized thirty-five open-ended, qualitative questions to measure the effects of the California budget crisis on their clinic. The inventory also contained four closed-ended, ordinal level questions which gathered demographic data about the agency represented. Specifically, the inventory gathered basic demographic information and measured how the services provided by the agency were impacted due to funding changes. It examined the means
by which agencies had adjusted their programs in order to continue to serve their clients. In addition, the ways in which funding had impacted agency employees was measured.

The inventory designed for clients contains twenty-six open-ended, qualitative questions which measured the types of health care programs clients utilized, the challenges they faced when accessing services and the changes they had experienced with the services they received. The inventory also contained two nominal level and three ordinal level questions aimed at gathering demographic information about the clients interviewed.

Data Collection Procedures

The data collection for agency representatives utilized the following procedure. The researcher first obtained a signed consent form from the participant. Then, the researcher asked the participant eleven general questions about the agency, eight questions about the services provided to children ages zero to five, eleven questions regarding services provided to women, and nine questions about services for undocumented clients. If an agency did not serve one of the above populations, those questions were excluded from that interview. Upon completion of the interview, the researcher filed the signed consent form in one envelope and the completed interview inventory in another envelope. Lastly, the envelopes were stored in a locked file cabinet in the home of the interviewer.

The data collection for individuals utilized the following procedure. The researcher first obtained a signed consent form from the participant. Then, the researcher asked the participants six questions regarding their experience with services for children
ages zero to five, five questions regarding their experience with services for women, seven questions about their experience with services for undocumented clients, and eight demographic questions. If the individual interviewed did not use one or more of the above services, those questions were omitted from that interview. Upon completion of the interview, the researcher filed the signed consent form in one envelope and the completed interview inventory in another envelope. Lastly, the envelopes were stored in a locked file cabinet in the home of the interviewer.

Data Analysis Procedure

A content analysis method was used in order to analyze the data collected from the inventory. Researchers reviewed the interview responses, identifying and then categorizing the emergent themes. Data within each theme provided insight into how agencies had been impacted by the budget, how health care services programs had been affected by the current crisis, how administrators had prioritized services at their agencies and how administrators perceived the future outlook of health care services and children’s health.

The quantitative demographic data gathered about the agencies was analyzed using statistical methods and presented in the form of percentages. This provided a statistical view of the agencies’ characteristics.

Human Subjects Protection

The Protocol for the Protection of Human Subjects was submitted and approved by the Division of Social Work at California State University, Sacramento, as a “Minimal Risk” study. The study was deemed “Minimal Risk” because the researcher proposed to
interview health care clients regarding their personal experiences in the health care system. Due to the personal nature of the questions, participants faced a small possibility of experiencing discomfort during the interview process.

A signed written consent was obtained from all participants (See Appendix A) before completing the interview. In order to protect the confidentiality of participants, the consent forms were stored separately from the completed interview inventories. The inventories did not ask for any identifying information, preventing the researcher from knowing which participants completed which interview inventories when analyzing the data. All forms were kept in a locked file cabinet until the completed project was approved, at which time they were destroyed.

Conclusion

This was an exploratory study designed to investigate how health care agencies and clients experienced the 2008-2009 budget crisis in the state of California. Agency representatives were asked to take part in an interview designed to discover how this crisis affected the services they offered. In addition, clients from each clinic were interviewed about how the crisis had affected their ability to access care for their children between the ages of zero and five. The researcher analyzed the data in order to begin to understand how Sacramento County children, ages zero to five, were affected by the budget cuts.
Chapter 4

FINDINGS

This qualitative, exploratory study was designed to examine the effects of the current budget crisis on health care agencies serving children ages zero to five and the individuals who use these services in Sacramento County, California. Researchers conducted face to face interviews with agency administrators as well as individuals who utilized health care services for children ages zero to five. Researchers created a 39 question inventory for agency administrators and a 26 question inventory for clients. Upon completion of the interviews, a thematic analysis of the data was performed.

Analysis of the data revealed common themes that appear relevant to this study of how the current economic crisis in California is affecting health care services for children ages zero to five years. This chapter will present the findings of this study, which include demographics and themes related to changes in eligibility requirements, the impact of the current recession on services offered as well as on agency employees, changes in outreach services for children ages zero to five, the ways in which agencies prioritize program reductions, the future outlook for health care services and the significance of the lack of agency representation for the county of Sacramento. Due to the limitations of sample size, the findings should not be used to generalize the actual effects of the current budget crisis on all agencies in Sacramento County or the state of California.
Demographics

Agency Sample

Researchers contacted attempted to contact a total of 148 agencies in Sacramento County. Of these agencies, 138 were contacted by telephone (93% of sample) and 38 of these agencies were also contacted by email (26% of the sample). A total of 59 agencies did not respond to researchers request for an interview (40% of the sample). Twelve agency respondents stated they were unable or unqualified to participate in the study and referred researchers to another individual they believed might be of assistance (8% of the sample). Additionally, 18 agency administrators declined to participate in an interview (12% of the sample) while 14 agency respondents agreed to, and completed an interview (9% of the sample). Of the 14 interviews completed, two were with clients, however, due to the small sample size, these two interviews were not analyzed as part of the study. Researchers were unable to include seven agencies in the study because they had been required to close their doors due to the budget crisis (5% of the sample).

Furthermore, of the 148 agencies, 11 agencies were not contacted by the researchers because they were directly run by the County of Sacramento’s Health Department (7% of the sample). In order for researchers to have access to the employees of these agencies, they were required to complete the county’s Internal Review Board process. Due to the limited time permitted to complete the study, the researchers opted to omit these agencies from the list.

In total, only nine percent of the agency sample completed an interview, five percent of the sample was unavailable because they were no longer in business and
67 percent, or 100 agencies, declined to participate in an interview either directly or indirectly.

