Michigan Children's Health Access Program

Year Two Evaluation Report

Issued 07.31.17, Updated 12.8.17

PSC

PUBLIC SECTOR
CONSULTANTS

Prepared by

Public Sector Consultants
Lansing, Michigan
www.publicsectorconsultants.com

Prepared for

Michigan Association of United Ways
Lansing, Michigan
www.uwmich.org

TABLE OF CONTENTS

INTRODUCTION

In February 2015, the Michigan Association of United Ways (MAUW) received a two-year grant from the Michigan Health Endowment Fund (MHEF) to implement the Michigan Children's Health Access Program (MI-CHAP).[1] The MI-CHAP initiative is intended to build on the successes of the CHAP in Kent County, which demonstrated improvements in health outcomes for children on Medicaid, as well as the Michigan 2-1-1 system (also referred to as "2-1-1"), which provides families with quick and easy access to information about health and human services in their community.

MAUW established the following four goals for the project:

1. Improve the health of Medicaid-enrolled children in MI-CHAP.
2. Improve the quality of and access to medical homes in MI-CHAP communities.
3. Lower the total cost of care by reducing emergency department (ED) visits and inpatient hospital admissions among children on Medicaid.
4. Innovate efficiencies and scalability by delivering components of the CHAP model statewide through a new virtual strategy.

MAUW is using the MHEF grant to support CHAPs in eight communities across the state. MI-CHAP sites form relationships with primary care providers and work directly with families on Medicaid to help strengthen their connections with these and other healthcare providers. CHAPs use a local multidisciplinary team to provide education, care coordination, community resource referral, transportation and other services to address the social determinants of health and barriers to medical access for children on Medicaid. This may include connecting their clients to a patient-centered medical home if they do not already have a primary care provider. Additionally, some CHAPS offer their own health programs, such as asthma education, Commit to Fit! nutrition initiatives, or FitKids360, which combines health and nutrition education with physical activity to help participants develop healthy lifestyles.

In the first year of the initiative, MAUW funding supported expansion of existing CHAPs in two communities, implementation of new CHAPs in three communities, and planning for implementation in three communities. During the second year of the initiative, CHAPs in the planning communities began providing services. MI-CHAP sites in the following counties and regions (often referred to as "local CHAPs") have received MAUW funding:

1. Genesee County	5. Macomb County
2. Ingham County	6. Northwest Michigan (Antrim, Emmet, Charlevoix, and Otsego Counties)
3. Kalamazoo County	7. Saginaw County
4. Kent County (existing CHAP)	8. Wayne County (existing CHAP)

MAUW is also using a portion of the MHEF funds to develop a system within Michigan 2-1-1 for identifying callers who are eligible for CHAP services and connecting them directly to a local CHAP site or with a virtual CHAP (V-CHAP) specialist. V-CHAP specialists, a new Michigan 2-1-1 component created as

[1] MAUW has received a no-cost extension from the Michigan Health Endowment Fund for the MI-CHAP initiative through September 30, 2017.

part of the MI-CHAP initiative, help connect callers to primary care providers and provide education and referrals to community resources. MAUW has also provided funding to the Upper Peninsula Commission for Area Progress to implement an enhanced V-CHAP site, called UP-CHAP that provides a blend of traditional CHAP services and V-CHAP services. As of February 2016, all eight CHAP sites, the V-CHAP screening and referral system, and the enhanced V-CHAP program in the Upper Peninsula were fully operational.

MAUW contracted with Public Sector Consultants (PSC) to conduct an evaluation of the MI-CHAP initiative. PSC employs a participatory evaluation approach and worked with MI-CHAP's Leadership Team—composed of representatives of MAUW, Health Net of West Michigan, and Michigan 2-1-1—to develop and finalize an evaluation framework (Appendix A) that connects the initiative's goals and objectives with evaluation questions and data sources and measures.

For the first-year evaluation report, PSC reviewed and analyzed information from documentation provided by the MI-CHAP initiative, interviews with CHAP program directors, and a survey of the MI-CHAP Leadership Team. PSC's analysis showed that the initiative's early developmental activities were beginning to produce results, including the development of partnerships with community organizations, establishment of agreements with primary care providers, and increasing numbers of clients served. The analysis also identified the challenges that surfaced as sites across the state worked individually and collectively to establish a system of services and supports for Medicaid-eligible children and their families. At the time PSC was gathering data for the first-year evaluation report, the newly established CHAPs had been operational for a very short time, and the number of healthcare providers engaged and the number of clients served were both limited, resulting in an inadequate pool of participants for parent focus groups and surveys of providers that had been planned as part of the original evaluation design.

As the second year of the MI-CHAP initiative drew to a close, PSC conducted interviews, surveys, and focus groups with a variety of program stakeholders to learn how they perceive the value and usefulness of MI-CHAP, as well as to identify successes and challenges in program implementation. Quantitative data on client services and healthcare utilization were not yet available for analysis.

Interviews with CHAP program directors, 2-1-1 staff, virtual CHAP specialists, and members of the MI-CHAP Steering Committee; surveys of practice managers; and focus groups with parents and caregivers were conducted over several months from November 2016 through March 2017. To support ongoing improvement and refinement of the MI-CHAP initiative, PSC shared key findings with the leadership team and program directors as analysis was completed on each of these components. Several recommendations emerged from the analyses, and the leadership team has already taken steps to address each recommendation. The recommendations and actions taken are described in this report, along with PSC's evaluation findings and summaries of the focus groups, interviews, and survey results.

FINDINGS AND RECOMMENDATIONS

The MI-CHAP initiative has achieved a great deal in just over two years, and has been faced with several challenges, albeit ones that are not unusual for a new initiative. Feedback from parents and caregivers, service providers, and leaders within the initiative shows that MI-CHAP is making progress toward its goals of improving health and access to medical homes for Medicaid-enrolled children; reducing ED visits for children enrolled in the initiative; and delivering components of the CHAP model through a new virtual strategy. The evaluation findings presented below are drawn from focus groups with parents and caregivers of children served by a CHAP, interviews with CHAP program directors, a survey of practice managers in medical homes with an established relationship with a CHAP, interviews with 2-1-1 staff and virtual CHAP specialists, and interviews with members of the MI-CHAP Steering Committee. More detail from each of these sources is provided in the following sections of this report. All data collection instruments are included in the appendices.

PROGRESS IN MEETING MI-CHAP GOALS

Goal One: Improve the health of Medicaid-enrolled children.

Improved health for children receiving services. Parents whose children have received services described specific health benefits they observed for their children, including better-controlled asthma and healthier lifestyles.

Development of clinical-community linkages. CHAPs have built relationships and established linkages between a variety of partners, including health plans, medical practices, and public health, to meet the needs of children and their families. Medical homes can refer patients to local CHAPs who help connect patients with community resources to address nonmedical issues that affect their health.

Goal Two: Improve the quality of and access to medical homes in MI-CHAP communities.

Improved access to care for children. Enhancing service delivery in two existing CHAPs and launching seven CHAPs in a variety of settings and different communities using an evidenced-based model tailored to the needs of the local community is a huge success. MI-CHAP plays a very important role in connecting children to a medical home and providing case management to address access issues for families with children. Program directors report routinely receiving positive feedback from clients about their staff and the services they provide.

Support for patient-centered medical homes. Some CHAPs have been successful working with physicians' offices to help manage care for children experiencing barriers to care. In a survey of primary care practices, all respondents report referring patients for CHAP services, and the majority report making some type of improvements to their services with help from the CHAP.

Goal Three: Lower the total cost of care by reducing emergency department visits and inpatient hospital admissions among children on Medicaid.

Improved use of healthcare services. Parents and caregivers of children who have received CHAP services described fewer missed appointments, increased comfort with healthcare providers, and improved use of healthcare services, including reduced ED visits.

Collaboration with managed care organizations. The MI-CHAP initiative has increased health plans' knowledge of CHAP and the services that could be provided to their members. Local CHAPs are establishing partnerships with health plans, who are beginning to refer patients to CHAPs and, in some cases, work closely with CHAPs to address the needs of their members.

Data tracking and sharing. Local CHAPs are using data systems to track services provided to clients and share the results of their work with referring providers. The local CHAPs and MAUW have researched legal issues and created the necessary agreements to be able to share data for the purpose of evaluating the initiative's impact on children's health and utilization of healthcare.

Goal Four: Innovate efficiencies and scalability by delivering components of the CHAP model statewide through a new virtual strategy.

Development of the statewide virtual CHAP 2-1-1 system. V-CHAP creates a way to deliver a limited set of CHAP services for children with Medicaid who do not have access to a local CHAP. Being able to implement a new program, develop the data and analytics to support it, and train 85 staff across the state is a major accomplishment. 2-1-1 call center staff and V-CHAP specialists report that the roles they play in connecting families to medical homes and related healthcare services have been very rewarding. However, according to these parties, the screening and referral system proved challenging to develop and was often cumbersome to use. Identifying the right level of staffing for the provision of V-CHAP services has also been difficult due to the variation in call volume across and within call centers.

SUCCESSES IN IMPLEMENTATION

Increased awareness of the CHAP model. Promoting new and existing CHAPS, as well as providing education on the CHAP model to various organizations, has raised overall awareness. Local CHAPs are building awareness of the program by engaging a variety of community partners and primary care practices who are, in turn, referring clients for services. Those who have received services report telling their family and friends about the program as well.

Learning opportunities for CHAPs and other stakeholders. Bringing people together in the program directors and 2-1-1 group has provided opportunities for networking, training, and sharing lessons learned. Program directors and 2-1-1 call center staff, including V-CHAP specialists, report enjoying the opportunity to meet with and learn from each other through meetings convened by MAUW.

Securing Medicaid matching funds. The Medicaid outreach funding negotiated through the Ingham County Health Department contract with the State of Michigan has led to greater availability of resources to support local CHAPs.

Focused discussions on sustainability. Convening representatives of local CHAPs, state departments, and other stakeholders on the steering committee has provided a forum to discuss a vision for funding, sustainability, and future steps for the initiative.

