

# THE GROUP HEALTH CHILDREN'S ACCESS FUND: Evaluation of the First Year



Prepared by the  
Center for Community Health and Evaluation

for the  
Group Health Foundation

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The Center for Community Health and Evaluation (CCHE) designs and provides evaluation services for health-related programs and initiatives throughout the United States. CCHE is part of the Group Health Center for Health Studies. This report was funded by the Group Health Foundation.

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*One of the most important strategies for improving child health is  
to make health services available to all children.*

— GRANTMAKERS IN HEALTH

## Introduction

Group Health has long been a champion of access to health care. Group Health Cooperative's voting membership overwhelmingly passed a universal coverage resolution in 2004, calling for continuous, affordable insurance and access to care for all Americans. Children's access is particularly important, as untreated childhood health problems can have lifelong consequences. One of the strongest predictors of whether or not children have access to care is health insurance coverage, but efforts beyond coverage are needed to improve access and quality of care, especially for low income and minority children (see page 3, "Why Cover Kids?").

In fall of 2006, Group Health established the Children's Access Fund (CAF) with a \$1 million gift to the Group Health Foundation. This fund was intended to support a combination of state, regional and community-based programs that offer effective approaches to increasing access to care for vulnerable children living in the Group Health service area outside of King County.

## Implementation Process

The Group Health Center for Community Health and Evaluation (CCHE) was charged with designing and facilitating a process for the selection of programs to receive CAF funding, and evaluating the progress of funded projects. A CAF working group was established that included CCHE staff as well as the Foundation's Director of Grants and Community Programs.

The Children's Access Fund marked a departure from the Foundation's biannual Children & Teen grant program, both in size of award and method of choosing grantees. The process of selecting programs for funding involved crafting criteria and guidelines, analyzing community needs, interviewing children's health leaders within and outside of Group Health, and inviting selected agencies to describe how an investment from Group Health would enhance their efforts to improve children's access to care.

*"When an organization like Group Health steps up to invest in your program, that means what you're doing is worthwhile."*

– CAF grantee

## Why cover kids?

- Health insurance coverage is the single best indicator of access to primary health care, but efforts beyond coverage are needed to improve access and quality of care, especially for low income and minority children.  
[Kaisernetwork.org HealthCast, 2007; *Ambulatory Pediatrics* 5(1), 2005; UCLA Health Policy Research Brief, 2007]
- The majority of uninsured children come from families where at least one parent works, but few of these working parents have access to employer-sponsored health insurance.  
[Campaign for Children's Health Care, 2006; Urban Institute, 2007]
- Among families who have lost jobs in the current economic recession, few can afford premiums to extend their employer-based coverage. Medicaid and SCHIP are often the only sources of coverage for their children.  
[Kaiser Commission on Medicaid and the Uninsured, 2008]
- Teenagers are much more likely to be uninsured than are younger children.  
[Campaign for Children's Health Care, 2006]
- Dental care is the largest unmet health need among low income children, who face substantial barriers in accessing dental services.  
[Kaiser Commission on Medicaid and the Uninsured, 2007]
- Parents of uninsured children report they worry all the time about their children's health, and even limit their children's participation in sports or recreation because of fear of injuries that would require care they cannot pay for.  
[Kaiser Commission on Medicaid and the Uninsured, 2007]
- Evaluation of a children's coverage initiative in California found that after four years of continuous coverage, preventive care increased while repeated sick visits decreased, parental worry was eased, and unmet need for medical or dental care was almost halved.  
[Mathematica Policy Research, University of California San Francisco & Urban Institute, 2007]
- Nearly nine out of ten insured children have someone they consider their personal doctor or nurse, compared with just a little more than half of uninsured children.  
[The Children's Alliance, 2008]
- When uninsured children are covered by health insurance, family health literacy—including appropriate use of health care—improves significantly.  
[George Washington University Department of Health Policy, 2007]
- Expansion in health insurance coverage to low income populations is related to overall improvements in health care quality and availability in local communities.  
[*Health Affairs* 26(5), 2007; Institute of Medicine Committee on the Consequences of Uninsurance, 2003]

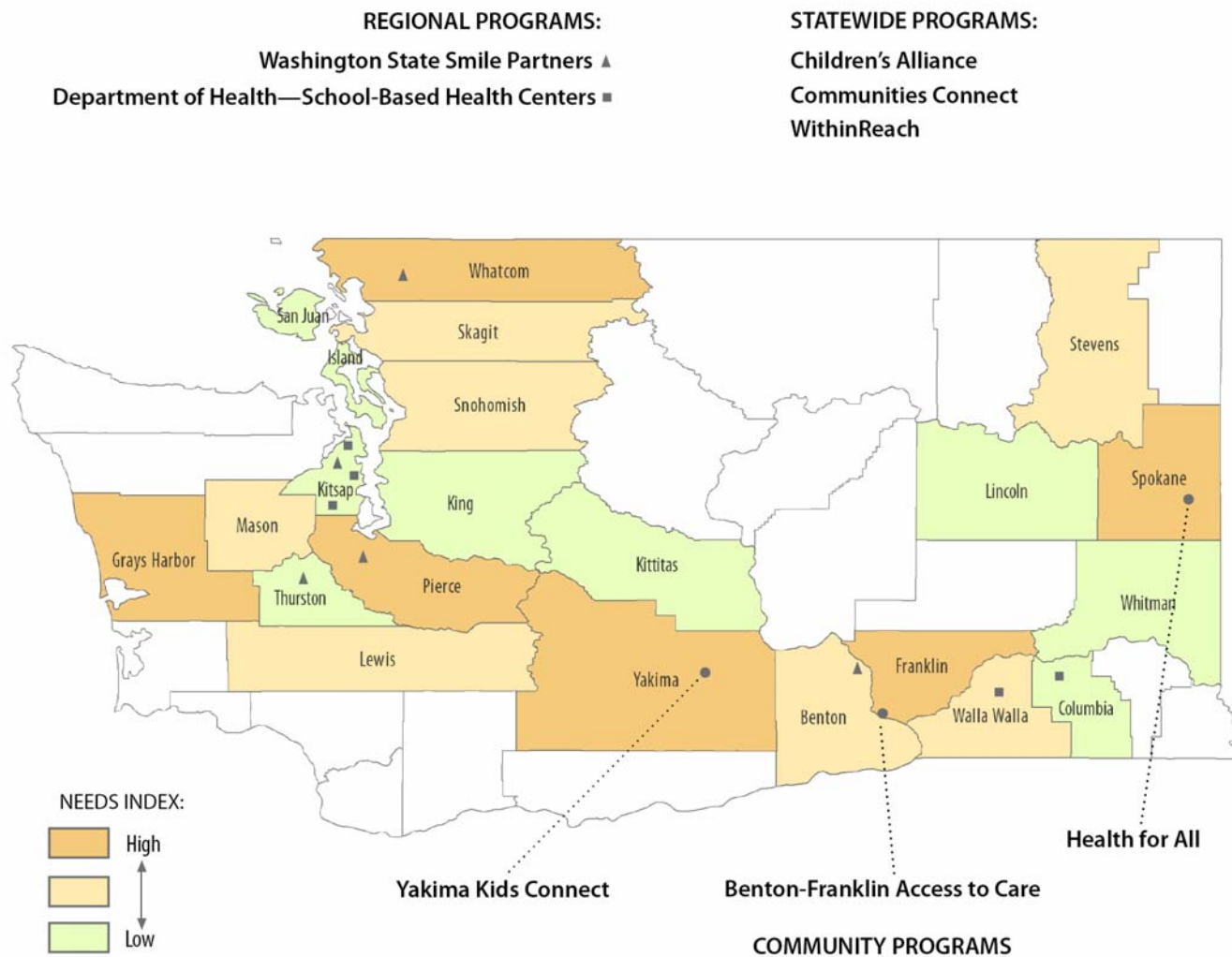
The guidelines and criteria for judging prospective programs were developed in collaboration with Group Health leadership. One criterion was that the CAF align with Washington Senate Bill 5093, known as the Cover All Kids law, enacted March 2007. The criteria favored programs that were innovative, evidence-based and with an outcome orientation. Other important factors were community readiness and engagement as well as potential for sustainability. (The guidelines and criteria are described in Appendix A.)

Through demographic analysis and key informant interviews, CCHE identified communities with high needs and suggested promising community-based and statewide efforts that met the criteria. (See Appendix B for a description of the selection process.) In July 2007 Group Health approved eight programs, including two pilot projects that received funding prior to the formal selection process; these are listed in Table 1 on page 5 with the amount of each grant. Figure 1, page 6, shows the location of CAF grantee projects as well as the relative needs index of counties in the Group Health service area.