Specifics of Agency Represented in the Study

From the data gathered, this researcher will present the demographics of the study, which includes the services offered at the agencies examined, the populations served at the agencies, the agencies’ annual budgets for fiscal year 2008-2009, the annual budgets for fiscal year 2009-2010 and the number of clients seen at the clinics. In addition, the researcher will present the forms of insurance accepted at the agencies which specifically serve a zero to five year old population.

Twelve administrators from twelve different health care agencies were able and willing to be interviewed for this study. Of the twelve agencies represented, ten offered direct client services (83% of the sample), while two agencies offered macro-level services to direct practice agencies (17% of the sample). Of the twelve agencies represented, seven offered services to the zero to five year old population (58% of the sample).

Of the ten agencies which offered direct client services, 4 agencies offered primary care; 3 agencies offered specialty care, such as cardiovascular services, speech and audiology services, cataract surgery, hernia surgery, or pain management; 3 agencies were reported to offer advocacy services; 3 offered health education services; 3 offered reproductive care; 2 were reported to offer ambulatory care; 1 agency offered dental care; and 1 agency was reported to offer immunizations.
Within the ten direct health care service agencies listed above, five offered services specific to the zero to five year old population (50% of the direct service sample). Three of the agencies were reported to offer primary care, which includes immunizations. Specialized services, such as speech, language and cardiology, were reported to be offered by two agencies.

With respect to the two agencies which offer policy level services to direct practice agencies, both were reported to be involved in advocacy services as well as collaboration and partnership services. One of these agencies also performed trainings to staff and county contractors. Both of these agencies were reported to serve agencies which offer services to children ages zero to five.

In response the question asking which populations were served by the agencies, nine of the 12 administrators reported to serve the uninsured and underinsured (75% of the sample); six administrators stated the agencies served individuals with specific medical issues (50% of the sample), such as reproductive health, cardiac problems, or speech and language; five agencies were reported to serve the medically indigent (42% of the sample); three administrators reported their agencies’ serve predominantly women (25% of the sample); two agencies were reported to serve only adults over the age of 18 years (17% of the sample). Two agencies were reported to serve hospital systems and health care providers (17% of the sample). Seven administrators reported their agencies’ specifically served Sacramento County residents (58% of the sample), while five agencies were reported to serve individuals within the Greater Sacramento County (42% of the sample).
Regarding agency budgets for the 2008-2009 fiscal year, it was discovered that three of the twelve agencies represented in the study had a budget over $3,000,000 (25% of the sample). Two agencies worked with an annual budget between $900,001 and $2,000,000 (17% of the sample). One agency represented had a budget between $500,001 and $700,000 (8% of the sample) and another agency worked with a budget between $300,001 and $500,000 (8% of the sample). One agency representative was unsure of the budget amount for that agency (8% of the sample).

Administrators were also asked for their agencies’ annual budget for the 2009-2010 fiscal year. Of the eleven administrators who were aware of their agencies’ annual budgets, all of them reported to have maintained the same budget range as the prior year (92% of the sample). One agency administrator was unsure of the annual budget for that agency (8% of the sample).

The findings show that one agency serves fewer than 500 patients a year; three agencies serve between 2,000 and 3,000 clients a year; one agency serves between 3,000 and 4,000 clients a year; one agency serves approximately 5,000 clients annually; one agency serves between 6,000 and 7,000 clients a year; one agency serves between 40,000 and 50,000 clients a year; one agency serves approximately 100,000 clients annually; and one agency serves approximately 250,000 clients annually. Two administrator were unsure how many clients were served annually. See Table 1 below.
Of the seven agencies serving children ages zero to five years, it was found that three agencies accepted Medi-Cal, two agencies accepted Healthy Families, two agencies accepted Healthy Kids, and two agencies accepted a sliding scale fee. Two agencies did not accept any form of health insurance. One of these agencies required an out of pocket payment for services while the other asked for a sliding scale fee.

**Themes Related To The Study**

*Changes In Eligibility Requirements*

Agency administrators where asked if they had seen changes in client eligibility since the current economic crisis began in 2008. Based on administrators responses, it
was found half of the agencies had not experienced changes, however, 42% of them had seen some aspect of client eligibility change. On the other hand, when considering changes in client eligibility specific to children between the ages of zero and five years, this study discovered no changes to be reported by agency representatives.

Administrators of all twelve agencies were asked about the ways in which they had seen changes in eligibility requirements at their agency. Of the twelve agencies represented, one administrator stated the question did not apply to the agency because this particular agency did not handle eligibility issues (8% of the sample). Five respondents reported to have seen some changes in eligibility requirements (42% of the sample) and six respondents reported not to have seen any changes in eligibility (50% of the sample). This means that of those eleven agencies that handle eligibility issues, the majority, or 55%, did not see eligibility requirements change as a result of the current budget crisis and the minority, or 45% did see changes.

Of the five administrators who reported to have seen changes, three acknowledged the recent change in the age requirement for mammogram examinations. Now, a mammogram for a woman under the age of 50 will not be covered by her insurance, no matter what insurance coverage she has. This means, the woman will either have to pay out of pocket, or wait. All three administrators expressed concern for women’s health due to the age requirement for a mammogram screening being pushed back from 40 years of age to 50 years of age. One administrator stated she will try to refer patients with abnormal breast exams to a mobile clinic which offers free mammograms; otherwise there is nothing she can do for her client. Two of these
administrators stated that despite what studies may say, they feel the age requirement was changed as a way for insurance policy holders to save money.

Two agency administrators reported to have seen reduced Medi-Cal reimbursements to their clinics. In addition, two administrators stated they have not necessarily seen eligibility requirements change, however, they have seen an increase in the number of people who are now eligible for Medi-Cal services.

One administrator stated the agency for which she works no longer serves the undocumented population. According to this administrator, this population was denied service by the Sacramento County Medically Indigent Program as a way for the county to save money. Therefore, since this agency follows the county’s guidelines for the definition of medically indigent, it is also no longer able to serve this population.