ONGOING CHALLENGES

Sustainable funding. Developing sustainable funding for the initiative as a whole and for the local CHAPs has been identified as a major challenge by steering committee members and some program directors. Development of a funding model should consider all possible funding sources to achieve

diversity of funding, including funding from the State, health plans, health systems, philanthropy, businesses, and local sources. A few steering committee members commented that MI-CHAP must move to the point where it is statewide or it will become problematic politically. They said it is hard to get funding strategies in place when CHAP is not provided everywhere. Other steering committee members spoke of the need for local CHAPs and the MI-CHAP initiative to remain visible at the state and local levels, stating that the CHAP model needs to become normative for the state health department and Medicaid health plans.

Fidelity to the model. Achieving fidelity to the CHAP model or at least some level of consistency was mentioned frequently as a challenge for the MI-CHAP initiative, especially by steering committee members and program directors. Some suggested that a core set of services should be established with flexibility to meet community needs. Some program directors said the definition of a CHAP is unclear and they are uncertain as to what are considered the core services.

Data collection and analysis. Another challenge has been the lack of data to measure outcomes for the initiative. Program directors and steering committee members stressed the need for outcome data in order to advocate for MI-CHAP and pursue sustainable funding. They said it is very important to finalize negotiations between the CHAPs and MAUW, and between MAUW and the Michigan Department of Health and Human Services (MDHHS) so data analyses can be conducted.

Awareness/relationships. Building awareness and developing relationships have been difficult for some CHAPs. Some program directors reported challenges in engaging primary care practices and in maintaining ongoing referral relationships with the practices. Parents of children served by CHAP and V-CHAP specialists noted that more people should know about the program.

RECOMMENDATIONS AND ACTIONS TAKEN

To support ongoing improvement and refinement of the MI-CHAP initiative, PSC shared preliminary evaluation findings with the leadership team and program directors as analyses were completed. Several recommendations emerged from the findings described above. These recommendations are listed below with a description of steps the leadership team and steering committee have already taken to address each recommendation.

1. Develop a sustainable funding model.

   MAUW, with guidance from the MI-CHAP Steering Committee, contracted with a consultant for development and implementation of a funding plan. As part of the effort to develop a funding plan, MAUW project staff have also assessed the funding available to local CHAPs from sources other than MAUW.

2. Ensure fidelity to the MI-CHAP model.

   MAUW project staff developed a CHAP model-fidelity tool and conducted site visits to local CHAPs to assess fidelity with each CHAP program director. PSC provided consultation on the development of the tool and participated in the site visits. Six of the eight sites achieved at least 80 percent fidelity to the model. Any sites with scores of less than 88 percent have been asked to prepare improvement plans to remediate fidelity gaps identified through the assessment.

3. Publicize data on outcomes and cost savings.

   As CHAP sites became operational, they began collecting data on the clients served and types of services provided. Over the past two years, MAUW and PSC have worked with CHAP sites and MDHHS to develop a process and protections that would permit PSC to obtain data on program services and healthcare utilization. Agreements and mechanisms were finalized in July 2017 for secure, electronic transmittal of client data to MAUW for analysis by PSC. PSC received Medicaid claims data in September 2017 and expects to receive data on program services in the fall of 2017. PSC is currently using the Medicaid claims data to analyze healthcare utilization among children served by the MI-CHAP initiative.

4. Promote understanding and support for the MI-CHAP model.

   MAUW project staff conducted a MI-CHAP legislative day in concert with local CHAP program directors and steering committee members. MAUW project staff also participated in meetings to present information on MI-CHAP to organizations representing key CHAP stakeholders.

5. Enhance physician leadership within the model.

   MAUW contracted with a primary care physician to help increase engagement of medical directors in local CHAPs.

FOCUS GROUPS WITH PARENTS OF CHILDREN SERVED BY MI-CHAP

To explore MI-CHAP's progress on improving the quality of and access to medical homes (MI-CHAP goal two), Public Sector Consultants conducted focus groups in late 2016 and early 2017 with parents of children who had received CHAP services. The focus group questions were designed to learn how the families became involved in CHAP services, whether or not they found the services helpful, and whether there has been any change in their use of healthcare services since receiving assistance from CHAP. During the discussions, some parents also shared stories that provide a glimpse of MI-CHAP's impact on children's health (goal one) and use of emergency services (goal three).

Staff at each of the CHAP sites recruited parents to participate, and PSC offered each participant a $50 gift card for their time. Ultimately, focus groups were conducted at five of the eight CHAP sites: Genesee, Kalamazoo, Kent, Macomb, and Wayne. In three regions, sites were unable to recruit a sufficient number of participants. A total of 43 parents participated in the focus groups, with the number of participants in each focus group ranging from three to nine people. Two focus groups were conducted at Kent CHAP—one with English-speaking participants and one with Spanish-speaking participants. Unfortunately, the recording of the Spanish-speaking focus group, which was later transcribed, was of poor quality, so the discussion yielded little information.

The extent of focus group participants' experience with CHAP services varied. While many had participated in or received core CHAP services, some participants were only aware of their local CHAP because they had participated in an ancillary program of the CHAP site (e.g., FitKids360 or a cooking class). The wide variety of experiences represented across focus group participants is indicative of the varied approaches taken by the CHAP sites to implement the program as well as to meet the needs of the populations they serve.

Findings from the focus groups are provided below. Parents described helpful services they received, health benefits for their children, improvements in their use of healthcare, and high levels of satisfaction with CHAP services.

LEARNING ABOUT CHAP

Participants were asked to say how they had first learned about their local CHAP. More than half of the participants said they were referred to CHAP by a medical provider. Of the remainder, the majority said they were referred by another type of service provider (e.g., a social worker, wraparound case manager) or community-based organization (e.g., WIC). A few said they had been referred by a friend or relative or had received a flyer in the mail about the program.

Participants indicated being referred to CHAP for a variety of reasons, including missed medical appointments, overuse of the ED, elevated blood lead levels, asthma, weight issues, and the need for general supportive services like case management.

CHAP SERVICES RECEIVED

Core CHAP services are parent education (regarding appropriate ED use, the importance of well-child visits and immunizations, and the need for children to have a medical home); coordination/provision of

same-day transportation; interpretation services for parents who do not speak English; referrals to community resources; and assistance with navigation of the healthcare system. About two-thirds (29) of participants said they had received at least one of these services from their local CHAP. More than half of those (17) said they had received help accessing a community resource, such as housing, food, or clothing assistance, or they had received a referral for lead abatement services for their homes. The second most commonly mentioned core services received were transportation (six people) and help with Medicaid enrollment (five people). Other participants indicated they had talked with CHAP staff about immunizations, when to use the ED, or finding a medical home, or had received help in obtaining behavioral or oral healthcare services.

In addition to these services, some CHAPs provide ancillary services. These include asthma education and nutrition and physical activity education and support (e.g., FitKids360 or a cooking class). About one-third of participants (15) said they had participated in this type of service delivered by a local CHAP or its partners.

HELPFULNESS OF CHAP SERVICES

Participants were asked to describe how the CHAP services have helped them and their families. They offered a variety of responses, including fewer missed medical appointments, improved health for their children, and improved use of healthcare services.

Fewer Missed Medical Appointments

A few said their children are missing fewer medical appointments because CHAP staff call to remind them of appointments and provide transportation to the appointments.

> My children's pediatrician referred me to CHAP because I missed a few appointments. The woman from CHAP said she could help me get a ride to our appointments and asked me if I needed car seats. She got one for me and then called and made the appointments and scheduled the ride for me.

> CHAP reminds me of my appointments and connects me to resources like transportation. The staff person will call me two days before my appointment and the day of to make sure I go.

One noted that after missing too many appointments, her daughter was dismissed from her pediatrician's practice. She said the CHAP staff talked with the doctor's office so her daughter could be reinstated as a patient, and have since helped her continue to get to scheduled appointments.

Reduced Asthma Symptoms

Those families who have received asthma education described great improvements in their children's health. They said the asthma is better controlled, leading to fewer hospital visits and fewer missed school days. And they said they and their children have a better understanding of the condition. Those with older children said the CHAP staff worked directly with the children to help them take responsibility for taking their medication and managing their symptoms.

My son still has asthma, but we used to be in the hospital all the time and now it has only been three times since we started CHAP. So, he spends more time in school than he does in the hospital.

My son was referred to CHAP because of his asthma. We were regularly in the ER and bringing him to the doctor for this. He is doing great now. He takes his daily medicine and is off of the albuterol and prednisone and hasn't had to take his emergency medications.

My 11-year-old feels like she doesn't have to take her medication and, if she doesn't take it, we end up in the ER. The CHAP asthma educator was able to get on her level and get her to take the medication. She helped her think about what would happen if she had an attack and she wasn't with me. She provided gentle education. Now my daughter carries her inhaler and does what she needs to do to manage her asthma.

They give the child a sense of independence and taking care of themselves. My kid couldn't understand why he couldn't breathe and why he couldn't do all kinds of things that other kids could. Now, he's been given tools and information to help him be more independent and do self-care.

Increased Physical Activity and Healthy Eating

Families whose children participated in FitKids360 reported similar improvements in their children's health and, in some cases, in the health of the entire family.

FitKids benefited our whole family. I was 200 pounds bigger than I am now. The kids see me being more active now. It made us more cautious about what we eat; we read labels and try different vegetables. My son was nearly diabetic, but now he is not. He is great!

FitKids has been the best. It taught my daughter how to prepare our meals. She wants to be a chef. She is cooking more with healthy food and exercising.

I have lost a lot of weight, too. I love that they work with the whole family and hold us accountable as parents for how we can contribute to our children's challenges and their health.

Lead Abatement Support

Families whose children had been found to have elevated blood lead levels described assistance they received with the help of their local CHAP to address lead hazards in their homes.

> I learned about the program when my three younger children tested positive for high levels of lead. [The CHAP staff] told me I could take classes at the farmers' market to get vouchers for free fruits and vegetables. I take the classes and learn how to prepare the food. People have come to my house to check the level of lead in everything—toys, plates, windowsills, dirt outside. They gave me a bunch of cleaning products and taught me how to wipe everything down. They also helped me fill out a grant application to remove lead from my home.