Table 1: Children's Access Fund: Organizations Funded

Organization	Area	Description	Amount
<b>Programs selected with CAF Guidelines and Criteria</b>			
Children's Alliance	State	Advocacy and planning for implementation of SB 5093	\$ 175,000
Within Reach	State	Marketing of and enhancements to ParentHelp123	\$ 150,000
Communities Connect	State	Conference sponsorship and performance measures	\$ 20,000
Washington State Smile Partners	Multi-county (E & W)	School-based preventive dental services with registered hygienists	\$ 170,000
Health for All	Spokane	Outreach, advocacy, enrollment support and follow-up	\$ 170,000
Kids Connect	Yakima	Outreach and case management for enrollment and linking to medical home	\$ 115,000
<b>Subtotal</b>			<b>\$ 800,000</b>
<b>Pilot Projects</b>			
Benton-Franklin Access to Care	Benton-Franklin	Outreach for enrollment and linking uninsured children to sources of care	\$ 100,000
Washington State Department of Health	State	School-based health center planning grants	\$ 100,000
<b>Subtotal</b>			<b>\$ 200,000</b>
<b>GRAND TOTAL</b>			<b>\$1,000,000</b>

Figure 1: Relative Need of CAF Counties and Location of Programs Funded



The CAF programs selected for funding implemented a range of strategies that include outreach to enroll children in coverage and link them to sources of care, developing technology and sharing knowledge, providing direct services, and developing policy. A Children's Access Fund logic model illustrating the selection and evaluation process is in Appendix C.

## **Evaluation goals and methods**

The goal of this evaluation is to determine if during the first year the funded projects were successful in contributing to the overall objectives of the CAF, which are listed below:

- Improved coverage of children and families
- Improved access to health care
- Standardized performance measures
- Stronger partnerships

Evaluation methods included review and synthesis of grantee progress reports, interviews with grantees and monitoring of grantee web sites, review of literature and state and national trends in coverage and access, interviews with technical assistance providers, and grantee focus groups. The planning process and progress to date are described below, including "Spotlight on Success" profiles for each grantee.

In addition, this report offers reflections on factors contributing to the success of the CAF initiative as well as future challenges and opportunities in ensuring children's access to health care.

## **Evaluation planning**

### **Development of grantee evaluation plans**

During fall 2007, CCHE team members visited each grantee in person (with the exception of the Department of Health<sup>\*</sup>) to learn more details

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<sup>\*</sup>The grant to the Department of Health was originally intended to augment start-up funds for school-based health centers in rural areas of the state. No rural community was prepared to respond to the call for proposals, so DOH decided to award \$20,000 planning grants to communities to allow them time to develop resources needed to establish a school health center. The Group Health funds supported planning grants in five school districts in the CAF service area: Bainbridge Island, North Kitsap, South Kitsap in western Washington, and Dayton and Walla Walla in the eastern part of the state.

about programs and to discuss proposed strategies and expected outcomes. Following these site visits, CCHE drafted a tailored evaluation plan that was reviewed, revised if necessary and approved by each grantee (the evaluation plan template is in Appendix D).

Each program's evaluation plan included specific activities, quantitative and qualitative indicators, and realistic outcomes. In order to decrease reporting burden, an effort was made to make quantitative measures align with those expected by other funders such as the Washington State Health Care Authority.

### **Strategies and outcomes**

The programs implemented by grantees incorporate one or more of the following strategies to improve children's access to health care:

- Outreach to enroll eligible children and families in state health plans
- Linking children and families to care providers
- Developing technology
- Sharing knowledge
- Providing direct service
- Developing policy and advocating on behalf of children and families.

Consistent with the logic model, CAF grantee strategies are closely aligned with the three legislative goals related to health care access. The outcomes identified by the grantees are shown in Table 2.\* It should be noted that prior to the CAF initiative several of the grantees already had given considerable thought to evaluation and outcomes measurement.

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\*Outcome measures for the Department of Health are derived from the request for proposals for school-based health centers issued in fall 2007.

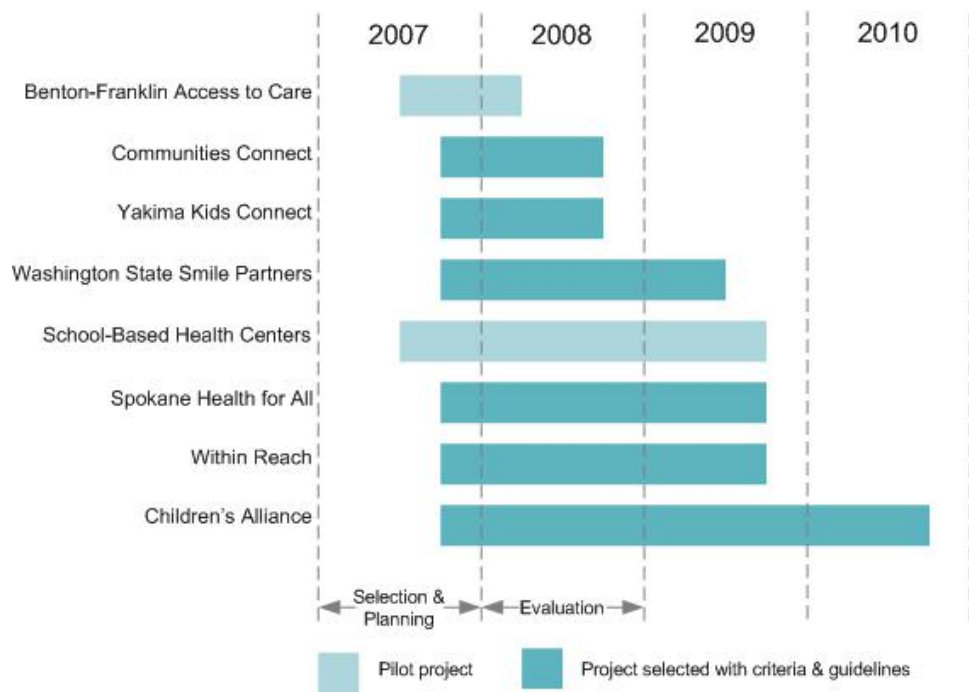
Table 2. Outcomes Identified by CAF Grantees

	Benton-Franklin Access to Care	Children's Alliance	Communities Connect	Department of Health	Health for All (Spokane)	Washington State Smile Partners	WithinReach	Yakima Kids Connect
Increased awareness of coverage options				X			X	
Reduced number of uninsured children/parents	X	X		X	X			X
Increased coverage stability		X			X			X
Increased number of children/families with health care home				X	X			X
Reduced number of children with unmet health needs		X		X		X	X	
Improved case management				X		X		X
Increased use of enrollment tools by providers					X		X	
Stronger community networks	X			X	X			X
Stronger relationships between state & community agencies	X		X	X			X	
Standardized outcome measures			X			X		
Simplified and streamlined enrollment procedures		X					X	
Legislative support for children's access to care		X		X		X		

**Progress reporting**

The funding period for the grants ranged from one to three years (Figure 2). The progress reporting schedule was determined in collaboration with the grantees and the Foundation's Grants and Programs director. Each grantee was provided a progress reporting template that reflected its evaluation plan (see Appendix E).

Figure 2. CAF Grant Timelines



*“Most foundations know evaluation is important, but don’t offer help—they don’t have the staff or expertise. The [CAF] evaluation process put grantees way ahead.”*

– CAF grantee

The reporting template was intended to capture quantitative indicators as well as anecdotal information—the “stories” of progress and success. As one grantee noted, “storytelling is a very powerful way to describe success... both the numbers and what’s behind the numbers: data, case studies, putting a face on kids and families and their lives.” In addition, the template provided an opportunity for grantees to describe their challenges and explain how they altered strategies based on lessons learned. Some grantees noted that evaluation can make organizations feel like failures if they “miss the mark,” and they appreciated being asked “What didn’t work? What would you do differently?”

## Strategy Summary: What have CAF grantees accomplished in the first year?

- BFAC Benton-Franklin Access to Care
- CA Children's Alliance
- CC Communities Connect
- DOH Department of Health
- HFA Health for All - Spokane
- SP Washington State Smile Partners
- WR WithinReach
- YKC Yakima Kids Connect

### OUTREACH & ENROLLMENT

- BFAC Distributed flyers with information on how to enroll in children's health insurance to schools and agencies; provided individual application assistance
- CA Brought together state agency and local community representatives to coordinate efforts to enroll eligible children and families
- CC Shared best practices with local access programs throughout the state
- HFA Conducted mass media (TV) campaign,; provided personalized assistance to community members needing insurance coverage
- SP Provided insurance coverage information in dental health reports that are sent home to parents
- WR Conducted outreach to social service providers on using ParentHelp123 Benefit Finder for screening and enrolling families
- YKC Re-established coordinated network of access specialists; provided enrollment assistance and consumer education on appropriate use of health system

### INNOVATIVE TECHNOLOGY

- CA Provided web-based communication system making it easy for citizens to contact state legislators
- SP Created shared web-based system to track oral health of school children served.
- WR Completed enhancements to Benefit Finder, including Spanish language version and expanded capacity for Within Reach to fax applications to the state on behalf of clients; made progress toward fully electronic application
- YKC Reinstated shared Tapestry case management database and enhancement to capture meaningful measures of progress

### SHARING KNOWLEDGE

- CA Held Health Policy Summit at Group Health headquarters
- CC Organized statewide conference for community and state stakeholders to share best practices
- HFA Provided training sessions and updates for other community agencies on rules and procedures for enrolling in state coverage
- SP Provided insurance coverage information in dental health reports that are sent home to parents
- BFAC CA Participated in HCCY and DSHS committees implementing *Covering All Kids* legislation
- HFA YKC
- WR

### DIRECT SERVICE

- SP Screened over 2,000 school children and referred many for follow-up dental care; provided cleanings and preventive care to children in need.
- DOH Improved readiness in several communities outside of Seattle to establish school based health centers

### POLICY & ADVOCACY

- CA Brought together state agency and local community representatives to coordinate efforts to enroll eligible children and families; facilitated AAG opinion to allow sharing of names of uninsured children with community access programs; continued advocacy on behalf of children in Washington.
- CC Served as unified voice for local community access programs; recognized by Health Care Authority for leadership.
- DOH Created heightened awareness statewide about the value of SBHCs; 11 SBHC planning grants are cited in a school health legislative task force report
- SP Collected outcome information for report to Legislature on first year of HB1298

## Progress toward CAF outcomes

The progress made during the first year by the CAF grantees individually and collectively is described below. Successful strategies are compiled in the “Strategy Summary” on page 11, and achievements in quantitative terms are listed in “By the Numbers” on page 17.

