



Covering Kids & Families

An RWJF national program

SUMMARY

The *Covering Kids & Families* (CKF) national program was designed to find, enroll and retain eligible children and adults in federal and state health care coverage programs.

In Part 1 of the program, statewide and local coalitions in 45 states and the District of Columbia participated.

- Conducted outreach to enroll eligible children and families in Medicaid and the Children's Health Insurance Program (CHIP)—formerly known as the State Children's Health Insurance Program (SCHIP).
- Promoted strategies for simplifying the eligibility, application and renewal processes.
- Encouraged better coordination of CHIP and Medicaid enrollment procedures, including a joint application and renewal form to improve access to the appropriate program.
- Implemented an electronic referral system between Medicaid and CHIP programs.
- Coordinated with federally subsidized school meals and the Supplemental Nutrition Assistance Program to determine potential eligibility for CHIP or Medicaid.

Eighteen local coalitions also participated in the *Covering Kids & Families* Access Initiative, intended to improve access to health services for children, adults and families covered by public health insurance programs.

Later, the five states not receiving grants in this phase—Kansas, Montana, South Carolina, South Dakota and Vermont—received liaison awards to conduct statewide communication campaigns, convene annual statewide meetings of stakeholders and attend *Covering Kids & Families* regional and national meetings.

From 2003 to 2006, GMMB, a strategic communications and advertising firm, worked under contract to the Robert Wood Johnson Foundation (RWJF), and in partnership with staff from the *Covering Kids & Families* national program office, to guide the Back-to-School campaign. That annual campaign used an integrated communications approach to inform parents that low-cost or free health care coverage might be available to their

uninsured children, and to generate calls to a national toll-free hotline. GMMB also provided technical assistance to the state projects as they developed and implemented their own marketing campaigns at the state and local levels, helped state coalitions with fundraising, created communications materials to guide outreach and helped with the program website.

[Mathematica Policy Research](#), based in Princeton, N.J., working with two subcontractors, Health Management Associates based in Lansing, Mich., and the Urban Institute in Washington conducted an evaluation of the program from 2001 through 2008. In addition, Carolyn Needleman, Ph.D., of Social Research Associates, evaluated the first phase of the *Covering Kids & Families Access Initiative* (ID# 059268). She reported her findings in *Follow-Up Evaluation of the Covering Kids & Families Access Initiative: Lessons from the 18 CKF-AI Grantees*.

Key Results from the National Program Office

- From 2000 to 2007, the total number of children enrolled in CHIP doubled, from 2.2 million to 4.4 million, according to the Kaiser Family Foundation. Kaiser data also indicated that total Medicaid enrollment increased from 32.6 million in December 2000 to 42.1 million in December 2006.

Although *Covering Kids & Families* was not the only program or organization working on this issue, “growth of enrollment in many states can be linked to policies and procedures that CKF grantees advocated,” according to the evaluation.

- The 18 Access Initiative grantees documented barriers that impeded access to health care services and then developed and tested strategies to address these barriers. Projects reported progress in:
 - Reducing language barriers
 - Improving prescription drug access
 - Developing health literacy and community health worker programs
 - Improving medical transportation
 - Rethinking emergency room services
- Every year, calls to the national toll-free number inquiring about available health coverage for children increased significantly during the annual Back-to-School campaigns. In 2006, the last year of the campaign, calls increased 248 percent by the end of the campaign, compared to the period before it was launched.

Key Evaluation Findings

Evaluators from Mathematica Policy Research reported in their final report, *Covering Kids & Families: A Continuing Program for Increasing Insurance Coverage in Low-Income Families*, that:

- Coalitions are an effective model for encouraging change. *Covering Kids & Families* grantees in each state were lead agencies for coalitions that included advocacy, health and social service organizations, government agencies and academic partners. These coalitions were able to build effective relationships and influence new approaches to increasing enrollment in public insurance programs.
- *Covering Kids & Families* helped influence the adoption of numerous measures to simplify and coordinate public health insurance enrollment and renewal. State officials reported that coalitions had an influence on at least 183 separate policy changes from 2002 through 2006, such as limiting documentation requirements, simplifying application forms and combining the Medicaid and CHIP applications. Most of these policies remained in effect two years beyond the grant period, according to state officials.
- Eighteen months after grant funding ended, half the *Covering Kids & Families* grantee projects and two-thirds of the coalitions were continuing at least some of their efforts to maximize enrollment in health coverage programs.
- In 2007, 83 percent of the 183 policy changes that were influenced by *Covering Kids & Families* between 2002 and 2006 remained fully in effect; in 2008, 75 percent remained fully in effect.

Other published evaluation reports include:

- [Topic briefs](#) that cover key findings from the evaluation
- Reports of lessons learned organized by key themes:
 - [Access to care](#)
 - [Coalitions](#)
 - [Economic and political barriers](#)
 - [Grantees](#)
 - [Outreach](#)
 - [Retention](#)
 - [Simplification and coordination](#)
 - [Sustainability](#)

— Policy change

- **Case studies** of 10 states (Arkansas, California, Illinois, Kentucky, Michigan, Missouri, New Jersey, North Carolina, Oregon and Virginia); a synthesis of the case studies is also available [online](#).

The case studies examined trends in new Medicaid and CHIP enrollment. In particular, these reports covered the potential links between new enrollment trends and major outreach strategies of policy changes that took place at the state and local level, especially those associated with a *Covering Kids & Families* project. Findings in the synthesis report include:

- In many states, *Covering Kids & Families* and state staff collaborated effectively on outreach and simplification.
- Many *CKF* projects adopted aggressive outreach, at both the local and state levels.
- States adopted numerous policies during the grant period aimed at simplifying program procedures and coordinating CHIP and Medicaid, including simplified forms, joint forms, elimination of face-to-face interviews, centralized eligibility processing and self-declaration of income.
- *CKF* grantees (and their partners) influenced many of these policies.
- Budget and other challenges slowed progress in many states, though political/public support for children’s coverage offered a potential counterweight.
- Major enrollment increases were evident in many states, some with close links to policy.

Management

The [Southern Institute on Children and Families](#), a public policy nonprofit organization in Columbia, S.C., administered the program and provided technical assistance and guidance to the grantee organizations. [Center for Health Care Strategies](#), a nonprofit health policy resource center in Hamilton, N.J., directed the Access Initiative.

Funding

The RWJF Board of Trustees authorized *Covering Kids & Families* in April 2001 for up to \$68 million.

THE PROBLEM & RWJF STRATEGY

In 1997, federal legislation authorized the Children’s Health Insurance Program (CHIP)—formerly known as the State Children’s Health Insurance Program (SCHIP)—to expand coverage to uninsured children. The U.S. Census Bureau reported that some 11

million children had no health insurance in 1998. The expansions meant that more than three-quarters of all uninsured children were eligible for public coverage by CHIP or Medicaid, but were not enrolled, according to an Urban Institute brief in the series “New Federalism: National Survey of America’s Families.” (B-35, “Why Aren’t More Uninsured Children Enrolled in Medicaid or SCHIP?” by Haley JM and Kenney GM)

Barriers Remain

A 2000 survey conducted by the research firm Wirthlin Worldwide found that six out of 10 families with eligible but uninsured children were not aware that their children could be covered by Medicaid or CHIP.

Even when families recognize their eligibility and try to sign up, they can face significant barriers. Editors Stephen Isaacs, J.D., and David Colby, Ph.D., in their introduction to “Enrolling Eligible People in Medicaid and the State Children’s Health Insurance Program,” a chapter in Volume XII of the *RWJF Anthology* (2009) explained why:

Forms are often long and complicated; eligibility requirements vary among programs and change frequently; documentation requirements can be onerous; legal immigrants face both language and cultural problems; and intake workers, concerned about fraud, can make the enrollment process difficult. Once enrolled, benefits last only for a limited period before eligible people have to go through the whole enrollment process again.

Moreover, the greater the number of people enrolled in Medicaid and CHIP, the greater the strain on state budgets, giving state governments an incentive to keep enrollment low, especially in hard economic times.

A further complication in some communities is that children may not have adequate access to health care providers even after they are enrolled in public programs. Multiple studies found that some families receiving Medicaid paid out-of-pocket for benefits that were supposed to be covered, deferred treatment until an illness became a crisis or used emergency room services that cost a great deal more than care in a physician’s office, poorly fit their health needs and marked them as “over users.” More importantly, too many people with Medicaid coverage went without professional health care altogether.

Making Inroads

To address these barriers, in 1999 RWJF began an ambitious decade-long effort to increase the health insurance coverage of lower-income children nationwide. First, RWJF implemented *Covering Kids*, a \$47 million national program that supported state and local organizations aiming to increase enrollment of children in Medicaid and CHIP. See [Program Results](#) for more information.

RWJF structured *Covering Kids* to achieve three goals through public-private partnerships—outreach to identify and enroll eligible children in Medicaid and CHIP, simplification of the enrollment process and coordination of existing health care coverage programs.

Covering Kids helped to change the culture within many public programs, making them easier to navigate, more “consumer friendly,” and less demeaning or stigmatizing. The number of uninsured children in the United States dropped from 11 million in 1997 to 8 million in 2002, and more than 4,000 organizations nationwide were actively engaged in finding, enrolling and retaining eligible children in public health insurance programs.

To augment the program, RWJF earmarked another \$26 million in 2000 for a four-year market research and communications campaign to publicize the availability of health insurance for children. As part of that effort, RWJF launched its first Back-to-School campaign, which used a host of communications strategies and partnerships to remind parents that low-cost or free health care coverage may be available to their uninsured children, and to generate calls to a toll-free hotline. The *Covering Kids* communications campaign is described in [Chapter 10](#) in Volume VI of the *RWJF Anthology*.

In a separate initiative, RWJF authorized \$5.9 million for *Supporting Families after Welfare Reform: Access to Medicaid, SCHIP and Food Stamps*. That national program ran from 2000 to 2003 to combat a trend in which families moving from welfare to work were losing their health insurance and other public benefits, even though many of them were still eligible. See [Program Results](#) for more information.

The Southern Institute on Children and Families administered both the *Covering Kids* and *Supporting Families After Welfare Reform* programs.

Continuing the Effort

In May 2001, RWJF launched *Covering Kids & Families* as a \$68 million successor national program to *Covering Kids*. The added emphasis on families aimed to take advantage of new coverage options for lower-income parents under Medicaid and CHIP. The program also was responding to research showing that when parents are insured, they are more likely to seek timely care for their children. To address the access issue, the

program added a new component—the Access Initiative—to support some states in identifying access barriers and designing interventions.

PROGRAM DESIGN

The goals of *Covering Kids & Families* (CKF) were to:

- Reduce the number of uninsured children and adults who are eligible for coverage through Medicaid or the Children's Health Insurance Program (CHIP) but remain uninsured
- Build knowledge, experience, commitment and capacity to sustain the enrollment and retention of children and adults in Medicaid or CHIP beyond the grant period

RWJF required *Covering Kids & Families* grantees to use three strategies to meet these goals:

- Outreach to encourage enrollment in CHIP and Medicaid
- Simplify CHIP and Medicaid policies and procedures to make it easier for families to enroll their children and keep them in the programs
- Coordinate between CHIP and Medicaid to ensure that families are enrolled in the appropriate program or transition easily between programs if their eligibility changes

RWJF envisioned state and local coalitions as the primary change agents for overcoming barriers to enrollment because their members often had the trust of families and the influence to overcome bureaucratic enrollment barriers.

A Three-Part Program

The program had three parts:

- Part 1: Enrolling and retaining eligible children
- Part 2: Enrolling and retaining eligible adults
- Part 3: Improving access to health services for covered children, adults and families

Under the 2001 call for proposals, applicants could apply for funding under Part 1 or Parts 1 and 2, but not Part 2 only. A year later, RWJF issued a separate call for proposals for Part 3. Only *Covering Kids & Families* coalitions that had already been funded could apply for Part 3.