CHANGES IN THE USE OF HEALTHCARE SERVICES

Focus group participants were asked how, if at all, the way they feel about using healthcare services (e.g., using their healthcare coverage, finding a doctor for their child, or visiting the doctor) has changed since they began working with CHAP. About half of the participants provided examples of the ways in which working with CHAP had either increased their confidence or improved the way they access and navigate healthcare services.

Increased Comfort and Confidence with Healthcare Providers

Several said that CHAP staff had helped them identify things to talk with their child's doctor about or questions to ask the doctor. Some said that because the CHAP staff take the time to talk through health concerns, they feel more prepared to talk to the doctor. A few said their children's confidence with the doctor has also increased.

> She has asked me questions to help me think about things my son may need at a doctor appointment.

> He's opened so many doors and helps us think about things like what questions to ask the doctor to get what we need.

> I learned how to let my child talk at the doctor's office. My son asked the doctor to break it down for him and explain what the health issue was and to talk about the reason for the medication he was being prescribed.

> I'm more comfortable going to doctor appointments.

Improved Use of Healthcare Services

One mother described how her teenage son has frequent headaches and insists on going to the emergency department to address them. A CHAP community health worker has worked with the mother and son to develop a strategy for communicating with their primary care physician first before deciding to go to the ED. This has led to far fewer visits to the ED and has saved the family money they would have spent on copays for those visits.

Another parent said that working with CHAP led to a revelation about the oral healthcare his son needed.

> We didn't take our son to the dentist until he was eight years old. We learned from CHAP that you are supposed to take them at age one. Until the CHAP staff talked to us about the importance of dental care, we didn't know.

Increased Understanding and Navigation of the Healthcare System

Some participants said that CHAP staff have helped them gain a better understanding of the types of healthcare services they can access using their health coverage, and they are better able to navigate the healthcare system.

> I didn't know I could go to other resources outside of my son's regular doctor. They told me I could see a specialist instead of a regular doctor. The specialist was able to tell me more about my son's condition. In the past, we had to get referrals, so we didn't know we could go straight to a specialist.

> Our son is eligible for Medicaid, but we didn't know it. CHAP has opened up our knowledge on how Medicaid works. It is so hard to figure out the system, but they show you where to go and how to do it.

> We used to use our insurance, but now we *really* use it. We know about the well-child visits; they're not just for babies. And the kids continue to need more vaccinations and screenings. CHAP helped us use this more effectively.

> They connected us with behavioral health services and my son has not been suspended since. He used to get suspended all the time.

CHAP PROVIDERS

While they were not directly asked to comment on the staff at the CHAP agencies, participants noted many times how much they appreciate the generous and kind nature of the CHAP staff with whom they worked. They described them as "fairy godmothers" and "miracle workers" who are willing and able to connect them with whatever services they need, especially when they had felt discouraged by previous attempts to obtain help for themselves.

They help right away. They don't wait for somebody else to do things. They are active and they are so friendly. They care about you.

The CHAP agency is just above and beyond my expectations. It's an agency that I thought couldn't exist. It's like a fairytale of mothers coming to check on me.

They opened up avenues for an evaluation and treatments for our daughter when no one else wanted to help us.

Their service is so good; they care about you. If you have a problem, they like to help you. We went to MDHHS for insurance, but they gave us a very hard time. Seven months I paid out of pocket for healthcare. The CHAP staff talked to a DHS supervisor for us and it ended up being a problem with the system. CHAP put the pressure on DHS because we are eligible for care, and they kept on top of it. They called me every day to let me know the status. I came here on a Monday and by Friday, I was approved for coverage and I had been waiting for seven months.

They identify with us. They don't treat us like a number or a case. They treat us like people, and I appreciate that.

SUGGESTIONS FOR CHAP IMPROVEMENT

At the end of each session, participants were asked to comment on the services provided by their local CHAP. They were asked to indicate what, if anything, they would like the CHAP to do differently; whether they would reach out to the CHAP again if they had a concern about their child's health; and if they would recommend the CHAP to others.

The responses to these questions were unequivocally positive. Every respondent said they would not hesitate to reach out to the CHAP agency in the future or refer a friend for services. The vast majority of participants said they could not think of anything that could be done to improve upon the services delivered by their local CHAPs. A handful of participants volunteered that their local CHAPs could market themselves better and increase their capacity so more parents would be aware of and use the services they offer. A couple suggested adding Spanish-speaking staff at their CHAP. Another suggested offering support groups for parents of children with autism. And a few agreed it would be nice if the CHAP could create a brochure or booklet with information about all of the local resources available to families.

Clearly, parents who participated in the focus groups are quite happy with the services offered by the local CHAPs. They identified several ways in which the CHAPs have helped them and their children, and they gave a lot of credit for their satisfaction to the staff who deliver the services. They feel comfortable with the staff and respected by them.

INTERVIEWS WITH CHAP PROGRAM DIRECTORS

PSC staff conducted interviews with the program directors of the eight CHAP sites as well as the director of the enhanced V-CHAP site[2] between December 2016 and February 2017. The purpose of the interviews was to learn how CHAPs are improving the quality of and access to medical homes (MI-CHAP goal two), particularly how healthcare providers and community partners work together with CHAPs and how challenges are overcome. PSC staff asked each program director about their site's organizational structure, referral relationships and sources, service delivery, data collection efforts, and plans for sustaining their programs after the grant period ends.

Program directors talked about the important role MI-CHAP plays in connecting children to a medical home, and some described success working with physicians' offices to help manage care for children experiencing barriers to care. They also described challenges they have encountered in building relationships with a variety of partners, and the linkages that have been developed to help meet the healthcare needs of children and their families.

CHAP STRUCTURAL COMPONENTS

The organizational structure and staffing models can vary across CHAP sites. Program directors described how their programs are structured and staffed, and discussed how they have enlisted support from medical directors and advisory committees.

Organizational Structures

Six of the nine CHAP sites are housed within larger organizations and three are standalone programs. The program directors that are part of larger organizations said this structure has been beneficial to their programs for many reasons, including:

- Ability for cross-program referrals within the agency
- Existing community relationships (i.e., social capital) from previous projects and programs, which increases referrals from external organizations
- Established community knowledge of the agency and CHAP staff
- Back office and administrative support, such as human resources, payroll, client intakes, and answering phones

Although most found it helpful, program directors also acknowledged that being part of a larger organization has some challenges and pointed to increased administrative bureaucracy. In some cases, it has slowed down implementation of the CHAP model, led to delays in creating agreements with medical provider practices, and created competing priorities and responsibilities for staff whose positions are only partially funded through the CHAP. Conversely, the program director of one of the standalone programs, indicated that her site may join another organization for the administrative support it would offer.

[2] The enhanced V-CHAP site is referred to throughout this section as a CHAP site without distinction from the other sites.

Staffing

The staff size and makeup of the nine CHAP sites varies significantly. CHAP sites that have been in operation longer have a larger number of staff. The CHAPs in Kent and Wayne Counties have been delivering CHAP services for the longest period of time and also have the largest number of staff (17 or more each). Genesee, Macomb, and Northwest CHAP, all of which began delivering services in 2015, each have eight to 10 staff members. And number of staff at the Ingham, Kalamazoo, and Saginaw CHAPs, which began delivering services in 2016 ranges from two to four people.

Although the staffing composition varies across the sites, program directors described several positions that were common, including a project director, community health workers (CHWs), social workers, nurses, and case managers. Many also reported having staff whose primary role is to engage primary practices or provide health education. Program directors who do not have anyone dedicated to practice engagement said that having someone in that position would be very helpful.

Just over half of the sites are planning to add staff over the next year, while the rest plan to keep the same number of staff. Some project directors want to alter their staffing plan, regardless of whether they plan to add staff. One said that a single person at her CHAP is responsible for both intake and providing services as a CHW, but she recognizes it will be helpful to have two different people play these roles. Another director shared that they would like to have more full-time employees, rather than multiple part-time employees, to increase case continuity. One director stated that having at least one staff person dedicated to the CHAP program full time would be very helpful.

Medical Director Engagement

Each CHAP is expected to engage a medical director whose job is to conduct outreach to pediatric practices, health systems, and health plans on behalf of the CHAP to build support for the model and establish referral agreements. Program directors at half of the CHAP sites report that their medical directors are very engaged in CHAP programming and implementation. These medical directors have reportedly been instrumental in connecting the programs to provider practices through peer-to-peer relationships and informational meetings. Additionally, some medical directors are engaged in program leadership and strategy development.

Most of the remaining CHAP program directors stated that they have medical directors who are either not significantly engaged or are not engaged at all. One of these said they plan to engage the medical director more this next year. One program director reported that her site is trying to recruit a medical director.

Advisory Committees

CHAPs are expected to convene advisory committees comprising key stakeholders in the community, including multiple health plans, health systems, and community agencies. Each of the CHAPs has taken a different approach to establishing an advisory or steering committee for their program. Some have formed advisory groups that are specific to their CHAP by inviting key community stakeholders to provide guidance and community advocacy for the program. Some CHAPs have a board of directors or an advisory committee for their parent organization that fulfills the purpose of the advisory committee. Others have identified existing community advisory groups where relevant stakeholders are already engaged and are willing to provide guidance and direction for the CHAP program. In one case, the advisory committee supports early childhood initiatives in the community and has added CHAP to those initiatives.

The types of stakeholders represented on the advisory committees also vary among the CHAPs. A couple primarily comprise parents from the community and community organizations, while others have representatives from medical practices, hospitals, and health plans, in addition to community organizations and parent representatives.

Two program directors said that they do not currently have an advisory committee; one said the CHAP is working to get one set up this year and the other said that an advisory committee does not fit their model.