When looking specifically at the seven agencies which serve the zero to five year old population, this researcher found six of the seven administrators reported not to have seen any changes in eligibility requirements for this population. The seventh agency administrator was with the agency that does not handle client eligibility issues. This means, 0% of the agencies serving this population and handling eligibility issues have experienced changes in eligibility requirements.

The Impact of the Current Budget Crisis on Services and Programs Offered

Researchers were interested in discovering how health care programs and services in Sacramento County were being impacted as a result of the current budget crisis. The findings from this study indicated that the majority of agencies represented have experienced negative impacts to the services and programs they offer the community. It
was also discovered that programs and services specifically aimed at children zero to five years of age have been negatively impacted, although to a lesser degree than those for the general public.

After examining the data collected from this study, it was apparent that the majority of participating agencies (67% of the sample) had experienced negative impacts to the services they offer, which in turn impacts the care their clients are able to receive. One hundred percent of agency administrators stated the quality of care received by patients had not been affected, even if the agency’s services had been impacted in some way.

Four administrators stated their agency had witnessed longer waiting lists for the services offered. Four agencies had experienced temporary clinic closures, either due to furloughs or the need to decrease operating hours in order to save money (33% of the sample). Two agency administrators reported the need for some programs and departments to close and stated others were currently at risk for closure (17% of the sample). Education and prevention were the services at risk at two of the agencies (17% of the sample). Two agency administrators stated they were required to cut out services which they considered to be “extras”, such as transportation to and from appointments and additional material used in the office (17% of the sample).

As a result of the current budget crisis, ten health care administrators reported individuals are experiencing greater difficulty accessing health care services (83% of the sample). One administrator stated that prior to the start of the 2008 crisis, it would take approximately four weeks for a patient to be able to see an ear, nose and throat specialist.
Today, the resources have become so limited, the wait time is approximately eight months. To make matters worse, this same administrator stated that because the wait is so long, the agency is losing many patients. Once the patient has finally reached the top of the waiting list and they are called to make an appointment, they have often times disappeared. The administrator is unsure of where these patients are going and whether their health care needs are being met.

Another administrator stated the current wait list contains 300 to 400 names. Clients were reported to be turned away at two agencies due to the constant over crowding. One administrator stated patients are having difficulty receiving the prescriptions needed because of the rising costs to prescription drugs and increasing co-pays.

While it was reported that the seven agencies which serve the zero to five year old population have not seen changes in eligibility requirements comparable to the sample of twelve agencies as a whole, the data shows that services for this young population have been similarly impacted. Three of the seven agencies serving young children (43% of the sample) reported negative impacts on the services offered. Of these three agencies, increased numbers of patients has resulted in longer wait times for appointments. This was the only negative impact reported by administrators.

Three respondents from agencies serving children zero to five years old reported their agencies have not experienced negative impacts to services offered to this population (43% of the sample).
One administrator from an agency which serves an adult population as well as a zero to five year old population reported improved services for clients. This respondent further explained that this was because the agency was recently approved as a Federally Qualified Health Clinic (FQHC), allowing it to now serve a larger number of individuals or all ages.

The Impact of the Current Budget Crisis on Agency Employees

Agency representatives were asked how employees from their agencies have been impacted as a result of the current economic crisis in California. The findings indicated that almost all of the agencies’ employees have been affected in some way. Various affects were reported by representatives, however the findings show that the most prevalent impact experienced was increased patient and work loads.

Eleven of the twelve administrators interviewed reported to have seen ways in which the current budget crisis has affected health care agency employees. Six administrators stated they have seen an increased case load for the employees at their agency. This has been seen in employees having to work longer hours without an increase in pay, staff has been required to “work harder and faster” as well as “find more efficient ways of getting things done.” One administrator stated the employees are now required to “do more with fewer resources.”

Four administrators reported the need to reduce payable working hours, either through furloughs or by cutting back employee hours. The need for clinics to have temporary closures was also reported. Pay increases were frozen at one agency, the need
to cut back on 401K retirement savings was reported by another and a hiring freeze was reported by yet another.

The need to lay off workers was reported by two clinics. In addition, one administrator reported to have seen decreased morale amongst agency employees. The administrator went on to explain that many employees are feeling increased anxiety because they are unsure of what the future holds for their careers.

*Changes in Outreach Service for Children Zero to Five Years Old*

Research has shown that outreach services play a large role in ensuring young children who are eligible for Medic-aid and State Children’s Health Insurance Program receive coverage (Dubay et.al., 2007, p. 375). Researchers were interested in determining if agencies were altering their outreach enrollment services during the current economic crisis. The findings from the study indicated that many of the agencies servicing young children have increased their outreach services in some way.

The data shows that the majority of agencies serving children zero to five years old, which participate in outreach services, have increased their activity. Five of the seven participating agencies were reported to have involvement in outreach services for children ages zero to five years (71% of the sample). Of these five agencies, two administrators indicated there had been no changes in their outreach services (40%), while three reported increased activity (60%). One administrator stated the agency has been working hard to inform county agencies that primary care services for young children are available at this agency. Another administrator indicated the agency has been enrolling more children to public insurance programs because more families have
become eligible. Although not exactly an outreach service, another administrator reported an increase in word of mouth referrals, referring to this as a great form of marketing.

*How Agencies Have Prioritized What to Cut*

Agency administrators were asked how they have prioritized cuts to programs and services during the current budget crisis. It was found that many of the agencies represented have had to make cuts to the programs and services they offer to the community. Additionally, many agency representatives reported not to have had to make cuts. These representatives went on to explain how they have been spared the need to make such prioritizations. In contrast, agency representatives for programs specific to children ages zero to five unanimously stated this question did not apply to these programs.

According to the data, five agencies have been forced to make cuts to their programs (42% of the sample) while seven agencies have not yet been required to make reductions to the programs they offer (58% of the sample). Of these seven agencies, however, five of them have been required to find supplemental funding in order to maintain their current operating costs. Therefore, a total of 10 agencies, or 83% of the sample, have been required to find ways in which to continue to serve the community to the best of their ability.