### Improved coverage of children and families

The stepped up efforts supported by Group Health and its partners in the public and private sectors have paid off. In 2006, 5.5 percent of Washington's children were uninsured; by 2008 the proportion had dropped to 4.6 percent.<sup>1</sup> In August 2008, nearly 33,000 more Washington children were enrolled in children's medical coverage than in September 2007.<sup>2</sup> Approximately 19,000 of those children live in the CAF service area, where coverage increased by 8.1%.

There are many pathways to coverage, and local access programs implemented strategies that made sense in their own communities (these are described in detail in the individual “Spotlight on Success” profiles). At the same time, the Children's Alliance worked diligently to bring state agency and community efforts into alignment, and WithinReach developed tools to encourage use of the ParentHelp123 benefit finder by local organizations that enroll families in coverage.

Outreach efforts were somewhat hampered by the delay in the Department of Social and Health Services (DSHS) public information campaign about coverage options, and inconsistent messages about enrollment procedures caused confusion at the local level. In summer 2008, more than a year after passage of SB 5093, DSHS launched *Apple Health for Kids* with a bus tour that visited communities with information about state and local health care resources for families.

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<sup>1</sup>2008 Washington State Population Survey,  
<http://www.ofm.wa.gov/sps/2008/default.asp>

<sup>2</sup>Latest available data from the Washington State Department of Social and Health Services; includes enrollment in Medicaid, the federal State Children's Health Insurance Program, and state-only programs;  
<http://fortress.wa.gov/dshs/maa/News/EnrollmentFigures/ChildrensEnrollmentinDSHSMedicalAssistancePrograms.xls>

One challenge to reaching the goal of covering all kids by 2010 is re-enrollment when the first year of a child's insurance expires. The Children's Alliance is participating with DSHS in pilot projects to simplify the cumbersome renewal process. Early results are promising, indicating that more families are recertifying their children's coverage. In partnership with DSHS, the Children's Alliance is convening a committee to examine "Express Lane Eligibility" policies that would allow state agencies and programs to share data to find and enroll eligible children.

### **Improved access to health care**

Children are much more likely to receive health care if they have coverage, but most states' health care systems lack sufficient capacity to care for children enrolled in public programs. One of the goals of the Cover All Kids law was the establishment of health care homes for all children. Unfortunately, this provision of the law was not funded in the 2008 legislative session, and given the economic climate it is unclear if medical homes will be a priority in the 2009 session. The Children's Alliance has continued to advocate for strategies that 1) encourage community access programs to link enrolled children to medical and dental care, and 2) reward providers who deliver systematic, high-quality care to covered children.

Among local access programs, Yakima Kids Connect has one of the strongest networks for linking enrolled families to health care homes, in part because of the case management system that is shared by several health and social service providers.

In all areas, adolescents are underserved by the health care system. They are more likely to be uninsured than younger children, and many engage in risky behavior, develop unhealthful habits and have unmet mental health needs.<sup>3</sup> School-based health centers (SBHCs) provide a means of delivering comprehensive health care to this age group.

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<sup>3</sup>National Research Council, Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development. (2008). *Adolescent health services: missing opportunities*. Washington, DC: National Academy of Sciences. <http://books.nap.edu/catalog/12063.html>

Evaluations of these centers show that students are more likely to receive needed health care if they have access to health care to school.<sup>4</sup> The number of SBHCs is increasing across the U.S. In Washington, all but one of the 17 centers currently in operation are located in King County. The state Department of Health (DOH) has committed funds to expanding SBHCs to other areas of the state, focusing on rural districts and those that serve low-income families.

State support can be crucial for establishing SBHCs in communities.<sup>5</sup> With the funds from the Group Health Foundation, the DOH was able to award SBHC implementation planning grants to 11 communities, including five in the Group Health service area outside of King County. The grants allowed each school district to build community support and establish medical and administrative procedures in response to local needs. In fact, some areas will be ready to open the doors of their SBHCs in the 2009-10 school year and others are ready to apply for operating support from the DOH.

Group Health recently completed a two-year pilot study of the medical home model in one of its medical centers, and it is so successful the model will be implemented throughout Group Health. Research under way by Group Health's MacColl Institute for Healthcare Innovation and partners is focusing on transforming safety net clinics into Patient-Centered Medical Homes. This model has promise for eliminating racial and ethnic disparities in access and quality of care, and is expected to contribute to policy solutions throughout the U.S.<sup>6</sup>

### **Standardized performance measures**

Outreach and advocacy activities are difficult to measure in quantitative terms. It is especially challenging to attribute enrollment numbers to any specific activity. For example families could hear about *Apple Health for Kids* at a health fair sponsored by an organization like Kids

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<sup>4</sup>National Assembly on School-Based Health Care, <http://www.nasbhc.org>

<sup>5</sup>Morone JA, Kilbreth EH & Langwell KM. (2001) Back to school: a health care strategy for youth. *Health Affairs* 20(1): 122-36.

<sup>6</sup>Partners in the Safety Net Medical Home Initiative are the MacColl Institute for Healthcare Innovation, Qualis Health and The Commonwealth Fund. <http://www.qhmedicalhome.org/safety-net/about.cfm>

Connect and then enroll their children at a local DSHS office, via ParentHelp123, or by applying directly to the state.

Even from a qualitative standpoint, measuring advocacy is elusive. As one grantee pointed out, relationship building is hard to document: “How do you articulate effectiveness when you can’t track a conversation you had in a hallway?” In many cases, successful public policy efforts can take years or even decades to have an effect.<sup>7</sup>

Communities Connect has made significant progress at implementing outcome measures that can be used by community healthcare collaboratives across the state in gauging success in reaching three goals:

1. Improving access to care, including establishing and using a medical home,
2. Increasing enrollment in health insurance, and
3. Reducing inappropriate emergency department use.

For each of these goals, a consultant researched best practices in performance measurement nationwide and created a menu of possible measures that gauge success at reaching programmatic objectives and the impact of interventions on improving access and reducing disparities. Next steps for adopting the measures involve determining data collection feasibility and collaborating with other state and local agencies that collect and analyze data, including DSHS, DOH and health district assessment coordinators.

Yakima Kids Connect has captured some of these measures in its local *Tapestry* case management system. It may be worth investigating the feasibility of replicating this system in other areas of the state. With the advice of an oral health epidemiologist the Smile Partners collaborative also was able to identify outcome measures that have been incorporated into its shared case management system.

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<sup>7</sup>GrantCraft. *Advocacy funding: the philanthropy of changing minds.*  
<http://www.grantcraft.org/index.cfm?fuseaction=page.viewpage&pageid=734>

*“Organizations that started out by meeting their own communities’ needs have now come together. As individual organizations we’re successful, but there’s a synergy and power in collaboration.”*

– CAF grantee

### **Stronger partnerships**

The CAF implementation process itself made grantees more aware of each other’s programs, and strengthened collaboration between the grantees. The Spokane event announcing the Group Health investment in fall 2007, the Communities Connect conference in June 2008, and the Children’s Alliance Health Policy Summit hosted at Group Health headquarters provided invaluable opportunities for networking and communication of best practices. Since the initiative began, WithinReach has joined Communities Connect, is working more closely with community agencies on data sharing, and collaborated with Yakima Kids Connect on a project to increase the utility and reach of ParentHelp123. In the past year Communities Connect has gained five new members.

As noted above, the Children’s Alliance has been instrumental at aligning state and local efforts to reach uninsured children and families, and local ideas were incorporated into the *Apple Health for Kids* promotional campaign.

## By the Numbers: What have CAF grantees accomplished in the first year?

### BENTON-FRANKLIN ACCESS TO CARE and community partners

- 2,452 children enrolled September 2007 – August 2008; 11.7% increase

### CHILDREN'S ALLIANCE

- 40,000 additional children enrolled since Cover All Kids law passed
- 19,108 more children enrolled in Group Health service area outside of King County September 2007 – August 2008; 8.1% increase

### COMMUNITIES CONNECT

- 5 new members, including WithinReach
- 17 health access performance measures identified

### DEPARTMENT OF HEALTH

- 11 communities closer to opening school-based health centers

### HEALTH FOR ALL and community partners

- 2,604 families added to HFA case management database
- 1,919 children enrolled September 2007 – August 2008; 6.1% increase

### WASHINGTON STATE SMILE PARTNERS

- 2,284 school children in disadvantaged areas screened for dental disease
- 703 children with unmet dental needs referred for care
- 831 children provided with sealants, 417 with fluoride treatments and 190 with teeth cleanings

### WITHIN REACH

- 7,651 ParentHelp123 Benefit Finder users, representing 20,100 households
- 1,041 applications for children's health insurance generated
- 435 applications for Basic Health Plan completed

### YAKIMA KIDS CONNECT and community partners

- 2,972 children enrolled September 2007 – August 2008; 8.6% increase
- 408 children and 297 parents registered in *Tapestry* case management system
- 284 children connected to medical homes
- 251 children connected to dental homes

*“After the Cover All Kids law passed, Group Health stepped up to the plate and got community partners earlier than the state could. This helped build momentum and awareness.”*

– CAF grantee

*“Group Health is a critical partner in working through issues—from both a philanthropy side and a policy side.”*

– CAF grantee

## What factors contributed to the success of the CAF initiative?

**Public-private partnership to improve children's health.** A third of all children and half of low income children in Washington receive some form of public health insurance.<sup>8</sup> In implementing the Children's Access Fund, the Group Health Foundation joins a growing number of health philanthropies that focus on expanding the reach of public health insurance programs, including increasing enrollment and stimulating policy change. Support for a public initiative right from the beginning can be critical; launching the CAF initiative directly after passage of the Cover All Kids law was seen by grantees as being very important in getting coverage expansion efforts off the ground.