Part 1: Enrolling and Retaining Eligible Children

RWJF set aside \$45 million to support statewide and local coalitions in up to 50 states and the District of Columbia to find, enroll and retain eligible children in existing public

health insurance coverage programs. Grant funds could range from \$500,000 to \$1 million over four years, depending on the scope of the state's uninsured problem and the applicant's proposed strategy to remedy it.

A lead organization in each state was to support both a statewide coalition and at least two local, broad-based coalitions that would serve as learning laboratories for the statewide coalition. At least half of RWJF funds were to be used to support the local coalitions.

To receive a full grant award amount, grantees had to obtain matching funds from other sources, equal to or greater than 50 percent of their four-year allocation from RWJF. The match had to be used no later than the beginning of year three of the grant period. The intent of the match requirement was to help projects look beyond the RWJF resources and start early to plan for long-term sustainability.

The projects carried out by the local coalitions also had to focus on outreach, enrollment and renewal simplification and coordination.

Part 2: Enrolling and Retaining Eligible Adults

RWJF set aside \$6 million to support coalition activities in up to 30 states targeting adults eligible for existing public health insurance programs. These funds were not subject to the 50 percent match requirement. Funds were available to two categories of applicants:

- The 19 states that had already expanded coverage to adults at or above 100 percent of the federal poverty level before *Covering Kids & Families* started were eligible to receive up to \$200,000 over a four-year period to find, enroll and retain uninsured adults in their existing health care coverage programs.

These applicants had to apply for Part 2 funds when they submitted their Part 1 applications. As with Part 1, Part 2 applications were required to involve both statewide and local coalitions (which were to receive at least half of the funding).

- In states that had been awarded Part 1 funds but had expanded coverage to adults at or above 100 percent of the federal poverty level after the initial application deadline for *Covering Kids & Families* had passed, coalitions could apply for Part 2 funds.

Part 3: Access to Health Services

RWJF set aside \$4 million over two years for the *Covering Kids & Families* Access Initiative, intended to improve access to health services for covered children, adults and families; grants were made to local level grantees.

During the first year of the Access Initiative (Phase I), each grantee was to investigate access barriers by collecting data directly from affected families and health care providers in their local area. The grantees would then move into Phase II in which they would:

- Select one or two barriers based on their Phase I findings
- Develop site-specific intervention strategies for addressing the barriers
- Field the interventions as pilot programs

Grantee Qualifications

The *Covering Kids & Families* initiative accepted only one application per state, from a lead agency working with a statewide coalition.

The lead agency could be a child advocacy organization; a medical or hospital association; a civic, educational, religious or philanthropic organization; a state government agency; or some other group with a statewide reach. Applicants had to have experience enrolling lower-income children and families in health care coverage programs, be capable of assuming a statewide leadership role, demonstrate capacity to direct local coalition projects and offer evidence of their qualifications to achieve the initiative's three goals. Grantees that had participated in the *Covering Kids* program were required to reapply for *Covering Kids & Families* and demonstrate that they could fulfill the program requirements.

At a minimum, the statewide coalitions had to include child advocacy organizations, provider groups, private health plans, business representatives, state officials with oversight over Medicaid, CHIP, Temporary Assistance for Needy Families (TANF) and education, and representatives of the local *Covering Kids & Families* coalitions.

By requiring grantees to include state Medicaid and CHIP officials in their coalitions, RWJF hoped to encourage relationships that would increase program enrollment and change enrollment and retention policies, making these programs easier for children and families to access and stay enrolled in.

Additional Program Components

In addition to direct grants to support the state coalitions, RWJF allocated funds for these program components:

- \$10 million for technical assistance and direction by the national program office
- \$1 million to plan an evaluation strategy, followed by \$6.95 million for the evaluation
- \$2 million for a special opportunities fund to respond quickly to new opportunities, such as policy analysis, convening of experts and technical assistance

RWJF also continued to fund the annual Back-to-School advertising campaign that encouraged parents of eligible, uninsured children to put enrolling them in Medicaid or CHIP at the top of their back-to-school checklist.

THE PROGRAM

National Program Office

The Southern Institute on Children & Families, a Columbia, S.C.-based nonprofit organization working to improve the well-being of children and families, was the national program office of *Covering Kids & Families*. The group also had served as the national program office for *Covering Kids* and *Supporting Families After Welfare Reform*.

The *Covering Kids & Families* national program office was responsible for:

- Organizing and administering the grant review process
- Providing technical support to statewide and local projects and coalitions
- Conducting monitoring activities
- Facilitating communication among the grantees and other organizations through publications, listservs, the national website and national and regional meetings
- Administering the \$2 million special opportunities fund. The *Covering Kids & Families* team at RWJF reviewed and voted on projects to be funded through this mechanism. It allowed for quick support of projects that would help advance the work of the program such as policy analysis, convening and needed technical assistance. Ideas were generated by the RWJF team and the national program office staff.

Sarah Shuptrine, the founder and past president of the Southern Institute, was national program director of *Covering Kids & Families* through the end of the final technical assistance and direction grant in May 2007. Nicole Ravenell and Nancy P. Pursley served as deputy directors, with Ravenell succeeding Shuptrine as president and CEO of the Southern Institute in June 2007. Shuptrine passed away in April 2008.

National Advisory Committee

A national advisory committee provided strategic guidance to *Covering Kids & Families*, reviewed proposals and made funding recommendations to RWJF (see list of members, [Appendix 1](#)).

Choosing the Sites

Prior to grants being awarded, the national program office staff invited teams of three to four people from the applicant states to attend a proposal presentation meeting. At these “reverse site visits” prospective grantees presented their proposals, met with RWJF staff, national program office staff and advisory committee members and received technical assistance to fine-tune their proposed projects. RWJF staff, national program office staff

and national advisory committee members also made individual site visits to a few applicant states for a more detailed assessment of their proposal projects.

Program staff awarded Part 1 grants to organizations in 45 states and the District of Columbia and Part 2 grants to organizations in 16 of these states.

Lead organizations for the *Covering Kids & Families* projects included:

- State Medicaid and CHIP agencies
- Other state health and human service organizations
- Universities (public health and health services divisions)
- Primary care, health center and hospital associations
- Health care foundations
- Health and human services nonprofit organizations
- Faith-based organizations
- State affiliates of professional organizations

Two-thirds of the grantees also had been grantees of the predecessor program, *Covering Kids*, and three-quarters of them had staff knowledgeable about the Medicaid or CHIP programs.

The five states not receiving Part 1 *Covering Kids & Families* grants—Kansas, Montana, South Carolina, South Dakota and Vermont—received liaison awards of \$50,000 apiece to conduct statewide communication campaigns, convene annual statewide meetings of stakeholders and attend *Covering Kids & Families* regional and national meetings. These states could reapply each year of *Covering Kids & Families* for a \$50,000 grant up to a total of \$200,000.

State and Local Projects

Each grantee was the lead organization of a statewide coalition that was responsible for designing and implementing outreach, simplification and coordination initiatives. See [Appendix 2](#) for a list of all the grantees that were part of the program. In 2003, one-third of state coalition members were community service organizations, one-fifth government entities and one-fifth health plans and providers. The organizational membership of the coalitions remained stable during the grant period.

The statewide grantees also were responsible for selecting and managing more than 140 local projects designed to increase health coverage for lower-income children and families using the same three overarching strategies of outreach, simplification and

coordination. Two-thirds of the local sites had some staff with knowledge of the Medicaid or CHIP programs.

Together, the state and local coalitions comprised a diverse national network of more than 5,500 member organizations.

While grantees devoted considerable attention to outreach, as the economic downturn hit most states strategies to simplify the enrollment process and improve coordination of Medicaid and CHIP became an increasing focus of attention.

Technical Assistance to State and Local Coalitions

Staff at the Southern Institute provided technical assistance and support to the state projects via site visits, meetings and seminars, conference calls, the *Covering Kids & Families* website, listservs and publications. Activities included:

- Some 140 site visits over the grant period to manage the projects and provide assistance
- Some 21 meetings and seminars to give grantees tools to implement their strategies, promote dialogue among the various groups involved in administering public health insurance programs and address issues and barriers
- Two Eligibility Process Improvement Collaboratives designed to improve the processes for determining eligibility, enrolling children and families and retaining them in coverage. Government officials and coalitions members from 21 states participated in at least one of these collaboratives, which were held in 2003 and 2005; seven states participated in both. See the sidebar [Collaboratives Propel Systems Change](#) for more information.
- Nine national conference calls offering technical assistance on an array of topics
- Reports, policy resources, announcements and other information provided for the website
- Two listservs for grantees, one for announcements and one for discussion

See [Appendix 3: Technical Assistance Provided by the National Program Office, Covering Kids & Families](#) for details about these activities.

Communications and Fund-Raising Support

The national program office also contracted with the strategic communications and advertising firm GMMB in Washington to:

- Provide technical assistance to the state projects as they developed and implemented their own marketing campaigns at the state and local levels

- Conduct a communications “boot camp” in November 2003 attended by 250 *Covering Kids & Families* project directors and coalition members. The three-day event provided in-depth media training and workshops on building business relationships, constructing fund-raising plans, forming media partnerships, developing outreach strategies and using market research in the community.
- Provide a fund-raising consultant to help state coalitions that were having trouble meeting the 50 percent funding match required by RWJF for a *Covering Kids & Families* grant
- Create communications materials to guide outreach for posting on the website

The Access Initiative

The Access Initiative, Part 3 of the *Covering Kids & Families* program, was directed by the [Center for Health Care Strategies](#), a nonprofit health policy resource center in Hamilton, N.J. Eighteen *Covering Kids & Families* sites received Access Initiative grants in 2003.

During Phase I, the grantees documented barriers that impeded access to health care services. During Phase II, they developed and tested strategies to address one or two of these barriers. Projects included:

- Reducing administrative barriers related to policies of state agencies, managed care organizations, hospitals or other care providers (a major focus for six projects, a secondary focus for 15 others)
- Educating consumers about system navigation (major focus for six grantees, secondary focus for five others)
- Improving “health literacy” about common illnesses and preventive care within families (major focus for four grantees, secondary focus for one other)
- Educating providers about benefit systems, reimbursement and existing barriers to care (major focus for two grantees, secondary focus for seven others)
- Helping consumers find alternatives to hospital emergency rooms for nonemergency medical services (major focus for two grantees, secondary focus for four others)
- Outreach to individuals and families officially enrolled in public health insurance programs but not connected with the health care system (major focus for two grantees, secondary focus for four others)
- Addressing delivery system problems, such as a lack of medical facilities, unaffordable cost-sharing requirements and providers who fail to comply with mandated standards of care (major focus for two grantees, secondary focus for four others)

- Reducing language and literacy barriers to care (major focus for two grantees, secondary focus for three others)
- Reducing barriers to getting prescriptions filled by pharmacies (major focus for two grantees, secondary focus for two others)
- Reducing medical transportation barriers (major focus for one grantee, secondary focus for two others)

The Center for Health Care Strategies provided technical assistance to the 18 grantee sites, including:

- A workshop giving a program overview and seven conference calls with guest speakers to address access topics, such as emergency department overuse, pharmacy use, after-hours helplines and navigation
- Two annual meetings for grantees to learn from one another and to refine best practices for reducing access barriers
- Publication of *Helping Families Enrolled in Medicaid Access Prescription Drugs*, a resource paper to assist community-based organizations working with families on Medicaid who have problems obtaining prescribed medicine
- Individual assistance to state organizations by phone, e-mail and site visits as needed
- Copies of *Health Care System Assessment*, developed by the Community Service Society of New York and Community Partners. The binder is a self-guided tool for assessing local health care systems to determine how readily they can be navigated by lower-income families.