Of the agencies which required service reductions, two respondents reported choosing to cut out “extras” in order to allocate these additional funds to the primary services offered. Some of the “extras” which were eliminated were transportation to and
from the clinic or supplies which were not necessary for service. Two administrators stated their agencies’ ability to acquire grants and funding for individual services offered determined whether or not they would be required to reduce or eliminate any programs. The agency’s mission and values played a role in prioritizing services according to two respondents. One administrator reported prevention was a primary value held by the agency, therefore, when the budget became tight, rather than eliminate prevention based services, the agency opted to lay off workers and cut back clinic operating hours. Three administrators stated they took into consideration the program’s benefit to the community, the community’s need for the program, and the demand for the program when determining whether to cut it.

The majority of agencies represented in this study have not had to reduce or eliminate services. Administrators gave various reasons for this. Some agencies are partners with larger private or non-profit agencies and organizations which have been able to supplement lost funding streams (17% of the sample). Other agencies have found alternative funding, either through new contracts, emergency loans, or fundraising (25% of the sample). One administrator reported the agency has not experienced any budget changes (8% of the sample) while another indicated having a surplus of funds to which it could use to make up for its currently declining budget (8% of the sample). The respondent from this last agency expressed concern regarding the agency’s ability to proceed without program reductions next year. The two agencies which provide services on a first come first serve basis also reported not to have made reductions in services,
however, they both indicated an extreme increase in the wait time necessary to receive services (17% of the sample).

When examining the data related to how service cuts have been prioritized for programs specifically serving children ages zero to five years, this researcher discovered that all of the respondents stated this question was not applicable to their agency because no reductions have been required for these programs.

The Future Outlook of Health Care

Finally, agency administrators were asked about their perceptions on the future outlook of health care in light of the current economic crisis. Administrators responses regarding the possible future outlook for health care related to the adult populations were quite different from results found for the outlook of health care for children zero to five years old.

Administrators comments regarding the possible long term affects of the budget crisis on health showed concern with regard to an increased cost to tax payers (25% of the sample) and to society (25% of the sample). In addition, 33% of administrators anticipated an increased use of emergency rooms due to the hardships being faced by other health care agencies. A quarter of the respondents anticipated decreased access to preventative care and 17% of respondents feared the closing of many valuable health care clinics.

A quarter of the administrators interviewed anticipated the occurrence of some form of health care reform. One respondent felt health care agencies would begin to find new funding streams, while another believed counties should “get out of the health care
business altogether,” stating the need for counties to begin contracting out to community clinics. Another administrator expressed faith that Obama’s health care reform bill would have a positive impact on the current health care system. Despite respondents expectation of reform, 17% of them also expected things would become worse before they begin to improve. One administrator stated, “I don’t see change happening in the next few years, until the county implodes.”

Another concern for the future of health care which was expressed by respondents was that individuals would wait until routine health issues became serious to seek care (17% of the sample). One administrator expected that after years of consistently declining birth rates, the state would see rates begin to rise due to cuts in family planning. Another respondent feared a loss of quality professionals because current professionals would retire earlier than originally planned and others would change professions because they are no longer willing to work harder and longer hours for less pay. Eight percent of respondents anticipated health care would have to move away from specialized care to more generalized care for budgetary reasons.

The administrators representing agencies that offered services to children zero to five years old were also asked how they believed children’s health would be affected by the current budget tightening. One respondent expected children’s health to improve once health care agencies reformed the way in which they did business (8% of the sample). Two respondents anticipated little change to children’s health in the future (17% of the sample). Both administrators explained their response by pointing out that
young children make up a “special population” and therefore it is politically challenging to reduce programs to this population.

Conversely, four respondents expected children’s health to be negatively impacted in the future (57% of the sample). One administrator anticipated a “snowball effect” to occur, in which the hardships parents are currently facing will cause their children to suffer as well. Similarly, another respondent predicted that children would be at an increased risk for child abuse and health related issues due to the increased stress experienced by parents and caretakers. Two administrators expressed concern regarding children’s academic success as well as their emotional and psychological well-being if they began to experience difficulty receiving the health care services they need.

Summary

Overall, the twelve respondents appeared to be open to discussing the ways in which their agency has or has not been affected by the state’s current budget crisis. The majority of the agencies represented in this study provided health care services to uninsured and underinsured adults in and around Sacramento County. In addition, the majority of agencies represented provided health care services for children between the ages of zero and five years. Two agencies did not provide direct health care services, but rather collaborative and policy related services to direct practice agencies. While these two agencies were not involved in direct practice, they appeared knowledgeable regarding the ways in which direct practice organizations are being impacted by the current budget crisis. The size of the agencies represented ranged from a small clinic to a
large hospital setting. This can be seen in the number of clients served as well as the annual budget amounts.

Based on the findings listed in this chapter, most of the health care agencies in Sacramento County have been impacted by the current budget shortfall in some way. Many agency representatives reported the need to prioritize the programs and services they offer, some respondents reported to have experienced decreased budgets. Many administrators stated the need to find new funding streams and some reported having to make cuts in order to save money. On the contrary, most health care programs which serve children zero to five years old reported to have felt few budgetary impacts to these programs. In addition, this researcher is able to draw further conclusions regarding the overall impact of the current budget crisis on health care services from the large number of agency administrators who were unable and/or unwilling to participate in this study.
Chapter 5

CONCLUSIONS AND IMPLICATIONS

The purpose of this study was to examine how the economic crisis of 2008 in California affected health care services in Sacramento County for children ages zero to five years. This was a qualitative study, in which data was gathered through interviews with health agency administrators and clients who accessed health services from these agencies. The goal of the study was to gain information from health care administrators about how their agencies’ services have been affected as a result of the budget crisis and what they are doing in order to continue to provide services to clients. In addition, researchers aimed to gain insight on how the clients who utilized health care services for children zero to five perceived the impacts of the budget crisis on these services. Data collected was then analyzed with the use of a thematic analysis.