PRIMARY CARE PRACTICE ENGAGEMENT

As part of the CHAP model, sites are required to establish agreements with primary care practices who will refer patients for CHAP services and work with CHAP staff to identify ways to improve the ability of the practice to meet patients' needs. Program directors described their efforts to engage primary care practices, including the strategies used, the number of practices with which they have agreements, and their efforts to improve practices' service delivery.

Practice Engagement Strategies

Program directors shared that they were most successful at engaging practices with which they had existing relationships, or by having their medical director or another physician make initial contact with the practice. Physicians appear to be more willing to learn about CHAP when it is described to them by other physicians, according to many program directors. Other strategies reported to work well include 1) identifying and connecting with clinics that have missions similar to the CHAP's and 2) emphasizing the CHAP's ability to help with patients who may struggle to follow through on physician instructions or repeatedly miss scheduled appointments, which can improve the practice's HEDIS scores.[3] One program added that being known in their community as a neutral convener has helped them engage practices in the CHAP model.

Primary Care Practice Agreements and Referrals

Program directors reported, however, that while practices are generally very interested in and supportive of the CHAP model, it often takes a lot of effort over weeks or months to get them to establish a formal agreement through a memorandum of understanding (MOU) or business associate agreement (BAA) with the CHAP.

Program directors identified two main challenges with getting the agreements in place. First, they said that some of the delays in receiving signed agreements were due to practices' concerns about patient privacy and the sharing of personal health information (i.e., they are reluctant to enter into an agreement that they thought could violate HIPAA requirements). Second, they said that in some practices, especially those associated with larger health systems, the agreements had to go through multiple people and departments before they were signed and returned. In other practices, the reason for delayed signing of BAAs was unclear, although program directors assume it is because staff at medical practices are very busy. In all cases, CHAP staff have found they must be diligent in following up with practices to establish formal agreements.

[3] HEDIS refers to the Healthcare Effectiveness Data and Information Set. It is a tool used by health plans to measure specific aspects of health issues, such as asthma medication use and childhood immunization status.

At the time of the interviews, all except one CHAP site reported having agreements in place with practices. Two CHAPs have agreements with one or two practices, six CHAPs have agreements with five to 11 practices, and one has agreements with 24 practices. Through these agreements, each CHAP practice is connected with anywhere from five to more than 40 physicians, depending on how many physicians work at each practice.

After the agreements are in place, CHAP staff must spend continued time and effort to engage these practices to encourage them to make referrals to CHAP or to educate them on appropriate referrals. Some directors said that practices would send referrals at first, but then they would appear to forget about CHAP and stop referring. Program directors have found that CHAP staff need to stay in frequent contact with practices to encourage continued referrals. A couple of program directors said that their staff meet regularly with healthcare practice staff to review lists of potential referrals and identify patients who would benefit from CHAP services.

Primary Care Practice Improvement

In addition to engaging primary care practices to refer patients for CHAP services, CHAPs are also expected to work to promote adoption of the elements of the patient-centered medical home model among practices with which they form agreements. They are also expected to engage them in quality improvement projects that will strengthen the care provided to patients in the practices.

The majority of program directors stated they are not yet engaging in any quality improvement projects with primary care providers or working with them to promote patient- or family-centered care. Some said that they are just beginning to think about how the CHAP program can work with providers to improve the delivery of services to children and families. One program director does not think CHAPs should be expected to take on this role with practices. Others said that after referral agreements are in place, they need to take time to build a relationship between the CHAP and primary care practice before shifting into trying to help the practice improve. They fear that providers would be offended if the CHAP began telling practices how to improve right after they agree to refer patients.

Two interviewees said their sites have begun to engage in practice improvement efforts and reported that their efforts have been well-received. One site reported encouraging the universal use of nationally-recognized best practices for the treatment of asthma as well as helping practices reduce ED utilization by disseminating after-hour contact policies, which ask patients to call the practice before they go to the ED. The program director reports that the distribution of the after-hour contact policies appears to be reducing the number of unnecessary ED visits by their patients. Another CHAP site is working with practices to improve service coordination for refugee families.

OTHER REFERRAL SOURCES

Referrals to CHAPs can come from sources other than primary care practices. CHAP sites are working with community-based organizations to encourage them to refer clients for CHAP services. Michigan 2-1-1 is screening callers to determine whether they are eligible for CHAP and is referring eligible callers to local CHAPs, when appropriate. CHAPs are also working to develop relationships with health plans, which can refer patients and help connect the CHAPs with primary care practices.

Community Organizations

Most program directors reported they are receiving referrals from community organizations, including social service programs, home visiting programs, educational organizations, and others. CHAP sites are using several strategies to educate the community and their community partners about CHAP and to encourage referrals to their programs. They said that face-to-face contacts and relationship building, combined with persistent follow up after presentations and meetings, has worked best for getting community-based referrals. In fact, many referrals come from organizations or programs that have an existing relationship with the CHAP or CHAP staff. Printed materials, participation in health fairs, and large group presentations about CHAP, however, have been less successful in producing referrals, according to a couple of program directors.

Michigan's 2-1-1

Michigan's 2-1-1 is a free, confidential service that connects callers with local community-based organizations across the state, offering thousands of different programs and services, from housing and food assistance to education and disaster relief services. MAUW supports the Michigan 2-1-1 program (as well as the MI-CHAP program). Through MAUW, 2-1-1 has an agreement with MI-CHAP to screen callers and refer those eligible to a CHAP if one is available in their area.

Most CHAP programs reported receiving at least some referrals from 2-1-1, but several reported they are not receiving very many or that they receive them inconsistently, where a few are received for a while and then they receive no referrals for a long period. At the time of the interviews, two program directors reported that their sites do not receive any referrals from 2-1-1. In one case, it is because the 2-1-1 system is not supported in the CHAP's region. In the other case, the director indicated that the CHAP site was not yet ready to accept referrals from 2-1-1. Since the interviews, however, that CHAP has also begun accepting referrals from 2-1-1.

The program directors shared that many, but not all, of the referrals received from 2-1-1 are appropriate. One program director gave an example of receiving referrals for individuals in an entirely different geographic region than they serve, and another cited receiving the occasional referral for childless adults. Some stated they are aware that the 2-1-1 screening process and questions have undergone changes, and as the process has improved, so has the appropriateness of the referrals.

When asked how the referral process could be improved further, a couple of directors said it would be helpful if the referral included the youth's information, instead of or in addition to the information about the parent. A couple of people also shared that when CHAP staff contact a family that has been referred, the family is not always aware they had been referred to CHAP, largely because they were calling 2-1-1 for an issue or need not specific to CHAP.

Health Plans

MAUW encourages CHAP sites to build relationships with Medicaid health plans for a few reasons. First, health plans may help CHAPs connect with primary care practices that serve a lot of Medicaid-eligible children; second, they may be a source of direct program referrals; third, they may share their enrollee utilization and cost data with the CHAP; and fourth, they may ultimately agree to contract with the CHAP site to provide a set of services to their enrollees. Most of the program directors report meeting with health plans to try and build these relationships. All of the program directors said it has been difficult to develop relationships. Program directors shared that they have struggled to connect with the right person

at the health plans, and changes in health plan leadership and staff turnover have made it difficult to develop partnerships. Others added that health plan staff can be resistant to partnering with the CHAP because they believe that CHAP services duplicate work the plans are already doing, such as providing transportation or offering the assistance of CHWs.

Despite these challenges, five of the nine CHAPs have relationships with health plans, whereby they are receiving client referrals or help in connecting with pediatric providers, or the CHAP and health plan are meeting to talk about patients who might benefit from CHAP services. Three of these CHAPs have agreements in place that allow them to be paid by the health plan for the services they provide, but they have found that the referrals they receive under these agreements are not always appropriate and, in some cases, it has added a layer of administrative oversight that they had not anticipated.

Several interviewees reported that when the CHAP model is described to health plan staff, they are initially interested, but that this has not always resulted in referrals or agreements with their sites. McLaren Health Plan was mentioned most often by program directors as being receptive to developing relationships and establishing agreements with CHAP sites.

One CHAP has established regular, periodic meetings with Michigan Medicaid leadership, the medical and executive leadership of the health plans, and key community physician and agency advisors. One significant outcome of this partnership is that Medicaid beneficiaries in the county can make same-day transportation requests from health plans for medical appointments. The statewide rule is that patients must request transportation assistance three days in advance of an appointment.

SERVICE DELIVERY

CHAPs use a local multidisciplinary team to provide education, care coordination, community resource referral, transportation and other services to address the social determinants of health and barriers to medical access for children on Medicaid. This may include connecting their clients to a patient-centered medical home (PCMH) if they do not already have a primary care provider. Additionally, some CHAPS offer their own health programs, such as asthma education, Commit to Fit! nutrition initiatives, or FitKids360, which combines health and nutrition education with physical activity to help participants develop healthy lifestyles.

Program directors were asked how CHAP service delivery is going at their sites, if they are meeting their service goals for the year, and about their plans for CHAP over the next year.

Service Quality

All program directors reported that service delivery is going very well. CHAP services, including site-specific programs (e.g., asthma education programs or nutrition classes), have been well received by clients and the community at large. Directors reported that they regularly receive positive feedback from clients about their CHWs, including on how well they follow through with promised actions and how they support the whole family. Several program directors stated that when their CHAP receives a referral for a specified child, they work with the whole family, not just the child, to deliver health education and any other supports the family needs. Directors indicated that the feedback suggests to them that clients feel supported and empowered to get the help they need and improve their children's health. As a result of positive experiences with services, CHAPs are seeing more referrals from their community partners, physicians, and from some former clients who are referring their friends to the CHAP programs.

A few program directors reported they are aiming to improve the quality of their services. Two program directors said they plan to review the data they have collected on outcomes, and will work with their primary care practices to review HEDIS scores as a part of their quality improvement efforts.

Service Goals

When the CHAPs were established with funding from MAUW, they set targets for the number of children they would serve over either a one- or two-year period, depending on when they began delivering services. Most of the program directors reported that they are either on target or close to being on target for achieving their goals. Some reported that because implementation of their CHAP took longer than anticipated in the first year of service delivery, they did not achieve their year-one goals and are now trying to make up for those shortfalls. Looking ahead, most program directors reported that they are hoping to grow the number of referrals received, people served, and services provided over the coming year.