More information about the [Access Initiative](#) can be found at the Center for Health Care Strategies website. See also [Overall Program Results](#)—the subsection on Access Initiative Activities and Results.

Back-to-School Campaign

From 2003 to 2006, RWJF contracted with GMMB to spearhead four Back-to-School communications campaigns, in collaboration with the *Covering Kids & Families* national program office. The Back-to-School campaign, launched in the summer of 1999, reached millions of families each year with messages about the availability of low-cost and free health coverage through partnerships with the media, corporations, school districts, national not-for-profit organizations, sports teams and others.

The campaign’s message to families is that health care coverage may be available, that enrolling children should be at the top of any “back-to-school checklist” and that healthy kids are better prepared to learn. The campaign provided a national hotline number (1-877-KIDS-NOW) designed to connect families directly to enrollment sites in their states.

The 2003, 2004 and 2005 campaigns differed from previous years in that there was no investment in national or regional paid advertising. By the 2005 campaign, RWJF and GMMB had decided to target populations and states with disproportionately high uninsured populations. Thus, the 2005 campaign sought to reach Latino and African-American working families and concentrated its media outreach in the 10 states where 64 percent of lower-income, uninsured children resided: Arizona, California, Florida, Georgia, Illinois, New York, North Carolina, Ohio, Pennsylvania and Texas. In addition to a national kick-off event in Washington, the campaign held major events that year in Chicago, Houston, Los Angeles, Miami, New York and Philadelphia.

The 2006 campaign resumed paid advertising, investing \$1.84 million in eight target markets—Baton Rouge, La.; Des Moines, Iowa; Helena, Mont.; Houston; Las Vegas; Milwaukee; Phoenix and Seattle. Because of its high price tag, paid advertising was placed where it was most likely to have impact, rather than nationwide.

See [Overall Program Results](#)—the subsection Back-to-School Campaign Activities and Results, for details about the impact of the campaigns.

Supporting the Back-to-School Efforts of the Coalitions

In addition to spearheading the Back-to-School national communication campaign, GMMB supported *Covering Kids & Families* grantees and coalition members and, in addition, national organizations and businesses participating in state and local campaigns by:

- Developing a [Back-to-School Action Kit](#) with tools, templates and guides to planning and implementing a fully integrated communications campaign. A Back-to-School Campaign Planning Center on the *Covering Kids & Families* website featured all of the materials in the action kit in an interactive, user-friendly format for anyone coordinating outreach and enrollment activities
- Hosting technical assistance conference calls with grantees, coalition members, national organizations and businesses and sending out program announcements to grantees through the *Covering Kids & Families* listservs.

EVALUATION

From August 2002 to April 2008, a team of researchers from Princeton, N.J.-based [Mathematica](#) and two partners collaborating under sub-contracts from Mathematica—[Health Management Associates](#) based in Lansing, Michigan and the Washington-based [Urban Institute](#)—conducted an evaluation of *Covering Kids & Families* to determine the impact of RWJF’s investment. Judith Wooldridge, senior vice president and director of strategy and development, at Mathematica, led the research team.

The evaluation was designed to:

- Document and assess the strategies and actions of *Covering Kids & Families* grantees and their coalitions
- Assess the effectiveness of the grantees and their coalitions in conducting outreach, simplifying the application process, and coordinating efforts by public health insurance programs to expand coverage
- Measure progress on the central goal of *Covering Kids & Families*—expanding enrollment and retention of all eligible individuals into Medicaid and the Children's Health Insurance Program (CHIP)
- Assess the sustainability of *Covering Kids & Families* after RWJF funding ended

The evaluation team responded to RWJF's desire for early formative feedback by participating in monthly information-sharing “partner” meetings with staff at RWJF, the national program office and GMMB, and by writing descriptive and analytic “highlight memos” to share with these partners.

The structure of the nationwide program precluded use of a comparison group design. Instead, the evaluation described findings from surveys of grantees, state officials and coalition members and combined exploratory analysis of Medicaid and SCHIP enrollment data with in-depth key informant interviews. Read more about the evaluation's [methods and data sources](#) on the RWJF website.

RWJF posted evaluation findings on its website throughout the grant period in a short, digestible format. Together, the articles, memos and issue briefs provide an in-depth description of every aspect of the *Covering Kids & Families* program. Some of this material was used during the congressional debate about CHIP renewal and expansion in 2008.

Available on the [Assessing the Impact of Covering Kids & Families](#) page on the RWJF website are:

- [Case studies](#) of 10 states; a synthesis of the case studies is also available [online](#)
- [Issue briefs](#) are posted on [rwjf.org](#) that cover key findings from the evaluation
- Chapters offering lessons and findings organized by key topics

Evaluating the Access Initiative

In a separate contract with RWJF, Carolyn Needleman, Ph.D., of Social Research Associates, evaluated the first phase of the *Covering Kids & Families* Access Initiative (CFK-AI) (ID# 059268). A Phase II evaluation of the Access Initiative was led by

researchers at the Urban Institute (working under a subcontract with the main evaluator, Mathematica) with contributions from Social Research Associates.

CHALLENGES & RESPONSES

The *Covering Kids & Families* grantees and coalitions varied considerably in their capacity to carry out the strategies of the program, and many required extensive technical assistance. Among the challenges and efforts to address included:

Strengthening the Coalitions

In a 2003 survey, 16 percent of grantees identified issues related to their coalitions as a significant barrier to achieving the goals of *Covering Kids & Families*. Challenges reported included:

- Recruiting members into the coalition
- Working with the coalition

Some grantees also said they had trouble:

- Getting coalition members to be more “hands-on,” rather than functioning only as a sounding board
- Keeping coalition members enthusiastic about and interested in the work
- Maintaining diversity in coalition membership

To address these issues, Southern Institute staff led two coalition-building seminars—in Tampa, Fla., in October 2005 and Kansas City, Mo., in June 2006—where a total of 52 participants gathered to learn from their peers about promising practices for developing and sustaining effective coalitions. The Southern Institute also hosted conference calls, made site visits to provide support and created a “coalition assessment tool” to help grantees assess their coalitions’ strengths and weaknesses, identify areas for improvement and prioritize strategies and activities.

Addressing Economic Barriers

Shortly after the *Covering Kids & Families* program began, the U.S. economy suffered a major downturn. With state revenues declining and social service demands on the rise, some states began scaling back coverage expansions, eliminating outreach and making other cost reductions in Medicaid and CHIP.

According to a survey by the Center for Budget and Policy Priorities, 34 states cut their Medicaid, CHIP or other state-funded health insurance programs in fiscal years 2003 and 2004, with almost half the cuts affecting children.

Policy changes also threatened enrollment and retention in insurance programs. Some states began requiring Medicaid and CHIP beneficiaries to renew their coverage every six months instead of once a year, virtually insuring quicker disenrollment and lower retention rates.

Some states closed CHIP enrollment altogether. In Florida, the number of kids enrolled in Florida KidCare, the state's CHIP program, dropped by 23 percent when the state effectively closed enrollment from July 2003 through December 2004. The state opened enrollment for one month in January 2005, and the Florida *Covering Kids & Families* coalition scrambled to launch a statewide communications campaign to inform potentially eligible families about it. [Read more about this effort.](#)

The economic situation caused new challenges for the projects. The grantee organizations “tried to be smart” in engaging with state officials, said Lori Grubstein, RWJF program officer, making the case that simplifying and streamlining the enrollment process would bring efficiencies that would save the state money. Simplification, however, proved to be a more difficult strategy than the states or the national program office had anticipated.

The state coalitions also began to think more about the renewal process for insurance programs. “They were asking, ‘What about people falling off the rolls?’” Grubstein said. “‘Are we making it too difficult for them to reenroll? Why are we having this problem where people are enrolled and then they do not renew?’”

To help address these challenges, the Southern Institute tapped the *Covering Kids & Families* “special opportunities fund” to conduct two Eligibility Process Improvement Collaboratives in 2003 and 2005 to identify and change the administrative processes that hampered enrollment and retention. See [Collaboratives Propel Systems Change](#) for more information.

Funding and Turnover

Because a number of grantees were having difficulty meeting the 50 percent match required under the *Covering Kids & Families* award, RWJF funded a consultant through GMMB to help grantees find local support, and all but one project ultimately met or exceeded the match requirement.

Significant staff turnover within grantee and coalition member organizations also threatened the sustainability of activities needed to meet program goals. When staff with many years of experience departed, the absence of institutional knowledge required the national program office to provide technical assistance to new staff in multiple states.

As the RWJF grant period neared completion, some state and local projects also had difficulty finding new agencies to head the coalitions and funding to support their activities. National program staff provided extensive consultation to grantees to help

them develop strategies for sustaining their activities and coalitions beyond the grant period (see [Afterward](#)).

For more details about the barriers, see the June 2007 report *What Prevents State Covering Kids & Families' Grantees from Achieving the Program's Goals? A Synthesis of Findings on Barriers, 2003–2006*.

OVERALL PROGRAM RESULTS

The national program staff and project staff reported most of the following results of the *Covering Kids & Families* program to RWJF; some results appeared in other documents, as noted.

- **The total number of children enrolled in CHIP doubled, from 2.2 million in 2000 to 4.4 million in 2007, according to the Kaiser Family Foundation.** Kaiser data also indicated that total Medicaid enrollment increased from 32.6 million in December 2000 to 42.1 million in December 2006.

While a number of other organizations, including *Covering Kids & Families*, worked on this issue on many fronts, “growth of enrollment in many states can be linked to policies and procedures that CKF grantees advocated,” according to the evaluation.

Outreach Activities and Results

Outreach was the strategy employed most often by the program’s grantees, who conducted school-based outreach, marketing and media outreach, provider-based outreach and community-based outreach.

Collectively, the state and local projects:

- Trained community-based organizations on their states’ outreach strategies, eligibility criteria and application requirements
- Established partnerships with businesses, such as drugstores and grocery stores
- Tailored outreach materials to specific community organizations likely to be in contact with eligible populations. For example:
 - Michigan worked with the Community Health and Social Services Center in Detroit to conduct bilingual outreach to a primarily Latino population.
 - The Virginia project worked with the Consortium for Infant and Child Health, which reached out to schools, child-care settings and faith-based organizations in seven cities.
- Developed unified brands and messages to communicate statewide

- Placed outreach workers in places likely to have contact with eligible children and families, such as emergency rooms and school-based health clinics
- Focused on geographic areas or special populations and circumstances—such as pregnant women, particular ethnic groups and children receiving free or reduced-cost lunches through the National School Lunch Program

Examples of state and local project results:

- Outreach efforts by the Florida *Covering Kids & Families* project helped generate 90,000 applicants for KidCare, the state’s children health insurance program, during the one-month enrollment period in January 2005 that followed the 18-month enrollment hiatus. Read more in the sidebar [Florida CKF Coalition Pulls Out the Stops to Enroll Children](#).
- The coalition in Hawaii collaborated with immigrant service organizations, faith-based groups and ethnic Chambers of Commerce to explain children’s health insurance programs, translate informational materials into 21 languages and sponsor marketing campaigns targeting specific ethnic groups. During the grant period, the population of uninsured children in Hawaii fell from 7 percent of all children to 5 percent.
- A local project called Louisiana Northeast *Covering Kids & Families* hosted a luncheon for human resource directors of 29 major businesses, representing a total of 16,800 employees. With follow-up, project staff was able to persuade a number of businesses to hold enrollment events, provide application assistance, insert applications into paychecks and train human resources personnel to identify potentially eligible families.
- In Nevada, volunteers with the Volunteers in Service to America (VISTA) program distributed information about public health coverage programs and provided application assistance to patients visiting Federally Qualified Health Centers. The centers subsequently contracted with the state to have their staff determine eligibility for coverage.

