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Covering Kids & Families[®] Evaluation

*Coverage is Not Enough: Lessons From the
Covering Kids and Families Access Initiative*



The Urban Institute

Ian Hill, *senior fellow*

Brigette Courtot, *research associate*

Louise Palmer, *research associate*

Credits

The Urban Institute

2100 M Street, NW
Washington, D.C. 20037
Tel: (202) 833-7200
Fax: (202) 223-1149

Ian Hill, *senior fellow*
Brigette Courtot, *research associate*
Louise Palmer, *research associate*

Design and Layout

Landesberg Design
Pittsburgh, PA

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Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543-2316

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The key informants that were interviewed for this study are identified below:

Bridgeport, Connecticut:

Raj Appalaneni, Rose Ciarcia, Barbara Edinburg,
Mory Hernandez, Mary Alice Lee, Marilyn Ondrasik,
Catherine Onyemelukwe, Rich Spencer

Baltimore, Maryland:

Kathleen Westcoat, Pamela Brown, Gloria Benalcazar,
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Najee Dawes, Gloria Ramos, Pat Letke-Alexander,
Gina Baez, Laurie Norris

Rochester, Minnesota:

Ginnie Westphal, Beth Arendt, Ron Buzard, Avni Patel,
Elaine Cunningham, Mary Lako, Sheila Lota

Asheville, North Carolina:

Althea Gonzalez, Linda Kinney, Miriam Schwarz, Nora Pena,
Arellys Chevalier, William Hathaway, Lisa Ebby, Alan
McKenzie, Jim Holland, Linda Tettambel, Jennifer Tynner

Olympia, Washington:

Annette Brown, Doug Busch, Doug Burt, Edward Cates,
Phyllis Coolen, Bethany Knotter, Trang Kuss, Sam Trimble,
Jeff Walker, Kristen West

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About the *Covering Kids & Families*® Evaluation

Since August 2002 Mathematica Policy Research, Inc., and its partners, The Urban Institute and Health Management Associates (HMA), have been conducting an evaluation to determine the impact of the Robert Wood Johnson Foundation's investment in the *Covering Kids & Families* (CKF) program, as well as to study factors that may have contributed to, or impaired, its efforts.

The evaluation focuses on these key issues:

- Documenting and assessing the strategies and actions of CKF grantees and their coalitions aimed at increasing enrollment of children and families and the barriers to their implementation.
- Assessing the effectiveness of CKF grantees and their coalitions in conducting outreach; simplifying the application and renewal process; and coordinating efforts by existing health insurance programs to expand coverage measuring progress on CKF's central goal—expanding enrollment and retention of all eligible individuals into Medicaid and State Children's Health Insurance Program (SCHIP).
- Assessing the sustainability of CKF after RWJF funding ends.

Findings from the evaluation can be found at www.rwjf.org/coverage/product.jsp?id=20929.

Executive Summary

As part of the *Covering Kids and Families* (CKF) Evaluation, The Urban Institute conducted case studies of five of the 18 Covering Kids and Families-Access Initiative (CKF-AI) grantees in late 2007. Supported by the Robert Wood Johnson Foundation (RWJF) and a component of the much larger CKF initiative, the CKF-AI was a two-year grant program that directed \$4 million to local projects to enable them to diagnose and address barriers to access for children and families enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP). The case studies found that projects succeeded in addressing a wide range of access barriers by implementing creative, focused strategies. For example:

- The Bridgeport Child Advocacy Coalition (BCAC) represents a group of more than 80 organizations (including health care providers, child-care centers, churches and synagogues and civic groups) joined in their commitment to improving the lives of the children of Bridgeport, Conn. Under the CKF-AI, the organization identified a range of problems that hindered families' access to pharmacy services under Medicaid—in particular, to temporary supplies of prescription drugs for children. To address these problems, the grantee developed clear and effective educational materials for parents, providers, and pharmacies to facilitate children's receipt of needed prescription medications from Medicaid managed care plans.
- Baltimore HealthCare Access (BHCA), a not-for-profit organization affiliated with the Baltimore City Health Department, was originally created to assist with the city's transition to a Medicaid managed care system. Their role has evolved over the years to include providing ombudsman and enrollment assistance to Medicaid enrollees, and conducting significant outreach to potentially eligible populations. During the barrier identification phase of its CKF-AI project, BHCA focused on immigrant families and found that pregnant Latino immigrants, especially those newly arrived, generally lacked awareness of their eligibility for Medicaid, where to get care, or of the importance of prenatal care visits. To address these barriers, the grantee developed informational brochures, educational materials, and cultural competency training to facilitate access to high quality, ethnically sensitive prenatal care for immigrant pregnant women.

- In Rochester, Minn., Olmsted County Community Services—the agency responsible for administering Medicaid eligibility, food stamps, and cash assistance—teamed with the Intercultural Mutual Assistance Association—a not-for-profit organization that provides a range of ethnically sensitive, multilingual services to immigrant families—to address barriers to access. A survey of mostly low-income immigrants and refugees found that choosing a health care plan and provider, and communicating effectively with health care providers, were the leading barriers facing families. In response, the grantee and its partner developed a sustainable community health worker (CHW) program that provides culturally appropriate services and support to recent immigrant families to assist them in linking with a primary care medical home and in communicating with their providers.
- In Asheville, N.C., the Buncombe County Department of Social Services oversees the provision of a wide range of social services and also operates a comprehensive primary health care center. The grantee conducted its needs assessment and determined that families were struggling to navigate the local health system and follow health care providers' instructions. Additionally, they discovered that severe language barriers existed for many families due to provider noncompliance with federal Title VI policy that requires health providers who receive federal funds to provide translation services. To address this barrier, an interpreter network was developed to provide translation support to limited English proficiency (LEP) families and enhance their receipt of high quality primary care services.
- The CHOICE Regional Health Network in Olympia, Wash., is a nonprofit organization representing safety-net hospitals and community health centers, as well as more than 500 private practitioners, across five counties in western Washington State. The grantee initially identified insufficient provider capacity as the leading barrier to access in its community. But over time, it focused its attention on the problem of inappropriate use of hospital emergency departments (ED). To improve access to high-quality primary care, CHOICE developed an emergency department care coordination program to identify frequent ED users, link them to a medical home, and reduce their reliance on expensive and inappropriate hospital emergency services.

A series of cross-cutting lessons learned from the case studies shed light on both the factors that contributed to grantee success and effective strategies for obtaining sustainable funding. These lessons included:

- 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, and 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 grantees' careful and accurate identification of access barriers and creative implementation of strategies to address these barriers;
- The national program office (Center for Health Care Strategies) 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; and
- Obtaining sustainable funding was challenging, even for "successful" grantees, but was more likely when sustainability planning began early in the grant period, and when access improvement strategies produced clear cost savings.

Multiple evaluations have demonstrated that expanding health insurance coverage is a critical first step in improving the odds that children grow up healthy (Wooldridge, forthcoming; Wooldridge et al., 2005; Kenney et al., 2003; Hill et al., 2003). But addressing the myriad barriers that limit a family's ability to obtain needed care from appropriate and high-quality sources is equally critical. The CKF-AI demonstrated the complementary nature of outreach, enrollment, and retention efforts, coupled with access improvement strategies. The grantees' experiences also provided vivid examples of how targeted strategies can positively impact the lives of children and families.

Introduction, Background, and Study Methods

The Covering Kids and Families (CKF) program was launched in 2002 by the Robert Wood Johnson Foundation (RWJF) and provided a total of \$55 million in grants to states and localities in support of their efforts to increase enrollment of low-income children and families into Medicaid and the State Children's Health Insurance Programs (SCHIP). Specifically, grants were provided to organizations in 45 states and the District of Columbia. These organizations, in turn, channeled sub-grants to more than 140 local-level entities. Both state and local grantees were charged with pursuing three primary strategies to improve children's enrollment in health insurance coverage:

- **Outreach** to encourage enrollment in SCHIP and Medicaid;
- **Simplification** of SCHIP and Medicaid policies and procedures to make it easier for families to enroll their children and keep them covered; and
- **Coordination** between Medicaid and SCHIP to ensure easy transition of families between programs if they apply for the wrong program or their eligibility changes subsequently.

Importantly, CKF grantees were *not* permitted to utilize grant resources to support families in overcoming barriers to care once they were enrolled in Medicaid or SCHIP. This restriction was often frustrating for grantees, especially those at the local level, who were often in contact with families who were experiencing difficulties accessing needed care.

To address this concern, the Covering Kids and Families Access Initiative (CKF-AI) was created as a subcomponent of the larger CKF program, and was designed to support grantees' efforts to improve families' access to health care services *after* enrollment in a public health insurance program. An additional \$4 million in grants was made available by RWJF, and all local CKF grantees were eligible to submit proposals for funding. Ultimately, two-year awards of approximately \$125,000 each were made to 19 grantees in September 2003.¹ Table 1 lists the 18 CKF-AI grantees that implemented their projects, by state.

Structure of the CKF-AI Projects

Guidance from RWJF stipulated that Access Initiative grantees were required to complete their work in two stages:

- During Phase I, grantees were to systematically identify and document barriers to the use of health care services for low-income children and/or adults enrolled in Medicaid and SCHIP; and
- During Phase II, grantees were to develop and implement one or more strategies to address the access barriers identified in Phase I.

In addition, during the two-year funding period, grantees were encouraged to collect data and assess the effects of their efforts, and to develop alternative funding sources to sustain access improvement on an ongoing basis after the end of the grant period.

CKF-AI grantees were also directed to select a “state partner” (defined as a state-level organization or person) to support and collaborate on grantees’ efforts to improve children and families’ access to care. State partners received their own small grants from the Center for Health Care Strategies (CHCS), the organization selected by RWJF to serve as the national program office (NPO) for CKF-AI. As the NPO, CHCS also provided technical assistance to CKF-AI grantees when requested, and typically gave guidance on both needs assessment and access improvement strategies.

Prior Assessment of CKF-AI Grantee Efforts

In May 2005 CHCS funded a small-scale assessment of the CKF-AI grant program. The assessment was conducted by Carolyn Needleman of Bryn Mawr College and entailed reviews of grantee reports, one round of telephone interviews with the project director and state partner of each of the CKF-AI projects, and conversations with the NPO. Needleman found that CKF grantees identified a variety of access barriers, though most could be categorized broadly as either: 1) problems resulting from unrecognized or neglected need (such as difficulties filling drug prescriptions); or 2) problems that resulted from a policy that could be changed (such as managed care practices that restricted appropriate access to care). Her findings also emphasized the importance of several factors associated with the success of grantees; including the presence of a pre-existing network or coalition dedicated to improving families’ health care access, and a well-positioned state partner, among others (Needleman, 2007).

TABLE 1

Covering Kids and Families–Access Initiative Grantees

State and City	Grantee Organization
Arkansas (Texarkana)	Multicultural Community Alliance
California (Fresno)	Our Children First Coalition
Connecticut (Bridgeport and “East Of The River”)	Bridgeport Child Advocacy Coalition, Eastern Connecticut Health Network
Idaho (Coeur D’Alene)	Kootenai Medical Center
Maine (Bangor)	Penquis Community Action Program, York Community Action Coalition
Maryland (Baltimore)	Baltimore HealthCare Access
Minnesota (Rochester)	Olmsted County Community Services
Minnesota (Minneapolis)	Minneapolis Dept. of Health and Family Support
North Carolina (Asheville)	Buncombe County Dept. of Social Services
New Mexico (Albuquerque)	Youth Development Inc.
Oregon (Portland)	Outside In
Pennsylvania (Philadelphia)	Philadelphia Citizens for Children and Youth
Pennsylvania (Pittsburgh)	Consumer Health Coalition
Texas (Houston)	Children’s Defense Fund of Texas
Texas (Progresso)	Migrant Health Promotion Inc.
Virginia (Radford)	Radford University Foundation
Washington (Olympia)	CHOICE Regional Health Network
West Virginia (Charleston)	United Way of Central West Virginia

Primary data collection for this short-term assessment ended in the fall of 2005, when many AI grantees were in the midst of implementing their access improvement strategies. Thus, a second round of phone calls was commissioned by RWJF from late 2006 to early 2007 after the grant period was over. The purpose of these phone interviews was to follow up with grantees, learn more about the outcomes of their efforts, and explore whether they had obtained sustainable funding. This assessment generally found that a considerable number of the CKF-AI grantee projects struggled to sustain their access strategies in the post-grant period, and some had been forced to shift their focus entirely to other, funded projects. However, the grantees as a group had succeeded in: producing new information and insights about the nature of access barriers; inspiring a number of innovative interventions to improve access to health care at the local level; and building grantee capacity to effectively address barriers to health care access in their community (Needleman, 2008).

Case Study Methods

Since August 2002 Mathematica Policy Research, Inc. and its partners, The Urban Institute and Health Management Associates (HMA), have been conducting an evaluation to determine the impact of the Robert Wood Johnson Foundation's investment in the Covering Kid's & Families (CKF) program, as well as to study factors that may have contributed to, or impaired, its efforts. As part of this evaluation, and building on the baseline information developed by Needleman, The Urban Institute conducted in-depth case studies of five of the 18 CKF-AI grantees. The case studies sought to develop more detailed and nuanced information on CKF-AI grantee efforts to identify and address access barriers, as well as to draw out a series of "lessons learned" that could inform RWJF, state policy-makers, and health research and advocacy communities in the future. Specifically, the case studies sought to answer the following research questions.