The CAF initiative incorporated elements that can be critical to the success of any public health initiative: strategies based in evidence, passionate advocates and policy change.<sup>9</sup> Some of the programs and activities funded by this initiative have been specifically cited in legislative reports, including Communities Connect, Benton-Franklin Access to Care, and the planning grants for school-based health centers.

**Criteria & guidelines for selecting projects to fund.** Establishing criteria for the selection of projects to fund was key to the success of the initiative. The programs that met the selection criteria were consistent with the intent of the Cover All Kids law, incorporated innovative strategies, and for the most part had a proven track record of success. This targeted approach worked for grantees as well; as one observed, “this was very positive for us, knowing ahead of time that we were a good fit for the funder.” Another echoed that opinion: “when we know we've been vetted, we know it's worth our time to prepare a proposal.”

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<sup>8</sup>2008 Washington State Population Survey, <http://www.ofm.wa.gov/sps/2008/default.asp>

<sup>9</sup>Larson EB, Roberts KB & Grumbach K. (2005) Primary care, generalism, public good: déjà vu? Again! *Annals of Internal Medicine* 142(8): 671-5.

*“Evaluation is always a challenging area—nonprofits don’t have the evaluation structure. Helping organizations improve their ability to evaluate programs will help the whole system move from best practices to proven practices.”*

– CAF grantee

**A collaborative evaluation process.** Nonprofit organizations frequently are challenged by finding the right balance between “doing the work” and committing time and resources to evaluation. The CAF grantees gave the Foundation high marks for the collaborative evaluation planning and agreed that this was a unique approach for a funder. They appreciated having the chance to meet in person to determine feasible objectives and how to report progress toward those objectives. In some cases, they were able to modify CAF outcome measures for other grants, keeping their strategies in alignment to meet overall program objectives. The flexibility of the evaluation and reporting templates allowed them to “tailor the template to our goals rather than tailor our goals to the template.”

**Investing in successful work.** While traditionally foundations have assumed that providing funds for new and innovative projects was the best strategic use of their dollars, many have shifted their focus to providing core support.<sup>10</sup> Nonprofits have experienced a significant erosion of funding from federal sources, including the organizations in Washington that lost their federal Healthy Communities Access grants midway through the program. CAF grantees emphasized that having funds for what they know works in their communities is critical for continuity of service, and that philanthropy helps fill gaps in funding. As one noted, “The Foundation’s approach [of supporting ongoing work] is good, rather than requiring programs that are new and different. All of the work we do is constantly improving to meet community needs. Our ongoing work is innovation.”

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<sup>10</sup>David T. (2002) *Reflections on sustainability*. Woodland Hills: The California Wellness Foundation.

## Spotlight on Success: The Children's Alliance

For over a decade, the Children's Alliance has worked diligently to advocate with one unified voice for health coverage for all kids via the statewide Health Coalition for Children and Youth (HCCY). With the ability to participate in the legislative process and speak directly to decision makers, this group was instrumental in ensuring passage of SB 5093, "Cover All Kids." The grant from the Group Health Foundation directly supports the Children's Alliance's continued advocacy for the health of Washington's children.

Focusing its attention on the numerous details of implementation, the HCCY is providing the connection between local activities—outreach and health care provision—and state agency decision making. Since passage of the new law, efforts to reach uninsured children and their parents are taking place at both the state and local levels, though there are several areas of "disconnect" between state and local efforts. The HCCY has convened various subcommittees that mirror those created by Department of Social and Health Services (DSHS). Children's Alliance staff and HCCY members are key resources for implementation of the legislation, serving in leadership roles on the state committees. Through the Children's Alliance's efforts, the state is working more closely with local community access organizations; in some counties the community organizations are reimbursed for their outreach activities.

Consistent public messaging about children's health insurance options in Washington has been a continuing challenge, and the phased-in eligibility for coverage made marketing more difficult. The Children's Alliance played a key role in the branding of the expanded health care coverage, and worked with DSHS to integrate local ideas and vision into the state media campaign. *Apple Health for Kids* was finally launched in summer 2008 with a bus tour that visited 15 cities. In addition, the Alliance has contributed to implementation of pilot programs to re-enroll children when their coverage expires, and is exploring the feasibility of automatically enrolling children who are covered by other state programs such as food assistance and the Women, Infants and Children (WIC) program.

The Children's Alliance attributes its success to monthly meetings of HCCY, strategizing with HCCY members before approaching DSHS with recommendations, listening to local concerns and giving those concerns voice at the state level, and regularly checking in with Legislative champions to report on implementation efforts.

In the first year of the new law, it is estimated that as many as 40,000 eligible uninsured children were enrolled in coverage. Unfortunately, with the looming state budget deficit, the Governor has proposed delaying the coverage of middle income families and eliminating outreach programs. In response, the Children's Alliance released a position statement calling for approaches that raise revenues rather than cut programs. On its web site, it is providing an online means for citizens to directly contact state legislators and voice their concerns regarding the future of Washington's children.

## Spotlight on Success: WithinReach

WithinReach connects more than 100,000 Washington families each year to food and health resources. For nearly two decades, WithinReach has operated a toll-free call center for individuals seeking assistance with food resources, family planning and pregnancy, children's health care, insurance coverage and other services. Because there are multiple state and local agencies involved in making sure children and their parents have health insurance, the many pathways to enrollment can be confusing to individuals and families seeking coverage.

In 2007, WithinReach launched an innovative web-based benefit finder and print-and-mail enrollment tool through its ParentHelp123 web site. This online resource is backed up with toll-free call centers, including bilingual Information & Referral specialists. The development of this award-winning tool has been supported by other major local funders including the Paul G. Allen Family Foundations and the Bill and Melinda Gates Foundation, with technical support from NPower-Seattle. With strong links to both state and community resources, WithinReach and ParentHelp123 facilitate integration of state and community-based efforts to reach out to eligible families. The grant from the Group Health Foundation supported enhancements to the web site and outreach to community organizations serving parents and children. Building relationships with state and local partners was another objective, and WithinReach strengthened its collaboration with other CAF grantees, including Yakima Kids Connect and Communities Connect. The web site enhancements include:

- Completion of a Spanish language version of the ParentHelp123 Benefit Finder
- A new—and very popular—feature allowing WithinReach to print and fax applications on behalf of families. The next step toward a paperless electronic system will be to launch electronic faxing of applications.
- A special section of tools for social service professionals, including local access specialists.

In February 2008 WithinReach hired an Outreach Specialist to develop marketing and communications strategies. Throughout the year, Call Center staff received specialized training to support ParentHelp123, and in May the phone system was upgraded to allow routing of calls directly to bilingual staff.

During the first year of the Children's Access Fund (October 2007-September 2008), there were 7,651 Benefit Finder users, representing 20,100 household members. Around three-quarters were individuals screening themselves or their families for eligibility for public programs. At least 1,040 applications for children's health insurance were generated by the ParentHelp123 system (this number does not include families who applied for food stamps as well as medical coverage, because those applications are submitted on the food assistance form).

In 2009 WithinReach will expand its outreach to social service providers and community agencies. A supplemental Foundation grant supports outreach to public library staff serving children and parents; WithinReach will be both an exhibitor and a presenter at the annual Washington Library Association conference. In collaboration with the Washington Dental Service Foundation, information about the Access to Baby and Child Dentistry program will be added to the ParentHelp123 Benefit Finder. Funding from both public and private sources is expected to support further development of electronic communication and enrollment.

## Spotlight on Success: Communities Connect

Over the past five years, Communities Connect (CC) has evolved from an informal working group into a statewide association of community-based coalitions working to improve access to health care. In January 2005, Communities Connect expanded its membership and elected officers. Since its inception, CC has established a reputation for providing policymakers with high-quality, objective information. Communities Connect promotes the sharing of best practices across the state and uses the combined voice of its membership to effect changes in state programs that support local solutions to health care access. Current membership represents 30 of the 39 counties in Washington State.

Challenges to successful implementation of the Cover All Kids law include lack of coordination between state agencies and non-governmental community based organizations. While the legislative intent is to cover more kids, the initial implementation efforts did not fully utilize the opportunity for working with the local organizations that build relationships with consumers and health care providers. In terms of sustainable results, "everyone measures differently," and there have been no standard statewide outcome measures. Communities Connect's goals for the Children's Access Fund project were to strengthen the collaboration among community access agencies and between access organizations and state agencies, and to develop measurable outcomes to evaluate access improvement efforts.