VISTA workers in Nevada also trained benefits coordinators at tribal clinics and have since become integral players on boards and councils concerned with tribal health. The VISTA program contributed to the state’s 14 percent increase in CHIP participation during the grant period, according to the national program director.

- The Virginia *Covering Kids & Families* coalition collaborated with Anthem, a managed care organization, and the state Medicaid/CHIP office to create a television campaign to reach eligible, uninsured children. Using a parent as a spokesperson, the campaign targeted parents who feel a lot of financial pressure and are not sure how to get health insurance for their children.

The number of applicants who reported television ads as their source of information about the children's insurance program increased 167 percent, according to one project survey.

Simplification Activities and Results

Covering Kids & Families grantees examined barriers that might prevent families from getting through the application process, with an eye toward how people accessed applications, whether they were easy to fill it out and what the verification requirements were. Based on their findings, the coalitions worked with states to simplify enrollment by:

- **Removing policy barriers.** For example, some states eliminated asset tests, face-to-face interview requirements or unnecessary document verification. Some implemented presumptive eligibility, which permits children to be enrolled temporarily in Medicaid and CHIP if they appear eligible while the family completes the full application process. This allows children to receive immediate medical care and allows providers to be reimbursed for delivering needed care.
 - Five states did not require an asset test for Medicaid in 2006 (47 states compared to 42 in 2000).
 - Six states did not require a face-to-face interview at the time of Medicaid enrollment in 2006 (46 states compared to 40 in 2000).
- **Streamlining enrollment bureaucracy.** States worked to improve customer service, to automate their systems, to change their work environment and improve work flow, and to improve communication across systems and workers. Many states now allow applications to be filed online or by mail, and some states also have simplified their renewal process.

Examples of state projects:

- The statewide *Covering Kids & Families* project in Connecticut developed and implemented an automated system that can track the status of Medicaid or CHIP applications by population subgroups. This tool allowed the project staff to document application and enrollment barriers, with the goal of reducing the number of cases denied or closed. They found, for example, that applications for pregnant women were not being processed in a timely manner. Project staff discussed their findings with the state Department of Social Services, which put a new system in place to ensure that processing applications for pregnant women was expedited.
- With support from the Iowa Department of Public Health, the Iowa *Covering Kids & Families* coalition implemented an online Medicaid and CHIP application process that allows families to apply or renew coverage anytime. The state reported that it received more than 50 percent of all applications through the Internet in 2006.

- Pennsylvania expanded COMPASS, its Web-based application system, to handle applications for all social service programs, including health insurance. The *Covering Kids & Families* statewide coalition extensively reviewed each modification of the system. Working through the project’s Eligibility Process Improvement Collaborative, Pennsylvania also tested taking applications by telephone and then expanded the option statewide, based on the results of the small-scale testing.
- The Indiana *Covering Kids & Families* coalition partnered with the state Family and Social Services Administration and the Department of Education to reach potentially eligible but uninsured children through the federally subsidized school meals program. Federal legislation in 2004 mandated that states draw data from other means-tested programs to qualify children for the school meals program. The change prompted the two state agencies to expand their computerized data matching system in order to increase enrollment in health insurance and other means-tested programs. Read more in the sidebar [Indiana—Building Bridges Between Programs to Enroll Eligible Children and Families](#).
- The Utah *Covering Kids & Families* statewide project worked with the Department of Health and the child nutrition programs in the Utah State Office of Education to match data from the school meals program to identify children and families without public health coverage. *Covering Kids & Families* outreach workers in two Utah school districts then helped students and their families apply for coverage. Based on that achievement, the program has been expanded to schools throughout the state.

Coordination Activities and Results

Coordinating CHIP and Medicaid reduces complexity for both applicants and agencies assessing eligibility. Most states currently have coordination measures in place at the time of application, but fewer have effective coordination at the time of renewal.

State *Covering Kids & Families* projects, in partnership with Medicaid and CHIP state partners, used the following strategies to improve coordination:

- Aligned verification requirements for Medicaid and CHIP
- Developed a joint application and renewal form
- Implemented an electronic referral system between the two programs
- Established one common program name and jointly promoted Medicaid and CHIP in marketing and outreach campaigns
- Established ex parte renewal, in which the agency relies on information obtained from sources other than the client, such as state agencies and case file records

See [Collaboratives Propel Systems Change](#).

Examples of state project results:

- The Alabama *Covering Kids & Families* project worked with the state Department of Public Health to connect the separate data systems for CHIP and Medicaid and create an online joint application. This eliminated the burden of transferring paper applications between the two programs, reducing processing time and improving the transition of families from one program to the other.
- The Arkansas *Covering Kids & Families* project collaborated with the state to improve coordination between the Medicaid and CHIP programs. The state simplified the application process by eliminating the asset test, allowing families simply to declare their income, and creating a joint mail-in application. The state also linked the Medicaid and Supplemental Nutrition Assistance Program application processes to promote information sharing.

Combined with improvements in the renewal process, Arkansas was able to reduce the uninsured rate for children in the state from 19 percent to 10 percent during the grant period.

Access Initiative Activities and Results

The 18 states that participated in the *Covering Kids & Families* Access Initiative tackled an array of barriers to health care access during Phase II of the program. The *Covering Kids & Families Access Initiative, Final Evaluation Report* reported these examples:

Reducing Language Barriers

- In North Carolina, hospital emergency departments and the county health clinic were the only places where families with limited English proficiency could reliably get medical interpreter services 24 hours a day. The Access Initiative grantee, the Buncombe County Department of Social Services, recruited and trained a group of Spanish-language medical interpreters, using a rigorous curriculum developed by a university-based expert in medical translation.

These interpreters then provided services through the community's four urgent care centers, which previously had lacked any translation services. This reduced access barriers while also easing the burden on overcrowded emergency departments.

At the end of the grant period, a network of medical interpreters was providing service in several languages.

Improving Prescription Drug Access

- Phase I research by the Texas grantee, the Children's Defense Fund, showed that providers and pharmacists did not fully understand the Medicaid guidelines governing pharmaceuticals, such as co-payment caps, access to emergency supplies and prior authorization policies. As a result, families were having problems getting

prescriptions filled, sometimes going without needed drugs or having to go to the emergency room to obtain medications. In addition, families were not getting accurate information about Medicaid's vision services.

To address these barriers, the Children's Defense Fund focused its Phase II intervention on educating pharmacists, providers and consumers about what was allowable and reimbursable. They organized broad, multi-stakeholder coalitions around the effort, enlisting support from city and state medical and pharmacists' associations, the state's largest children's health plan, existing statewide CHIP advocacy coalitions and the University of Texas School of Public Health.

The educational effort included:

- Heavily attended continuing education workshops for pharmacists and providers
- A large "town hall meeting" to inform the staff of managed care health plans
- Widely distributed consumer educational materials in both English and Spanish

This work has been highlighted at state conferences, in professional newsletters, Medicaid health plan manuals and elsewhere. Feedback from providers, pharmacists and consumers has been positive.

Developing Health Literacy and Community Health Worker Programs

Especially in rural areas and areas with rapidly growing immigrant populations, many grantees found that large numbers of Medicaid families were completely out of touch with the nonemergency health care system.

To address the inappropriate reliance on emergency services, grantees in a number of states developed health literacy and community health worker programs based on the "promotora" (lay health promoters) outreach model. Their outreach efforts included culturally comfortable one-on-one counseling that went beyond consumer education based solely on written materials.

- In rural West Virginia, nonemergency health services had limited hours of availability, leaving families with no option but the emergency room on weekends and evenings. The West Virginia grantee, United Way of Central West Virginia, decided to focus on empowering Medicaid families to better assess and home treat their children's minor illnesses, while recognizing illnesses that genuinely needed emergency care.

Building on an existing "Parents as Teachers" program, they developed a community health worker outreach program to families in their homes and distributed *What To Do When Your Child is Sick*, a reader-friendly book developed by two nurses in California. Self-reported data from parents show increased confidence, the use of more well-child care and declines in emergency room use and number of workdays missed due to children's illness.

Improving Medical Transportation

- In Pennsylvania, Phase I research of the grantee, Philadelphia Citizens for Children and Youth, found that the Medical Assistance Transportation Program was not serving Latino families very effectively. It had:
 - No Spanish-speaking schedulers
 - A policy that prohibited parents from bringing their well children with them when they used the service to transport a sick child to the doctor's office
 - Cumbersome procedures for accessing the service
 - Inadequate interfacing with the public transportation system
 - Insensitivity to consumer satisfaction and cultural concerns

When the state contract for the Medical Assistance Transportation Program came up for renewal, the grantee worked with its state partner, the Pennsylvania Health Law Project, as well as the Pennsylvania Department of Public Welfare to develop the RFP for a new medical transportation contract. It also had a representative on the consumer committee that reviewed the competitive bids.

Once the new medical transportation provider was selected, the coalition worked with the new contractor to make a number of policy changes designed to increase ridership and lower costs.

Rethinking Emergency Room Services

- In Washington State, the Access Initiative grantee, CHOICE Regional Health Network, sought to improve service for Medicaid patients who used the emergency room several times a month for nonemergency health complaints.

Working collaboratively with health care providers and hospital staff, Providence St. Peter Hospital in Olympia, Wash., a CHOICE network member, set up a team to identify a group of frequent emergency room users, look more deeply into their health complaints, and develop treatment supports for their problems, which typically included chronic pain.

The grantee's analysis of the first four patients in this program (all that their time frame would allow) showed that emergency room visits dropped by 50 percent, from an average of 34 in the year prior to the intervention to 17 in the year following it. Patient satisfaction with care improved, as did health outcomes, and the hospital saved an average of \$15,203 per client per year. This small pilot project had 57 participants by the end of the grant period. See [Sidebar](#) to learn about the work of the CHOICE Consistent Care Program after RWJF support ended.

Back-to-School Campaign Activities and Results

The strategic communications and advertising firm GMMB measured the impact of the annual Back-to-School campaigns primarily by comparing the number of calls each year to the national toll-free hotline (1-877-KIDS-NOW) during the pre-campaign period (the first two weeks of July) with the number in the period after the campaign was launched (typically the first two weeks of August). Calls increased by:

- 102 percent in 2003
- 314 percent in 2004
- 260 percent in 2005
- 248 percent in 2006

The enrollment campaign continued to garner attention from the nation's news media year after year, according to GMMB, which attributed the achievement in part to the campaign's compelling message about the health of kids, as well as to a traditional August news lull.

In 2006, the final year in which the Back-to-School campaign was part of the *Covering Kids & Families* initiative, the grantee reported these results to RWJF:

- A total of 102,100 calls were made to the national hotline during August and September to inquire about available health coverage, with calls during the campaign period increasing by 248 percent. Of these, 63,313 (62 percent) came from the eight target markets where paid advertising was used.
- Media coverage of the campaign reached families through 582 television, 421 radio, 328 print and 15 online stories in English and Spanish, generating nearly 267 million media impressions.
- More than 425,000 applications for Medicaid and CHIP were distributed to potentially eligible families through a record 4,386 events and activities, with every state participating. These events included health fairs, enrollment fairs and community campaign kick-off events.
- School districts in 28 states participated in major school-based efforts to reach and enroll eligible children.
- Ten corporate partners promoted *Covering Kids & Families*: the Amateur Athletic Union, Aramark, Capital One Financial Corporation, Giant Food LLC, Kroger Co. Family of Pharmacies, Major League Soccer, National Association of Chain Drug Stores, Pfizer Inc, Stop & Shop and Univision. These partners reached more than 67 million people by promoting the national hotline number on milk cartons, cereal boxes, paycheck inserts, in-store displays, advertising circulars and websites.