- Who were the CKF-AI grantees and what was their history in working with low-income children and families?
- What methods did grantees use to assess community needs and identify barriers to access?
- What were the range and types of access barriers identified by the grantees?
- What strategies did the grantees develop to improve access to care?
- How and why were these strategies chosen?
- How well did the implementation process go?

- What challenges to implementation did grantees encounter and how did they overcome them?
- What were the perceived effects, if any, of the strategies to improve access?
- Were the grantees able to measure the effects of their efforts and, if so, how?
- What steps have the grantees pursued to sustain or institutionalize improvements in access?
- What challenges to sustainability have grantees encountered, and to what degree were grantees able to overcome these challenges?

To answer these questions, we conducted site visits in five (of the 19) grantee communities from August 2007 to November 2007. Sites were selected based on information gathered from grantee reports and notes from the second round of Needleman telephone interviews. Evaluators chose to study grantees that:

- Were relatively successful in their efforts to both identify and address access barriers;
- Represented efforts to address a wide range of access barriers;
- Implemented a diverse set of access improvement strategies; and
- From their efforts, offered the greatest potential to render a set of valuable lessons for both RWJF and communities striving to improve access for their residents.

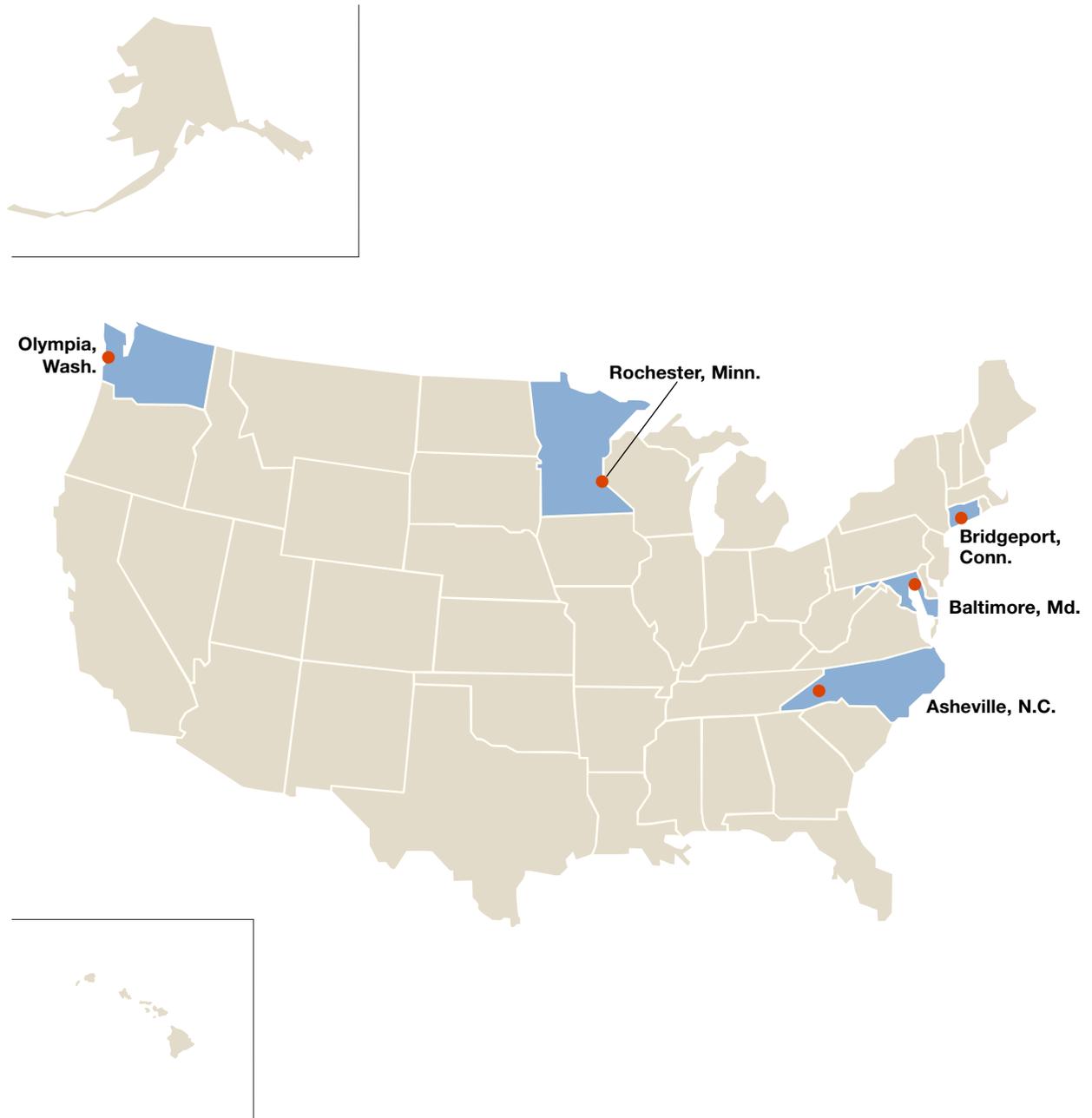
The projects that were selected are displayed in Figure 1 and included:

- Bridgeport Child Advocacy Coalition, Bridgeport, Conn.
- Baltimore HealthCare Access, Baltimore, Md.
- Olmsted County Community Services, Rochester, Minn.
- Buncombe County Department of Social Services, Asheville, N.C.
- CHOICE Regional Health Network, Olympia, Wash.

While on site, evaluators met with a broad range of key informants involved in the CKF-AI effort, including not only grantee leadership and staff, but also state partners, local physicians and clinical staff community-based organizations, health plans, state Medicaid/SCHIP agency staff and advocacy groups. In most cases, evaluators also made direct observations of access interventions (e.g., by attending home visits with community health workers), and interviewed clients of the grantees (e.g., persons who received assistance with their access problems). Detailed protocols were developed for these interviews which permitted the site visit teams to collect information consistently.

FIGURE 1

Locations of the CKF-AI Case Study Grantees



Findings from our case studies of five CKF-AI grantees are presented below. Within each case study, discussion is divided into six parts: background on the grantee and its community; processes for identifying barriers to access; strategies to improve access; perceived program effects; efforts to secure sustainable funding; and overarching lessons learned.

The last section summarizes the cross-cutting lessons learned by the five grantees regarding access barriers, strategies to improve access, and efforts to develop sustainable funding.

Case Study of Bridgeport Child Advocacy Coalition

The Bridgeport Child Advocacy Coalition (BCAC) received a two-year grant under the RWJF-sponsored CKF-AI program. Between September 2003 and December 2005, the nonprofit agency worked to eliminate barriers related to navigating managed care and, specifically, access to prescription drugs. Partnering with Eastern Connecticut Health Network East of the River Collaborative (EOTR), local pharmacists and Managed Care Organizations (MCOs)—and with the support of the state partner Connecticut Voices for Children—BCAC addressed problems with access to temporary supplies of prescription drugs for children enrolled in HUSKY A, (hereafter called “HUSKY”), the state’s Medicaid program.

Bridgeport Child Advocacy Coalition and its Partners

BCAC is a coalition of nearly 80 organizations, parents, and other community members, joined in their commitment to improving the lives of Bridgeport’s children. Coalition membership is diverse, including health care providers, child-care centers, community leaders, churches and synagogues and civic groups. BCAC conducts its work through research, advocacy, community education and mobilization. The organization convenes task forces focused on three broad-based children’s issues, including one on child health and behavioral services. The Child Health Task Force meets for 90 minutes every other month. According to grantee staff, “it is a vehicle for as many as 35 to 50 parents and service providers to be involved with BCAC and an important issue for children.”

Facilitated by this task force, BCAC has a long and successful record of improving children’s access to health care. When the HUSKY program moved from a fee-for-service to a managed care model in the 1990s, for instance, BCAC surveyed parents to explore their experiences with the transition. After learning that families “really struggled with the Medicaid managed care system,” the organization adopted strategies to address health system navigation problems. Consumers have long been integral partners in BCAC’s work, and the

organization has valuable experience using grassroots processes to identify issues they need to work on, and also with evaluating their intervention strategies for continuous improvement.

BCAC also has a long history with the Covering Kids Initiative. The organization received its first Covering Kids grant in 1999, and then became a CKF local grantee in 2002. When the request for proposals for the Access Initiative grant was released, BCAC officials said that they “realized it was just what we wanted to do, not only work on outreach and enrollment [through CKF] but also work on policy barriers” related to access. The additional funding for the CKF-AI grant—which was awarded to both BCAC and another local CKF project in Connecticut, the Eastern Connecticut Health Network/East of the River HUSKY Collaborative (EOTR) project²—allowed outreach workers to meet regularly and collaborate on coordinating their efforts to improve access to care for the HUSKY families they served.

A research and advocacy organization called Connecticut Voices for Children (CVC) served as the CKF-AI state partner and worked closely with BCAC (and EOTR) to develop and implement the chosen access strategies. CVC had taken over this role when the original state partner, the Children’s Health Council (CHC),³ was eliminated through state budget cuts in 2003. Both CHC and CVC established good working relationships with key stakeholders in the project. According to CKF-AI project staff, these relationships were incredibly valuable since “Connecticut Voices had the clout and expertise to bring the right decision-makers to the table” and provided “the statewide visibility needed to make real systemic change.” CVC was the state CKF lead grantee—BCAC staff reported that the two organizations had developed a strong relationship working closely together on the CKF grant.

The Connecticut Department of Social Services (DSS), the state agency that administers HUSKY, and the pharmacy benefits directors for the HUSKY A managed care plans were both key stakeholders and essential partners during the grant period. The participation of these stakeholders was critical because of their key positions in making and implementing policy.

Identifying Barriers to Access

During the barrier identification phase of the grant period, the CKF-AI grantee conducted a series of one-on-one interviews with parents, pharmacists, pediatricians, and office managers in both the Bridgeport and East of the River area, as well as a number of focus groups with HUSKY parents. The grantee also surveyed pharmacists. Ultimately, the grantee decided to focus on the problem of pharmacy access—especially access to a temporary supply of prescription drugs—for children enrolled in HUSKY.

Site visit informants described two primary reasons for selecting this access barrier. First, it was often identified as a barrier to health care for children on HUSKY. Virtually all the stakeholders reported problems with pharmacy access, including parents, physicians and their office staff, and pharmacists in both urban Bridgeport and the rural East of the River area:

- Parents reported problems filling prescriptions for non-formulary drugs and drugs for which they did not have prior authorization, particularly during evening and weekend hours. Grantee staff described instances where parents had to choose between paying for the entire cost of their child’s prescription or leaving the pharmacy without filling it at all. The grantee saw the pharmacy access issue as “a crucial, potentially life-or-death, issue” for families.
- Providers reported problems with understanding HUSKY policies and procedures, particularly the health-plan specific drug formularies and procedures for obtaining prior authorization.
- Pharmacists reported problems with helping individual families troubleshoot prior authorization denials or other problems at the pharmacy. Many pharmacists were not aware of the DSS policy allowing pharmacies to dispense a 30-day temporary supply of medicine in urgent or emergency situations that involve a prescription that has not had prior authorization. Pharmacists feared that if they dispensed medicine requiring prior authorization through a temporary override, they would not get reimbursed by the managed care plan for that medicine.

The pharmacy access barrier was also narrow enough in scope that grantee staff felt confident in its ability to plan, implement, and measure the effects of their intervention within the two-year grant period. The grantee described very specific guidelines from RWJF *not* to choose large-scale issues that were prevalent in many communities, like access to dental or behavioral health care through Medicaid programs. They felt that the access barrier they chose to address was “such a great fit for BCAC.” The Child Health Task Force of the coalition, which needed to approve the issue, had its own selection criteria—whether it was “realistic to realize success” within the grant period. These key stakeholders agreed that the project could achieve sustainable, long-lasting change by addressing the pharmacy access barrier.

Strategies to Improve Access

Many stakeholders—including parents, task force members, BCAC and EOTR staff, and the state partner—were involved in designing approaches to improving access to prescription drugs for children enrolled in HUSKY managed care. Collectively, they developed an intervention for each type of stakeholder affected by the access barrier. The interventions focused on eliminating the access barrier and providing user-friendly education materials for families, providers, and pharmacists.

For families, the grantee developed a brightly colored flyer outlining steps to take if a pharmacy refuses to fill a prescription or if a health plan sends a bill to HUSKY families in error. The grantee estimated that the flyer reached as many as 30,000 parents. Though BCAC has had “a lot of practice with making user-friendly health materials for parents,” grantee staff noted that the services of a medical literacy consultant, sponsored by RWJF through the CKF-AI grant, were very helpful in developing the flyer.

For pharmacists, the grantee developed another brightly colored flyer suggesting steps for dispensing non-formulary and “prior authorization required” prescriptions under the four different HUSKY managed care plans. Each health plan approved the language in the pharmacy flyers and paid for the cost of printing and mailing. The flyer was distributed to all 650 HUSKY participating pharmacists statewide.