One of the strategies was a two-day statewide conference to share best practices. The June 2008 event attracted over 125 attendees from all corners of the state who were welcomed by Group Health CEO Scott Armstrong. Since then, five new members have joined CC, including WithinReach and Molina Healthcare, the health plan that covers the majority of the state's Medicaid enrollees.

Outreach and enrollment present the most challenges for documenting success. CC hired an experienced consultant to research programs throughout the United States and draft community access outcome measures and potential data sources. Preliminary review by members indicates agreement that the measures are clear and will provide useful information.

CC is part of a larger national collaborative, Communities Joined in Action, which held its annual conference in Seattle in October 2008—allowing many members to participate in a national dialogue on measuring outcomes. CC has been recognized by the Washington State Health Care Authority as a valuable partner that provides leadership in promoting and sharing best practices and strategies.<sup>a</sup>

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<sup>a</sup>Washington State Health Care Authority. Report to the Legislature: Evaluation of the Community Health Care Collaborative Grant Program, September 2008. [http://www.hca.wa.gov/documents/legreports/chcc\\_letter\\_grant\\_program.pdf](http://www.hca.wa.gov/documents/legreports/chcc_letter_grant_program.pdf)

## Spotlight on Success: Department of Health—School-Based Health Centers

School-based health centers (SBHCs) are recognized as an effective way to provide primary care—including mental health and dental care—to children and teens. In general, adolescents are the age group least likely to receive health care. SBHCs provide access for many youth who would otherwise not receive care because of lack of insurance or parents' inability to take time off work. Clinical services in each center are provided by a qualified health care provider such as a health system, health department or medical practice. In Washington there are 17 SBHCs, all but one in King County. Group Health operates four SBHCs in Seattle and provides mental health services at three sites in partnership with Public Health Seattle and King County (PHSKC).

Assessments have shown that SBHCs contribute to improvement in students' school performances and create safer and less stressful school environments. Students who use SBHCs are more likely to finish high school and report increased levels of healthier behaviors such as exercise. "When the clinics work well, staff members win a reputation among students for compassionate, confidential, and nonjudgmental treatment. Students actually use the services. They have a safe place to take their aches and anxieties."<sup>a</sup>

In 2007, the State Department of Health (DOH) announced three-year grants—supplemented by the Group Health Foundation—that would support operation of three new SBHCs in underserved areas. It became apparent, however, that many communities interested in establishing a school health center were not ready to offer services, and none outside of King County applied for a grant. Instead, the DOH awarded \$20,000 grants to 11 communities to develop local implementation plans, of which the Foundation funded five: three school districts in Kitsap County, plus one each in Walla Walla and Columbia counties. Technical assistance to all 11 grantees was provided by PHSKC and Kitsap County Health District.

The planning grants allowed the five communities in the Group Health service area to make great strides toward establishment of their SBHCs. According to the PHSKC technical assistance provider, the planning grants were "immensely successful," particularly because they facilitated a greater level of community buy-in. Planning grant recipients formed community advisory boards, assessed student health status and access to care, developed governance, clinical operations, administrative and quality assurance plans, and determined sources of in-kind and financial support (the Foundation recently facilitated donations of surplus Group Health exam room equipment to SBHCs in Kitsap County). Those communities that have a committed medical partner are the closest to being able to open the doors of their health centers.

Another important outcome of the planning grants is moving SBHCs "past the tipping point of being a Seattle-only phenomenon." There is a heightened legislative awareness of the value of SBHCs: a recent report to the Legislature specifically mentioned the grants and recommended state support of schools in fulfilling their roles as health care homes for their students.<sup>b</sup>

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<sup>a</sup>Morone JA, Kilbreth EH & Langwell KM. (2001) Back to school: a health care strategy for youth. *Health Affairs* 20(1): 122-36.

<sup>b</sup>Final Report, The Select Interim Legislative Task Force on Comprehensive School Health Reform, December 2008; [www.leg.wa.gov/documents/joint/cshr/FinalReport.pdf](http://www.leg.wa.gov/documents/joint/cshr/FinalReport.pdf)

### The future: challenges and opportunities

**Sustainability.** Uninterrupted support is a challenge for programs that do not generate revenue and are mainly supported by private and government grants, especially as public financing of programs waxes and wanes. As shown in Table 3, CAF grantees depend on a patchwork of support for their operations.

Table 3: Sources of Support for CAF Grantees

	Government grants & contracts	Local health care organizations	Insurance reimbursement	Foundations & other private funders	Memberships	Donations (cash & in-kind)
Benton-Franklin Access to Care*	X	X		X		X
Childrens Alliance				X	X	X
Communities Connect				X	X	
School based health centers	X	X	X	X		X
Smile Partners			X	X		X
Spokane Health for All	X	X		X		X
Within Reach	X			X	X	X
Yakima Kids Connect	X	X		X		X

\*BFAC suspended operations in early 2008 because it lost the local match to its state Health Care Authority grant

Despite the challenges, CAF grantees have continued to attract funding to support and grow their efforts to improve children's access to care. Since the CAF grants were awarded, all three of the community-based programs have received grants from the state Health Care Authority (though Benton-Franklin Access to Care had to return a portion of its grant). The Children's Alliance received a three-year, \$750,000 Finish Line grant from the David and Lucile Packard Foundation. On a smaller scale, Within Reach secured grants to add eligibility information for the ABCD early childhood dental program to the ParentHelp123 benefit finder and to collaborate with outreach workers in Yakima County. The grantees were unanimous in their opinion that Group Health support gave their programs credibility to raise funds from other sources.

In some cases, programs are able to move forward when grantmakers choose to support them in a new phase of development. For example, with a relatively modest investment, the work of both Communities Connect and a statewide coalition of school-based health centers could continue to make progress with part-time paid staff.

Having the Foundation as an active partner in evaluation planning for the Children's Access Fund was very successful. Partnering in sustainability planning could be equally valuable: at least one other funder has suggested that grantmakers should provide training and resources for sustainability planning early in a funding cycle.<sup>11</sup>

**Economic downturn and increased demand for public coverage.**

Parents who have lost jobs in the current recession turn to Medicaid and the State Children's Health Insurance Program (SCHIP) for insurance for their children. Governor Gregoire's proposed delay in expansion of eligibility will leave many families scrambling for coverage. At the same time, passage of SCHIP expansion is expected soon after President Obama takes office. If passed, the new law will lift eligibility restrictions for documented immigrant children, and community access programs will need to revise and expand their outreach strategies. Taking the state's recertification pilots to scale is critical: recent research indicates that children who drop out of SCHIP coverage are likely to become and remain uninsured.<sup>12</sup>

**Accurate and meaningful quantitative data.** Statistics from different state agencies can present seemingly conflicting information. The State Population Survey (SPS), a telephone sample of residents, is conducted every two years, and includes questions on insurance coverage. DSHS collects monthly statistics on the number of children enrolled in coverage, but at present publicly available data does not indicate the rate of "churn," or dropping off and re-enrolling. While DSHS data indicate an increase in enrollment of nearly 40,000 children

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<sup>11</sup>Partnership for the Public's Health. (2007) Strategies for building community-public health partnerships. Oakland CA: PPH. [http://www.partnershipph.org/downloads/Strategies\\_for\\_Building\\_Community-Public\\_Health\\_Partnerships.pdf](http://www.partnershipph.org/downloads/Strategies_for_Building_Community-Public_Health_Partnerships.pdf)

<sup>12</sup>Trenholm C, Mabli J & Wilson A. (2008) *SCHIP children: how long do they stay and where do they go?* Princeton NJ: Mathematica Policy Research.

since the Cover All Kids law was enacted, according to the SPS only 5,000 additional children had gained coverage between 2006 and 2008.

Another challenge is obtaining data for small geographic areas. Some of the outcome measures proposed by Communities Connect are not readily available at the local level. The SPS sample sizes for rural areas are too small to provide county level data, and data for rural counties must be aggregated. Funding that supplements state appropriations can improve public data collection; for example, in California health plan and foundation support has expanded the capacity of the California Health Interview Survey to provide information on health care needs and access that is useful to both local and state policymakers.

**Persistent unmet health needs.** Even with the progress made in providing more access to health care for children, some problems will require significant investment to solve. Dental care is the largest unmet health need among low-income children.<sup>13</sup> Though overall philanthropic investments in the dental care system have been small,<sup>14</sup> the Group Health Foundation has played an important role in supporting the dental care safety net, including the CAF support of dental hygienists' expanded scope of practice. Other opportunities for philanthropy include building public awareness about the importance of oral health, piloting new approaches such as the Foundation-funded study of oral health promotion in primary care settings, and supporting evaluation of innovative interventions.

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<sup>13</sup>Felland L, Lauer JR & Cunningham J. (2008) *Community efforts to expand dental services for low-income people*. Center for Studying Health System Change, Issue Brief No. 122.

<sup>14</sup>Gehshan S. (2008) Foundations' role in oral health: nothing to smile about. *Health Affairs* 27(1): 281-7.