- High-profile sports figures and celebrities participated in campaign activities across the country. Eleven Major League Soccer teams held Children’s Health Care Coverage Days at which they distributed information, played public service announcements on the large-screen stadium televisions known as JumboTrons and included ads featuring the national hotline number in event programs.
- Some 210 *Covering Kids & Families* national organizations helped spread the word about the availability of low-cost and free health care coverage to more than 2 million professionals through their websites, newsletters and member communications. For example:
 - The American Federation of Teachers had a *Covering Kids & Families* booth at its annual conference, where an average of 4,000 members gather. Members ordered large quantities of materials and agreed to distribute them at their schools in the fall.
 - The National PTA included information about *Covering Kids & Families* in all of its newsletters (with a combined circulation of about 75,000) and posted an article on its website.
 - Parents’ Action for Children created an animated video that promotes the availability of low-cost and free health care for families and promoted the video to its membership of more than 35,000 parents.
- Paid television ads aired nationally on the Univision network and locally in six markets: Baton Rouge, La.; Des Moines, Iowa; Helena, Mont.; Las Vegas; Milwaukee; and Phoenix.
- More than 2 million fliers, posters, stickers, fans, bookmarks and other materials were ordered from the *Covering Kids & Families* website and distributed at events across the country.
- More than 7,000 products, including toolkits, guides, public service announcements and videos, were downloaded or ordered from the *Covering Kids & Families* website, and used locally in outreach efforts.

Communications

The Southern Institute, the national program office for *Covering Kids & Families*, produced 13 reports and gave presentations and speeches throughout the initiative at the request of state and national organizations (see the [Bibliography](#)). For example:

- Each fall through 2006, Shuptrine, the national program director, spoke at the national Back-to-School campaign kickoff.
- In September 2005, Judi Cramer and Sondra Gardetto, regional coordinators for *Covering Kids & Families*, gave a presentation on the processes, challenges and

accomplishments in building collaborations at the Northwest Health Foundation's second annual Community-Based Collaborative Research Conference.

- Vicki Grant, vice president for process improvement at the Southern Institute, gave three presentations to national audiences on eligibility system process improvement in 2006:
 - Washington Health Foundation's annual Quality Conference
 - National Association for Program Management and Performance Measurement's Professional Development Conference
 - U.S. Department of Agriculture Food Benefits Innovations Conference

At the international level, the World Health Organization (WHO) profiled the *Covering Kids & Families* local project in Houston in its “Voices from the Frontline” Web feature series. The segment was published electronically in April 2006. Of 12 WHO Web profiles, it was the only one featuring a project in the United States.

EVALUATION FINDINGS

The evaluators from Mathematica, Health Management Associates and the Urban Institute reported their final findings in *Covering Kids & Families: A Continuing Program for Increasing Insurance Coverage in Low-Income Families*.

Final Evaluation Findings

- ***Covering Kids & Families* grantees built diverse, experienced and broad-based coalitions that advocated for coverage in their states.**
 - Diverse coalitions began with diverse grantees. The lead agencies for *Covering Kids & Families* were themselves diverse, including advocacy, health and social service organizations, government entities and academic institutions.
 - The *Covering Kids & Families* coalitions represented broad constituencies with well-aligned goals. Most members contributed time, technical expertise, in-kind support and political influence, rather than direct financial support.
- **Coalitions at both the state and local level built effective relationships and encouraged change, taking many different pathways to reach their goals.**
 - Grantee project directors told evaluators that their coalitions helped them overcome an array of policy and economic, program-related and operational barriers to enrolling children.
 - State coalitions that included state officials and state-level advocates who were already connected with policy-makers were effective at influencing government policies and procedures.

- *Covering Kids & Families* grantees and coalition members became “trusted partners” of state agency staff. Long-term relationships developed, with coalitions providing information on legislation, policy changes and program improvements. The coalitions “provided a foundation on which states could build and enhance their community partnerships,” wrote the evaluators.

While some tensions initially occurred, Medicaid and SCHIP officials surveyed in 46 states in 2007 had no negative reports about grantees or coalitions.

- Local coalitions tended to have the trust of low-income families and were able to inform state officials about the need for simpler enrollment processes and other policy changes. For example, the local sites could tell officials that adding documentation requirements would dampen enrollment. The local coalitions could also provide accurate information to their community partners about who might be eligible for SCHIP and Medicaid.
- **Outreach was resource-intensive and a high priority for *Covering Kids & Families* grantees.** About half the state grantees and two-thirds of local grantees reported that two or three major outreach activities consumed the majority of their grant resources. Evaluators found that the most effective outreach strategies were targeted, viable, measurable and adaptable.
 - Community partnerships at the state and local levels appear critical to sustaining quality outreach. In particular, partnerships with community-based organizations had the potential to ensure continued outreach after the grant period ended. Partnerships with businesses, especially those employing low-wage workers, were less successful, partly because they take time to build.
 - State Medicaid and SCHIP officials identified 26 instances in which *Covering Kids & Families* grantees influenced outreach policy and practice. For example, because of their expertise and close ties with state officials, some grantees trained state and local health and human services agency staff to help families apply for SCHIP or Medicaid.
 - School-based outreach appears to be the most promising outreach tactic. Some 60 percent of state and local grantees reported that school-based outreach (often in coordination with the *Back-to-School Campaign*) was a successful way to reach families with children.
 - State budget woes created both challenges and opportunities for outreach. For example, California stopped paying assistants to help families complete applications, and Kentucky, Oregon and Washington ended their statewide outreach programs. Some states reduced outreach with a deliberate intent to slow the growth of Medicaid and SCHIP, and became less cooperative with *Covering Kids & Families* grantees. A handful of states, however, saw the program as crucial for maintaining outreach at a time of state cutbacks.

- Some grantees focused on retention when state cooperation on outreach waned. Realizing that they could make significant enrollment gains by ensuring that fewer eligible children lost coverage, they targeted outreach to those already enrolled and attempted to reduce re-enrollment barriers. Most states supported these efforts despite their budgetary concerns.
- **State SCHIP and Medicaid officials reported that *Covering Kids & Families* grantees influenced at least 183 separate policy or process changes from 2002 through 2006.** Despite the resources the projects devoted to outreach, most of these focused on simplifying enrollment and renewal and improving coordination.
 - More than one-third of the policy or process changes that grantees influenced involved simplifying enrollment, according to state officials.
 - Other policy changes to increase enrollment involved easier renewal processes and eliminating barriers to coordination between SCHIP and Medicaid. For example, coalitions in Washington and Nebraska helped their states implement renewal forms already populated with applicant information. Michigan’s grantee helped the state develop and implement a shortened and combined SCHIP and Medicaid application.
- **Some of the policies and procedures that *Covering Kids & Families* grantees advocated increased enrollment in public health insurance programs.**
 - Rebranding and destigmatizing Medicaid programs appears to increase enrollment. For example, Arkansas brought its Medicaid and SCHIP programs under a common umbrella program, called ARKids, to avoid using the word Medicaid and to ensure that children would be considered for both programs. Coupled with a joint application, these changes sharply increased Medicaid enrollment, and led to smaller increases in SCHIP enrollment.
 - Effective centralized processing appears to boost enrollment. During the grant period, Illinois, Michigan and Virginia were among the states that began to process some or all applications through a single state-based system. This program feature was strongly associated with increased enrollment in Virginia.
 - By contrast, ineffective processing can capsize enrollment growth. In New Jersey, SCHIP program enrollment dropped dramatically over a one-year period when the vendor was unable to process the large number of applications that resulted from an aggressive media campaign to enroll low-income parents.
- **In states with committed leadership and adequate resources, a process improvement collaborative is an effective model for changing Medicaid and SCHIP enrollment and retention processes rapidly and sustaining improved processes.** Successful *Covering Kids & Families* collaborative teams learned methods and approaches that improved processes in the short run and led to positive changes in the philosophy and culture of state administration in the long run. Some of the

changes clearly improved efficiency and conserved resources in ways that probably would not have occurred without the collaborative. Some teams also reported increases in enrollment or retention rates. See the sidebar, [Collaboratives Propel Systems Changes](#).

- **Enrollment is most likely to increase when a number of state and grantee program features coincide.**
 - Important features at the state level included an emphasis on simplified enrollment and better coordination, sustained and intensive outreach, strong leadership and championship of children’s coverage in the state, a willingness to collaborate with advocacy groups closely tied to families, adequate infrastructure and a positive economic climate.
 - Features of *Covering Kids & Families* projects that increased enrollment include coalitions in which state officials were active members; reliable information provided by local pilot sites; and successful efforts to influence simplified enrollment and coordinated coverage strategies. The absence of any one of these factors can limit enrollment growth.
- Strong state champions can offer protection during economic downturns and are an important catalyst for enrollment growth. For example:
 - Because the Arkansas governor was a strong supporter of children’s coverage and coverage expansions, the state pursued significant steps to destigmatize coverage and experienced strong growth in new enrollment despite critical budget problems in 2002 and 2003.
 - In Virginia, the governor’s steady support for children’s coverage led the state to simplify the application process and improve SCHIP and Medicaid coordination, suspend premium payments and introduce a “no wrong door” policy, which allowed children’s applications to be submitted at local Department of Social Services offices or the state’s central processing unit. New enrollments went up as a result.
- **The economic downturn of 2001–2002 resulted in policy changes and spending reductions that reduced enrollment.** Some states cut back outreach (California and Colorado, for example) or froze enrollment (Colorado, North Carolina and others). States also changed the period of eligibility before requiring a new application (from 12 months to six months in Washington, for example).

Earlier Evaluation Findings

Reports of the evaluator’s earlier findings have been published on RWJF’s website, on the page, [Assessing the Impact of Covering Kids & Families](#).

Issue Briefs

The evaluators [Issue briefs](#) cover key findings from the evaluation.

Issue Brief #1: Deficit Reduction Act Citizenship Requirements through the Eyes of Covering Kids and Families Grantees

The Deficit Reduction Act (DRA) of 2005 attempted to reduce the federal budget deficit by implementing changes in a wide range of federal programs, including Medicaid. Among other changes to the Medicaid program, the DRA required that all Medicaid recipients and future applicants prove their citizenship and identity, effective July 1, 2006, or at first subsequent redetermination of eligibility.

Most states had less than five months to develop and implement procedures for complying with DRA citizenship documentation requirements. In July 2006, researchers with Mathematica interviewed 31 state *CKF* grantees to understand how states were implementing DRA citizenship requirements in Medicaid. Among the findings:

- Some 22 of the 31 states had issued procedures to address DRA citizenship and identity requirements in Medicaid; nine states had no procedures in place as of July 1, 2006.
- Most state *CKF* grantees expected the DRA to reduce Medicaid and CHIP enrollment.
- Nearly all state *CKF* grantees were trying to improve implementation of the DRA documentation requirements.
- Most state *CKF* grantees believed the DRA was a barrier to achieving *CKF*'s goals of enrolling and keeping people enrolled in Medicaid and CHIP. However, only a few grantees viewed the DRA as the greatest barrier they faced over the four years of the *CKF* grant.

See also [A Policy Perspective on the Deficit Reduction Act](#), a commentary in response to this brief.

Issue Brief #2: Making Health Care a Reality for Low-Income Children and Families

This February 2007 brief assesses the role of the three *CKF* strategies for increasing enrollment of eligible uninsured children and families—outreach, simplification of policies and procedures, and coordination between CHIP and Medicaid—and the role of coalitions and collaboration. In summarizing their findings, the researchers noted:

“Our study shows that enrollment increases were most likely when the full set of *CKF* strategies was implemented: an effective coalition, successful efforts to simplify

enrollment and coordinate coverage, sustained intensive outreach, and innovative projects emanating from local programs. Also required were:

- strong leadership and championship of children’s coverage in state government;
- state willingness to collaborate with CKF grantees on the frontline; with close ties to families; and
- adequate infrastructure.