For providers, the CKF-AI grantee created a toolkit—available in hard copy and online—to help pediatric office managers gain a better understanding of HUSKY policies and procedures, including a section on pharmacy access. The EOTR project staff worked on this strategy, and had to obtain approval from DSS before finalizing the product.

The state partner, CVC, pursued policy change at the state level and submitted recommendations to “strengthen both the oversight and contract provisions in the DSS pharmacy contract.” These recommendations included consistent monitoring of the HUSKY telephone information line (e.g., the HUSKY Infoline) to identify calls for problems concerning pharmacy access, as well as a requirement that health plans regularly inform pharmacists of their DSS temporary supply policy.

The grantee and state partner also convened a series of meetings with DSS and the four MCOs to first identify a best practice adopted by one MCO (changing the “default” action to filling a prescription rather than denying it) and then to urge the other three MCOs to adopt the practice. During the meetings, BCAC, EOTR and CVC discovered that for two MCOs, when non-formulary prescriptions for HUSKY enrollees were entered, a denial screen appeared on pharmacist’s computer screens that simply read “NOT COVERED.” One health plan had not yet adopted a formulary. For the fourth plan, pharmacists were able to override the denial code through a “one-time fill procedure,” and a message appeared on the computer screen prompting this procedure.

Rather than deny the prescription, pharmacists dispensed the drug and conducted follow-up with the prescribing doctor to get authorization the following day. The grantee and state partner identified this procedure as a best practice, which DSS subsequently requested the other two health plans to adopt. However, according to informants, DSS is “incredibly understaffed, and they don’t monitor whether the health plans have made the change that they requested.” The third health plan had still not adopted a formulary by the end of the CKF-AI grant, but indicated that the best practice would be implemented when they had a formulary. (Site visit informants did not know whether this had ever happened.)

Grantee staff reported minimal barriers to implementation, and these were mainly associated with partnering effectively with the state’s HUSKY MCOs and DSS. One informant noted the large effort required to get “the right people to the table, and then getting them to agree on the change.” In addition, the CKF-AI grantee emphasized the significant amount of time required to implement policy changes at the MCO level, and acknowledged that many steps would be required “to get the overall change that we wanted.” Officials from partnering MCOs also noted the lengthy timelines that policy changes typically required. They also indicated that it could be challenging to craft messages about filling prescriptions “that would be compliant with national pharmacy standards and could be linked to all the necessary, non-formulary drugs.”

Perceived Effects

To assess the effects of the CKF-AI effort, BCAC held access-related focus groups with HUSKY A parents after the CKF-AI grant ended, talking with at least 200 people participating in 24 focus groups. Though these focus groups were sponsored by a subsequent grant rather than CKF-AI, BCAC considered them an informal indicator of the earlier project’s success. Parents in the focus groups reported a range of access barriers—including some issues related to prescription drugs—but none mentioned problems receiving a temporary drug supply at the pharmacy.

As part of their initiative, the grantee encouraged two of the MCOs participating in HUSKY A to adopt the best pharmacy practice identified at another HUSKY MCO. While both MCOs committed to adopting the best practice at the end of the grant period, site visit informants reported that just one of the organizations had actually followed through with the change. Still, the fact that one MCO had adopted the best practice was “a major success for the project and for over 100,000 HUSKY enrollees in that health plan.”

BCAC indicated that other positive CKF-AI effects—though only indirectly related to the specific access barrier that CKF-AI addressed—included the new skills and expertise gained from working on the pharmacy access issue. After the grant period, the organization and its partners continued to work on access issues; at the time of the site visit, BCAC was working on improvements to policies in in-service training for pharmacy technicians. BCAC also gained valuable experience working with a range of stakeholders (including representatives from DSS and the MCOs participating in HUSKY) with different interests to accomplish a common health care access goal; they described the work they did under CKF-AI as a “unique collaboration” that benefited all involved parties and raised awareness of pharmacy access issues.

Sustainability

Some of the CKF-AI strategies were sustained in the post-grant period and in the Bridgeport area only, since the EOTR project stopped when grant funds ended. The flyers to parents were still being produced and distributed at the time of the site visit. The pharmacy fact sheet was no longer being distributed, though key informants reported that it was still actively used by some pharmacists in the area. The physician’s toolkit was still in use by pediatrician’s offices—both the hard copy and online versions.

Though some CKF-AI products were still being distributed and/or used in the Bridgeport community in the post-grant period, BCAC officials noted that there were no dedicated resources available to keep the materials (e.g., the parent flyers, pharmacy fact sheets, and toolkit) up-to-date. Materials with information on Medicaid policies and procedures (particularly those related to managed care) often have a short shelf life, and site visit informants told us that these resources “would need serious updating to stay useful.” Even at the time of the site visit, the parent flyers and the pharmacy fact sheets contained some inaccurate information that restricted their effectiveness.

Monthly meetings with MCO representatives did not continue in the post-grant period, due to both limited resources and personnel changes at the MCOs. Grantee staff also reported that without the dedicated resources the CKF-AI grant provided, it became impossible to follow up with the MCOs on their promised pharmacy-related improvements—including their commitment to adopting the identified best practice. According to the grantee, partners are less likely to follow through on their promised activities without intensive follow-up. Indeed, one of the MCOs that had committed to adopting the best practice had not done so at the time of the site visit. Moreover, the CKF-AI state partner reported that there were no resources to follow up with DSS regarding the set of policy recommendations related to HUSKY MCO contract provisions. These recommendations had not, as of the time of the site visit, been put into practice.

The collaborative of outreach workers formed in the initial stages of the CKF grant (and subsequently supported by CKF-AI and other grant funds) continued to meet even after the grant period and funding ended. At the time of the site visit, this group was involved in monitoring and conducting regular trainings on HUSKY policy changes that impact access to care. This collaborative, and the communication channel it represents, continues to be a significant part of BCAC outreach efforts, since “it is very important for families to get HUSKY information from someone they know and trust. It’s especially important for immigrant communities—of which there are many in Bridgeport.”

Lessons Learned

BCAC and EOTR experienced success as CKF-AI grantees. Among the larger group of CKF-AI projects, the Connecticut team is notable for: 1) a thorough exploration of access barriers during the identification phase, as they engaged many different stakeholders via interviews, focus groups, and a survey; 2) selecting a problem that was narrow in scope and therefore reasonable to address in a short time frame; and 3) collecting information that allowed them to assess the effects of their project after it was over. Grantee staff indicated that these three features of their project were significant factors in their success. They also shared the following lessons with the evaluation team:

- **The CKF-AI grant provided BCAC with an important opportunity to address health access problems that they had identified while working on other grants.** As a CKI and then a CKF project, BCAC became a go-to organization for HUSKY application assistance. Working with parents in this way, the grantee learned about a variety of access problems, but they were not able to focus on these issues before they received the CKF-AI grant.
- **The two-year grant period was not long enough for follow-up and evaluation of access improvement strategies.** BCAC staff reported, “We ran out of time. We could have used another six to 12 months, even at a scaled-back level of effort, to do follow-up and evaluation.” They noted that grant-dependent agencies cannot follow up without foundational support, and must instead move on to new grant opportunities without fully understanding the impact of the initiatives they carried out under previous grants.

- **Materials created with time-limited grant funds may have a short shelf life if grantees cannot shift the cost of updating those materials to another grant.** After the grant ended, BCAC officials did not have the staff time or the resources necessary to update the materials developed under CKF-AI. Unless CKF-AI products became relevant to other grants and projects (and could be updated with funds from those projects), grantee staff expressed concern that the materials might become so outdated that they would fall out of use.
- **The data collection experience gained by grantees during the ‘barrier identification’ phase of the project was very valuable.** BCAC officials reported that they used their experience conducting interviews and focus groups in a subsequent grant which required this same sort of data collection. As part of their new grant (which is related to a campaign for universal health care), they conducted 24 “house meetings” to discuss broader health care issues with Bridgeport residents. The organization also conducted a survey related to variations in prescription drug costs among Bridgeport area pharmacies, and reported that their experience surveying pharmacists under CKF-AI helped with this effort.
- **Collaboration between two local organizations—BCAC and EOTR—and the state partner—Connecticut Voices—was essential for statewide implementation of access improvement strategies.** Key informants noted “the importance of exploring problems at the local level, and the need for personal contact with parents at that level.” By partnering with EOTR, the grant could reach most of the state. In addition, BCAC explained the partnership with Connecticut Voices was a means “to impact statewide policy change.”
- **Working on the CKF-AI grant increased organizational capacity within the grantee and state partner organizations, and strengthened inter-agency relationships.** All stakeholders benefited from the initiative and the opportunity it brought for collaboration. According to one informant, the MCO policy meetings that the state partner convened for CKF-AI “may very well have been the first time all of those MCO pharmacy directors had ever sat down at the table together” to work on an access issue. Indeed, managed care officials indicated that the temporary supply issue had been on their radar “on and off, over the years” and DSS had even communicated with the plans about the issue. CKF-AI represented an opportunity for these partners to dedicate their time to addressing an important access barrier for HUSKY A families.

The CKF-AI project in Connecticut identified a common access barrier that was appropriate in scope for the CKF-AI grant, and then implemented a strategy targeting various stakeholders via a multipronged approach. Through the development of educational materials on pharmacy access and other HUSKY policies, and by engaging MCO and DSS officials to bring about procedural changes related to a temporary supply of prescription drugs, the grantee and state partner succeeded in improving pharmacy access for thousands of children enrolled in the HUSKY program.

Case Study of Baltimore HealthCare Access

Maryland-based Baltimore HealthCare Access (BHCA) received a CKF-AI grant. Over the two-year grant period, the nonprofit agency worked with a wide range of community stakeholders, especially those serving pregnant Latina women, to develop several strategies designed to improve access to care. The strategies were aimed particularly at improving access to prenatal care by addressing cultural and linguistic problems. These strategies included leaflets for newly arrived pregnant women detailing where to get prenatal care services, an educational DVD for clinic waiting rooms, and cultural competency training at four key area hospitals.

Background on Baltimore HealthCare Access and its partners

BHCA is a 501(c)(3) nonprofit established in 1997 as an affiliate of the Baltimore City Health Department. Originally, BCHA's objective was to assist with the city's transition from Medicaid fee-for-service to a managed care system ("HealthChoice"). Their role has evolved over the years to include providing ombudsman services to HealthChoice enrollees, managing the eligibility process for the Maryland Children's Health Insurance Program (MCHP) in Baltimore City, and a significant outreach role.

BHCA's outreach role is multifaceted. In connection with its care coordination services (described below), the agency receives referrals from managed care organizations to reach out to enrollees who are not complying with provider appointments to identify and remove barriers preventing them from accessing and using health services. Another population that BHCA targets through its outreach efforts, Hispanic immigrants, has grown in numbers over the last few years. BHCA staff reaches out to this population to provide eligibility and enrollment assistance, health education, and system navigation support. To facilitate assistance to immigrants and other hard-to-reach populations, BHCA outstations workers at seven sites in the community, including food pantries, shelters, and health clinics.

BHCA also has a case management and care coordination role. As part of its maternal and child health services, BHCA receives referrals from Medicaid managed care organizations of persons who are noncompliant with care plans. BHCA case managers conduct home visits to these patients, identify the problems they are having in receiving care, and attempt to resolve these problems. Some of the patients identified this way may subsequently be referred to long-term case management programs, such as Healthy Start. Additionally, BHCA staff described a new program targeting substance abusers, which incorporates case management for primary care and a new medication program.

To fulfill these various roles, BHCA has a staff of 98, many of whom are bilingual. Additionally, BHCA works with several well-established, community-based organizations that provide outreach and advisory services to immigrant and low-income families.

Examples of these organizations include:

- The Esperanza Center, a part of Catholic Charities which has worked with the immigrant community for more than 40 years, offering a variety of services including access to health care;
- Care-a-Van, a mobile health clinic serving many undocumented Latinos;
- Adalante Familia, a part of Vincent de St Paul, which provides an emergency food pantry and assistance to victims of domestic violence; and
- La Carolina Clinic funded by the Baltimore Department of Health to provide a range of primary, preventive, dental, and maternal and infant health care services.

To further these partnerships, BHCA attends the monthly meetings of the Latino Provider Network, an umbrella organization for all community-based organizations in Baltimore City serving the Latino population. Through these networks, BHCA ensures it utilizes the resources in the community to best serve its clientele.

The Access Initiative was a natural fit for BHCA, with their long-standing focus on access to care in Baltimore. Additionally, at the time the request for proposals was released, Baltimore City had experienced a rapid increase in the Latino population, and many in this group were eligible for state health programs (for example, pregnant women and children). This created an extra incentive for BHCA to apply for the grant, which would build on their efforts as a local grantee under the Covering Kids and Families initiative.

BHCA chose to work with the Public Justice Center as its state partner. The Public Justice Center was established in 1985 as a nonprofit legal services organization focusing on a broad spectrum of issues affecting the poor. The Public Justice Center provides individual, class action, and appellate litigation services; legislative and policy advocacy; and public education in a variety of areas, including access to health care. BHCA had previously worked with the Public Justice Center to better understand and educate staff about immigrants' eligibility for state health programs. Since BHCA envisioned the grant would focus on the immigrant population in Baltimore, the Public Justice Center was an appropriate and natural partner.