## Spotlight on Success: Washington State Smile Partners

Tooth decay is the most common childhood chronic disease, and many children miss school because of dental-related illness. Even children who have health insurance may not have coverage for dental care, and children from low-income families face substantial barriers in accessing dental services. School-based oral health programs have the potential to prevent and arrest dental disease by reaching every child and have been shown to be very effective in reducing dental caries in children. Since 2000, licensed dental hygienists in Washington have been able to apply sealants and fluoride without a dentist's supervision.

In 2007, the Washington State Legislature enacted HB1298, expanding the services hygienists can provide at schools to include professional cleaning. At that time, dental hygienists in five school-based programs covering six counties formed a coalition under the umbrella Washington State Smile Partners (WSSP), offering preventive and referral services to dentally underserved students. (Since then, one of the partners withdrew from the coalition and another will be replaced for the second year of the project.)

Focusing on schools with a high percentage of children enrolled in subsidized lunch programs, the WSSP hygienists screen students for dental disease and tooth decay, and with parental consent provide cleaning, fluoride varnish and sealants. In each community, the partners are developing networks of providers willing to take referrals. Communication with parents included information on options for health insurance coverage. One of the key activities funded by the Group Health Foundation grant is development of a common data and case management system that can be used by the geographically dispersed partners. This system is intended to provide information on outcomes for policymakers as well as serve as a model for best practices for others in the field.

In the first year, the hygienists screened over 2,000 children in Benton, Franklin, Kitsap, Pierce, Thurston and Whatcom counties. Of those, over half had untreated visible tooth decay and many had urgent dental problems. Data collected in year two will provide comparison information; WSSP expects that there will be far fewer students with unmet dental needs.

WSSP has encountered some problems during the first year, including technological and logistical problems implementing the Dentrix data collection system. Once software and hardware issues were resolved and participants became adept at entering data, running reports has proven to be easy. Pioneering a new and collaborative outcome tracking system can present many challenges. Nonetheless, the WSSP project will generate data that demonstrate the success of school-based oral health services, as well as provide a model that could be implemented on a larger scale.

## Spotlight on Success: Yakima Kids Connect

Yakima County has one of the highest child poverty rates in the state. Two-thirds of the county's school children receive free or reduced meals, and over half with health insurance are covered by public programs. In 2006, an estimated 4,500 children lacked health coverage, and up to 9,000 children and families had not identified a medical home. Over half of Yakima County children are of Hispanic heritage, a group that is much more likely to be uninsured.

Many of the same people from Yakima County's health and social service organizations come together to address various community needs, and have a strong tradition of supporting each other and solving problems collaboratively. The Yakima County Health Care Coalition established Yakima Kids Connect in 2005 with a federal Healthy Communities Access Program grant. The funding supported coordination of the work of community-based access specialists and the development of Tapestry, a sophisticated case management information system customized to meet local needs and provide meaningful measures of progress. These activities were suspended when the federal grant was terminated in March 2007.

The Group Health Foundation grant—along with a Health Care Collaborative grant from the Washington State Health Care Authority—allowed Kids Connect to restore the case management system and reinstate the position of Operations Manager to coordinate the network of access specialists. Expected outcomes were 1) reduced number of uninsured children, 2) increased coverage stability, 3) establishment of medical and dental care homes, and 4) more families seeking care from their own care providers rather than hospital emergency departments.

During 2008, Kids Connect coordinated outreach efforts throughout the Yakima Valley. A total of 708 individuals (408 children and 297 parents) were registered in the shared system. Many of those already had coverage, but not a usual source of care, and the access specialists successfully connected 284 children to medical homes and 251 to dental homes. In addition, the access specialists completed nearly 150 insurance renewals for children and parents, supplementing the efforts of DSHS workers stationed at community health centers. The Tapestry database was modified to provide information on continuity of coverage and reasons for emergency department use.

In summer 2008, the state's *Apple Health for Kids* bus stopped in Yakima, and all of the Kids Connect agencies participated in a "festival in the parking lot" that included a visit by U.S. Senator Patty Murray. During the project year, Kids Connect also received funding to participate in a UCLA/Johnson & Johnson Health Care Institute health literacy program for parents. Kids Connect distributed a book *What to Do When Your Child Gets Sick?* at a special event for parents, and will follow up in 2009 with interviews about health care use. The access specialists are once again functioning as a cohesive team, committed to finding the hardest to insure members of the community. The branding of the Kids Connect effort has been an asset for Yakima—supporting an interagency project that is recognized as successful in helping children and families.

## Spotlight on Success: Health for All

A program of Spokane-based Community Minded Enterprises, Health for All (HFA) is a proactive healthcare access project that reaches out to the uninsured and underinsured with advocacy, education on access and healthy behaviors, and insurance application support and follow-up. It is estimated that well over a third of households in Spokane County have incomes at levels qualifying them for state-sponsored coverage. Unemployment in the Spokane area has increased, reflecting layoffs from high-tech jobs, in part due to overseas outsourcing. Many of these individuals who lost employer-based insurance are eligible for state programs for the first time in their working lives. HFA supports these families in keeping their health care homes by helping them apply for the state-supported health plans with which HFA providers have contracts.

The non-English speaking population of the Spokane area is growing, and eastern Washington is a popular destination for immigrants from Eastern Europe. There are an estimated 90,000 residents from former Soviet republics, many of whom are highly suspicious of government agencies and people outside of their own ethnic communities. HFA outreach strategies are very responsive to the changing ethnic diversity in eastern Washington. Immigrant community leaders are trained and supported to work within their own communities to deliver information about health care resources.

One of the most successful outreach strategies in the Spokane area is using mass media, particularly television, to deliver messages about health care resources. Television campaigns generate high call volumes to HFA, and callers are given personal assistance in enrolling in insurance and linking to health care providers. HFA is known for persistent follow-up with DSHS to ensure applications are processed properly. In fact, HFA's director makes a point of keeping current with changing regulations, and provides training and consultation to other agencies providing health care access—including local DSHS offices. HFA makes every effort to maintain good working relationships with state agencies that handle applications for coverage, including three-way conference calling with clients and DSHS to expedite applications.

During the first year of Group Health Foundation funding, HFA experienced greatly increased volumes of calls from people inquiring about coverage options with an increase in first-time callers. HFA has sent out over 1,000 letters to families of children already enrolled but at risk of losing coverage, including instructions on how to submit documentation to keep their children enrolled. Despite increasing levels of need due to the recent economic downturn, HFA is committed to reducing or eliminating barriers and ensuring that all members of its service area have access to health care.

## Spotlight on Success: Benton-Franklin Access to Care

In 2007, there were 34,000 people in Benton and Franklin Counties who did not have health insurance. Of those, just over 18,000 were below 200% of the federal poverty level, including approximately 4,000 children. There are particularly high needs among Franklin County's children and teens, with a high percentage living below poverty and either uninsured or enrolled in public insurance and food assistance programs. Franklin County has a large Hispanic population, and there appears to be a high level of both English and Spanish language illiteracy among immigrant adults.

Benton-Franklin Access to Care (BFAC) was created in 2004 by the Benton-Franklin Community Health Alliance and was funded by a federal Healthy Communities Access Program grant until February 2007, when the grants were terminated. BFAC had many community partners, with financial and in-kind support from local hospitals and other health care providers, local DSHS offices, pharmaceutical companies and foundations. In many ways BFAC served as the "safety net for the safety net," locating sources of primary and specialty care and prescription drugs for uninsured and uninsurable adults. In addition, BFAC helped many parents apply for state-sponsored insurance coverage for their children.

BFAC's goals with the Group Health Foundation grant were to develop more proactive strategies for reaching parents of uninsured children, specifically by developing stronger referral relationships and distributing information at area schools. The school-based outreach met with mixed results, but provided valuable lessons in working with area schools in the future; BFAC discovered that face-to-face contact in individual schools, particularly with school nurses, seemed to work best for getting the word out to parents. The flyers distributed at schools and community agencies serving children resulted in an increased number of calls to WithinReach from Benton and Franklin counties.

In early 2008, BFAC lost funding from one of the hospitals that supported the program. As a result, it suspended operations and was forced to return part of a state Community Health Care Collaborative grant. BFAC was considered to be a successful, well-run program, but without local support it was not sustainable. The program recently was recognized by the state Health Care Authority as a model for having clients invest up front in a portion of their care, greatly increasing the likelihood that they keep their medical appointments. Currently, the Community Health Alliance—of which Group Health is a member—is leading new efforts to connect community members to affordable and accessible health care and find a sustainable, long-term solution for the uninsured in the two counties.

*"We need more partnerships like  
the one with Group Health."*

– Paola Maranan  
Executive Director,  
The Children's Alliance

## **Conclusion**

By all accounts the Children's Access Fund is a successful initiative. From the perspective of the grantees, the CAF offered a unique opportunity to work together to articulate strategies and outcomes. From the perspective of the Foundation and Group Health, identifying and supporting successful programs has made a difference to families and communities, and more children in the state are assured access to health care. As one grantee observed, "Group Health is a critical partner in working through issues. It is one of the few statewide entities committed to larger health goals."