“Weakness in any of these areas limits programs’ ability to enroll children efficiently. Combining them can lead to highly effective programs for insuring children.

“The evaluation also provides one further lesson for SCHIP reauthorization: the best results occur when states are not facing budget pressure (and thus not inclined to cut outreach or make enrollment more difficult).”

Issue Brief #3: The Deficit Reduction Act’s (DRA) Citizenship Documentation Requirements for Medicaid Through the Eyes of State Officials in December 2006 and January 2007

In December 2006 and January 2007, Health Management Associates interviewed 60 state officials from Medicaid, separate CHIP, or combination Medicaid/CHIP programs in 46 states on an array of topics. Findings in regard to the impact of the DRA citizenship documentation requirement included:

- Officials from many states expected a negative effect on previous efforts to simplify enrollment using mail-in, fax or telephone applications (26 states) and Web-based or other paperless applications (14 states).
- While most officials indicated that DRA citizenship documentation requirements would increase the complexity of their processes, fewer Medicaid and combination Medicaid/CHIP officials (56 percent) expected that these requirements would reduce the number of children and families enrolled in their programs.
- A smaller percentage of CHIP and combination Medicaid/CHIP officials (33%) expected a negative effect on CHIP enrollment.
- Just over half (52 percent) of officials in states for which coordination between Medicaid and CHIP was relevant indicated that the DRA citizenship documentation requirements already had affected, or would affect, efforts to improve coordination. Many states had implemented a variety of strategies to assist clients in retrieving identity and citizenship documentation.

Issue Brief #4: Improving Processes and Increasing Efficiency: The Case for States Participating in a Process Improvement Collaborative

The brief looks at the impact of a process change model that the Southern Institute used to help state Medicaid and CHIP agencies improve the administrative processes involved with enrollment and retention. The researchers drew these conclusions from their study:

- Process improvement collaboratives can improve efficiency and save money, but commitment, buy-in and resources are needed to succeed.
- Teams learned the importance of testing rapid small-scale improvements in ways that helped identify the success of changing one variable.
- The process improvement collaborative identified many promising practices that participants believe improved enrollment and renewal processes. Practices that also demonstrated savings or improved efficiency were easier to spread statewide.
- The process improvement collaboratives helped participants achieve short-term improvements in processes and long-term changes in the philosophy of state administration.

Issue Brief November 2007: CKF Coalitions Propel Policy and Procedural Changes

This brief describes how states built coalitions to achieve policy change, the types of changes the coalitions supported, and the sustainability of capacity and change after the grant period. Key findings:

- State CKF grantees built diversified coalitions; this diversity gave coalitions advantages in pursuing CKF goals.
- State coalitions provided a place to work with Medicaid and CHIP officials to change policies and procedures.
- State coalitions pursued CKF strategies to increase coverage, resulting in policy and procedural changes.
- Coalitions can outlive initial funding and continue to work on increasing insurance coverage.

Lessons Learned

Assessing the Impact of Covering Kids and Families has chapters on “lessons” from the program organized into topics. Some of these chapters do offer lessons; some only present findings from the evaluation. Here are major topics with key lessons or findings:

Access to care

Reports in this section document difficulties Medicaid and CHIP enrollees have in accessing health care and study the impact of the CKF-Access Initiative in addressing those barriers. Key lessons for improving access are:

- Do a thorough and systematic needs assessment in the community. The CKF-AI projects sometimes found that what they thought was a barrier was something different upon closer examination.
- Narrowly targeting strategies to improve access improves the odds that they can be implemented and be effective, particularly when participating in a relatively small and short-term grant program.
- Getting sustainable funding to address access issues was challenging. The CKF-AI projects were more effective when they planned for sustainability early on and when access improvement strategies produced clear cost savings.

Economic and political barriers

CKF projects faced an array of barriers in carrying out their strategies to enroll and retain children and families in public health insurance programs. The greatest barriers reported were environmental (policy changes, political environment, Medicaid and state bureaucracy, for example).

The CKF coalitions were the key factor in helping grantee organizations overcome barriers because they rooted CKF in the community and gave grantees access to support from state officials or from others who could help sustain CKF after the grant ended.

Outreach

CKF grantees used a variety of strategies to find and enroll eligible children and families.

The chapter links to two reports from 2003 that studied the impact of budget stringency on CKF grantees' outreach efforts. In the first, *Outreach in a Time of Budget Tightness*, grantees agreed that several principles led to more effective outreach, even in trying financial times. Effective strategies:

- Are doable—they work.
- Have measurable outcomes or should incorporate measurement whenever possible.
- Will usually be transferable or adaptable to other locations.
- Must be better targeted in a tight budget environment.
- Should be institutionalized so that the infrastructure of outreach does not have to be continually reinvented.

The May 29, 2004, report, *Targeting Special Populations in the CKF Program: Lessons from Site Visits to Ten States*, documented a number of approaches that helped overcome barriers to reaching diverse groups:

- Including representatives from special populations on coalitions.
- Fostering one-on-one interactions between parents and trusted community members who are promoting CKF goals.
- Using churches, schools and workplaces as points of contact and locations for enrollment activities, especially when targeting rural and working families.
- Drawing on multilingual outreach resources (whether CKF-funded or through partnership efforts) to reach families with little or no English capability.
- Involving the immigration service in outreach events.

Simplification and Coordination

Three reports document grantee organizations' efforts to simplify the application and renewal process and improve coordination between Medicaid and CHIP. Key findings include:

- Three-quarters of grantee's simplification activities and over 90 percent of their coordination activities led to improvements in Medicaid and CHIP.
- According to grantees, two-thirds of the Medicaid and CHIP simplification and coordination improvements implemented would not have occurred without CKF.
- State officials in 45 states believe the CKF initiatives have improved the reenrollment processes and those in 44 states believe they eased the initial enrollment processes for children and families eligible for state-run government insurance programs.
- Among state officials reporting a simplification or coordination improvement, 85 percent said that the improvement either would not have occurred without CKF or that it would have occurred without CKF but occurred more slowly.

Sustainability

Five documents in the sustainability chapter report on grantee organizations' early strategies to sustain the work of CKF after the grant period. The December 2005 report, *Strategies for Sustaining CKF: Interim Synthesis of Evaluation Findings*, notes that:

- Changes in Medicaid and CHIP policies and procedures in many states had already left a legacy.
- Some 96 percent of grantees and 68 percent of state officials expected CKF activities to continue—but not necessarily the CKF coalitions.

- Project staff and coalition leaders expected to sustain the CKF strategies of outreach, simplification and coordination—but not at the same level.
- Two-thirds of grantee organizations were seeking new funds to support their activities after the grant period; one-third had secured such funds.

Policy Change

Three reports in this chapter look at the impact of CKF on policy change. *Sustaining the Effects of Covering Kids & Families on Policy Change* notes that:

“The program’s legacy includes an extensive set of state communication networks of local organizations and government agencies dedicated to children’s health and coverage. This largely permanent presence may indirectly improve coverage over the long run by raising the profile of public health programs among state legislative leaders, whose influence has such enormous sway over the direction of Medicaid and SCHIP policies.”

Case Studies

Case studies of 10 states are available online. In addition, a synthesis of the case studies is also available [online](#). The following case studies are available on [rwjf.org](#):

- Arkansas
- California
- Illinois
- Kentucky
- Michigan
- Missouri
- New Jersey
- North Carolina
- Oregon
- Virginia

The case studies examined trends in new Medicaid and CHIP enrollment. In particular, these reports covered the potential links between new enrollment trends and major outreach strategies or policy changes that took place at the state and local level, especially those associated with a *Covering Kids & Families* project. Findings in the synthesis report include:

- **In many states, *Covering Kids & Families* and state staff collaborated effectively on outreach and simplification.** In New Jersey, for example, the state grantee undertook extensive outreach and trained state staff to do outreach. When staff members worked together on simplification (such as simplified application forms)

and coordination (including developing a joint Medicaid and CHIP application form), they often developed a new respect for each other.

- **Many CKF projects adopted aggressive outreach, at both the local and state levels.** Case study findings suggest that outreach in and around schools holds significant promise for increasing enrollment of children and families.
- **States adopted numerous policies during the grant period aimed at simplifying program procedures and coordinating CHIP and Medicaid, including simplified forms, joint forms, elimination of face-to-face interviews, centralized eligibility processing and self-declaration of income.**
- **CKF grantees (and their partners) influenced many of these policies.** Several of the grantees in case study states developed close and trusting relationships with state staff. For example, in both Virginia and Arkansas, the grantee organizations worked closely with the state to modify Medicaid and CHIP enrollment and renewal policies.
- **Budget and other challenges slowed progress in many states, though political/public support for children’s coverage offered a potential counterweight.** Strong political support for children’s coverage limited program cutbacks in at least three case study states—Virginia, Arkansas and Illinois.
- **Major enrollment increases were evident in many states, some with close links to policy.** One example was Arkansas’ rebranding of CHIP and Medicaid (under a common brand—ARKids), together with the abandonment of face-to-face interview requirements and the introduction of a mail-in application.

Evaluation Findings: Access Initiative

Carolyn Needleman of Social Research Associates, evaluated the first phase of the *Covering Kids & Families Access Initiative* (CFK-AI) (ID# 059268). She produced two reports.

- *Covering Kids & Families Access Initiative, Final Evaluation Report* (January 2007). It describes how the 18 grantee sites approached their Phase I data-gathering, offers examples of how grantee experience was affected by the context in which they worked, provides local and state partner perspectives on the initiative’s design and management and presents “lessons learned.” Its findings are not reported here because they were built on and extended by Needleman’s next evaluation report.
- *Follow-up Evaluation of the Covering Kids & Families Access Initiative: Lessons from 18 CKF-AI Grantees* (March 2008). This evaluation also addresses questions about the status of the projects 18 months after RWJF funding ended.

A Phase II evaluation was led by researchers at the Urban Institute included contributions from Social Research Associates. It was reported on in:

- *Coverage Is Not Enough: Lessons From the Covering Kids & Families Access Initiative* (May 2009). It describes the Phase II work of local projects in five states, based on site visits by Urban Institute researchers.

Phase I Evaluation Findings

Follow-Up Evaluation of the Covering Kids & Families Access Initiative: Lessons from the 18 CKF-AI Grantees offers the following findings:

- **The Access Initiative project directors believed their interventions had a positive impact, but most were unable to gather hard data on those effects.** They felt their organizations were stretched too thin to undertake systematic data-gathering and analysis in the absence of dedicated evaluation funding.

The project directors reported frustration at being unable to document their projects' impact, since evidence of effectiveness would help promote their access-improvement activities. In a number of cases, relevant data sources already existed in hospital records and medical claims databases if staff time had been available to extract and analyze the appropriate information.

See Access Initiative Activities and Results in the [Overall Program Results](#) section for examples of projects that were able to track outcomes.

- **Important indirect effects of the Access Initiative—such as building skills among participants, strengthening advocacy networks and changing the framework of policy discussion—should be recognized in assessing the initiative's value.**
- **After policy-makers formally agree to make a system change, implementation of the change needs to be regularly reviewed.** Policy change is not a one-shot effort. Making sure that system-level changes to improve access have staying power requires monitoring and periodic reinforcement over a period of at least several years.
- **“Sustainability” is a more complicated concept than it first appears, since the shift to a new funding source can involve considerable reshaping of project goals.** Although project staff was fairly successful in finding alternative funding, efforts to get their programs adopted by school systems, hospitals or managed care organizations inevitably changed how the program operated.
- **Although the leadership or location of a project sometimes changed as the grant came to an end, it did not seem to adversely affect the Access Initiative.** Typically, the new organizational home had been involved with the project throughout the grant period and the new leaders already had good working relationships with the original project directors.