Identifying Barriers to Access

During the first phase of its project, BHCA conducted a variety of research activities. To identify access barriers, BHCA focused most of its research on Medicaid-eligible and immigrant families, conducting a total of two focus groups, six bilingual interviews with individuals, and 50 interviews with Latino women with newborns. Phase I research focused mostly on Spanish-speaking families and particularly Latino women because of the recent influx of Latin-American families into the Baltimore area. BHCA also sought the opinions of providers and discussed access barriers with a number of hospital and clinic administrators.

Multiple access barriers were identified. BHCA found a lack of information on system navigation was prominent among the Latino population. Pregnant Latino immigrants, especially those newly arrived, were generally unaware of their eligibility for Medicaid coverage (provided they met income and documentation status requirements), where to get care, or the importance of prenatal care visits. Cultural and linguistic barriers added to their difficulty in accessing and navigating care. For instance, in most Latin-American countries babies are given both their mother's and father's last names; BHCA discovered that this often created confusion among hospital administrative staff, especially when medical records are not consistently filled out using the same surname, with the result that files were lost or mislaid. New mothers did not know how to get birth certificates and who to contact about mistakes in the reporting of the child's name. Compounding these problems, BHCA found there was little to no understanding among providers of federal Title VI requirements to provide translators at federally funded health facilities, and limited English proficiency (LEP) pregnant women encountered many communication barriers in accessing and using services. Finally, the grantee discovered that the existing health literature available to pregnant women—which included information on where to get care, how to sign up for Medicaid, and instructions for pre- and post-natal care—was written at too high a literacy level.

Strategies to Improve Access

To help interpret their findings and design the project, BHCA created an Advisory Commission, which met bimonthly and was composed of members from local hospitals, managed care organizations, and community-based organizations. Together, BHCA and the Commission realized some of the barriers were too big to tackle within the scope of this relatively small grant, and decided to focus on helping the target population they felt was in most need—Latino immigrants, especially pregnant women. One focus was to address the confusion surrounding Latino babies' names. BHCA developed a one-page information leaflet for Latino pregnant women explaining the importance of ensuring that hospital and administrative staff correctly records the baby's name. The leaflet also included information about what to take to the hospital, where to call if they do not receive the birth certificate or if it contains errors, as well as steps to take if they do not receive the baby's social security card.

An eight-page leaflet "I am pregnant and living in Baltimore City: Where do I go for help?" was also developed to target newly arrived Latino pregnant women who need information about where and how to get prenatal care. The leaflet explains where women can get free or low-cost pregnancy tests, and contains contact information for MCHP and clinics that provide low-cost prenatal care. Also provided is information on their rights as patients and rights under Title VI to have an interpreter at facilities that are funded by state or federal monies.

BHCA distributed both the one-page and eight-page leaflets through the network of community-based agencies with which they work. The materials were handed out by their outreach workers. A major challenge in the development of the materials was to keep the information generic, so that the leaflets would continue to be relevant over the years and would not become obsolete because of changes in Medicaid or MCHP eligibility rules.

A third CKF-AI project was to make a short film titled "Senora de la Cruz," which aims to educate Latino immigrants about the U.S. health care system and has a particular focus on the needs of pregnant women. The script for the video was developed in-house with input from the Public Justice Center, the Advisory Commission, and the film director. The film depicts the experiences of two Latino pregnant women as they navigate the health care system—one who gets help from the Department of Health with health care costs and a clinic interpreter, and one who does not. The film entertainingly demonstrates how complicated the U.S. health care system can be to new immigrants, but also how, by engaging the help available, it's easier to access the system. Topics covered in the DVD include: the financial help available to pay for prenatal care services (for both documented and undocumented immigrants); the right to ask for an interpreter

at clinics; how to apply for and renew MCHP (to cover labor and delivery costs and to insure the newborn); the importance of recording names the same way on all documents; and the assistance available at the Department of Health.

BHCA connected with community-based organizations to screen and distribute the DVD, including the Latin Providers Network which disseminated the product to all Network partners. The DVD received national attention when it was highlighted in the Kaiser Family Foundation Daily Health Policy Report, and BHCA received many out-of-state requests for the film.

A final strategy developed was to provide cultural competency training sessions at four hospitals participating on the Advisory Commission. Training was given to residents and attending physicians on a variety of culturally sensitive issues, using the Office of Minority Health standards for providing culturally competent care and integrating Baltimore-specific subjects. Examples of training content include explaining the importance of having a translator for women in labor and not transferring babies to neonatal intensive care units without first discussing the situation with the child's family.

Throughout the initiative, BHCA consulted with the Public Justice Center on Medicaid eligibility rules surrounding citizenship and documentation status of immigrants. Additionally, as described above, the Public Justice Center collaborated on both the DVD script and participated in its filming.

Perceived Effects

BHCA found measuring any effects of their work difficult but felt it was not a priority of the grant. They also did not have a staff member who could be dedicated to evaluation. They considered various ways of measuring effects, such as analyzing over the grant period the number of pregnant women getting timely prenatal care in the first trimester. However, ultimately they focused on solving the access barriers they had identified quickly and did not evaluate the interventions.

However, qualitatively, BHCA feels the Access Initiative has raised the organization's profile in the community. Grantee staff reported that they are called on more frequently now, for example by the Department of Health, to weigh in on issues surrounding access to health care for immigrants. Indeed, one stakeholder told us: "BHCA has emerged as a major leader in supporting the Latino community." The commitment of BHCA to community collaboration has also strengthened the community as a whole in its capacity to cope with immigrant health issues and stakeholders believe the Access Initiative was fundamental in making this happen. Anecdotal reports from stakeholders in the community suggest the DVD is received very well by families, and every parent can identify with some aspect of the film. Some community-based organizations think the DVD has more of an impact than the leaflets because of literacy problems.

Also, the film is a convenient way to reach people in waiting rooms, when they are otherwise unoccupied.

Sustainability

BHCA has been able to continue virtually all the activities developed under the Access Initiative. BHCA thought about sustainability from the start of the grant and assumed they would continue the efforts developed under the Access Initiative. They continue to distribute all the materials produced under the grant, the funding for which has been folded into other budgets. However, the cultural competency training has not been sustained, even though this is something they feel is required as an ongoing part of provider training.

On an organizational level, BHCA took the lessons they learned during the grant period about providing culturally competent services and translated them into an organizational goal. The agency now ensures that every department has a bilingual staff member. They also have a much more sophisticated outreach team with finely tuned outreach skills, which has expanded to serve other immigrant groups.

Lessons Learned

BHCA felt a key factor to their success was having a dedicated project staff member who was passionate and knowledgeable about the issues. Another factor was their decision to get input and insight from the hospitals, clinics, community-based organizations and target population themselves.

“BHCA served as a catalyst in bringing people together and solving problems.”

(Stakeholder, 2007).

BHCA found it particularly helpful to work within existing structures in the community, such as the Latino Service Provider Network, and to convene local experts in the Advisory Commission. By taking advantage of existing relationships in the Baltimore community, they harnessed wide support for CKF-AI and its efforts. In fact, implementation of all of BHCA’s strategies was made easier because of the established and stable health care provider base in the city. BHCA had long-standing relationships with most of these providers and this helped to achieve the grant goals, according to grantee staff.

Finally, the grantee found that the flexibility provided by RWJF was key to ensuring they addressed local problems with appropriate strategies.

Case Study of Olmsted County Community Services

The Olmsted County Department of Community Services, specifically its Division of Family Support and Assistance, was the grantee under CKF-AI in Minnesota. Between September 2003 and December 2005, the county agency worked in partnership with the Intercultural Mutual Assistance Association (IMAA) to help families overcome language, cultural, and administrative barriers to health care. Through a careful developmental process, persistent implementation, and a multipronged sustainability strategy, the county used the CKF-AI grant to build a Community Health Worker (CHW) program that continues, to this day, to help immigrant families in the Rochester, Minn. area to access critical health and social services.

Background on Olmsted County Community Services and its Partners

The broad mission of Olmsted County Department of Community Services is to work in partnership with the community to promote the safety, well-being and stability of vulnerable children, families and adults in the county. The Division of Family Support and Assistance, in turn, is charged with administering a broad range of services that support those objectives, including energy assistance, food stamps, child support, child care assistance and cash assistance (among others). Importantly, they are also the agency that determines eligibility for the Medicaid and MinnesotaCare⁴ programs, and thus are integrally involved in issues surrounding access to health coverage and care. It is this background and mission that placed the agency in an ideal position to serve as one of Minnesota's local grantees under the broader CKF program, and to also pursue and obtain one of that program's Access Initiative grants.

The IMAA is a not-for-profit organization that assists Olmsted County's immigrants by providing a range of culturally appropriate, multilingual programs and support services to individuals and families. Specifically, the organization provides: professional document translation and oral interpretation services; refugee social service and education programs to help new immigrants learn how to navigate public systems; confidential assistance to victims of crime; employment guidance, education, and referral services; and training and employment assistance to persons interested in becoming personal care attendants or certified nurse assistants. In the years leading up to the CKF-AI grant, IMAA was also involved with a community health worker program called *Pathfinder* which was run out of the Mayo Clinic and provided hands-on assistance to clients struggling to access needed medical, dental, and mental health services.

When the request for proposals for the CKF-AI grant was released, Olmsted County officials immediately decided to apply. They knew that many of the county's residents, mostly in the city of Rochester, were experiencing barriers to accessing needed care. They also knew that the county's most vulnerable residents were often recent immigrants. As described by county officials, Rochester had emerged as a beacon to a large and diverse immigrant community—comprising Somalis, Sudanese, Vietnamese, Cambodians, Bosnians, and Latinos, among others—largely because of its history employing persons of diverse ethnic and cultural backgrounds at large organizations such as IBM and the Mayo Clinic. The fact that the city also possessed strong and welcoming public and nonprofit social service systems further fueled the influx of immigrants. Coincidentally, IMAA was an active member of the county agency's Advisory Board and when the CKF-AI grant program was announced, IMAA and Olmsted County Community Services decided that it offered an ideal opportunity to enhance the county's capacity to assist families in accessing care. They worked collaboratively on the grant proposal, and Olmsted County Community Services received its CKF-AI grant in 2003.

Olmsted County officials enlisted the Minnesota Children's Defense Fund (CDF) as its "state partner." CDF was Minnesota's state-level grantee under the broader CKF initiative, possessed extensive expertise in access issues and the technical workings of the state's Medicaid and MinnesotaCare programs, and was already a strong and well-known partner with Olmsted County.

Identifying Barriers to Access

The first phase of the Access Initiative grant required Olmsted County Community Services to systematically identify the leading access barriers confronting the target population of persons enrolled in MinnesotaCare and Medicaid. Like many grantees, Olmsted initially considered conducting a series of focus groups to help with barrier identification. Instead, however, they opted to develop and administer a formal survey, believing that it would yield more precise and detailed findings. Olmsted enlisted the assistance of IMAA, as well as the Multicultural Healthcare Alliance and Data Matters (a private evaluation firm) to help develop the survey instrument. During what was described as a "lengthy and sometimes grueling" process, the instrument went through numerous revisions and was finally completed after approximately one year. Because the majority of people to be served through the initiative would possess little or no English literacy skills, the team decided to administer the survey orally, using the bilingual staff of IMAA. Twelve case workers with diverse ethnic backgrounds, as well as a number of staff of the Division of Family Support and Assistance were trained in survey interview techniques by the Data Matters consultant.

Between January and February 2005, 220 surveys were administered, representing more than 900 household members. Eighty percent of respondents had children under age 21 covered by public insurance programs, and 83 percent were immigrants or refugees. Their demographic breakdown was as follows: 37 percent African; 25 percent Asian; 18 percent Latino; 11 percent Anglo; 8 percent European/other; and 1 percent African American or Native American.

Prior to the survey, county officials expected to find that transportation would be the leading barrier to health services. Instead, they found that “paperwork” was the number one problem area for both immigrants and U.S.-born clients, including renewing public health insurance coverage (63 percent reported this as either “always” or “sometimes” a problem), choosing a health care plan and provider under the county’s new managed care system (54 percent), and understanding medical bills (54 percent). The second leading access barrier, primarily for immigrant respondents, was inability to communicate effectively with health care providers (56 percent of immigrants reported this as either “always” or “sometimes” a problem). While satisfaction with quality of care was high, respondents consistently reported needing help in overcoming confusing language barriers throughout the process of care, including making appointments, understanding doctor advice, and arranging for follow-up care.

Because helping families with eligibility renewal was already an objective of the larger CKF grant, this barrier was not selected to be addressed through the Access Initiative. Instead, assistance with choosing a health plan or provider was chosen as part of the intervention addressing “paperwork” barriers, and assistance with communicating with health care providers and systems, specifically for immigrant populations, was chosen as the second intervention area.

Strategies to Improve Access

Even while Olmsted County and IMAA were conducting their survey, they were formulating a plan for how to intervene on behalf of immigrant families. From the beginning, staff believed that a Community Health Worker (CHW) program, modeled after *Pathfinder*, represented the optimal strategy for assisting this population. Olmsted County assumed the lead management role in this partnership and contracted with IMAA to recruit, train, and oversee the work of a cadre of CHWs with diverse cultural and linguistic skills.