# APPENDICES

## The Group Health Children's Access Fund

Appendix A: Guidelines and Criteria

Appendix B: Program Selection Process

Appendix C: Logic Model

Appendix D: Evaluation Plan Template

Appendix E: Progress Report Template



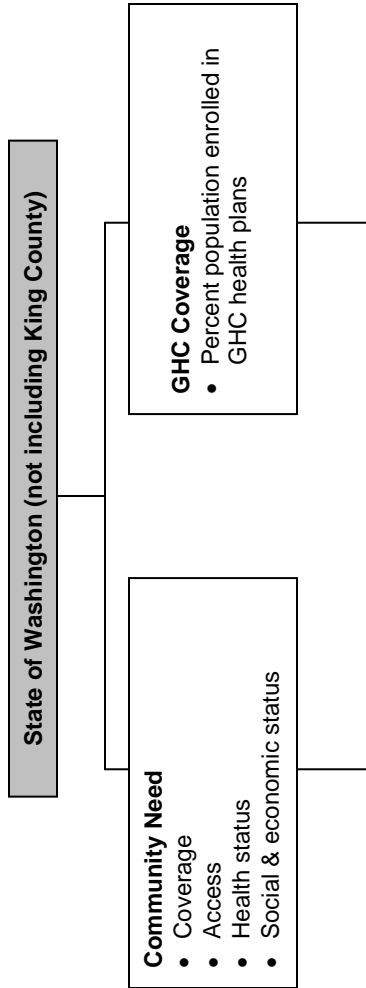
Appendix A: Children's Access Fund Guidelines and Criteria

Guiding Principles

<b>IDENTIFICATION OF TARGET COMMUNITIES</b>	
<b>Need</b>	Focus on communities and populations with the greatest need
<b>GHC Coverage</b>	Consideration of the proportion of the population enrolled in GHC health plans
<b>CRITERIA FOR PROGRAMS &amp; INITIATIVES</b>	
<b>Sustainability</b>	Program will continue beyond the Fund's initial investment
<b>Community Engagement</b>	By fostering community partnerships, the program will deepen GHC's relationships and advance GHC's visibility in communities it serves
<b>Community Readiness</b>	There is evidence the community is ready to take action to improve children's health
<b>Innovative and Evidence-Based</b>	Strategies are innovative and informed by evidence and provide an opportunity for Group Health to learn how to better serve children
<b>Outcome Orientation</b>	Program includes measurement of outcomes and evaluation of success and advances Group Health's mission to transform children's health and health care
<b>Alignment with State Legislation</b>	Program aligns with <i>Senate Bill 5093: Health Coverage for All Children</i> , as signed by Governor Chris Gregoire on 3/13/07.*

\*<http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Senate%20Bills/5093-S2.pdf>  
[http://childrensalliance.org/4Download/health/cover\\_all\\_children\\_summary.pdf](http://childrensalliance.org/4Download/health/cover_all_children_summary.pdf)

## Process for Identifying Target Communities



CRITERIA FOR PROGRAMS & INITIATIVES						
RATING	Sustainability	Community Engagement	Community Readiness	Innovative & Evidence-Based	Outcome Orientation	Alignment with SB 5093
1	Sustainability plan in place	Limited potential for relationship and visibility is identified	Need is recognized by community	No evidence in support of strategies	No outcomes identified	
2	Sources of support identified	Potential opportunities for relationship and visibility identified by GHC/GHCF	Community agencies address identified need	Strategies based on continuation of current work	Outcomes stated; no indicators identified	Alignment not addressed
3	Record of success in mobilization of resources	Opportunity to continue current relationship/visibility within the community	Formal collaborations to address need	Evidence in literature and evaluation studies in other geographic areas	Outcomes and indicators stated; no methods identified	
4	Integrated with larger health care system	Proposed establishment of formal relationship	Well-mobilized community advocacy	Strategies include improvements resulting from strong, local evaluations	Outcomes, indicators, and methods specified	Alignment is implicit
5	Formal commitment(s) for continued support	Agreement reached with community partner(s) on action plan for increased relationship/visibility	Record of success in addressing community needs	Strong evidence and clear rationale for strategy	Clear outcomes with valid & feasible evaluation measures and analysis plan	Links to SB5093 specifically described

## **Appendix B: Children's Access Fund Program Selection Process**

The Children's Access Fund initiative marked a departure from the Foundation's bi-annual Children & Teen grant program, both in size of award and method of choosing grantees.\* The process of selecting programs for funding involved crafting criteria and guidelines, analyzing community needs, interviewing children's health leaders within and outside of Group Health, and inviting agencies to describe how an investment from Group Health would enhance their efforts to improve children's access to care.

### **Criteria and Guidelines**

One of the first steps was defining guiding principles and criteria for selection of programs to fund, outlined below.

#### Guiding Principles:

- Focus on communities and populations with the highest needs
- Limit to programs serving communities in the Group Health service area outside of King County
- Fund a small number of programs with relatively large grants

#### Criteria:

- Alignment with SB 5093
- Innovative and evidence-based: Strategies are innovative and informed by evidence and provide an opportunity for Group Health to learn how to better serve children
- Community readiness: There is evidence the community is ready to take action to improve children's health
- Outcome orientation: Programs incorporate measurement of outcomes and evaluation of success
- Sustainability: Programs will be able to continue with other resources
- Community engagement: Fostering community partnerships will deepen Group Health's relationships in the communities it serves.

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\* One of the components of the Foundation's Children's and Teens grant program is support for improvements in access to care. Two smaller grants were awarded to agencies implementing outreach and enrollment strategies similar to those of CAF grantees.

### **Community need profile**

Areas of the state with the highest needs in terms of children's health were identified through analysis of demographic, health status, health coverage and access data.

Findings from this analysis include the following:

- In 2006, nearly 95,000 children and teens in the state were uninsured – 5.5%. Over 55,000 of those uninsured children live in the GH service area outside of King County.
- Children 14 and younger are more likely than teens to be covered by Medicaid insurance; adolescents 15 and above are more likely to be uninsured.
- The state is becoming more ethnically diverse through its children. Well over half of the children under 19 in several eastern Washington counties, including Yakima and Franklin, are of Hispanic background. Counties in western Washington with the highest proportion of minority children are Pierce and Kitsap. Hispanic, American Indian and Black Washington residents are less likely to have health insurance than other groups.
- Uninsured low-income children and teens are more likely to report fair or poor health. Those with no health insurance or public health insurance are less likely to have had both a medical and preventive dental visit in the past 12 months.
- Community health centers – i.e., safety net clinics – are the medical home for over half of the uninsured youth in Washington. Franklin and Pierce counties have lowest safety net capacity for children and teens.

To determine the relative need in the GH service area, counties were stratified by size – large, medium and small. The rankings in each group were determined for each of 12 indicators, and a composite score was calculated, with a possible range of 10 (highest need) to 1 (lowest need).\*

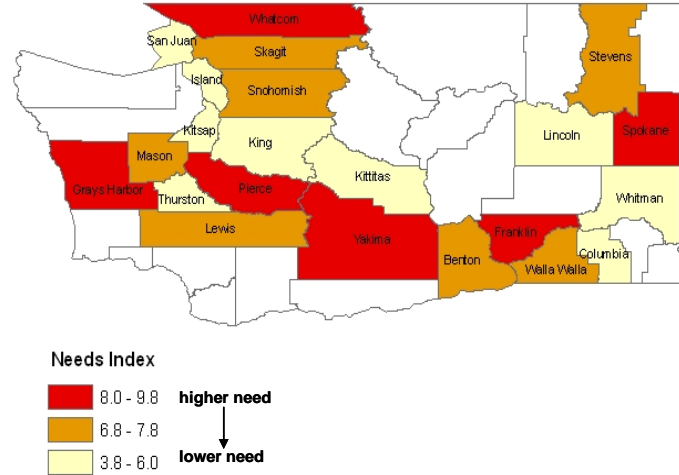
The results are displayed in the map below (for comparative information, King County is included in the calculation). The composite index suggests that the counties with highest needs are Yakima, Franklin, Grays Harbor, Pierce, Spokane and Whatcom.

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\* Indicators included in composite index:

- Pct. 0-19 non-white 2006
- Pct. 0-19 Hispanic (white) 2006
- Pct. 0-19 below poverty level 2000
- Pct. infants enrolled in WIC 2006
- Pct. applications reduced cost school meals 2006
  
- Pct. births with inadequate prenatal care 2005
- Teen pregnancy rate 2001-03
- Pct. adequately immunized entering school 2005-06
- High school dropout rate 2004-05
  
- Pct. 0-19 uninsured 2006
- Pct. 0-19 with public coverage 2006
- Population 0-19 below poverty / safety net clinic

Counties in Group Health service area



### Key informant interviews

A series of interviews were conducted with care providers and children's health advocates that were identified by Group Health leadership and through a snowball sampling process. These key informants identified communities and groups of children with particularly high needs as well as promising community-based or statewide efforts that should be considered for the Children's Access Fund.

Several informants mentioned the need for outreach to eligible children and families to make sure they are enrolled in federal or state-sponsored coverage, as well as the need for access to dental and mental health care. Nearly all mentioned that children in rural areas and immigrant populations are particularly underserved.

Nineteen promising statewide and community based efforts to improve children's access to health care were identified during the interviews. Representatives of these agencies were sent a letter asking them to describe in writing how a one-time contribution from GHCF might assist their efforts to improve children's access to care; 17 agencies responded to the letter with brief proposals.

### Proposal review

The responses from the 17 agencies were reviewed according to the guidelines and nine were identified as being most closely aligned with the criteria and expectations for the funding. Group Health approved further investigation of these programs, and representatives from the nine agencies were interviewed by telephone to learn how they would measure success and ensure accountability, what their budget requirements would be, and how their experience could benefit others in the state.