- **The link between local grantee organizations and their state partners proved hard to sustain during the post-grant period.** Although interest in working together remained high, these partnerships were crowded out by other urgent activities once they were no longer required as a condition of funding.
- **The strength and promise of Access Initiative projects at the end of the grant period turned out to be a fairly poor predictor of how well they fared 18 months later.** A more powerful factor over the long term was external events, which brought to a halt some of the projects that had seemed most promising based on preliminary results.

For example, shortly after funding ended, the grantee organization in Houston, considered a “star” by the staff of the Access Initiative’s national program office, had to put aside its programs for reducing prescription drug barriers in order to deal with a crisis related to the vendors used for Medicaid/CHIP enrollment.

- **Eighteen months after the grant expired, project directors continued to give the Access Initiative very high ratings, even where their own projects were struggling.** However, they were unanimous in noting that the initiative’s two-year time frame was very short to meet its stated goals.

Phase II Evaluation Findings

The evaluation report *Coverage is Not Enough: Lessons From the Covering Kids and Families Access Initiative* gleans these crosscutting conclusions and lessons from site visits to Access Initiative projects in five states:

- **The CKF-AI case study grantees were agencies with a long history and successful track record of providing community-based support and services for children and families.**
- **The CKF-AI grantees built and depended on strong partnerships in their communities to fulfill the missions of their projects.**
- **Thorough and systematic needs assessment (including focus groups, surveys, and in-depth interviews) is critical.** It often rendered surprising results for grantees by identifying barriers to access that were not previously thought to be widespread or significant.
- **Defining access barriers and targeting access improvement strategies narrowly is critical to improving the odds of success under a relatively small and short-term grant program.**
- **The CKF-AI grant structure and RWJF’s flexibility were praised highly for facilitating grantee organizations’ careful and accurate identification of access barriers and creative implementation of strategies to address these barriers.**

- **The national program office provided helpful and effective technical assistance to grantees in support of their efforts.**
- **The scope of work for CKF-AI was large and ambitious.** A longer time frame for the initiative would have permitted grantees more complete implementation, better data collection and evaluation, and more thorough searches for sustainable funding.
- **Obtaining sustainable funding was challenging, even for “successful” grantee organizations.** It was more likely when sustainability planning began early in the grant period, and when access improvement strategies produced clear cost savings.

LESSONS LEARNED

Overall Lessons

1. **System change may be more effective than outreach in affecting the number of children and families enrolled in public insurance programs.** Broad changes in procedures and processes, such as easing documentation requirements and reducing renewal requirements, may improve enrollment more effectively than targeting individual families and neighborhoods. (Vice President of Communications, RWJF/Morse)
2. **Incorporating local projects into a larger initiative provides “grassroots” information that can contribute to a program’s effectiveness.** *Covering Kids & Families* state grantees were required to allocate half their funds to local coalitions, which provided reliable information about the barriers families encounter enrolling in or renewing their public insurance coverage. They also helped broker important relationships with staff responsible for enrollment in these insurance programs. (CKF Summative Report)

Lessons about Running a National Program Office

3. **Create a program management handbook, as well as detailed internal procedures that describe the processes, workflow and documents required for the necessary planning and business activities.** A large national program needs such a document, which should also describe the roles of RWJF, the national program office and the grantees. (Program Director/Shuptrine)
4. **Continually assess and provide the kinds of technical assistance that grantees need to meet the goals of the program.** For example, most grantee organizations were more skilled at doing outreach than at developing strategies to simplify enrollment processes or coordinate Medicaid and CHIP. The process improvement collaborative was a particularly useful strategy for providing the specialized help they needed. (Program Director/Shuptrine; Southern Institute on Children and Families President and CEO/Ravenell)

5. **Be sure to have enough staff to provide adequate technical assistance not only struggling sites, but to ones that are doing OK but could do even better.** During the *Covering Kids* program, the Southern Institute did not have enough staff to provide all the technical assistance needed. “The ones that seemed to be doing okay but could have used some additional assistance... were not always provided with that, unless they asked,” Ravenell said. “That’s not the way you want to run an initiative of that magnitude,” says Nicole Ravenell. This situation was rectified with *Covering Kids & Families*, when RWJF provided enough funds for significant increases in staffing at the national program office. (Program Director/Shuptrine; Southern Institute on Children and Families President and CEO/Ravenell)

Lessons about the Back-to-School Campaign

6. **Outreach efforts are most effective when connecting with families where they live, work and play.** In particular, studies have shown that school-based outreach is one of the most effective ways to reach parents with enrollment information, since school personnel provide a natural gateway to eligible families. Partnerships with corporations were also essential, providing ready access to workers and their families through paycheck inserts. (GMMB 2006 Final Report)
7. **The most effective outreach takes place in communities with strong grantees and coalitions.** By providing the training and resources local organizations need to build their capacity and implement their work, projects can seed the field with well-equipped leaders committed to carrying out program goals. (GMMB 2006 Final Report)
8. **Paid television advertising remains a powerful tool for reaching the target population, but requires a sizable investment.** “TV advertising can have a very strong effect but the minute you are off the air the effect is almost totally eliminated,” said Elaine Arkin, former RWJF communications officer. “It is very expensive and it has to be used in very specific ways.” She is less enthusiastic about public service advertising, which she believes “has almost no effect... and you still have to pay for development and production.”
9. **Local outreach events are an effective way to engage legislators and encourage their support of policies to broaden access to CHIP.** It is critical to maintain a visible and vocal presence before legislators with the power to implement policy changes at the local and national level, and to get elected officials on record supporting public health coverage programs. (GMMB 2006 Final Report)
10. **Most grantees and partners did not have a communications background and needed tools and technical assistance to be effective at local outreach.** They come instead from the policy or social services side, and often need communications basics, such as how to place an article or op-ed in the paper, how to purchase ad space, etc. (Southern Institute Communications Director/Shine)

Lessons from the Access Initiative

11. **When carried out by trusted community entities, small-scale qualitative research can work well to clarify the access problems experienced by families on Medicaid.** Some Access Initiative grantees initially wanted to do elaborate community surveys. However, technical assistance staff felt strongly that the purpose of the effort was not to document the full magnitude of access barriers in the community, as might be suitable in an academic context. The goal instead was to gain enough qualitative insight into the range of access problems—as perceived by families on Medicaid—in order to select a focal point for pilot interventions. (Access Initiative Final Evaluation Report)
12. **Use any means available to get input from hard-to-reach health care providers.** The Access Initiative grantees found it difficult to reach Medicaid providers—including physicians, physicians’ office staff, pharmacists and managed care administrators—through e-mail surveys or focus groups. Instead, they resorted to face-to-face interviews with small numbers of health care professionals to gain this important input. (Access Initiative Final Evaluation Report)

AFTERWARD

Program Continuity

According to *Covering Kids & Families* evaluators at Mathematica Policy Research:

- About half the *Covering Kids & Families* grantee projects survived in some form 18 months after the RWJF funding ended. Of these, about half were absorbed by host agencies, transferred to other agencies or split up so that their activities were adopted by several agencies.
- By mid-2008, state Medicaid and State Children’s Health Insurance Program agencies were giving support to six grantee projects to continue their activities, and coalition members were providing additional funding to other projects.
- Some 83 percent of the 183 policy changes that were influenced by *Covering Kids & Families* between 2002 and 2006 remained in effect in 2007; in 2008, 75 percent were still fully in effect.
- Enrollment policy and procedure simplifications were not only the most common types of change influenced by *Covering Kids & Families*, but the most durable. Some 85 percent of enrollment simplifications were retained two years after the program ended.
- Some 70 percent of procedures to simplify Medicaid or CHIP renewal applications were still in effect in 2008 (down from 88 percent a year earlier).

- By contrast, many of the outreach policies were discontinued or repealed. In 2008, only nine of the 26 instances in which *Covering Kids & Families* influenced outreach policy or practice were still in effect.
- *Covering Kids & Families*' continued influence "takes the form of increases in community capacity to address problems of the uninsured," given the extensive advocacy and coalition-building skills that many grantee staff developed.

RWJF Initiatives

RWJF continues to work toward the goal of affordable and stable health care for all, primarily through its [Cover the Uninsured](#) project. The Cover the Uninsured website now houses many of the tools, templates and resources formerly on the *Covering Kids & Families* website.

In February 2007, RWJF funded a [National Covering Kids & Families Network](#) (IDs# 058903 and 065764) to:

- Sustain and build on the strength and collective expertise of *Covering Kids & Families* grantees
- Continue the advances made in providing quality health care for children and families across the country

Community Health Councils of Los Angeles manages the program.

Lessons learned from *Covering Kids & Families* have informed three RWJF national programs:

- The [State Health Access Reform Evaluation](#) program, launched in 2007, funds 15 grantees to develop an evidence base about state health reform. The national program office is at the State Health Access Data Assistance Center, a research center in the division of health policy and management at the University of Minnesota School of Public Health.
- [Consumer Voices for Coverage](#), launched in 2008, supports consumer health advocacy networks in 18 states to increase their capacity to participate with businesses, hospitals, insurers, providers, government officials and other stakeholders in health care reform efforts. Community Catalyst of Boston manages the program.
- Launched in February 2009, [Maximizing Enrollment for Kids](#) is a four-year initiative to increase enrollment and retention of eligible children in public health insurance programs. The program office at the National Academy for State Health Policy in Portland, Maine, provides funding and technical support to eight states that have shown a strong commitment to increasing children's enrollment in public coverage programs even during difficult economic times. The states are Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia and Wisconsin.

RWJF also funded the Georgetown University Center for Children and Families (ID# 062027) to synthesize the research and experience gained over decades of efforts to cover children. Its May 2009 report, *The Last Piece of the Puzzle*, provides a blueprint of what children and families need from national health reform, including an overview of the remaining gaps in children’s coverage and the key challenges that must be addressed.

Congress Expands CHIP

In February 2009, the U.S. Congress passed, and President Obama signed, a bill to expand CHIP. The bill authorized an additional \$32.8 billion to extend health coverage to about 4 million more children, including, for the first time, legal immigrants with no waiting period.

Prepared by: Kelsey Menehan

Reviewed by: Karyn Feiden and Molly McKaughan

Program officer: Lori Grubstein

Communications officers: Elaine Arkin and David Morse

APPENDIX 1

Covering Kids & Families National Advisory Committee

(Current as of the date of this report; provided by the grantee organization; not verified by RWJF.)

Donna E. Checkett (Chair)

Chief Executive Officer
Missouri Care Health Plan
Columbia, Mo.

Rebeca Maria Barrera, M.A.

President
National Latino Children's Institute
San Antonio, Texas

Sheila P. Burke, M.P.A.

Under Secretary
American Museums and National Programs
Smithsonian Institution
Washington, D.C.

Margaret Dunkle

Senior Fellow
Health Insurance Reform Project
George Washington University
La Canada, Calif.

Jack C. Ebeler

President and CEO
Alliance of Community Health Plans
Washington, D.C.

Cornelius D. Hogan

Consultant
Plainfield, Vt.

J. Douglas Porter

Assistant Secretary
Medical Assistance Administration
State of Washington Department of Social
and Health Services
Olympia, Wash.

Sandra L. Robinson, M.D.

Deputy Director
New Orleans City Health
New Orleans, La.

Blair L. Sadler, J.D.

President and CEO
Children's Hospital and Health Center
San Diego, Calif.

Michael S. Sparer, J.D., Ph.D.

Associate Professor
Mailman School of Public Health at Columbia
University
New York, N.Y.

Robert Otto Valdez, Ph.D., M.H.S.A.

Senior Health Scientist
RAND Health Sciences Program
Arlington, Va.

APPENDIX 2

Project List

Project directors are listed as of the time of the RWJF grant(s).