During the summer and fall of 2004, IMAA hired 10 CHWs to work with African (Somali, Sudanese), Asian (Cambodian, Hmong), Bosnian, and Latino immigrants, while Olmsted County staff and the coordinator of the Multicultural HealthCare Alliance developed a CHW training curriculum. The newly hired CHWs then each participated in 20 hours of training.

Once trained, CHWs began marketing their services by visiting community- and faith-based organizations and a local adult education center, and by attending community events involving the Olmsted County CKF project. Events included the “Running Start” back-to-school kickoff, area high school health fairs, county public health vision and hearing screening clinics, Mayo Clinic African and Cambodian health fairs, and a Cinco de Mayo celebration, among others.

Workers then began providing one-on-one assistance to families either in their homes, in the community, or at the IMAA offices. All contacts were typically by appointment and focused on helping families choose health care plans and providers, understand their health insurance coverage, medical bills and copayments, and communicate with providers. They also assisted with scheduling medical visits and arranging transportation. CHWs also could refer families for help with food, child care, school registration, and other social services. IMAA’s original plan also included group teaching in Alliance’s classroom. But this approach was quickly dropped when staff experienced very poor sign-up rates and attendance for classes and realized that, for many of the cultural and ethnic groups they served, health issues were viewed as quite sensitive, and family members did not feel comfortable addressing them in a group setting.

Implementation of the CHW program met with certain challenges. Over the course of the project’s second phase (October 2004 through December 2005), there was considerable staff turnover and a significant change in program leadership. At one point, as many as 12 workers were on staff, organized into five teams with five team leaders, each focusing on a distinct cultural/ethnic group. This structure proved unnecessarily complex, led to role confusion, and was eventually streamlined to two teams. More generally, several employees came to realize that they were not well suited to be CHWs, liking the job for its flexibility but not fulfilling the responsibilities of always documenting their work, attending scheduled meetings, and accommodating shifts in community needs. By June 2005 a new Education and Outreach Program Coordinator was hired who had all the requisite skills and temperament, and the program began to “hit its stride,” according to the IMAA director. This individual enhanced the CHW program’s policies and procedures, ongoing training capacity, and data systems for tracking and monitoring the activities and interventions of CHWs on behalf of the target population.

The Minnesota CDF, as the grantee's state partner, worked to address Olmsted County's identified access barriers on a broader scale to bring more attention to the issues and to facilitate systemic changes. To address the "billing and paperwork" priority, CDF developed a "paperwork matrix" by collecting bills, guidelines, rules, and forms that were promulgated by the state Medicaid agency, as well as by the health plans that were participating in Medicaid. This matrix shed light on both the complexity and redundancy of much of this paperwork, and facilitated discussions with state and health plan officials designed to simplify and streamline written materials shared with Medicaid enrollees.

This work dovetailed with Minnesota's larger initiative to design and develop a centralized electronic eligibility system, called HealthMatch. CDF collaborated with state and health plan staff to develop a set of recommendations on what types of information clients need to be able to access through HealthMatch, how notices to families should be sent, and how notices, bills, and paperwork need to be organized and identified. Literacy experts were also brought into the discussions by CDF to review notices and billing information, and to promote the development of simpler and clearer written communications.

CDF was also active in helping to sustain the CHW model in Minnesota. Specifically, CDF worked to expand the application of the CHW training curriculum across the state, helped secure grant funding to establish a certified training program at three metro-area community colleges, and supported efforts to develop policy that would allow certified CHWs to obtain third-party reimbursement for their services under Medicaid.

Perceived Effects

No formal evaluation of the CHW program was conducted by either Olmsted County or IMAA, but considerable anecdotal evidence from project staff point to the effort's positive effects. Key informants interviewed for this case study spoke of how CHWs had succeeded in getting families help, facilitating their receipt of primary and acute care, and helping individuals manage their chronic conditions. Staff also described how they believed that they were empowering families to work through challenges presented by the health care system, helping them to learn how to do things on their own. Such impressions were informed by a series of random follow-up telephone calls with clients that were conducted by CHWs during the spring and summer of 2005. CHWs had records of the issues with which they had assisted these clients, and interviews with a total of 99 clients revealed that almost all had a better understanding of the issues with which they were helped.

In total, the grantee reported that they served 540 clients by the end of the grant period and conducted a total of 1,033 CHW visits (85 percent of which were in the families' homes). Furthermore, these clients (all but eight of whom were immigrants) had a total of 1,059 family members who were indirectly impacted by the program (most of whom were children under age 21). Fifty-one percent of clients were African, 25 percent Latino, 12 percent Asian, and 10 percent Bosnian. Program data show that paperwork was the most commonly addressed issue during a CHW visit (discussed during one out of three visits), followed by assistance with health plan services, scheduling medical appointments, accessing transportation, obtaining language services, choosing a provider or health plan, and understanding cost sharing.

The apparent success of the CHW program also helped to spur the further development of a CHW training curriculum. With input from Olmsted County, IMAA, and Mayo Clinic staff, educators at a local community college formalized the curriculum and instituted a new certificate program at the Rochester Community and Technical College (RCTC). Subsequently, three other community colleges across the state adopted the program. The program comprises 16 credits—11 in CHW skills training, and five in nursing assistance—and the Mayo Clinic has provided scholarship tuition grants to support the training of program enrollees. (Reportedly, the inclusion of the nurse assistance component in the training curriculum “cemented” Mayo’s buy-in and support for the effort.)

Sustainability

With the end of the grant, Olmsted County largely withdrew their involvement with the CHW program, aside from referring county clients in need of help to IMAA. But IMAA has worked hard to continue its operation and, while it has pared down the program’s size, it has succeeded in keeping the program afloat. At the time of this writing, there were five fully accredited CHWs on staff (each of whom had completed the training curriculum at RCTC), and two additional “trainees” working through the curriculum; ultimately, IMAA would like to employ 10 workers. The program director says that the program, while smaller, is “better.” The formalized training is credited with improving the quality of service, as well as the morale of the CHWs (since it places them on a more identifiable career path).

A primary funder after the CKF-AI grant has been the United Way. Indeed, United Way's support was secured well before the end of the CKF-AI grant and permitted IMAA to continue its operations without disruption. IMAA was able to use its data and experience developed under CKF-AI to present the United Way with a proposal for a "proven, sustainable model," according to the program director. More generally, the strong imprimatur of RWJF funding has paved the way for other groups to lend their support; additional grant monies were secured (in 2006) from the Blue Cross/Blue Shield Foundation of Minnesota. The Mayo Clinic also provides a small annual grant to support training costs.

Various recent data reports illustrate how IMAA has continued to provide high levels of service to the Rochester community. For example, in calendar year 2006, CHWs served 1,216 clients. From July 2006 through June 2007, workers conducted 970 home visits.

A long-term sustainability goal of IMAA has been to secure third-party reimbursement for the provision of CHW services. To this end, the organization was involved with a committee that developed legislative language to make CHW services reimbursable under Medicaid.⁵

At the time of our visit, passage of the provision looked promising,⁶ and IMAA officials were preparing to implement procedures that would permit their billing of Medicaid. Interestingly, while such reimbursement would likely benefit the sustainability of the program, IMAA officials also wondered if it might produce some unintended, negative consequences for IMAA. For example, it might result in new providers of CHW services entering the market to compete with IMAA. Alternatively, health plans might see it as an opportunity to develop their in-house capacity to provide CHW services. The longer term impacts of third-party reimbursement will only become clear over time.

Lessons Learned

The CKF-AI grant in Minnesota was successful along many lines. First, it represented a strong and complementary partnership between a county social services agency and a nonprofit community-based organization. Second, the project engaged in a careful and thorough needs assessment process that not only produced some surprising results, but also taught those involved new and more sophisticated survey skills. Third, the project built and refined an apparently effective CHW program that has assisted thousands of immigrant community members to better negotiate health systems in the Rochester area.

Finally, by planning from the beginning, grantees succeeded in arranging numerous sources of sustainable funding while also influencing developments in the educational systems that will help ensure a steady flow of well-trained CHWs into the market. While achieving these successes, Olmsted County and IMAA learned several important lessons, including:

- **It takes special people with the “right qualities” to be successful CHWs.** According to grantee and IMAA officials, these qualities include “strong connections with their respective ethnic communities...strong bilingual skills...proactive, autonomous...professional conduct...paperwork and computer skills or a desire to learn technology” (Grantee final report, 2006). Once again, IMAA did not necessarily find these “right” people initially, but over time, persons who were not well suited to the job moved on and IMAA learned how to better recruit individuals with the aptitude for the position.
- **Maintaining a paper trail and good documentation is critical for ongoing success.** It took time for the grantee to understand the importance of documenting the detailed activities of their workers, and that the nature of the job did not easily lend itself to careful tracking. In time, the IMAA project director was able to develop a simple-but-effective tracking sheet and staff was trained in the importance of program monitoring. In the end, by compiling good data on CHW activities, IMAA was able to successfully raise new monies by demonstrating the effects of their program.
- **Specifying and fine-tuning the roles and responsibilities of CHWs is critical to maintain program integrity and to avoid role confusion.** Given the plethora of needs and issues among the diverse target population they served, CHWs described the challenges surrounding their jobs and confusion over boundaries dictating what they should and should not do. When working with clients, CHWs were tempted to help with anything and everything, yet different grant funding sources required that only certain issues be addressed.
- **The CHW model can be an effective one, but it requires close management and supervision, clear policies and procedures, and consistent enforcement.** By its very “lay” nature, the CHW model brings with it the potential for service delivery that is less tied to established professional norms by staff with less formal training. But Olmsted County and IMAA officials learned how to manage a consistent and accountable model through careful supervision and oversight. And by working with the educational system to establish an accredited training program, it made huge strides in creating a more established, professional foundation upon which to build its model into the future.

- **Planning for sustainability from the beginning is critical.** IMAA, working with Olmsted County, was forward-looking throughout the grant period. Staff understood the limited time frame for the grant and took steps to help ensure sustainable funding early on. These steps included building a strong reporting and data system (so that program effects could be documented), working to establish a formal training system (so that the CHW model could gain credibility and professionalism), exploring and supporting the development of third-party reimbursement sources (to create the potential for future funding support), and (successfully) applying for additional grant funding before the end of the CKF-AI grant period.
- **A partnership involving government and non-governmental agencies can be challenging.** Both Olmsted County and IMAA had distinct missions, philosophies, and perspectives, not to mention administrative, fiscal, and reporting systems, going into this partnership. And, over the course of the grant, the partners learned that working across the two systems was sometimes challenging. Establishing clear lines of authority and responsibility is critical, and concentrating administrative responsibility within a single agency may be a preferred approach long-term.
- **A two-year time frame for such an ambitious scope of work is too short.** Both the grantee and its state partner agreed that two years was too short a time to both assess community needs *and* develop and implement a successful program. The clearest impacts and lessons from the CHW program emerged over a longer period of time and into the post-grant phase. Furthermore, if RWJF wants grantees to more formally evaluate their impacts, a longer time frame would be required to collect and analyze data.

Overall, the Olmsted County Access Initiative and its CHW program proved to be an effective effort to address a critical need among vulnerable immigrant populations. A strong partnership between a county agency and a uniquely-skilled community organization resulted in the building of a CHW program that promises to serve families in need for years to come. The seed money for this effort, provided by RWJF, was critical in permitting the partners to systematically identify needs, design an intervention, fine-tune a program, and build an infrastructure for sustainability, all geared toward helping families to access more culturally appropriate health services.

Case Study of Buncombe County Department of Social Services

The Buncombe County Department of Social Services (DSS) was the CKF-AI grantee in North Carolina. From the outset, Buncombe County DSS engaged key health stakeholders in the community to identify access barriers and develop targeted strategies. This process of broad community engagement produced two strategies—a parental guide to childhood symptoms and a medical interpreter’s network—that were implemented and sustained successfully. Most notable among the project partners was Buncombe County Medical Society (BCMS), which became a vehicle for both project implementation and sustainability. This case study details the process of collaboration, barrier identification, and strategy implementation undertaken in the county for the Access Initiative, locally known as “ABC Kids.”

Background on Buncombe County DSS and its Partners

The Buncombe County DSS served as a local grantee under the Covering Kids and Families grant and was the main grantee under the Covering Kids and Families Access Initiative. The mission of Buncombe County DSS is to “provide Buncombe citizens resources and services to maximize their well-being and self-determination.”⁷ Besides overseeing the provision of a wide range of health and social services, the DSS operates the Buncombe County Health Center (BCHC), which became central to CKF-AI. The health center provides comprehensive primary and preventive care services, including dental health, breast and cervical cancer screening, prenatal care, and an onsite pharmacy. The DSS places great importance on partnerships and the Buncombe County community as a whole has a long history of working together—independently from the state—to mobilize local resources and create local solutions for community problems. This tradition of partnership and collaboration proved a great strength to the CKF-AI project.

“There is a history of collaboration in Buncombe County, especially regarding vulnerable people.”

(Stakeholder, 2007).

A key partner in the Access Initiative, BCMS is a membership organization supporting Buncombe County physicians. BCMS also has a charitable foundation that focuses on local community health issues. The activities of the foundation are directed by a strategic plan and currently include access to care, chronic disabilities, and end-of-life care. The foundation houses Project Access, which has provided free health care to the uninsured since 1996. Under Project Access, 85 percent of Buncombe County practicing physicians donate their time and local hospitals their facilities to treat uninsured patients.