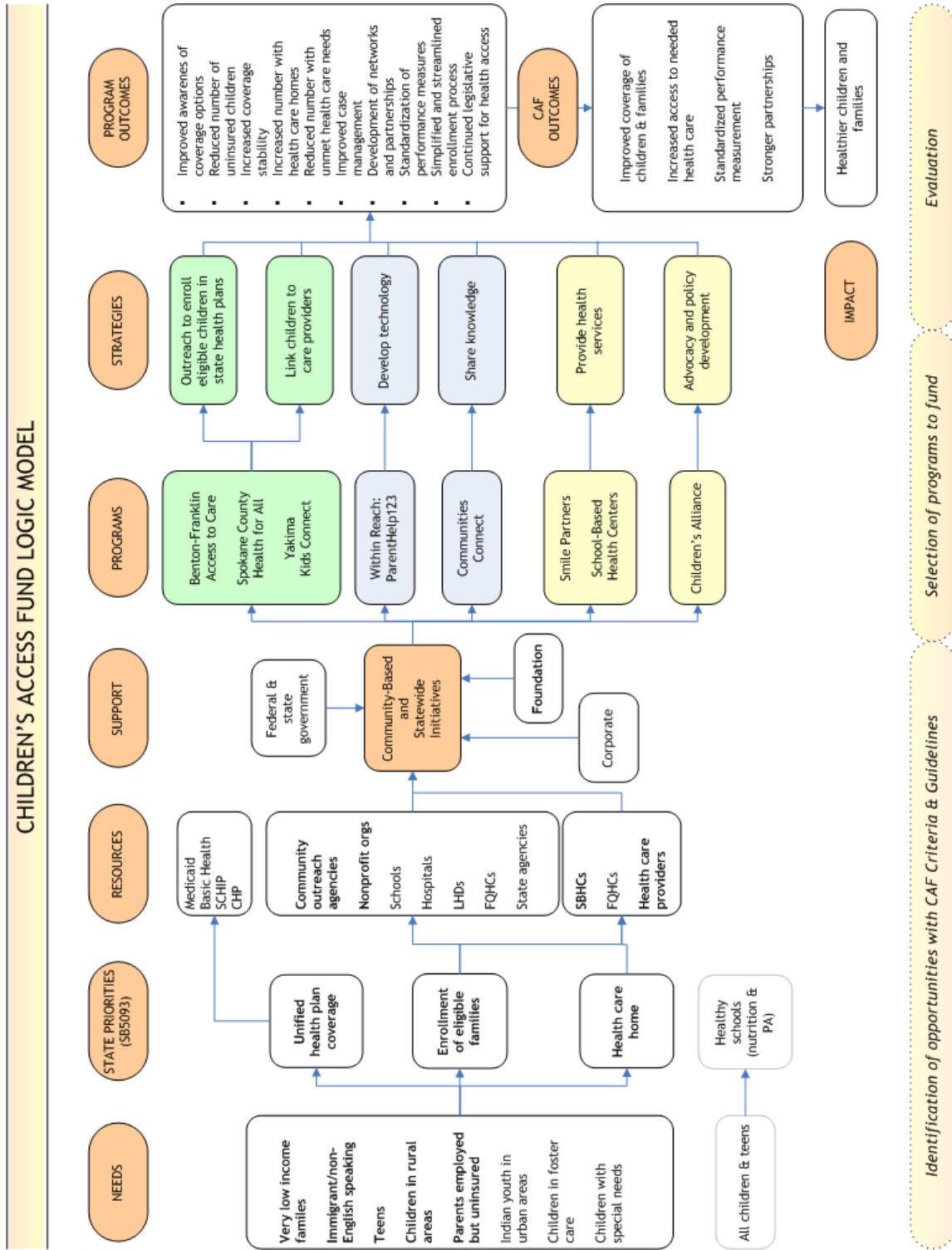
**Final selection**

The CAF working group recommended six programs for funding, which were approved by Group Health. These include statewide, regional and community-based efforts that serve regions and populations with highest needs. The award of the grants was announced on September 27, 2007 in Spokane at a public event attended by grantees, community health advocates and the executive leadership of Group Health.

The programs that were selected are described below. Included in the list are two “pilot” projects that were funded outside of the CAF review process.

Program	Area served	Timeline
<b>Children’s Alliance:</b> Actively working on implementation of SB 5093, providing connection between local activities and state agency decisions. Funding supports enhanced policy development, including immediate action and long term planning.	Statewide	September 2007 – August 2010
<b>Within Reach:</b> Recently launched ParentHelp123, an innovative web application that allows parents to determine eligibility and apply for public health insurance and food assistance. Funding supports marketing and outreach.	Statewide	October 2007 – September 2009
<b>Washington State Department of Health:</b> DOH is committed establishing new school-based health centers ideally in rural areas. CAF funds will be used for community planning grants.	Statewide	<b>Pilot project</b> January 2008 – September 2008
<b>Communities Connect:</b> Association of community-based coalitions; CAF will support conference to share best practices and establishment of standardized performance measures.	Statewide	September 2007 – August 2008
<b>Smile Partners:</b> Coalition of registered dental hygienists with a pilot program to expand school-based preventive and referral services. Activities include identifying students with dental needs, offering screening and preventive services, communicating with parents, and establishing a network of providers willing to take referrals.	7 counties in western and central Washington	September 2007 – June 2009
<b>Community-Minded Enterprises:</b> Health for All actively reaches out to the un/underinsured with education on access, advocacy and application and follow-up support. Activities include educating parents on appropriate use of health care, targeted outreach to individuals, training of community agency staff, and mass media campaigns.	4 counties in NE Washington, including Spokane	September 2007 – August 2009
<b>Yakima Kids Connect:</b> Coordination of of access specialists to proactively locate families with uninsured children and help them find and maintain coverage and establish ongoing care with a medical home. Program features web-based case management system.	Yakima County	October 2007 – September 2008
<b>Benton-Franklin Access to Care:</b> Community outreach to reach uninsured children and assist with enrolling in state health plans.	Benton & Franklin counties	<b>Pilot project</b> July 2007 – June 2008

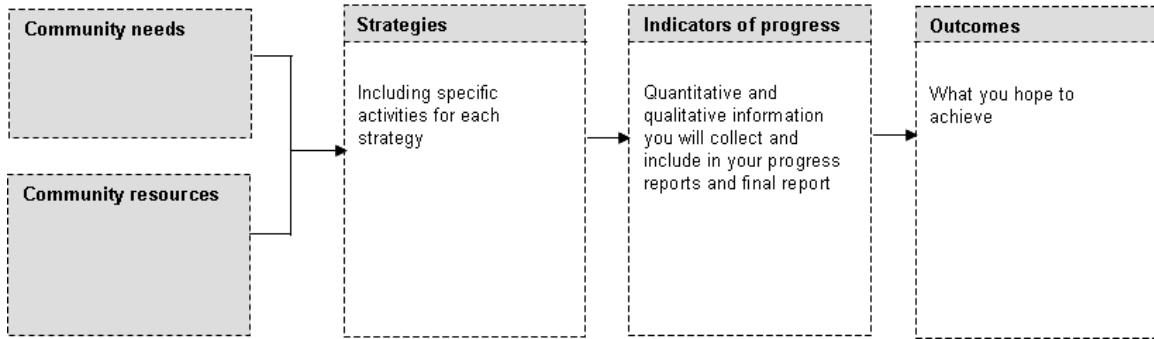
## Appendix C: Children's Access Fund Logic Model



Appendix D: Children's Access Fund—Evaluation Plan Template

<b>&lt;name of project&gt;</b>	
<b>Grant period:</b>	<b>Amount:</b>

**EVALUATION TEMPLATE**



<b>Progress Reporting Schedule</b>	
Progress Report 1	
Final Report	

<b>COMMUNITY NEEDS</b>
<b>COMMUNITY RESOURCES</b>

**STRATEGIES**

--

<b>INDICATORS</b>	
<b>Qualitative</b>	
Description of your experiences implementing proposed strategies, including: <ul style="list-style-type: none"> <li>• Successes</li> <li>• Lessons learned and strategies revised</li> <li>• Anecdotal: "stories"</li> </ul>	
<b>Quantitative</b>	<b>Source</b>

<b>OUTCOMES EXPECTED</b>
<ul style="list-style-type: none"><li>•</li><li>•</li><li>•</li><li>•</li></ul>

Appendix E: Children's Access Fund—Progress Report Template

<b>&lt;name of project&gt;</b>	
<description>	
Grant period:	
Report: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Final <input type="checkbox"/>	
Report date:	Reporting period:

**Expected Outcomes:**

*What have you been able to achieve? Please thoroughly describe your progress implementing proposed strategies, including qualitative and quantitative indicators from your Evaluation Plan.*

OUTCOMES
<outcome 1>
<outcome 2>
<outcome 3>
<outcome 4>

**Successes and Challenges:**

*What contributes to successful implementation of your strategies, e.g. stronger partnerships, policy support, etc.?*

*What challenges have you encountered in implementing your strategies?*

*If you have revised any of your strategies, please describe how.*

## **FOR FINAL REPORT**

### **Sustainability**

*How will you or other organizations in your community continue to make progress toward your goals?*

*Are there any insights about sustainability of community-based access efforts that you wish to share?*

### **Impact**

*Are there lessons from this project that can be shared with others in the state?*



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