ALASKA

Alaska Native Tribal Health Consortium (Anchorage, Alaska)

Grant ID# 044012 (October 2002 to September 2006)

Project Director

Lue Rae Erickson

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lrerickson@anthc.org

ALABAMA

State of Alabama Department of Public Health (Montgomery, Ala.)

Grant ID# 051609 (July 2004 to June 2006)

Project Director

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Arozelle@adph.state.al.us

University of Alabama College of Human Environmental Sciences (Tuscaloosa, Ala.)

Grant ID# 044003 (May 2002 to April 2006)

Project Director

Rex E. Culp, Ph.D., J.D.

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rexculp@ches.ua.edu

ARKANSAS

Arkansas Advocates for Children and Families (Little Rock, Ark.)

Grant ID# 043188 (January 2002 to December 2005)

Project Director

Rhonda Sanders

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rhosan@swbell.net

Our Children First Coalition, Inc. (Texarkana, Ark.)

Grant ID# 049075 (September 2003 to August 2005)

Project Director

Debbie Lashford-Smart

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dlash@ocfci.org

ARIZONA

Children's Action Alliance Inc. (Phoenix, Ariz.)

Grant ID# 043441 (May 2002 to April 2006)

Project Director

Kimberly Van Pelt

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kvanpelt@azchildren.org

CALIFORNIA

Community Health Councils Inc. (Los Angeles, Calif.)

Grant ID# 044001 (May 2002 to April 2006)

Project Director

Caroline Rivas, M.S.W.

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caroline@chc-inc.org

Fresno County Economic Opportunities Commission (Fresno, Calif.)

Grant ID# 049072 (September 2003 to August 2005)

Project Director

Margarita Rocha

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mrocha@centrolafamilia.org

COLORADO

Colorado Community Health Network, Inc. (Denver, Colo.)

Grant ID# 049072 (May 2002 to April 2006)

Project Director

Polly Anderson

(303) 861-5165, ext.246

polly@cchn.org

CONNECTICUT

Bridgeport Child Advocacy Coalition Inc. (Bridgeport, Conn.)

Grant ID# 049076 (September 2003 to August 2005)

Project Director

Barbara Edinberg

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bse@bcacct.org

Hartford Foundation for Public Giving (Hartford, Conn.)

Grant ID# 043189 (January 2002 to December 2005)

Transferred to:

Connecticut Voices for Children (Hartford, Conn.)

Grant ID# 050508 (March 2004 to December 2005)

Project Director

Judith Solomon, J.D.

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DISTRICT OF COLUMBIA

DC Action for Children Today (Washington, D.C.)

Grant ID# 043998 (July 2002 to June 2006)

Project Director

Angela M. Jones

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DELAWARE

Medical Society of Delaware (Newark, Del.)

Grant ID# 045184 (February 2003 to January 2007)

Project Director

Mark A. Meister

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FLORIDA

University of South Florida, Lawton and Rhea Chiles Center for Healthy Mothers and Babies (Tampa, Fla.)

Grant ID# 043439 (April 2002 to March 2006)

Project Director

Jodi Ray, M.A.

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jray@health.usf.edu

GEORGIA

State of Georgia Department of Community Health (Atlanta, Ga.)

Grant ID# 043439 (September 2002 to August 2006)

Project Director

Trudie Nacin

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HAWAII

Hawaii Primary Care Association (Honolulu, Hawaii)

Grant ID# 045176 (June 2002 to May 2006)

Project Director

Barbara Luksch

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IDAHO

Mountain States Group (Boise, Idaho)

Grant ID# 045174 (October 2002 to September 2006)

Project Director

Mary Lou Kinney

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Kootenai Hospital District (Coeur d'Alene, Idaho)

Grant ID# 049073 (September 2003 to August 2005)

Project Director

Karen Cotton

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IOWA

State of Iowa Department of Public Health (Des Moines, Iowa)

Grant ID# 045172 (July 2002 to June 2006)

Project Director

M. Jane Borst, R.N., M.A.

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jborst@idph.state.ia.us

ILLINOIS

Illinois Maternal and Child Health Coalition (Chicago, Ill.)

Grant ID# 050054 (January 2004 to December 2005)

Grant ID# 043204 (January 2002 to December 2005)

Project Director

Laura Leon

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lleon@ilmaternal.org

INDIANA

Health and Hospital Corporation of Marion County (Indianapolis, Ind.)

Grant ID# 044010 (December 2002 to November 2006)

Project Director

David A. Roos, Ph.D.

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KANSAS

Kansas Children's Service League (Lenexa, Kan.)

Grant ID# 048696 (May 2005–April 2006)

Project Director

Tracie Lansing, L.M.S.W.

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Grant ID# 048695 (May 2004 to April 2005)

Project Director

Vickie Burgess McArthur

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vmcarthur@kcsf.org

Grant ID# 048501 (May 2003 to April 2004)

Project Director

Teresa R. Schwab, L.M.S.W.

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tschwab@kcsf.org

KENTUCKY

University of Kentucky Research Foundation (Lexington, Ky.)

Grant ID# 043207 (January 2002 to December 2005)

Project Director

Julia Field Costich, J.D., Ph.D.

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LOUISIANA

Agenda for Children, Inc. (New Orleans, La.)

Grant ID# 045180 (September 2002 to August 2006)

Project Director

Sharon Pomeroy

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MASSACHUSETTS

Health Care for All, Inc. (Boston)

Grant ID# 043191 (January 2002 to December 2005)

Project Director

Lucy Meadows

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MARYLAND

Baltimore Health Care Access, Inc. (Baltimore)

Grant ID# 049084 (September 2003 to August 2005)

Project Director

William Sciarillo, Sc.D., M.S.N.

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wsciarillo@bhca.org

University of Maryland Baltimore Foundation, Inc. (Baltimore)

Grant ID# 045185 (July 2002 to June 2006)

Project Director

Linda Reynolds Wise

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MAINE

Maine Primary Care Association (Augusta, Maine)

Grant ID# 045387 (July 2002 to December 2005)

Grant ID# 043190 (January 2002 to December 2005)

Project Director

Darcy Shargo

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Penquis Community Action Program, Inc. (Bangor, Maine)

Grant ID# 049078 (September 2003 to August 2005)

Project Director

Jennifer Brooks

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MICHIGAN

Michigan Public Health Institute (Okemos, Mich.)

Grant ID# 043208 (February 2002 to January 2006)

Project Director

Cynthia A. Cameron, Ph.D.

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MINNESOTA

City of Minneapolis Department of Health and Family Support (Minneapolis, Minn.)

Grant ID# 049088 (September 2003 to August 2005)

Project Director

Gretchen Musicant

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County of Olmsted Community Services (Rochester, Minn.)

Grant ID# 049081 (September 2003 to August 2005)

Project Directors

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Ginnie Westfall

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Children's Defense Fund (Saint Paul, Minn.)

Grant ID# 045168 (July 2002 to June 2006)

Project Director

Elaine Cunningham

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MISSOURI

Missouri Coalition for Primary Health Care (Jefferson City, Mo.)

Grant ID# 045169 (September 2002 to August 2006)

Project Director

Lane DePrima

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MISSISSIPPI

State of Mississippi Office of the Governor (Jackson, Miss.)

Grant ID# 043206 (September 2002 to August 2006)

Project Director

Maria D. Morris

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MONTANA

Healthy Mothers, Healthy Babies, The Montana Coalition, Inc. (Helena, Mont.)

Grant ID# 048694 (May 2005 to April 2006)

Grant ID# 048693 (May 2004 to April 2005)

Grant ID# 048503 (May 2003 to April 2004)

Project Director

Michael Cooney

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NORTH CAROLINA

Buncombe County Department of Social Services (Asheville, N.C.)

Grant ID# 049096 (September 2003 to August 2005)

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APPENDIX 3

Technical Assistance Provided by the National Program Office, *Covering Kids & Families*

Site Visits

National program staff made some 140 site visits over the grant period to manage *Covering Kids & Families* and to provide assistance to the state projects. These included:

- 42 site visits immediately after the grant awards were made
- 65 site visits during the grant period
- Three site visits to document state-specific enrollment and renewal policies and procedures for case study process improvement
- 28 site visits as part of the process of two Eligibility Process Improvement Collaboratives

Covering Kids & Families staff also conducted two joint site visits with staff from *Supporting Families After Welfare Reform*, the national program directed by the Southern Institute, and attended five Supporting Families technical assistance site visits. The purpose was to leverage resources and expertise between the two programs, which had similar goals and strategies. See [Program Results](#) on *Supporting Families* for more information on the program.

Meetings

The Southern Institute conducted 21 seminars and meetings:

- Two orientation & training seminars provided *Covering Kids & Families* grantees tools for implementing outreach, simplification and coordination strategies and an opportunity to network among themselves, Southern Institute staff, RWJF staff and experts who presented at the sessions. The first seminar, in Seattle in July 2002, was attended by 173 people. The second seminar, in Savannah, Ga., in February 2003, was attended by 119 people.
- Five meetings where state and national health coverage policy experts shared information relevant to *Covering Kids & Families* goals and strategies. The meetings were held in Washington in May 2003, October 2003, January 2004, September 2004 and October 2006.
- Two annual meetings with grantees, coalition partners, state and federal Medicaid and CHIP officials and representatives from other interested regional and national organizations. A total of 371 participants attended the 2003 annual meeting in St. Louis, and 340 participants attended the 2005 annual meeting in Washington.
- Four regional meetings in 2004 as part of an ongoing effort to foster regional partnerships among *Covering Kids & Families* grantees, state officials and the federal Centers for Medicare & Medicaid Services, which administers the Medicaid and CHIP programs.
 - Southern regional meeting: May 4–6, 2004, Miami
 - Western regional meeting: May 26–28, 2004, San Francisco
 - Northeastern regional meeting: June 22–24, 2004, Boston
 - Midwestern regional meeting: July 13–15, 2004, Chicago

A total of 316 participants attended the meetings.

- One regional partnership meeting in Atlanta in February 2004 convened 20 representatives of advocacy and provider groups to discuss ways in which southern states could work together to reduce the number of uninsured.
- Three regional partnership forums convened representatives from state governors' offices to discuss barriers and opportunities to enrolling and retaining eligible children and adults in public health coverage.
 - Western partnership forum: November 16–17, 2004, Denver
 - Midwestern partnership forum: September 13–14, 2006, Chicago
 - Southern partnership forum: December 6–7, 2006, Atlanta

- Two seminars on hospital-based eligibility determination. Participants discussed major barriers and opportunities to implement and maintain onsite hospital-based Medicaid, CHIP or other public health coverage eligibility determination processes. (October 2005, Annapolis, Md., attended by 15 participants; July 2006, St. Louis, attended by 16 participants.)
- Two coalition-building seminars. Members of *Covering Kids & Families* statewide coalitions learned from their peers about promising practices for developing and sustaining effective coalitions.
 - Coalition-building technical assistance meeting, October 2005, Tampa, Fla., 20 participants.
 - Seminar on building and sustaining effective coalitions Seminar, June 2006, Kansas City, Mo. 32 participants.

Eligibility Process Improvement Collaboratives

To help grantees improve their administrative processes for determining eligibility, enrolling eligible children and families and retaining them in coverage, the Southern Institute also conducted two Eligibility Process Improvement Collaboratives, described in the sidebar [Collaboratives Propel Systems Change](#).

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www.thesoutherninstitute.org/PublicationsCategory.aspx#HealthCoverage. This section of the Southern Institute on Children & Families website contains reports, articles and resources created during the *Covering Kids & Families* national program.

The most up-to-date list of resources on the uninsured can be found at the Cover the Uninsured website: <http://covertheuninsured.org>.

Evaluation

(Current as of date of this report; as provided by grantee organization; not verified by RWJF; items not available from RWJF.)

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SIDEBAR LIST

- Collaboratives Propel Systems Change
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- The Florida CKF Coalition Pulls Out the Stops to Enroll Children