This chapter will discuss the conclusions and implications of this study. This researcher will discuss main themes from the literature and how these themes compare to the findings of this study. One of the main themes discovered in this study was that the health care programs for children between the ages of zero and five have not experienced as many budget related impacts as health care programs serving adults. Another theme found in the study is related to increased outreach services in programs for children zero to five years old. In addition, a common theme experienced by researchers in this study was agency administrators who were unable and/or unwilling to participate. While the lack of participation resulted in a limited amount of data collected, it provided researchers with insight as to the challenges agencies are facing during the current budget crisis. The
final theme uncovered from the study considers participants’ perspectives regarding the future of health care services. In general, most administrators expressed concern regarding the immediate future of health care and the well-being of the community as a result.

Also discussed in this chapter are future research implications and implications for policy which resulted from the findings of this study. This researcher will also make suggestions for future research methods which could be effective in gathering a deeper understanding of how the current budget is impacting health care. In addition, based on challenges experienced while completing this study, this researcher will make recommendations to future researchers who will conduct further studies. Finally, an examination of possible policy implications that can be deduced from the literature and the study findings will be addressed.

Discussion of Findings

The Existence of a Health Care Safety Net for Children Ages Zero to Five Years

As stated in the findings, of the agencies serving underinsured and uninsured adults and handling eligibility matters, 45% of the respondents experienced changes in the eligibility requirements for individuals accessing their services. On the other hand, 0% of the agencies serving children zero to five and handling eligibility issues reported to have seen changes in eligibility requirements for this specific population. This finding is consistent with the information found in the literature, which has shown that health care coverage for adults has experienced greater volatility than coverage for young children.
According to the data, 67% of the participating agencies have experienced negative impacts on the services offered due to the current budget crisis. In contrast, only 43% of the agencies that provide programs for children reported to negative impacts on these programs. In addition, the sample of agencies which serve children ages zero to five years reported to have suffered the same negative consequence, longer wait times. In contrast, the programs serving other populations were reported to have experienced a variety of negative affects on these programs.

Similarly, when examining how agencies prioritized their programs and services during the state’s budget tightening, it was found that 83% of the participating agencies have experienced cuts in funding. However, only 42% of the agencies have been required to make cuts to their programs. On the other hand, not one of the respondents representing agencies which serve children zero to five years old felt this question even applied to their program.

The findings from this study imply that funding streams for programs serving children ages zero to five have been impacted to a lesser extent than funding streams for other health care programs. In her research, the author did not examine policy changes that might have occurred specific to health care programs serving uninsured and underinsured adults and therefore can only speculate. Perhaps policy makers made deeper reductions to these programs and/or these programs did not receive the same additional assistance from the federal government and commissions such as First Five.
Should this be the case, it could be an area for further research; examining how policy makers prioritize health care programs in a period of economic crisis.

_Outreach Services for Children Zero to Five Years Old_

According to the Kaiser Family Foundation, in the United States, a one percent increase in unemployment would increase the number of uninsured by 1.1 million (Kaiser Family Foundation, 2008, p. 5). Additionally, children of parents who are uninsured are three times more likely to also be without insurance (UCLA Center For Health Policy Research, 2009, p. 61). Considering that California’s unemployment rate had reached a high of 12.2 percent (Calvan, 2009, para. 14), this researcher was interested in discovering if health care agencies had made any changes to their outreach services in order to ensure Sacramento children were continuing to receive necessary medical care. The data did show changes in the outreach services offered by participating agencies (60% of the sample). Due to the small sample size, however, it is difficult to know if this is representative of all health care agencies in Sacramento.

_Significance of the Lack of Response for Interviews_

As shown in the findings, a large majority of the health care agencies from the original targeted sample did not participate in this study. While researchers were unable to gather concrete data from these agencies, researchers were able to gain insight regarding how agencies’ services have been impacted by the 2008 budget crisis through their inability and/or unwillingness to participate. For instance, based on the literature as well as the responses from participating administrators, researchers can assume that many of the agency administrators did not respond to researchers attempted contact because...
they did not have the time or the resources to do so. Many agencies are functioning with limited staff and high case loads, therefore, allotting time to make contact with researchers, let alone to participate in an interview, is not currently possible. As agency administrators are required to prioritize their time and resources, it is a more important for them to place their energy in the daily operations of the health care programs they provide.

Researchers acquired their sample of health care agencies from a public list of agencies, and therefore were not required to gain permission from the Sacramento County Review Board in order to contact county operated agencies. However, when county officials learned about the study, they stated this process was necessary. This leads these researchers to question the county’s intentions. Perhaps they are stepping in as a way of ensuring county agency staff are able to focus on the increasing number of clients at their clinics. It could also be possible the county does not want researchers to see the extent and effects of the reductions that have occurred as a result of the current budget crisis. Whatever their reasoning, Sacramento County seems to be protecting its health care agencies more than usual during this period of economic downturn.

Finally, researchers were not able to contact seven health care agencies from the list of agencies because they had closed their doors and were no longer providing health care services. The agencies no longer in service were: Northeast Health Center, South City Health Center, Capital Health Center, Clinica Tepati, Oak Park Neighborhood Multiservice Center, Young Women's Christian Association (YWCA), Sacramento Community Clinic Consortium (SCCC). These seven agencies give a lot of information
regarding the impact of the 2008 budget shortfall. Due to budget cuts and program reductions, these agencies no longer had the resources necessary to provide health care services to the community. From this, researchers might suggest that many of the patients who previously accessed services from these agencies are now receiving services from other community agencies, making up a percentage to their increase in patient numbers.

Although researchers were unable to acquire the sample size they had hoped for in this study, they were able to gain further understanding of the impacts of the crisis indirectly through the lack of agency administrator participation.

The Future Outlook for Health: Children Zero to Five Years Old

The perceptions of respondents regarding the long term effects of the state’s current budget crisis for health care services for uninsured and underinsured adults and for children are quite different. With regard to services for adults, participant responses reflected impacts that would be felt on a societal level. For instance, a quarter of respondents anticipated an increased cost to tax payers, a quarter expected a negative impact to be felt by society as a whole and a quarter predicted this crisis would eventually result in health care reform.