CHAP Definition

A few program directors raised the concern that the definition of a CHAP and what its core services are is unclear. They stated that work should be done to further define the CHAP model so there is consistency across the state, even if some CHAPs offer additional programs beyond the core services.[4]

DATA COLLECTION

CHAP sites are expected to collect data on referrals, demographics of the population served, and the types of services delivered. Several sites started by using the client data management program used by Kent County's CHAP program. Others, however, chose to use a different data system or to create their own. Some have changed data management systems over the course of program implementation in response to their or MAUW's data needs and requirements.

About half of the program directors reported challenges related to CHAP data collection, while the others reported that it is going smoothly. Three are getting new data management systems, which, they said, will lead to more consistent collection of the data elements needed for program management and evaluation. One person stated they are looking for a new data management system because, although the data has not been difficult to collect, there is no easy way to use the data once it is in the system. Another interviewee said they experienced several challenges with their previous data system and made several adjustments to improve it, but ultimately had to implement a whole new system. The program director said that, unfortunately, now that they have a new data management and collection system in place, there is not enough funding available to support its implementation with training for their staff.

SUSTAINABILITY

Most CHAPs' funding from MAUW will be exhausted within the first six months of 2017. Program directors were asked to discuss their plans for sustaining the program beyond the grant funding period.

[4] Since these interviews were conducted, the MI-CHAP Leadership Team developed a model fidelity measurement tool to specify core CHAP services and has utilized the tool with each of the eight CHAP organizations.

All of the program directors reported that they are still working on their sustainability plans. Several program directors are hoping to continue to build on their relationships with health plans with the goal of obtaining some financial support for CHAP services going forward. Two sites already have contracts in place for some funding from health plans. All CHAPs have contracts in place to conduct Medicaid outreach and enrollment. Several also said they are planning to look for additional funding from foundations and other grantmaking organizations, partner and parent organizations, the broader community, and local governments. Some directors reported their concern that without more funding, they will not be able to continue delivering CHAP services to the degree they are now.

TECHNICAL ASSISTANCE

Program directors identified areas in which they will need individual support for their program as well as areas where they thought it would be helpful to strengthen and sustain the MI-CHAP system. Many of the directors indicated that they think MAUW should play a role in providing support in these areas. Their requests include:

- Networking and educational opportunities, which could be offered through continued program meetings and convening programs at a summit like the one that was held in fall 2016
- Providing quality improvement support
- Collecting and sharing data effectively
- Marketing CHAP statewide with consistent messaging
- Engaging health plans and providers in the CHAP model
- Creating centralized contracts with the health plans
- Assisting with program sustainability, such as with individual sustainability plans or by securing federal funding or funding through larger foundations
- Advocating for the MI-CHAP model to legislators and other stakeholders

CHAP OVERALL

Program directors concluded the interview by sharing the most challenging and most positive aspects of implementing a CHAP program. Most program directors mentioned that they have been frustrated with how slowly progress has been made at every step of program implementation, including the securing of business agreements between practices and the CHAP sites. Many also lamented the difficulty they have had engaging health plans in making referrals or entering into contracts to help their members.

Program directors also named several positive aspects of CHAP implementation. Several shared that implementing the CHAP program has enabled them to deliver services to families in a way has been very rewarding. Others said they have experienced an increased level of collaboration among service providers in the community and are finding that their partners have embraced the program and the services it offers. Others mentioned that they have seen an increase in the number of referrals they receive for CHAP services, which, to them, indicates their outreach efforts are successful and their services are well-received by providers and clients alike.

SURVEY OF MEDICAL HOME PRACTICE MANAGERS

PSC conducted a survey of practice managers in medical homes with whom local CHAPs have established relationships. The survey explored how CHAPs have supported patient care in these medical homes and whether the services provided by CHAP teams are helpful to patients and the practice (MI-CHAP goal two).

Practice managers from 22 out of approximately 70 medical homes responded to the survey. The medical homes that participated were associated with seven out of the eight CHAP sites. The survey results are summarized below, followed by tables presenting the frequency of responses for each question.

RESULTS

- Respondents are largely familiar with the CHAP services available in their region and are comfortable sharing information about CHAP services with patients and making referrals to CHAP sites.
    - On a scale of one to five, where one means "not at all familiar" and five means "very familiar," most respondents rated their familiarity with CHAP services at either a four (27.3 percent) or five (54.5 percent).
    - On a scale of one to five, where one means "not easy at all" and five means "very easy," most respondents rated the ease of sharing information about CHAP services with patients at either a four (27.3 percent) or five (63.6 percent).
    - All of the respondents indicated that they know how to contact the CHAP team in their region, that providers in their practice know when a referral for CHAP services would be appropriate, and providers in their practices have referred patients to the local CHAP team for services.
- Practices that responded to the survey are making improvements in a variety of aspects of patient care and service delivery with support from the local CHAP teams.
    - Most respondents said that improvements they are making in the following areas have been facilitated by their local CHAP team:
        - Increased availability/use of transportation services (90.0 percent)
        - Linking patients/families to appropriate community resources (85.7 percent)
        - Access to services (84.2 percent)
        - Relationships with community resources (83.3 percent)
        - Cultural effectiveness or sensitivity (55.6 percent)
        - Increased patient/parent education and instruction (55.0)
        - Coordination of services with other providers (52.6 percent)
    - A third of respondents or fewer said their practice is making improvements in the following areas with the help of their local CHAP team:
        - Patient satisfaction with care (35.3 percent)
        - Dedicating additional staff/resources to care coordination and referral tracking (33.3 percent)
        - Making printed materials available in languages other than English (22.2 percent)
        - Increasing the number of openings for new Medicaid patients (16.7 percent)

    - Increasing same-day appointment availability (11.1 percent)
    - Hiring bilingual providers and staff (11.1 percent)
- Respondents rate the support provided by the local CHAP teams to their practice and to their patients very highly.
    - On a scale of one to five, where one means "poor" and five means "excellent," the vast majority of respondents rated the support provided to their practice at either a four (40.0 percent) or five (55.0 percent).
    - On the same scale, a large majority of respondents also rated the support provided to their patients at either a four (25.0 percent) or five (60.0 percent).
    - About three-quarters of respondents indicate that someone in their practice participates in CHAP provider meetings organized by the local CHAP site. Most of them find the meetings at least somewhat useful, rating them at either a four (23.5 percent) or five (47.1 percent) on a five-point scale where one means "not at all useful" and five means "very useful."
- A handful of respondents indicate that they have seen improvements in their practices' quality scores as well as in the engagement of their patients.
    - Slightly less than one-fifth of respondents (19.4 percent) indicated their practice has experienced a decrease in patient no-show rates since establishing a relationship with and making referrals to the local CHAP team.
    - Just under one-third of respondents (30.0 percent) indicated that their practice's HEDIS scores related to well-child visits, childhood immunizations, or lead testing have improved since establishing a relationship with the local CHAP team.
- Most responding practices are involved with an insurer-led initiative to promote the implementation of patient-centered medical homes (57.1 percent) and/or have earned or are planning to earn recognition as a PCMH from the National Committee on Quality Assurance (NCQA) or other organization (61.9 percent).

FREQUENCIES

1. With which local CHAP is your practice associated?

	Percent	Number
Genesee CHAP	22.7%	5
Kent CHAP	22.7%	5
Northwest Michigan CHAP	18.2%	4
Wayne CHAP	13.6%	3
Ingham CHAP	9.1%	2
Kalamazoo CHAP	9.1%	2
Saginaw CHAP	4.5%	1
Macomb CHAP	0.0%	0
Total respondents		**22**

2. On a scale of one to five, how familiar are you with the CHAP services available in your region?

	Percent	Number
5—Very familiar	54.5%	12
4	27.3%	6
3	18.2%	4
2	0.0%	0
1—Not at all familiar	0.0%	0
Total respondents		**22**

3. Do you know how to contact the CHAP team in your region/county?

	Percent	Number
Yes	100.0%	22
No	0.0%	0
Total respondents		**22**

4. Do providers in your practice know when to make a referral (i.e., when a family would likely benefit from receiving CHAP services)?

	Percent	Number
Yes	100.0%	22
No	0.0%	0
Total respondents		**22**

5. Has anyone in your practice referred patients to the local CHAP team?

	Percent	Number
Yes	100.0%	22
No	0.0%	0
Total respondents		**22**

6. On a scale of one to five, how easy is it for you and others in your practice to share information about CHAP services with patients?

	Percent	Number
5—Very easy	63.6%	14
4	27.3%	6
3	9.1%	2
2	0.0%	0
1—Not easy at all	0.0%	0
Total respondents		**22**

7. Has the local CHAP team helped your practice make improvements in any of the following areas?

	Improvements we are making (or have made) in this area have been facilitated by CHAP		We are/were making improvements in this area without CHAP assistance		We are not making any improvements in this area		Total respondents
	Percent	Number	Percent	Number	Percent	Number	Number
Access to services	84.2%	16	15.8%	3	0.0%	0	**19**
Relationships with community resources	83.3%	15	16.7%	3	0.0%	0	**18**
Cultural effectiveness or sensitivity	55.6%	10	38.9%	7	5.6%	1	**18**
Coordination of services with other providers	52.6%	10	47.4%	9	0.0%	0	**19**
Patient satisfaction with care	35.3%	6	64.7%	11	0.0%	0	**17**

8. What changes, if any, has your practice made to improve how services are delivered because of its relationship and work with the local CHAP team?