BCMS has a long history of working with the DSS, and BCHC is the main referral site for Project Access clients. Additionally, a DSS staff member is outstationed at BCMS to provide advocacy services to physicians. Because of their long-standing focus on access to health care, and their connections in the community with providers, BCMS became a natural partner for DSS.

A third, integral project stakeholder was the state partner, the University of North Carolina Greensboro Center for New North Carolinians. Established in 2001, the center links immigrant populations to the university and other communities for educational and research purposes. The center also conducts training for immigrants to assist them in securing jobs, and provides other outreach activities to meet their specific needs.

Access to health care is increasingly becoming a concern in the county. There is a growing population of low-income, Latino and Eastern European immigrants with limited English proficiency (LEP) who experience access and system navigation problems. Additionally, Buncombe County is experiencing a decline in primary care physicians, which stakeholders predict could create future capacity and access problems. This has resulted in a situation where the county has “more folks with fewer options” (Stakeholder, 2007). In this climate, and to build on the community’s access to care commitment and the groundwork laid by the Covering Kids and Families grant, the DSS viewed the Access Initiative as a timely opportunity to continue local efforts to improve access.

Identifying Barriers to Access

As a first step under the Access Initiative, grantees were required to research the access barriers in their communities. During this barrier identification phase, DSS worked with Sage Partners Inc. (a consulting firm) to identify access barriers in the county. Together, DSS and Sage Partners Inc. reviewed extensive literature and used DSS claims data to randomly select (with over sampling of ethnic groups) 62 families to interview one-on-one about the barriers they may have encountered accessing health care services. Of the 62 interviews, 10 were with Latino families. Two types of health care users were identified for the interviews—inappropriate health care users—who either over-utilized the emergency room (ER), or underutilized health care services, such as preventive care—and appropriate users. Interviewees represented a diverse group, including English- and Spanish-speaking families, as well as families from different parts of the county and with differing employment statuses and family structures.

Additionally, from the beginning, the DSS assembled an informal advisory group consisting of 10 to 12 stakeholders (including BCMS). During the barrier identification phase, DSS discussed with these stakeholders their perceptions of local access problems. DSS also facilitated group and one-on-one interviews with other community stakeholders including key health care groups and staff from DSS Medicaid/SCHIP offices. In bringing together stakeholders across different service areas and communities, the interviews simultaneously strengthened relationships, discussed access to care, and brainstormed possible interventions for the initiative. These multiple data collection strategies provided different perspectives on the access-to-care problem, while strengthening community relations.

While DSS expected transportation issues to be the primary problem reported by families, they uncovered a variety of different barriers to access. The research revealed inappropriate users faced access difficulties related to system navigation (how to access services and navigate the medical system) and inability to follow doctor's instructions. Additionally, they discovered that language barriers existed as a consequence of provider noncompliance with the federal Title VI policy (which requires health providers receiving federal funds to provide translation services), as well as system delivery and capacity problems.

Many of the inappropriate users of the ER were Latinos with limited English proficiency (LEP). DSS discovered inability to speak English was compounded by a lack of provider capacity at BCHC to see all LEP patients on any given day. Patients who are unable to schedule an appointment at BCHC are triaged by phone either to wait for an appointment the following day, or be referred to the Urgent Care Center. However, the Urgent Care Center, unlike BCHC, does not have translators on staff and patients referred there would often turn instead to the ER where there are interpreters on duty 24 hours a day. Other systemic access barriers related to language were uncovered—including lack of interpreter services at specialist physician offices and lack of after-hours care at private practices for LEP patients.

In addition to realizing why LEP patients were overusing the ER, DSS also found that providers' lack of understanding, or knowledge, about Title VI requirements and about the role of trained medical interpreters compounded the language barrier. DSS realized that alongside providing medical interpreters, there was a need for staff education about the role of qualified interpreters and sensitivity training to overcome clinic staff prejudice about patients with LEP.

Ultimately, Buncombe County DSS chose to focus primarily on language barriers because of the difficulties patients with LEP were experiencing in accessing non-ER services with medical interpreters. Additionally, improving health literacy among this population was chosen as the second focus area, to improve self-efficacy in dealing with the health care system and health care problems. By improving system capacity to address language and literacy barriers, Buncombe County sought to reduce overuse of the ER in the community.

DSS did not know who their state partner would be at the time of application for the grant. However, when it emerged that lack of medical interpretation was the major access barrier, they linked with the UNC Greensboro Center for New North Carolinians, which was already engaged with these issues. The state partner's role in the Access Initiative involved lobbying the state for an interpreter training certification program (a pre-requisite for Medicaid reimbursement of interpreter services, and to ensure quality interpretation services), as well as developing the training course, which was already in early stages of development by the state partner when work on the CKF-AI grant began.

Strategies to Improve Access

Based on phase one findings that a lack of medical interpreters at health care facilities created language barriers resulting in overuse of the ER, the DSS decided to create a bank of qualified medical interpreters. There had been several attempts to start a network in the past and feedback from Project Access also highlighted growing language problems in the county.

To create a bank of trained medical interpreters, DSS relied heavily on their collaboration with BCMS and the state partner. First, the team identified (through word-of-mouth and some local advertising) several interpreters in the area who were interested in the training and interpreter network. These initial interpreters formed an 'informal' pilot network. DSS and BCMS also received advice from existing interpreters about the type of characteristics interpreters needed to possess and which providers the network could work with.

Formalizing the group of interpreters as a cohesive network was challenging because the interpreters previously functioned as independent businesses. DSS also encountered "predatory" interpreters in some communities, who provided informal and ethically questionable services. These interpreters designated themselves as community leaders and would encourage new immigrants to pay them a monthly fee in return for any interpreting services they might need.

A first major step in the development of the interpreter network was to train the interpreters using the course developed by the state partner. Interpreters had to pay \$150 for the training, which created some reluctance at first, but most interpreters ultimately saw the benefits. Training not only provided interpreters with the skills and vocabulary for medical interpreting, but promised to also lead to state certification, necessary for Medicaid reimbursement of interpreter services (the state partner also took on the task of seeking state certification for medical interpreters). The training course consisted of three modules—Training One, required of all translators of all languages, covers interpretation ethics; Training Two covers medical terminology and role playing; and Training Three, more advanced medical terminology. Trainings Two and Three were only required of Spanish interpreters. The final examination consisted of 100 questions.

Initially, the interpreters were introduced to providers through Project Access but eventually interpreters were requested by other providers throughout the county, and in some instances, in other counties. To improve knowledge and understanding of medical interpreting, DSS and their state partner conducted a conference to educate practice managers and physicians about Title VI. As an additional step in strategy implementation, the state partner developed policy and procedure guidelines for establishing an interpreter network business model.

At first, scheduling was facilitated by a basic online scheduling system which interpreters and clinics could access, involving interpreters uploading their calendars and availability. Over time, a more sophisticated online scheduling system was developed which allows physician offices to put in a request for an interpreter online. The secured Web site is HIPAA compliant and is much more time efficient and easier to use for clinic offices.

A second access strategy was developed to improve the self-efficacy of parents and caregivers with newborns to deal with health care problems. DSS involved BCHC nurses who worked with LEP parents and caregivers to develop a strategy, which not only tapped local knowledge but also created support for the project. Nurses provided insight into how fever is used as a key diagnostic factor in the decision to send a child to the ER. When nurses triage patients over the phone parents will often say their child feels “hot” or has a fever, and if there are no available appointments at BCHC, nurses will triage the child to the ER, often when not necessary. However, if a parent could explain exactly how hot their child was, unnecessary visits to the ER could be avoided. After asking parents what tools would help them the most, the nurses developed the idea of providing parents and caregivers with a checklist of childhood illness symptoms and a thermometer they could use to describe their child’s symptoms and temperature. A subsidiary component to this strategy was to train providers how to demonstrate using the checklist and thermometer to patients.

The checklists were translated into Spanish by a bilingual DSS staff member. When piloting the checklists, nurses realized that the reading level and layout design was too complicated for the education level of the families and that the translation had many errors. DSS worked with a reading grade expert to redesign the checklist so that the layout was simpler, and then employed a professional translator to retranslate the checklist into Spanish.

The main vehicles for distributing the checklists and thermometers were BCHC community health nurses who visit most newborn children within the first two weeks of their life. Using the intervention early in the child's life enabled nurses to connect with caregivers from the beginning. DSS also distributed the checklists and thermometers to physicians and trained them in how to effectively demonstrate their use to the target population.

To implement both strategies, DSS relied heavily on their internal expertise, state partner, and stakeholders. DSS received some assistance from the national program office (NPO), in particular when trying to select a state partner. While not heavily involved, the NPO would frequently send useful, relevant literature or connect them with other CKF-AI grantees that might be of assistance. DSS did not find the two-year implementation timeline problematic; rather, it encouraged them to keep pushing the project along.

Perceived Effects

The growth of the interpreter network (now called Western North Carolina Interpreter Network, or WIN) during and after the grant period is evidence of the project's success. The original network of four Spanish interpreters has grown to 40 interpreters serving clients in 11 different languages (including American Sign Language). By the end of 2007, WIN interpreters had provided services for 952 appointments and 366 patients, in approximately 90 of 200 practices in the county. This compares to 524 appointments and 265 patients in 2006, and 194 appointments and 129 patients in 2005. Additionally, anecdotal evidence suggests WIN has made an impact on the community.

“Since WIN, it’s easy—I can’t remember a time with WIN when it (seeing patients with LEP) has been a problem.”

(Provider, 2007)

“Doctors are very happy to have interpreters in the community. These doctors won’t see those patients without the interpreter now. Patients are very thankful; it gives them peace of mind.”

(Interpreter, 2007)

Other anecdotal stories include that of a father whose child (unbeknownst to the father) had a burst appendix. After looking up his child’s symptoms on the checklist, the father rushed the child to the hospital.

By using trained medical interpreters (instead of lay interpreters or family members), stakeholders believe that patients are getting better quality care because physician instructions, for example, how to take prescriptions, are now being relayed correctly. Additionally, emotionally distressing situations are avoided, such as instances where children (serving as stand-in interpreters) must relay poor prognoses to their parents. However, the persistent lack of interpreters at specialty care providers causes concern for stakeholders because of the potential for misunderstanding—a situation which, according to one stakeholder—“is a train wreck waiting to happen.”

While the network has proven popular with many advantages, state certification of interpreters was not achieved during the grant period. This challenges the financial sustainability of WIN since certification would allow for Medicaid reimbursement of services. In seeking certification, the Access Initiative experienced resistance from state officials. One particular concern raised was that certification (based on successfully passing the training course) could result in interpreters failing and a decline in the number of available interpreters.

DSS attempted to analyze the effect of both interventions on ER use but they were hampered by a short time frame. With consultants, Sage Partners Inc., they compared ER use before—and six months after—the interventions using claims data. They saw an insignificant reduction in ER visits, which DSS feels might have proved significant if they were able to analyze the data over a greater time period. To this end, additional grant money to evaluate effects further would have been useful.

Several factors contributed to the success of the Buncombe County access strategies. Overall, DSS credited the independence and flexibility of the grant with providing freedom to adapt their strategies according to the results of their research on access barriers. This was especially important given the discovery that Buncombe County access barriers were *not* related to transport problems, as previously thought.

A second overarching factor of success relates to the culture of community collaboration in the county. DSS believes having all the key people engaged and committed from the outset drove the project's success. This is underpinned by the county view (or "spirit in the community" as one stakeholder described it) that they all have a common goal to work together to improve the health care system, and have a long history of doing so.

For the strategies themselves, a key factor of success for the checklist was engaging the nurses in its development and implementation. These nurses were able to draw directly from their daily experiences interacting with LEP families and create an appropriate initiative. It also had the secondary effect of building nurse buy-in for the project.

A significant contributing factor to the success of the interpreter network was DSS' reliance on existing structures, such as BCMS, which used its credibility among physicians to leverage support for the use of medical interpreting and provided a vehicle for rolling out the network (Project Access).

Sustainability

Towards the end of the grant period the administration of the interpreter network was permanently passed onto BCMS. The remaining grant funds were used as seed money to establish WIN's business model and the network continues to grow and move toward a fully sustainable business. Just prior to the grant's end, WIN received funding from the Mission Healthcare Foundation (of Asheville's Mission Hospital) to help support the network. Most recently, in 2008 they were awarded funds from BlueCross BlueShield of North Carolina Foundation. While they are making great strides towards achieving the necessary 100 appointments per week needed for financial viability, WIN faces a funding challenge. Cost is a barrier for doctors using interpreters, since interpreter services are not reimbursed by health plans. As one stakeholder explained, "Title VI is another mind-boggling, unfunded mandate." To be competitive and affordable, WIN tries to keep their translation costs low, which means they rely on other sources of money to cover administrative overheads. The lack of reimbursement for interpreter services prevented the Urgent Care Center from continuing with the network.

"Everyone would jump on it if it were free."

(Stakeholder, 2007)

While everything is in place to ensure reimbursement—a training course ready for certification and a network with the capacity to take on more clients—the political will to authorize certification and reimbursement remains absent.