Although the data shows health care services for children have not experienced as many negative affects as health care services for other populations, the majority of respondents did not hold promising expectations for children’s health in the future (57% of the sample). The concerns expressed by respondents were in line with the literature. It has been found that children who receive consistent health care services have an
increased likelihood for later academic success (UCLA Health Policy Research 2008, p. 1). For this reason, it is understandable why respondents would express concern regarding children’s academic success during a time when health care services are in danger of facing future cuts. One respondent also expressed concern about children’s health and safety as their parents struggle with the stresses of the recession.

Two of the respondents did not foresee future changes to children’s health (17% of the sample). This finding is also consistent with the literature. Current research clearly illustrates ways in which health care coverage for children zero to five years old provides a larger safety net than public coverage available for adults (UCLA Center For Health Policy Research, 2009, p. 3; Families USA, 2009, p.1).

Interestingly, concerns related to health care for adults focused on potential difficulties that would be felt on a macro level while the concerns for children were centered on the individual affects on the health and future of the child.

**Implications for Future Research**

The budget crisis that struck the state of California has been reported to be the worst economic recession in the state since the Great Depression (Center on Budget and Policy Priorities, 2009b; Center on Budget and Policy Priorities, 2010, States Deficit sec.; Center on Budget and Policy Priorities, 2010c; Baker, 2009, para. 2). Due to the historical nature of the event, it is necessary for policy makers, social workers, and the public to be aware of how public health care services are being impacted by budgetary decisions. For this reason, it is crucial that more studies be conducted to examine how services and clients are being affected as the recession continues. As a result of the small
sample size in this study, the conclusions cannot be generalized to the actual effects of the current crisis, making the need for further research greater. Based on this researcher’s experiences during the study, she will make suggestions for conducting similar research in the future that can potentially provide more extensive and detailed conclusions.

One possible way in which to carry out future research on this subject might be to have the county conduct the research project. While the county is likely to hold strong biases, it would have the easiest access to agency administrators as well as agency information. In addition, because the county provides necessary resources to the health care agencies, administrators are more willing to find the time to participate in the study. Although a study conducted from within the county is likely to provide a greater breadth of data, there is the possibility the information gathered and/or presented may not accurately represent what is occurring. The authority position of a county researcher could possibly influence what agency representatives are willing to share. Additionally, the county might decide to share only the information which benefits it in some way. In other words, county officials would have the greatest access to respondents, but one must question the results presented in the study.

For a researcher who is not affiliated with the county who chooses to conduct further research, a snowball sampling method of agencies might be more successful. Many of the administrators contacted knew administrators of other agencies. It is possible that some agency representatives might be more willing to meet with an individual referred by another colleague than a stranger cold calling and asking for an interview. In addition, this researcher experienced a higher response rate from
administrators to whom she contacted by email, as opposed to by telephone. Unfortunately, email addresses could not be found for the majority of agencies on the list. Future researchers might consider finding an agency list which contain email contacts for agency representatives.

Researchers attempted to interview clients who access the services provided by the sample of health care agencies. Unfortunately, researchers did not anticipate running into issues related to Health Insurance Portability and Accountability Act (HIPPA) when accessing this sample. Future researchers will need to find a sampling method for clients of health care services that do not interfere with HIPPA. If this researcher were to sample health care clients again, she would use a snowball sampling method.

Another challenge with this study is related to the fact that the state is currently in the midst of this recession. The state, counties, and health care agencies have not yet felt the full impact of this economic crisis. In fact, analysts are predicting the recession may still get worse, stating that many states will experience budget shortfall as big or bigger in 2011 (Center on Budget and Policy Priorities, 2010b, para. 1). In order to understand how health care services have been affected by the crisis, which began in late 2008, researchers might want to wait another year or two, after the worst of the recession has passed. Data gathered at this time is likely to portray a more accurate picture of how health care services have been impacted by budgetary cut backs.

Implications for Policy

This study examined how policy enacted prior to the 2008 budget crisis and policy decisions stemming from this crisis have impacted health care for children zero to
five years old in Sacramento County. The study also examined how these decisions have affected health care for uninsured and underinsured adults. Based on the findings, social workers and policy makers can gain insight regarding the positive, negative, and unintended consequences of these decisions during the initial stages of the state’s recession.

According to the literature, the health care policies designed to cover young children, such as Medi-cal programs for children, Healthy Families and Healthy Kids, have been enacted as a means of ensuring this population is able to access health care services no matter the economic status of their families. This has created a public health care safety net which has become far larger than that available to low-income adults. The findings of this study are consistent with the literature, showing that programs serving children have experienced fewer impacts during the current recession than health care programs serving other adult populations. While further research needs to done to verify these findings, one might consider societal, community, and individual benefits to a larger public health care system for both for children and for adults.

Summary

It appears to be clear that the 2008 budget crisis in California has negatively impacted health care services in the state, and this study has given researchers reason to believe these negative impacts have been felt by health care agencies in Sacramento County. The majority of agencies in this study reported increased work loads and patient loads, negative impacts to programs and services, and a need to prioritize programs to cut or a need to find new sources of funding. In addition, researchers can infer findings
based on the high number of agency administrators who declined to participate in this study. Their unwillingness and/or inability to participate gives an indication of the stress and the challenges they are facing within their agencies, quite possibly as a result of the current budget crisis.

It is also apparent that children between the ages of zero and five years old are eligible for a broader range of public health care coverage than adults, thereby creating a larger safety net for this population during the state’s current recession. The findings from this study have indicated this safety net is providing protection to health care programs that serve this population. Despite the reports of multiple negative impacts to programs serving uninsured and underinsured adults, programs for young children only reported increased patient loads which lead to increased waiting periods.