	Changes we are making (or have made) on this have been facilitated by CHAP		We are/were making this change without CHAP assistance		We have not made this change and are not currently working on this change		Total respondents
	Percent	Number	Percent	Number	Percent	Number	Number
Increased availability/use of transportation services	90.0%	18	0.0%	0	10.0%	2	**20**
Linked patients/families to appropriate community resources	85.7%	18	9.5%	2	4.8%	1	**21**
Increased patient/parent education and instruction	55.0%	11	35.0%	7	10.0%	2	**20**
Implemented previsit and/or reminder phone calls to facilitate transportation and/or to collect information relevant to the patient's upcoming visit	47.4%	9	36.8%	7	15.8%	3	**19**

	Changes we are making (or have made) on this have been facilitated by CHAP		We are/were making this change without CHAP assistance		We have not made this change and are not currently working on this change		Total respondents
	Percent	Number	Percent	Number	Percent	Number	Number
Dedicated additional staff/resources to care coordination and referral tracking	33.3%	6	33.3%	6	33.3%	6	**18**
Made printed materials available in languages other than English	22.2%	4	44.4%	8	33.3%	6	**18**
Increased the number of openings for new Medicaid patients	16.7%	3	72.2%	13	11.1%	2	**18**
Increased same-day appointment availability	11.1%	2	77.8%	14	11.1%	2	**18**
Hired bilingual providers/staff	11.1%	2	38.9%	7	50.0%	9	**18**
Expanded hours of operation	0.0%	0	38.9%	7	61.1%	11	**18**

9. Has your practice experienced a decrease in patient no-show rates since establishing a relationship with and making referrals to the local CHAP team?

	Percent	Number
Yes	19.0%	4
No	52.4%	11
I don't know	28.6%	6
Total respondents		**21**

10. Have your practice's HEDIS scores related to well-child visits, childhood immunizations, or lead testing improved at all since establishing a relationship with the local CHAP team?

	Percent	Number
Yes	30.0%	6
No	30.0%	6
I don't know	40.0%	8
Total respondents		**20**

11. Do you or does anyone else in your practice participate in CHAP provider meetings?

	Percent	Number
Yes	76.2%	16
No	23.8%	5
I don't know	0.0%	0
Total respondents		**21**

12. On a scale of one to five, how would you rate the usefulness of those meetings?

	Percent	Number
5—Very useful	47.1%	8
4	23.5%	4
3	23.5%	4
2	0.0%	0
1—Not at all useful	5.9%	1
Total respondents		**17**

13. On a scale of one to five, how would you rate the support given to your practice by the local CHAP team?

	Percent	Number
5—Excellent	55.0%	11
4	40.0%	8
3	5.0%	1
2	0.0%	0
1—Poor	0.0%	0
Total respondents		**20**

14. On a scale of one to five, how would you rate the support given to the patients you have referred to the local CHAP team?

	Percent	Number
5—Excellent	60.0%	12
4	25.0%	5
3	15.0%	3
2	0.0%	0
1—Poor	0.0%	0
Total respondents		**20**

15. Is your practice involved in any insurer-led initiatives to promote the implementation of patient-centered medical homes?

	Percent	Number
Yes	57.1%	12
No	33.3%	7
I don't know	9.5%	2
Total respondents		**21**

16. Has your practice earned (or is it planning to earn) recognition as a PCMH from the National Committee on Quality Assurance or other organization?

	Percent	Number
Yes	61.9%	13
No	19.0%	4
I don't know	19.0%	4
Total respondents		**21**

INTERVIEWS WITH 2-1-1 STAFF AND V-CHAP SPECIALISTS

PSC conducted interviews with 2-1-1 call center staff and V-CHAP specialists to learn about the challenges and successes associated with the virtual strategy for delivering components of the CHAP model (MI-CHAP goal four). The virtual strategy includes 1) screening and referring 2-1-1 callers to local CHAPs and V-CHAP specialists and 2) delivering a limited set of CHAP services to callers who live in a region without a CHAP. Both 2-1-1 call center staff and V-CHAP specialists were asked about the training and technical assistance they have received, the screening and referral process, how to increase the number of people screened and served, and the RiverStar data system used to track information about callers who are screened and served. PSC conducted interviews with twelve 2-1-1 call center staff and with four V-CHAP specialists between November and December 2016. While two separate interview instruments were used, the findings from the interviews are summarized together below due to the close connection between the roles of 2-1-1 call center staff and V-CHAP specialists.

TRAINING AND TECHNICAL ASSISTANCE

PSC asked 2-1-1 call center staff and V-CHAP specialists about the training and technical assistance they received to prepare them for screening callers for CHAP eligibility, making the appropriate referrals, and providing V-CHAP services to eligible clients.

Preparation for Screening and Referral

According to 2-1-1 call center staff, the MI-CHAP program director and V-CHAP coordinator from MAUW provided group and one-on-one training sessions to 2-1-1 staff to prepare them to screen callers for MI-CHAP eligibility and make referrals for eligible callers. They said the training included a script for screening callers, a demonstration of the screening process, and a one-on-one walk through of the RiverStar data system, which is used for capturing screening and referral information. Most of the staff interviewed said the script and one-on-one demonstration were the most helpful components of the training. Call center staff also indicated they have found it helpful to receive periodic updates on MI-CHAP. Some indicated they receive this information through the weekly "MI-CHAP Minute" videos created by MAUW staff to provide project updates.

Some 2-1-1 staff said it would have been helpful to have more information up front on the scope of the MI-CHAP program and the services that are offered by local CHAPs and V-CHAP specialists. They said this type of information would have prepared them better to explain to callers how the services might benefit them. Some of the staff suggested that future trainings include talking points to help them describe the MI-CHAP program more succinctly to callers. Others said that a refresher training should be conducted annually.

Three 2-1-1 call center staff indicated they did not think additional training was necessary. One said, "MI-CHAP is a fraction of the work we do at the center; the amount of information and contact we receive from MAUW is too much."

Preparation for Providing V-CHAP Services

Virtual CHAP specialists say they received an initial training that described their role and how to support callers who are referred to them. They said the training materials for their role have evolved and changed a great deal since the beginning of the initiative, and they expect the materials will continue to change.

One of the newer specialists who did not participate in the initial training said she received a binder filled with charts, PowerPoint slides, and written scenarios for calls with clients, and she shadowed another V-CHAP specialist to learn more about the role. Following the initial training, V-CHAP specialists have participated in biweekly phone calls and bimonthly face-to-face meetings with MAUW to come together to talk about their experiences, learn about the number of callers being screened across the state, and share best practices. In between, they say, their supervisors and the MI-CHAP coordinator are always available to answer questions. V-CHAP specialists also say they have found it beneficial to meet with local CHAP teams to learn about their services and identify any issues with the occasional referrals made to them by the specialists

All the specialists say they have all the information they need to appropriately address the needs of V-CHAP clients. The tools and information that the V-CHAP specialists find most helpful are reference documents stored in the RiverStar data system, pamphlets from local CHAP sites that describe their services, and a document that describes how to access transportation services offered by health plans. They also indicated using the 2-1-1 database and the Internet to help callers.

Some specialists, however, said the tools they use could be more accessible so their time on the calls is used more efficiently. One said the information "feels scattered and disorganized." Another suggested creating something akin to the 2-1-1 database where all the information a specialist would need is all together and organized. Another specialist said that she would like to have a better understanding of well-child visits and immunizations (e.g., to know what immunizations a child gets and at what ages) so she could share this information with parents more effectively.

The V-CHAP specialists said the following would be helpful to support their work in the coming year:

- Updates on MI-CHAP program developments and successes
- An opportunity to meet with MDHHS to discuss how V-CHAP services can support the work of the department
- Data or information that helps them see whether they are making a difference in the lives of families
- Information on the services that each local CHAP provides to families, especially within their own regions (for example, to know more about Wayne County's FitKids360 and asthma services)
- A set of clear talking points on what to say to callers about the purpose of well-child visits and the importance of immunizations

The Role of a V-CHAP Specialist

A couple of specialists said they would like the scope of V-CHAP services to be expanded. One specialist said referring a caller to his or her MDHHS case worker does not feel like she is helping the caller enough. Others made the following comments:

> There's not much service we can provide further than what 2-1-1 is already providing. I thought V-CHAP specialists would have more capability to help callers get services. For example, we can access MI Bridges to [identify] why the caller is experiencing a problem [related to Medicaid coverage], but we can't help beyond that. We need to be able to go beyond what we are capable of providing right now.

> We need to be able to provide services like the local CHAP, where we can actually contact local transportation to set up rides or look at Medicaid status to see the issue to help the caller understand how to get it resolved; if we had more access to that information we could provide better services to them.

SCREENING AND REFERRAL PROCESS

V-CHAP specialists are employed by 2-1-1 call centers and, because their time is not fully engaged with delivering V-CHAP services, they also work in the call center, answering 2-1-1 calls and screening callers for eligibility for CHAP services. Thus, both 2-1-1 call center staff and V-CHAP specialists were asked to share their perspectives on how well the screening and referral process is working; the number of screenings they typically conduct; what, if anything, prevents them from conducting more screenings; and how well the RiverStar data system is working. V-CHAP specialists were also able to consider the screening and referral process as well as the data system from the perspective of their role as V-CHAP service providers.

Perspectives on the Screening and Referral Process

When asked to share their perspective on how well the screening and referral process has worked, a few 2-1-1 staff said they think the screening process is working well, but most expressed dissatisfaction with the way it works. They said callers are reaching out to 2-1-1 for other issues that are critical to them, such as assistance with utilities, food, and shelter, and healthcare is not typically a priority. Call center staff said they feel uncomfortable asking the screening questions when people call about other issues, and that the script does not provide a way to smoothly transition to asking questions about a person's healthcare needs. In addition, some call center staff feel like they do not have a clear understanding of V-CHAP services, which makes them even less comfortable conducting the screening. Unlike most call center staff, V-CHAP specialists think the screening and referral process is going well, although they acknowledged that the process was "rocky" in the beginning and identified several ongoing challenges and recommendations for improving the process.

Screening Targets and Volume

MAUW has set a target of screening 15 percent of all 2-1-1 callers for CHAP eligibility. There appears to be confusion among call center staff about this goal and how they are expected to reach it. They are uncertain about whether they are to screen all calls or specific calls. For example, one said,

> The training we received focused on what kinds of calls should be screened based on the needs of the caller. For example, we conduct the screening when we know the caller has young children in the home because they are asking where they can get free diapers. But, the emphasis is now on the number of screenings no matter the reason the caller has.