The laminated checklists and thermometers are still being distributed by hospitals. The cost of providing these materials is small and has been folded into other DSS budgets.

Lessons Learned

The ultimate success of Buncombe County's Access Initiative was due to a combination of factors. The commitment in the Asheville community to solving local problems, especially towards tackling health access issues, contributed from the outset. DSS relied heavily on long-standing partners and collaboration with stakeholders to ensure they identified access barriers accurately and that the strategies were feasible and appropriate. DSS also delegated tasks to groups in the community who they knew had the knowledge and skills to successfully complete the task.

"We know who does what well, so why fight it?"

(Stakeholder, 2007)

Phase One of the grant was crucial to the design of relevant strategies. Without this phase, DSS could easily have proceeded with their initial hunch that transportation was the main access barrier in the county and created a strategy that did not tackle the most pertinent access problems for families.

The DSS found access to be a multifaceted issue, which made it difficult to focus on one manageable access barrier and solution. While the grantee was comfortable with the implementation time frame, they would have liked more time to conduct a thorough evaluation. Indeed, DSS believes if they could have conducted the claims data analysis over a longer time period, they would have found significant and positive effects.

While the project was able to take on local problems and successfully create solutions, matters tied to the state level were not as easy to tackle and change. While state certification of interpreters would help the future viability of the interpreter network, local level political leverage was not enough to move certification forward over the project time frame.

Case Study of CHOICE Regional Health Network

The CHOICE Regional Health Network (CHOICE) of Washington State received a two-year grant under the Robert Wood Johnson Foundation-sponsored CKF-AI program. Between September 2003 and December 2005, the nonprofit agency worked to improve access to appropriate sources of care and reduce unnecessary use of the Emergency Department (ED) for chronic ED users in western Washington State. Working with local hospitals and community-based primary care providers, CHOICE developed a process to identify and engage community residents who were not using the ED appropriately, with the goal of reducing unnecessary ED use through new and improved linkages with primary care and intensive case management.

Background on CHOICE Regional Health Network and its Partners

The CHOICE Regional Health Network is a nonprofit network of providers practicing across five counties in western Washington State: Grays Harbor, Lewis, Mason, Pacific, and Thurston. CHOICE members comprise safety-net providers—including seven public and nonprofit hospitals and three federally-funded community health centers—as well as more than 500 private practitioners. In exchange for member contributions (either monetary or in-kind), health network members benefit from CHOICE’s four departments of activity: community development, access advocacy, regional planning, and client services. Direct services to clients, in particular, accounted for more than half the organization’s budget in fiscal year 2007. These services include enrollment in health and social service programs, health system navigation, and case management and care coordination for complex cases. As of September 2007 CHOICE had assisted 28,000 clients, with a focus on low-income and uninsured residents.

CHOICE’s past record of improving access to health care for residents across the region qualified the organization to participate as a local CKF grantee in Washington State and then as one of the CKF-AI grantees. As one staff member reported, “identifying [access] barriers is part of our everyday job.” The organization was instrumental in the establishment of two community health centers (Sea Mar and Valley View Health Center), and participated in a number of provider capacity-building initiatives in the community. For instance, CHOICE recently acted as a mediator for many players in the delivery system during a mental health provider crisis in Washington’s Thurston County. Because of its status as a provider network organization, CHOICE was already linked with emergency room and community-based primary care providers—two key partners in its CKF-AI strategies. As part of the overall CKF project, CHOICE worked with these and other health care providers to reach and enroll eligible and uninsured families into public coverage programs.

CHOICE's state partner for the CKF-AI grant, the Humanlinks Foundation, did not provide a strong presence throughout the initiative because of serious health problems among Humanlinks staff. But CHOICE staff did not feel that they needed a high level of state partner support, since they had many in-house resources and strong relationships with state and local policy-makers.

Health care providers in the CHOICE network were important partners in implementing the CKF-AI project. The initiative requires the commitment of and regular interactions between the grantee, primary care providers, emergency room providers and the clients themselves.

Identifying Barriers to Access

Phase I of the CKF-AI grant required CHOICE to identify the primary barriers to health care access for Medicaid enrollees in the grantee's community. To do this, CHOICE staff conducted four consumer focus groups in two languages. They also carried out 18 in-depth interviews with health consumers, and observed 26 visits between health consumers and providers.

The grantee identified provider capacity as the health access barrier they wished to address, after the Phase I data collection efforts suggested that a) for Medicaid clients, finding a provider was difficult and b) for providers, reimbursement rates and administrative hassles were at the root of their reluctance to accept a greater number of Medicaid clients. As grantees transitioned to the second phase of CKF-AI, however, it became clear to CHOICE and the CKF-AI NPO that its selected barrier would be very difficult to address in any effective way through CKF-AI because it was too broad and ambitious. Low provider participation was, according to grantee staff, in large part due to low provider reimbursement rates (rather than administrative hassles). Reimbursement rates, however, were a policy issue with many complexities that CHOICE was not equipped to address with limited grant resources, and in such a short time frame.⁸

Fortunately, around that same time, a local nonprofit community hospital asked CHOICE to develop an initiative that would address a health access problem the hospital identified—overcrowding of emergency rooms. Physicians in the hospital's Trauma III level emergency department had identified certain frequent ED users who would be better served in the primary care setting. These were typically patients addicted to opiates for real or perceived pain, or patients with mental or behavioral health issues who had the potential for serious depression. Accordingly, CHOICE made the decision to shift its course during the strategy development phase; the organization maintained a peripheral focus on provider capacity, but its main strategy to improve access addressed a different barrier—inappropriate use of the ED.

Strategies to Improve Access

Initially, CHOICE chose to implement two strategies: 1) maintaining an accurate list of providers taking Medicaid clients to assist people in finding a primary care provider, and 2) working with providers to address administrative hassles they encounter in working with Medicaid clients. When developing the second strategy, CHOICE—with guidance from the NPO—decided that the problem of provider capacity was generally beyond the scope of the CKF-AI grant (as described in the previous section). Therefore, CHOICE decided to spend most of its CKF-AI grant period implementing a third strategy: collaborating with the ED and with community-based primary care providers to assist frequent ED users with access to appropriate care.

Regarding the first strategy, the list helps facilitate referrals for the clients for which CHOICE provides case management services, as well as other people in the community who contact CHOICE for assistance. Since every county in the CHOICE region is now served by Medicaid MCOs, it is relatively easy to maintain the list, which requires regular updates with the MCO plans to determine which providers are still participating and are currently accepting clients. Though a somewhat straightforward task, grantee staff reported that maintaining the participating provider list required CHOICE to play an intermediary role, “knowing the providers personally and knowing if there will be a good match” between provider and client.

The other strategy CHOICE implemented—indeed, its primary focus during the grant period—was the Emergency Department Care Coordination Program (EDCCP), a client-based intervention program for heavy ED users. In December 2003, after six months of development by CHOICE and the local nonprofit hospital that served as a partner in the initiative, EDCCP enrolled its first client. The point of the intervention is to manage frequent and avoidable use of the ER by Medicaid enrollees, with three goals: reducing inappropriate use of the ED, improving clients’ health status, and increasing the capacity and integration of the health care safety net.

The basic steps of the EDCCP are:

- **Step One:** A health provider identifies an appropriate candidate for the program: someone with a high frequency of ED use, defined as at least two visits in one month or four visits in six months. Initially the team conducted an ED records review to identify potential enrollees, but the hospital did not possess the technology needed to do that sort of systematic review on a regular basis. After that initial period of recruitment through record review, EDCCP has relied on referrals from health care providers—primarily from providers in the ED, though primary care providers (PCPs) had also begun making referrals to the program recently.

- **Step Two:** The EDCCP team (consisting of an ED physician coordinator, the ED manager, an ED nurse care coordinator, an administrative coordinator from CHOICE, a CHOICE Health Resources Coordinator, and a representative from a partnering local safety-net clinic) meet twice a month to review referrals, prioritize clients for intervention, and assign case numbers.
- **Step Three:** A CHOICE team member contacts clients, discusses the program and its goals, and encourages clients to enter the program voluntarily by signing a Release of Information form. If the client fails to cooperate they are placed in the involuntary program component. According to project staff, only about 25 percent to 30 percent of those who are invited to participate in the program do so voluntarily. Yet, one project team member described the program as helpful even for an involuntary patient, who may benefit from knowing that their problems “are not invisible” and that physicians have noticed the patterns in inappropriate ED use.
- **Step Four:** The EDCCP team establishes a medical home for the client by matching the client with a community-based primary care provider (PCP). The program worked with roughly 30 different PCPs at the time of the site visit.
- **Step Five:** EDCCP develops a Plan of Care (or Care Plan) for how the client will seek medical care in the future. Clients are invited to participate in this part of the process but rarely do. Care plans are developed for both voluntary and involuntary clients; plans are mailed to involuntary clients with an open-ended invitation to participate in the program. The Plan of Care includes:
 - Plans to make further diagnoses or confirm prior diagnoses, such as through subsequent medical testing;
 - Plans for involving other providers (such as a psychiatrist) beyond the primary care provider; and
 - A schedule of PCP counseling visits, set on a frequent and regular basis (for example, every two weeks).Care plans are continually revised to incorporate significant new information. The plan is posted on the hospital’s computer system to facilitate use by the ER physicians.
- **Step Six:** Team members support the client in meeting non-clinical needs that impact health (such as housing or other social supports).
- **Step Seven:** Team members work with insurers to provide enhanced case management, to the extent possible.

- **Step Eight:** EDCCP team provides ongoing monitoring of health delivery, status, and ED use, as well as support and consultation with the client's PCP. The monitoring protocol includes guidelines for action when an EDCCP client has visited the ED inappropriately. The ED physicians have been instructed to make note of the visit on the client's file for required follow-up by the PCP. EDCCP team members may also contact the PCP or patient regarding continued inappropriate use.

Perceived Effects

With regard to the Medicaid Provider List, it was difficult for grantee staff to document its impact. At the time of our site visit, the grantee still received frequent calls from community members seeking assistance with locating a primary care provider (other agencies refer Medicaid enrollees to CHOICE to find appropriate providers) and from providers themselves seeking help with identifying specialists who will accept fee-for-service Medicaid clients.

With regard to the EDCCP, by the end of the official CKF-AI grant period, EDCCP had enrolled 25 participants. However, EDCCP continued beyond the grant and, as of February 2007, a total of 156 patients had been referred and discussed by the program team. Ninety-three of those referrals were ultimately enrolled in EDCCP, with 80 percent enrolled on an involuntary basis.

For EDCCP clients, CHOICE was able to document improvements in service quality and savings to the hospital ED. For example, though the project did not have the resources under CKF-AI to conduct a full-scale evaluation,⁹ they conducted a preliminary analysis. The analysis found that a subset of program enrollees experienced a 50 percent reduction in average number of ED visits and a 40 percent reduction in average hospital charges, from the 12 months pre-intervention to 12 months post-intervention. According to this analysis, the average charge reduction per client in the first year of program enrollment was \$9,000.

Thus far, only anecdotal and self-reported evidence has been collected on changes in client's health status and satisfaction with the program, though the findings have been positive. A case study informant enrolled in the EDCCP, for example, reported that she had been without a usual source of care and had seen a series of PCPs before she agreed to voluntarily participate in the EDCCP. Since enrollment, she had visited her new PCP on a consistent (at least monthly) basis, reduced her number of needed prescriptions, and reduced her ED visits by an estimated 75 percent—from 20 to five visits a year. Also, since being enrolled in the program, she now thought of the emergency department as a last resort; typically, she contacted her PCP or one of his colleagues at the community

health center when she was considering a trip to the ED. That doctor may counsel her to wait until the next day for an appointment with doctors at the health center (thus averting the unnecessary ED visit).

The EDCCP team had also collected anecdotal evidence on the impact of the EDCCP for safety-net capacities and system integration. Results have been quite positive, with reports of decreased staff frustration and increased efficiency. By establishing a common approach to a problem that all staff encounter (i.e., inappropriate ED use), the program provides “a quick way to refer frequent inappropriate users and to treat those with written plans of care.”

Sustainability

Both of the CKF-AI interventions that CHOICE implemented were sustained after the two-year grant period ended. The task of maintaining the Medicaid participating provider list was folded into existing CHOICE staff duties—an easy fit since the organization was already experienced with Medicaid case management and had been involved with issues surrounding provider capacity for some time. The EDCCP was sustained on a smaller-scale, using “slim resources” from the organization’s general funding, while CHOICE staff pursued a more permanent source that would allow for expansion of the program, as discussed below.

In the year following CKF-AI, CHOICE succeeded in obtaining two grants that would allow them to sustain and expand the EDCCP. In mid-2007, the agency received a community collaborative grant from the Washington State Health Care Authority. A portion of the two-year grant, which is intended to enhance and support broad and collaborative, community-based efforts to deliver health care, has been directed to EDCCP activities. Also, Washington State U.S. Senator Patty Murray was successful in obtaining a 2009 federal appropriations earmark of over \$300,000 for the CHOICE Regional Health Network. The funds were expressly targeted at sustaining the EDCCP by securing program staffing; expanding the program to other willing hospitals in the CHOICE region; establishing an electronic information sharing system between participating hospitals to share client utilization, cost, and Plans of Care data; and encouraging other hospitals across the state to adopt a similar model of care coordination for their ERs. Staff told us they plan to use the savings from an expanded EDCCP program to “provide better care to more people at less cost.”