Further research needs to be done in order to gain a greater understanding of how the 2008 economic crisis is impacting health care services for children between the ages of zero and five years. The findings from this study, while narrow in scope, show promise for the strength of the health care safety net California has worked hard to put in place for this population. Should future research result in similar findings, then policy makers and society in general will have a lot to learn from the policies in place for young children and will hopefully begin to expand them to the general public.
APPENDIX A

Human Subjects Approval Form

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

DIVISION OF SOCIAL WORK

TO: Jennifer Dobbins

Date: October 27, 2009

FROM: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “The Effects of the 2009 California Budget Crisis on Health Care Agencies Serving Children 0-5 years of age” has been__X__ approved as _____EXEMPT _____NO RISK _____MINIMAL RISK.

Your human subjects approval number is: 09-10-030. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Teiahsha Bankhead, Chrys Barranti, Andy Bein, Joyce Burris, Maria Dinis, Susan Eggman, Serge Lee, Kisun Nam, Sue Taylor

Cc: Dr. Teiahsha Bankhead
APPENDIX B

INTERVIEW QUESTIONS FOR HEALTH ADMINISTRATIVE PROFESSIONALS/STAFF

General Agency Questions:

1. Please describe the top 3-5 programs/services this agency offers.
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2. Please describe the specific populations that benefit from each of these programs.
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3. Has client eligibility for health services changed as a result of California’s current budget crisis?
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4. How does your agency prioritize which programs or services to keep and which programs to cut?

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5. In relation to California’s current budget crisis, which programs within your agency have been (negatively) impacted the most?

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6. How has California’s budget crisis impacted the employees of this agency? (i.e. Have employment rates, case loads, and the number of out-referrals changed within the last 12 months? What has been the impact of these changes to employees?)

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7. How has the quality of care for patients been impacted due to the state’s budget cuts and decreased funding?

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8. What may be the long-term effects of the state’s current tightening of the budget in relation to health care?

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9. What was your annual budget for 2008-2009?

   ____ Less than $50,000
   ____ $50,001-$100,000
   ____ $100,001-$300,000
   ____ $300,001-$500,000
   ____ $500,001-$700,000
   ____ $700,001-$900,000
   ____ $900,001-$2,000,000
   ____ $2,000,001-$3,000,000
   ____ $3,000,000 +
   ____ Unknown
10. What is your annual budget for 2009-2010?

_____ Less than $50,000
_____ $50,001-$100,000
_____ $100,001-$300,000
_____ $300,001-$500,000
_____ $500,001-$700,000
_____ $700,001-$900,000
_____ $900,001-$2,000,000
_____ $2,000,001-$3,000,000
_____ $3,000,000 +
_____ Unknown

11. Approximately how many patients does your agency currently serve?

_____ 100-200  _____ 701-800
_____ 301-400  _____ 801-900
_____ 401-500  _____ 901-1,000
_____ 501-600  _____ 1,000 +
_____ 601-700  _____ Unknown

**Children Ages Zero to Five Population:** The next section of questions will request information that is specific to this age group.

12. What type of insurance, if any, does a child need in order to be seen at this agency?
13. How have eligibility requirements for children ages zero to five been affected by the budget crisis?

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14. Has this agency seen any changes in outreach services provided to inform potentially eligible participants during the current budget crisis?

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15. What services/programs does this agency provide for families with children zero to five years of age?

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16. Which services do children zero to five seek most frequently at this agency?

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17. How have these services been affected by the current economic situation?

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18. How has this agency prioritized its services in order to insure children can receive the care they need during the budget crisis?

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19. How do you believe children’s health will be affected in the future due to the recent budget crisis?

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Women’s Health: The next section of questions will request information that is specific to this group of people.

20. How long has this agency provided services specific to women? (Please check the best response.)

_____ 1-10 years
_____ 11-20 years
_____ 21-30 years
_____ 31-40 years
_____ 41-50 years
_____ 51-60 years
_____ 61-70 years
_____ 71-80 years
_____ 81 + years
_____ Unknown

21. What is the age range of women who seek out services at this agency? (Please check all that apply to the agency.)

_____ 0-17 years
_____ 18-24 years
_____ 25-30 years
_____ 31-40 years
_____ 41-50 years
_____ 51-60 years
_____ 61 & above
22. Please describe the services and/or programs this agency offers specifically for women’s health.

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23. How have services specific to women's health been eliminated or reduced due to the recent budget crisis?

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24. How have female patients/clients been impacted by the elimination or reduction of services?

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25. How have employees who specialize in women’s health been impacted by the current budget crisis?

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26. How have eligibility requirements for women seeking health services been affected as a result of current the budget crisis?

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27. How has the budget crisis impacted you decision-making and the agency’s priorities surrounding programs geared towards women’s health?

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28. How have you seen women’s health be impacted by the change in services?

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29. What services pertaining to women’s health are most important to you?

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30. How may women’s health be impacted in the long run if the services are cut?

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Undocumented Immigrant Population: The next section of questions will request information that is specific to this group of people.

31. Please describe the top five programs and/or services this agency offers specifically to undocumented immigrants.

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32. How do undocumented immigrants receive information regarding the services this agency provides?

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33. What types of insurance does this population require in order to receive services from this agency?

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34. What challenges does this population face when gaining access to health care services at this agency?

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35. How do agency employees respond to the needs of undocumented immigrants seeking services?

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36. What health needs does this population present that the agency has difficulty managing?

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37. How have the programs and/or services offered to undocumented immigrants been impacted by the current economic situation?
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38. How is the undocumented immigrant population’s ability to receive adequate care being impacted by any funding cuts within the agency?
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39. What is your job title within the agency? ___________________________________ 

Today’s Date: _______________    Interviewer/Researcher: _______________
APPENDIX C

INTERVIEW QUESTIONS FOR CLIENTS

Children Ages Zero to Five: The following questions request information that is specific to this group of health care recipients.

1. Do you have health care coverage for your child? ___________

*If yes, what types of coverage do you have? (Continue to question 2)
*If no, for what reasons do you not have health coverage? (Skip to question 3).

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2. What health care programs does your child utilize?