One V-CHAP specialist said, even after a refresher training, there is still some confusion among 2-1-1 agents and across call centers about which calls to screen for MI-CHAP. According to this specialist, "each call center should [only attempt] to screen when it seems applicable to the caller, and it should not be mandatory to screen all calls."

One suggestion for improving the appropriateness of screening included having schools, health provider offices, urgent care centers, and EDs refer people to 2-1-1 to learn more about CHAP services. To facilitate this, one specialist said, there could be a prompt in the 2-1-1 system that allows the caller to identify themselves as someone who might be eligible for CHAP services. For example, one V-CHAP specialist suggested that callers could be prompted to press the pound or hash key if their child has a medical issue they would like help with.

The number of callers that each 2-1-1 staff person reported screening for CHAP service eligibility ranged from two or three per day up to 30 per day. This high level of variability appears to be driven by a few factors:

- **Call center call volume:** Some 2-1-1 staff said that call volume varies across centers and also day-by-day within centers, so that sometimes not enough staff are available to cover the number of calls received. When centers are receiving large numbers of calls and do not have enough staff on hand, screenings tend to be bypassed.
- **Selective screening:** Call center staff say they can often tell from the initial conversation with someone that the person would not be eligible for CHAP services and they try only to screen people they believe might be eligible.
- **Varied work schedules:** Some staff work part time or work during times of day when call volume is lower, so they are not able to conduct as many screenings as those who work full-time or at different times of the day.
- **Callers declining to be screened:** Some callers say they would prefer not to answer additional screening questions when offered the opportunity by the 2-1-1 agent.

When asked to provide suggestions on ways to increase the number of eligibility screenings and reduce the number of callers who decline a screening, 2-1-1 staff and V-CHAP specialists said that MAUW should:

- Provide 2-1-1 call center staff with a robust understanding of what MI-CHAP can do for families and report back to call centers on how the families referred for services are helped.
- Restructure the script to better integrate the eligibility and screening questions. For example, move the eligibility questions to the beginning of the script where staff are asking general information about the caller.
- Market MI-CHAP in the schools, healthcare systems, and communities to encourage families to call 2-1-1 centers to be connected with MI-CHAP.

For callers who decline to respond to the screening questions because they do not have time, allow 2-1-1 call center staff to provide them a toll-free number or website where they can reach a specialist directly to have a screening and learn about CHAP services when it is convenient for them.

In conducting the interviews, it also became clear that the way screenings are counted varies across staff and call centers. For example, some staff count any callers who are asked any of the eligibility screening questions, regardless of their eligibility status, while other staff were only counting callers that were found to be eligible and referred to a local CHAP or V-CHAP specialist.

Increasing Connections Between Callers and V-CHAP Specialists

According to data from the RiverStar system provided by MAUW, most callers who are screened and found eligible for CHAP services choose to schedule a callback rather than be transferred immediately to a V-CHAP specialist. In addition, only two-fifths of callers who choose to receive a callback are ever reached by a V-CHAP specialist, and specialists are only speaking with an average of five V-CHAP clients each week. PSC asked the V-CHAP specialists how to increase the rate of connection between eligible callers and V-CHAP specialists. They offered several suggestions for increasing the number of live transfers. They said the 2-1-1 agent should:

- Let the caller know they are qualified for the services and offer a transfer first, instead of offering a call back first.
- Assure the caller it will not take a lot of time to talk with a specialist.
- Give the caller a clear understanding of MI-CHAP. (The script might need to be updated to support this.)

The V-CHAP specialists also recommended that Michigan 2-1-1:

- Make sure that the call management system is set to ensure that calls are appropriately directed to V-CHAP specialists when callers are screened as eligible for the services.
- Provide a prompt in the 2-1-1 call system for the caller to choose "issues with children's medical insurance" that will connect them directly with a specialist.

To improve the percentage of callers who are reached by V-CHAP specialists after requesting a callback, the specialists recommended that the 2-1-1 call center staff person making the referral let the caller know the phone number they will see in caller ID will include "2-1-1" in it. They also indicated that the two attempts that V-CHAP specialists currently make to reach a caller may not be sufficient; two said that making three attempts is "the general rule of thumb in customer service." One specialist suggested leaving a voicemail on the second attempt to let the client know they will call back only one more time, and another suggested getting an email address for the caller during screening so the specialist can follow up a fourth time via email.

The RiverStar Data System

Feedback on the RiverStar data system was mixed among the 2-1-1 staff and V-CHAP specialists interviewed. Most everyone said that there were a lot of glitches in the system at first that have since been fixed. Several 2-1-1 staff said the system is simple to use. Two issues a few call center staff said were not yet resolved at the time of the interviews are that 1) they are unable to add information to the online screening form after the caller has disconnected the line, and 2) occasionally fields that were completed by call center staff are empty when V-CHAP specialists open the referral form, which leads to the specialist repeating the screening process before helping the caller. In addition to fixing those ongoing issues, the following suggestions were made to help make using the system easier:

- Repurpose the blank home page on the RiverStar system to show the screening script, or move the "Run script" button to the center of the home screen where it would be easier to find.

- Reorder the call script and/or provide a more detailed script to help 2-1-1 staff share better information with callers about the services they can receive from a V-CHAP specialist or CHAP site. Some call center staff suggested moving the CHAP eligibility questions up to the beginning of the call where it would feel more natural.
- Reword screening questions to make them more effective for identifying CHAP eligibility. One specialist suggested that the current screening question "Where do you normally go for children's healthcare?" could be changed to "Are you able to find a primary doctor for your children who accepts your insurance, or do you need help with that?"
- Increase the efficiency of data entry by changing some of the text boxes to check boxes. For example, instead of writing out a caller's response as "yes" or "no" in some of the data fields, specialists could click on a box.
- Allow V-CHAP and 2-1-1 staff to pull reports from the database to learn how people were helped.

V-CHAP specialists say that issues with the system are regularly reported to MAUW, but they are told the issues may not get resolved due to lack of capacity on the part of the system developer. One specialist said, "They need to build capacity to make updates or find a whole new system." A couple of specialists said they would like to be kept up to date on what is happening with the RiverStar data system so that if anything is changing they can provide feedback before it is implemented statewide.

CHALLENGES AND SUCCESSES

PSC asked 2-1-1 staff and V-CHAP specialists to share the most challenging and successful aspects of implementing the MI-CHAP screening and referral process and delivering V-CHAP services.

2-1-1 Call Center Staff

Call center staff said connecting families and children to healthcare services they need is the most positive aspect of the MI-CHAP program, but they identified several challenges along with some potential solutions.

- **Screening Versus Addressing Immediate Needs.** Most of those interviewed indicated the most challenging aspect of the screening and referral process is working the screening questions into a call that is unrelated to CHAP services in a way that feels natural and appropriate. They do not want a caller to feel like their immediate need is being ignored or diminished. And some staff feel they are invading callers' privacy when they are asking the screening questions. They suggested sharing strategies across 2-1-1 call centers on what is working at centers where higher numbers of eligibility screenings are being conducted.
- **Lack of awareness of the MI-CHAP program in communities.** Staff said families need to know they can call 2-1-1 to get connected to MI-CHAP services. They suggested building awareness of both the program and families' ability to connect to MI-CHAP through 2-1-1 call centers.
- **Lack of staff engagement.** Some of the call center staff we spoke with said they still have a hard time remembering to conduct a screening, and some are uncertain of the value of the program (i.e., they do not know if the program is helping families). To address these issues, they suggest continuing to promote screening contests among call centers, and/or providing information to staff on how MI-CHAP is helping families that are referred for services.

- **There is not enough staff to handle call volume.** At the time of the interviews, staff said they were receiving a large volume of calls about basic needs such as utility shut off or shelter. Call volume varies during different times of the year (e.g., winter, holidays, tax season), and during busy times, the call queue will be so long that staff feel they do not have time to conduct a screening. Staff were not sure how to address this issue, but did suggest taking contact information from the caller to conduct a screening at another time.
- **Screening goals seem unrealistic.** Some call center staff think the screening goals are unrealistic. Some, however, remain under the mistaken understanding that only eligible calls are supposed to be counted as screened. The lack of clarity about screening goals and which calls should be counted should be addressed by MAUW.

Virtual CHAP Specialists

Challenges identified by the virtual CHAP specialists are as follows:

- **Working as both a 2-1-1 call center staff person and a V-CHAP specialist.** More than one specialist said it is difficult to navigate back and forth between these two responsibilities because they require different talking points and activities, and they may miss a transfer from an eligible V-CHAP caller because they are on the phone with a 2-1-1 caller.
- **Keeping up with changes as they are made to the screening and referral process and the data system.** One said, "Recent changes to the 2-1-1 phone system require us to refer to different screens [for information]. Each of these screens has updates made to it, *and* we have to keep up with all the emails [from MAUW] with information about updates to the screening and referral process. And that is not easy to do."
- **Keeping other 2-1-1 staff motivated and engaged with the initiative to conduct more eligibility screenings.** One said, "You are a cheerleader for CHAP, but you also understand 2-1-1 staff have other work to do too." Another said, "A specialist has to be self-motivated, and it's on our shoulders to motivate the call center staff and remind them of the importance of the initiative."

Through the interviews, it became very apparent that the virtual CHAP specialists are committed to helping families and are engaged in their roles as 2-1-1 staff and V-CHAP specialists. All of them said the most positive aspect of working as a specialist is hearing that families successfully get the help they need. Specialists also said they enjoy the collaboration with CHAP program directors and learning best practices, and that they would like to hear more about the outcomes of their work. One said,

> I would like to get feedback from families on how we could improve services. What 2-1-1 could improve on, and what we could do differently, from the families' point of view.

Overall, 2-1-1 call center staff and V-CHAP specialists do think the screening and referral process could help families; however, incorporating the questions on eligibility into their script has been difficult, especially when the caller's immediate need is not related to healthcare. Because of the positive impact this program could have on vulnerable families, some call center staff say they are motivated to improve how they conduct the screening to help boost the number of eligibility screenings.