Early on, the strategy for sustaining EDCCP involved trying to get the state Medicaid program to reimburse for EDCCP-related services such as case management. Staff noted, however, that to encourage this, “Medicaid must share data on how much money the program has saved them.” At the time of the site visit, CHOICE had not succeeded in engaging the Medicaid program in this way.

Lessons Learned

Among the CKF-AI grantees, CHOICE stands out as a particularly successful model. Despite a complete change of strategy during the second phase of the project—and with only eight months remaining in the two-year grant period—CHOICE was able to develop and implement a pilot project with demonstrable impacts on cost and health service quality (by reducing emergency department use). Moreover, the grantee successfully sustained both components of its CKF-AI project after the grant period ended.

Site visit informants shared the following lessons with the evaluation team:

- **The CKF-AI grant team included several dedicated and passionate individuals, all of whom benefited in significant ways from the project and who helped to make it a success.** For instance, the CHOICE project team member responsible for coordinating services for EDCCP enrollees (the health resource coordinator) built a close “transformational relationship” with clients and played a key role in encouraging their active participation in the intervention. The ED physicians were also critical stakeholders; project staff noted that the physicians had been willing, as a group, to cover the small amount of administration time EDCCP required. Finally, the project recruited PCPs who were willing to accept EDCCP clients (typically with complex medical and social needs). According to one such PCP, the benefits of participating in the program outweighed the costs of the additional work involved in providing care to EDCCP patients—this provider described the “palpable” sense of relief he gained from working with the project, noting that “at least I know that I am not alone in this.” Considering their dedication to and the benefits they took from EDCCP, these stakeholders had a strong impetus to sustain the project.
- **The initiative CHOICE implemented served dual purposes—it led to improvements in access to appropriate care for clients and also saved money for health care payors and providers.** Grantee staff described EDCCP as a quality improvement program that also contained costs—at its roots, it is about “better care for the patient, not just getting them out of the ED.” They emphasized that cost-savings, though “inevitable with this model,” were not the essential aim of the initiative. It is important to note, however, that the project’s ability to contain costs remained critical to the overall sustainability of the project.
- **From the beginning, the EDCCP was designed as a replicable project, and this feature contributed greatly to the project sustainability.** CHOICE staff reported that the organization has always tried to establish best practices that could be adopted by other agencies, remarking that they were “in the replication business.”

From the early stages of the CKF-AI grant, staff planned to eventually expand the initiative to other hospitals beyond the initial pilot site. To this end, the EDCCP project activities were well-documented and monitored. At the time of the site visit, replication had already begun, with an additional regional hospital adopting a small-scale EDCCP roughly two years after the CKF-AI pilot was established. Additionally, the Covering Kids and Families Washington State grantee—the Washington Health Foundation—began a Health Home initiative that, according to CHOICE staff, “built off of the emergency department diversion program.”

- **CHOICE had a long history of carrying out projects that successfully improved access to care for low-income residents of the community.** As an informant aptly noted, “Part of the reason we’re still around is because our access projects pre-dated CKF-AI and we have huge penetration into the low-income, uninsured population. We’re very deeply connected and involved.”
- **Receiving an RWJF grant—in and of itself—had important effects on grantee sustainability.** Project staff indicated that RWJF’s investment in their pilot program “gave CHOICE asking rights, and staying power” and noted that the funding had another powerful effect: increased visibility in the local community. At the same time, project staff were unsure whether the EDCCP would have been established in the absence of the CKF-AI grant, noting the fact that “everything the organization does is related to health access” made it more likely that their project would have happened, even without the RWJF funding. However, the grant gave them a critical opportunity to use their knowledge of regional access barriers to implement a practical and effective pilot program.
- **Carrying out the EDCCP as a small-scale pilot project was a key to its success, since “relationships are already in place at the local level and bottom-up planning can occur.”** Key informants reported that, if the program had initially been implemented on a grander scale, it would have been more difficult to work out the kinks.

Overall, the EDCCP project was practical, well-targeted, and the appropriate scope for the CKF-AI grant. Ultimately, several stakeholders benefited from the project: 1) in the ED, EDCCP reduced the number of non-emergent cases; 2) both emergency care and primary care providers benefited from the care coordination and the “relief” of knowing that other providers were concerned with and involved in the patient’s care; 3) the Medicaid program and other payors saved money with the reductions in ER use; and 4) the client received better-targeted and coordinated care.

Conclusions and Lessons Learned

Case studies of the five Covering Kids and Families-Access Initiative grants render a rich set of cross-cutting “lessons learned” that shed light on both the factors that contributed to grantee success and effective strategies for obtaining sustainable funding.

These lessons included:

- **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.** Consistently, our case studies revealed that the grantees did not begin their work on addressing barriers to access under the CKF-AI program. Rather, they each had a long tradition of advocating for and assisting vulnerable families, and built successfully on that foundation in crafting their CKF-AI interventions. The Bridgeport Child Advocacy Coalition, Baltimore HealthCare Access, Olmsted County Community Services, Buncombe County Department of Social Services, and the CHOICE Regional Health Network were all well established in their communities and possessed stellar reputations for effectiveness.
- **The CKF-AI grantees built and depended on strong partnerships in their communities to fulfill the missions of their projects.** CKF-AI grantees did not work alone; rather, they each formed strong and mutually supportive partnerships to carry out various aspects of their work. For example, Olmsted Community Services was ideally suited to assess the needs of the Rochester, Minn. community, but chose to partner with the Intercultural Mutual Assistance Association, with its diverse bilingual staff, to design and implement its community health worker program. Similarly, Buncombe County Department of Social Services understood the needs of its residents for translator services, but partnered with the region’s medical society to garner the support and buy-in of area physicians. Strong partnerships such as these were critical to the success of the grantees.
- **Thorough and systematic needs assessment was the critical underpinning of the CKF-AI projects, and often rendered surprising results.** During the first phase of each project, grantees were required to identify the primary barriers that were impinging on children and families’ access to care, and each did so by conducting formal and systematic community needs assessments. Grantees employed diverse strategies for assessing needs—including focus groups, in-depth interviews, secondary data collection and surveys—and consistently reported that the exercises were great learning experiences. Furthermore, the needs assessment often resulted in unexpected findings. For example, Olmsted County officials assumed that problems with

transportation were the primary barrier to access among low-income families in Rochester. But the project’s survey revealed that problems with paperwork and communications with providers were much more critical; in fact, “getting to a provider” was ranked as the eighth most important barrier to access. Buncombe County Social Services had a very similar experience; county officials had a “hunch” that transportation was the leading barrier to care in the Asheville community, but in-depth interviews with caregivers found that families faced a wide variety of barriers, including problems navigating health systems, following doctor’s instructions, and (among non-English speakers) communicating with their providers.

- **Targeting access improvement strategies narrowly was critical in improving the odds of success under a relatively small and short-term grant program.** Consistently across the case study projects, grantees were wise to target discrete problems and devise relatively small interventions to help families in their communities to access care. For example, BHCA focused on maternity care access for immigrant Latino mothers—where to go for care and how to fill out medical record forms for their infants consistently. BCAC homed in on families’ difficulty obtaining non-formulary and prior authorization-required prescription drugs for their children. In Olympia, Wash., the CHOICE Regional Health Network initially had great ambitions and set out to tackle Medicaid paperwork hassles and low reimbursement rates that it believed were suppressing provider participation in the program. But staff quickly realized that this systemic problem was too large to take on within the constraints of the CKF-AI grant, and refocused their attention on a more viable strategy—developing an Emergency Department Care Coordination Program for high users of the ED.
- **The CKF-AI grant structure and RWJF’s flexibility were highly praised for facilitating grantees’ careful and accurate identification of access barriers and creative implementation of strategies to address these barriers.** Grantees were complimentary in their praise of the two-phase structure of the CKF-AI grant. As stated above, the needs assessment step was consistently described as a valuable learning experience, as well as one that shed light on previously unknown (or underappreciated) access barriers. Subsequently, the interventions designed by the grantees were well informed and based on clear, fresh data, and succeeded in targeting specific aspects of communities’ most pressing needs.

- **That said, the scope of work for CKF-AI was large and ambitious, and a longer time frame would have permitted more complete implementation, better data collection and evaluation.** Without exception, along with their gratitude, grantee staff expressed frustration with the short time frame of the CKF-AI grant. Two years was typically described as too short a period within which to conduct a full needs assessment, design and implement an intervention, assess the intervention's effects, and obtain (or plan for) sustainable funding. State partners, who were not identified or involved until the second phase of each project, were especially vexed by the compressed timetable, saying things like: "How much could we help or get done in just a year?" While data collection and evaluation were not requirements of CKF-AI, grantees felt pressure to be able to at least describe qualitatively, the impacts they had had on access barriers. Furthermore, they were keen to collect the data that would help demonstrate the extent of their effectiveness. Yet none felt that they had adequately evaluated their efforts, nor that they could have within the two-year cycle.
- **Obtaining sustainable funding was challenging, but was more likely when planned for early on and when access improvement strategies produced clear cost savings.** Another challenge for grantees within the two-year grant cycle was planning for sustainability. Grantees were barely in the midst of implementing their interventions when they needed to consider how to carry on their activities after the CKF-AI grant expired. Naturally, those grantees that anticipated this need early on were more successful in obtaining bridge or ongoing financial support. In Olmsted County, IMAA was seen as the natural organization to carry on with the project's community health worker program, and during Year 2 they approached various foundations and presented their model as one that could be self-sustaining within five years. (As described in the case study, the project's pursuit of legislation that would provide Medicaid reimbursement, as well as its involvement in the development of an accredited training program in a local community college, were evidence of its potential for self-sustainability.) In addition, projects that could point to cost savings also faced fewer barriers to ongoing funding. The CHOICE Regional Health Network, in particular, could cite significant reductions in ER use (and concomitant cost savings) resulting from their care coordination program, and was successful in obtaining a 2008 federal appropriations earmark of \$300,000 through the efforts of Washington State's U.S. Senator Patty Murray.

- **The national program office (Center for Health Care Strategies) provided helpful and effective technical assistance to grantees in support of their efforts.**

Grantees also had high praise for the staff of CKF-AI's national program office—the Center for Health Care Strategies. CHCS consultants provided targeted advice and guidance on needs assessment techniques, interpretation of needs assessment data, selection and design of access improvement interventions, and strategies for sustainability. Interactions with the NPO were consistently described as “helpful” and “facilitative,” and never as bureaucratic or onerous.

Multiple evaluations have demonstrated that expanding health insurance coverage is a critical first step in improving the odds that children grow up healthy (Wooldridge, forthcoming; Wooldridge et al., 2005; Kenney et al., 2003; Hill et al., 2003). But addressing the myriad barriers that limit a family's ability to obtain needed care from appropriate and high quality sources is equally critical. The CKF Access Initiative demonstrated the complementary nature of outreach, enrollment, and retention efforts, coupled with access improvement strategies. The grantees' experiences provided vivid examples of how targeted community-based strategies can make a positive impact on the lives of children and families.

Endnotes

1. Only 18 CKF-AI grantees implemented and completed the grants.
2. When the CKF-AI grant period ended, only BCAC continued with grant-related project activities; accordingly, our evaluation of long-term effects and sustainability focused on BCAC.
3. The Children's Health Council was created by the state legislature in 1995 to ensure that children enrolled in HUSKY managed care received the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to which they are entitled.
4. MinnesotaCare is the state's subsidized health insurance program for individuals and families earning too much income to qualify for Medicaid.
5. The following language was considered during the 2007 legislative session: "Community health worker. (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has: (1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or (2) at least five years of supervised experience with an enrolled physician, registered nurse, or advanced practice registered nurse. Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment (b) Community health workers must work under the supervision of medical assistance enrolled physician, registered nurse, or advanced practice registered nurse."
6. In January 2008 the Minnesota Legislature passed a bill that allows for third party reimbursement for CHW services. The reimbursement covers the expenses for a CHW to provide physician- or advanced practice nurse-approved patient education and/or care coordination. The reimbursement does not allow for the "front-end" work that is completed before a client is able to receive services, including help applying for health coverage, identifying needs, selecting a provider, arranging interpreter services, and scheduling a medical appointment. These services continue to be supported by grant funds. (Available at www.ima.net/CHW_files/CHW%20Summary%20for%20website%203-08.pdf, accessed 12/08.)
7. Available at www.buncombcounty.org/governing/depts/dss/.
8. Medicaid provider capacity continues to be a major problem in the state, mainly related to low rates of Medicaid reimbursement. According to CHOICE officials, the number of practices contracting with the state's Medicaid program is high, but the proportion of those practices open to new clients is low, "perhaps as low as 25 percent." Of Medicaid provider participation, CHOICE staff said, "on paper it appears that not many doctors take Medicaid, but we can work on a personal level, a case-by-case basis, with providers to patch together a plan to serve one or more Medicaid patients."
9. At the time of the site visit, however, EDCCP was being evaluated under a small grant provided by a local foundation. That evaluation included measures of cost-savings and improvements in quality of care and client health outcomes.

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Robert Wood Johnson Foundation

Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543-2316
www.rwjf.org

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