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3. Which two programs do you feel are the most important/beneficial for your child?
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4. What challenges are you facing in accessing or maintaining health care for your child?
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5. How do you believe the current economic situation is impacting your child’s access to health care?
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6. How do you believe the current economic situation is impacting the quality of care your child is receiving?

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Women: The following questions request information that is specific to this group of health care recipients.

7. What types of health services do you feel are most important to women?
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8. What are some barriers to health care and medical services women may face?
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9. What types of programs specific to women’s health do you use?

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10. As a woman, do you feel that you receive quality health care that meets your specific health needs? Please explain.

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11. Please describe any changes in your ability to obtain health coverage and/or medical services in the past 5 years.

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Undocumented Immigrants: The following questions request information that is specific to this group of health care recipients.

12. Please describe any health coverage or benefits you receive. If you do not have health coverage, please explain why.
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13. What types of medical services or health programs do you use?
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14. Do you use emergency care or primary care for your health needs? Please explain why.
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15. Do you feel that the medical care you receive is adequate? Please explain.

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16. How does health care in the U.S. today compare to the health care you have received in your home country?

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17. Please describe any changes in your ability to obtain medical services or care in the last 5 years.

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18. In what ways is the health care you receive being impacted by California’s current economic situation?
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Demographics:

Please respond and check the section that best applies to you.

19. Age:  
18-24  25-30  31-40

41-50  51-60  61 & above  Decline to Answer

20. Sex/Gender:  
Female  Male  Decline to Answer

21. Ethnic Identification:  
_____ African American/Black  
_____ Asian/Pacific Islander  
_____ Latino/Hispanic  
_____ White/Caucasian  
_____ Other  
_____ Decline to Answer
22. Citizenship Status:  
_____ U.S. Citizen  
_____ Non-citizen of U.S. (Undocumented Immigrant)  
_____ Work Visa  
_____ International Student Visa  
_____ Other  
_____ Decline to Answer

23. Number of family members in your household: ______________________________

24. Number of children ages 0-5 in your household: ______________________________

25. Number of adult women in your household: _________________________________

26. Occupation: __________________________________________________________

Today’s Date: _______________    Interviewer/Researcher: _______________
APPENDIX D

Consent Form - Administrators

Study on the Effects of the Budget Crisis on Health Care Agencies and Their Clients

I ______________________________ have been asked to participate in a research study conducted by Jennifer Dobbins, a current M.S.W. student at Sacramento State University.

Purpose:
I understand the purpose of this study is to determine the effects of the current budget crisis on health care agencies and their clients.

Duration:
I understand the interview will take approximately one hour.

Procedures:
I will be asked to answer questions about the agency, the programs provided, the populations served, and the impact of the budget crisis.

Risks/Discomforts:
It has been explained to me that there is no risk presented to me in participating in this study.

Benefits:
I understand that the benefits of my participation in this study can help researchers to better understand how the current budget crisis is impacting health care agencies and the individuals they serve.

Confidentiality:
I understand that no identifying information will be asked during the interview or used in the project.

Right to Withdraw:
I understand I have the right to withdraw from participating in this study at anytime throughout the interview. I understand that once interview has been completed and filed it cannot be withdrawn because it contains no identifying information, such as name, address, or identifying code, which will allow it to be identified as mine and removed.
Signatures:
I have read the above consent form in its entirety and understand my rights as a potential research subject. I voluntarily consent to participate. I have been informed and understand I can contact Jennifer Dobbins, her project advisor Dr. Teiahsha Bankhead, or the Sacramento State University Institutional Review Board with any further questions regarding this research study.

______________________________  _______________
Participant Signature     Date
APPENDIX E

Consent Form - Clients

Study on the Effects of the Budget Crisis on Health Care Agencies and Their Clients

I ______________________________ have been asked to participate in a research study conducted by Jennifer Dobbins, a current M.S.W. student at Sacramento State University.

**Purpose:**
I understand the purpose of this study is to determine the effects of the current budget crisis on health care agencies serving children zero to five and their clients.

**Duration:**
I understand the interview will take approximately one hour.

**Procedures:**
I will be asked to answer questions about the my experiences with my health care agency.

**Risks/Discomforts:**
It has been explained to me that there is a small risk that the questions presented could create some personal discomfort.

**Benefits:**
I understand that the benefits of my participation in this study can help researchers to better understand how the current budget crisis is impacting health care agencies and the individuals they serve.

**Confidentiality:**
I understand that no identifying information will be asked during the interview or used in the project.

**Right to Withdraw:**
I understand I have the right to withdraw from participating in this study at anytime throughout the interview. I understand that once interview has been completed and filed it cannot be withdrawn because it contains no identifying information, such as name, address, or identifying code, which will allow it to be identified as mine and removed.
Signatures:
I have read the above consent form in its entirety and understand my rights as a potential research subject. I voluntarily consent to participate. I have been informed and understand I can contact Jennifer Dobbins, her project advisor Dr. Teiahsha Bankhead, or the Sacramento State University Institutional Review Board with any further questions regarding this research study.

__________________________________  _______________
Participant Signature               Date
Researcher Contacts:

Jennifer Dobbins
Jdobbs11@aol.com
530-305-3898

Dr. Teiahsha Bankhead
Bankhead@csus.edu
916-278-7177

Referrals:

Adult Access Team
Monday-Friday
8:00 AM-5:00 PM
Call: (916) 875-1055 or 1 (888) 881-4881
Interpreter services available

The Effort
8233 E. Stockton Blvd., Bldg. D
Sacramento, CA  95828
&
6015 Watt Avenue, #2 No.
Highlands, CA 95660
Call: (916) 875-1055 or 1 (888) 881-4881

CSH Wellness & Recovery Center
North Area: 3815 Marconi Avenue, Suite 1
Sacramento, CA 95821
(916) 485-4175 or walk-in.

South Area: 7000 Franklin Blvd., Suite 110
Sacramento, CA 95823
South (916) 394-9195
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