INTERVIEWS WITH STEERING COMMITTEE MEMBERS

The MI-CHAP Steering Committee, which began meeting in late 2015, convenes on a bimonthly basis to identify and consider policy- and system-level changes that are needed to support the long-term sustainability of MI-CHAP. This group of healthcare policy leaders focuses on the development of public-private partnerships, promotion of policies that support integration of MI-CHAP with healthcare providers and payers, and identification of opportunities to improve the model as it expands.

PSC interviewed MI-CHAP Steering Committee members to hear their perspectives on the challenges and successes they experienced as they worked toward the goals of the MI-CHAP initiative, as well as to identify the roles of the steering committee and MAUW in supporting the growth and future success of the initiative. Twenty-two people participated in the interviews. (In two of the interviews, a second person from the local CHAP joined the steering committee member.) Five steering committee members were unavailable for an interview or declined due to their limited participation on the committee. The findings from these interviews are presented below.

All of the committee members who were interviewed acknowledged that the MI-CHAP initiative is closely aligned with their work. They comprise representatives of local CHAPs, health providers, funders, health plans, advocacy groups, or policymakers who all have an interest in improving child health.

Most of the committee members said their understanding of the CHAP model has increased as a result of participation on the committee. Some of these said they had a basic understanding of the model before, but added that they gained a broader perspective and more thorough understanding because of participation on the committee. A few commented that the composition of the committee—with representation from all of the local CHAPs, statewide organizations, and government entities—provided good opportunities to hear different approaches and perspectives, discuss ideas, and expand support for the initiative.

Among respondents who said their understanding of the model had not increased, most said this was because they had previous experience developing a CHAP or a Pathways to Better Health model, which they considered similar.

To begin the interview, steering committee members were asked to describe the importance of MI-CHAP in addressing the healthcare needs of Medicaid-eligible children and their families. They responded with comments about the local CHAP model as well as the MI-CHAP initiative overall.

THE CHAP MODEL

Addressing Access Issues

All respondents said the CHAP model plays a very important role in connecting children to a medical home and providing case management to address access issues for families with children. Many elaborated by pointing out that navigating the health system can be cumbersome and difficult for many people, particularly for Medicaid-eligible families who face access barriers. Several mentioned the CHAPs' role in addressing social determinants of health—factors such as lack of transportation, unstable housing, and low income that have a significant impact on health risks and outcomes. They also credited the CHAP model with increasing families' understanding and appropriate use of the healthcare system, providing families with information, and connecting them with community resources.

There are significant access issues for the Medicaid population that the CHAP model addresses. So much of health is affected by social determinants of health. The CHAP model is structured to address social determinants of health with patients, providers, and the system to meet the needs of the child and family—both healthcare-related and social and environmental needs. We work with many providers and services, such as transportation, to address barriers in the system or things that don't work for the family.

The CHAP model moves us in the right direction in assisting people in managing their healthcare, increasing health literacy, and helping physicians understand how to help people who are not familiar with the healthcare system and may have barriers to using healthcare created by the social determinants of health.

MI-CHAP fills in the gaps. We used to believe if you could find health insurance for people, they could get all the help they needed. But experience has shown that even when they have insurance, many people have difficulty accessing healthcare. Through CHAP, we can help them and do it in a proactive, positive way so they use their medical home instead of the ER.

CHAP is filling an important gap in care coordination between clinicians, health plans, and social programs where people are currently falling through the cracks. CHAP is helping families understand the care process and get timely transport. Through CHAP, families can get information from someone they trust who is not motivated by payment or profit.

It meets the needs of Medicaid-eligible children by being a community extender. The model includes RNs [registered nurses], MSWs [masters of social work], and CHWs [community health workers] who work in the community to meet the needs of children where they are located rather than trying to get to them through the traditional healthcare delivery system.

Responding to Community Needs

A few respondents pointed out that the CHAP model is responsive to the unique needs of each community. They said a CHAP, by virtue of its relationships with other providers and community services, can bring different resources together to address issues.

> The CHAP model has the ability to link sectors that have not been talking to each other, such as the basic resource sector (like 2-1-1 and everything they offer), the early childhood sector, and the health sector. Even stakeholders within the health sector are better connected through the CHAP model. Health plans are talking to providers via the CHAP linkage and that doesn't happen often. The education and health sector don't typically think of 2-1-1 as some place to link their patients to, and in the past, 2-1-1 hasn't had a good understanding of the health sector.

> The problem of disparities persists within our communities. And when we have emergency situations, like in Flint, having the CHAP operating for children has proven essential. We have all of the social service agencies, nonprofits, and medical providers at the table so we could respond quickly and make referrals as needed. Following the Medicaid health plan rebid, we've been able to convene the plans and work on systems change.

> The CHAP model permits a proactive approach to identify areas where there is unmet need, or inadequate or absent linkages, and we stand ready to address those gaps and meet those needs.

MI-CHAP INITIATIVE

Providing a Statewide Infrastructure

In addition to the importance of the CHAP model at the local level, a few committee members spoke about the importance of the MI-CHAP initiative at the state level. They noted that the infrastructure created for MI-CHAP plays an important role of bringing together all local CHAPs and maintaining a recognizable core.

> MI-CHAP is helping the local CHAPs understand what each other are doing and find synergies between all of them. [The local CHAPs] initially felt separate and independent, but we've started to move the needle in terms of them thinking of themselves as one. Branding helped, and so did bringing them together for the summit and for meetings. Now they are a linked cohort across the state. We've come leaps and bounds from a year ago.

> Because [MI-CHAP] is a statewide effort rather than just individual programs addressing social determinants of health, it has the ability to reach different levels of influence and really advocate for the families.

> The MI-CHAP initiative has the potential to really improve children's health in Michigan in ways that other initiatives have not been able to do.

SUCCESSES

When committee members were asked how well the MI-CHAP initiative is doing, they all said MI-CHAP is doing well, particularly given it has only been funded for two years. Most respondents also acknowledged there is more to be done.

> The grant money from the Michigan Health Endowment Fund is giving MI-CHAP the capacity to form itself so it has a presence. [Funding] allowed for a lot of links and integrated expansion, and building a backbone infrastructure that links all the CHAPs and builds model integrity.

> It is amazing when I think about how much infrastructure has been laid down in the last two years. We created and implemented nine local CHAPs and then a statewide 2-1-1 system. Of course, there are things we can improve upon, but all the work we have done to lay the foundation has gone well.

> They are doing an outstanding job and have come a long way in a short amount of time. There are still a lot of opportunities and ways to evolve as the healthcare system changes in front of us.

Some respondents commented that the local CHAPs are doing good work. They noted that, generally, the CHAPs that are doing better were developed or in the planning stages before the MI-CHAP initiative began.

> Local CHAPS are at different stages, some that have been around longer are doing a little better. As a result of the MI-CHAP initiative overall, there are improvements in the way services are delivered. The approach is much more holistic to help parents get healthcare for their children.

> Some [local CHAPs] are doing well, others are encountering some barriers. It's kind of a mix. Some have only been running about six months; it takes time to get established.

A few committee members mentioned that the local CHAPs have benefitted from technical assistance and sharing of strategies and lessons learned that the MI-CHAP initiative has supported.

> MI-CHAP opened up the conversation more broadly in terms of what is different across the state. What lessons can we learn from other CHAPs, and what lessons learned do we have to offer to other CHAPs? For example, the Macomb CHAP came up with a foster care initiative that's great. I wouldn't have thought of it, but now we are looking into how we can better serve the foster care population. MI-CHAP has brought that sharing of ideas to the table; it wouldn't have happened otherwise.

When committee members were asked what the initiative's key successes have been, they named the following achievements, with the most frequently mentioned listed first:

- **Improved access to care for children.** Launching seven new CHAPs in a variety of settings and different communities, using an evidence-based model and tailored to the needs of the local community, is a huge success. It is uncommon for multiple partners to collaborate to replicate a model focused on addressing access issues for Medicaid children.
- **Development of the statewide V-CHAP 2-1-1 system.** V-CHAP creates a way to provide virtual access to care for Medicaid children. Being able to implement a new program, develop the data and analytics to support it, and train 85 staff across the state is a major accomplishment.
- **Linkages between community organizations and resources.** Some CHAPs have built relationships and established linkages between a variety of partners, including health plans and public health, to meet the needs of children and their families. Usually when people talk about saving money in healthcare, they focus on adults, but CHAP has provided an opportunity for the community to talk about children in a multistakeholder way.
- **Support for patient-centered medical homes.** Some CHAPs have been successful working with physicians' offices to help manage care for children experiencing barriers to accessing care. The CHAP model has provided a bridge to primary care, thereby helping children connect with a medical home.
- **Learning opportunities for CHAPs and other stakeholders.** Bringing people together who are working on the ground to meet their peers and share lessons learned has been helpful. Other groups that have been created, such as the program directors' group and the 2-1-1 group, have provided opportunities for networking and training.
- **Increased awareness of the CHAP model.** Promoting existing CHAPS and the new ones coming online, and providing education on the CHAP model to various organizations, has raised overall awareness.
- **Focused discussions on sustainability.** Convening representatives of local CHAPs, state departments, and other stakeholders on the steering committee has provided a forum to discuss a vision for funding, sustainability, and how to move the initiative forward. One person stated, "It is a huge benefit to have some folks from the state involved and give them a chance to see the progress—it keeps it front and center."
- **Securing Medicaid matching funds.** The Medicaid outreach funding negotiated through the Ingham County Health Department contract with the State has led to the ability to draw down additional funding to support local CHAPs.
- **Collaboration with managed care companies.** The MI-CHAP initiative has increased health plans' knowledge of CHAP and the services that could be provided to their members.

- **Data sharing.** The local CHAPs and MAUW have researched legal issues and created the necessary agreements to be able to share data for the purpose of evaluating the impact of the initiative.

CHALLENGES

All interviewees identified sustainable funding as either the greatest challenge facing the initiative or the main area on which the steering committee should focus in the next year or two. Other challenges that steering committee members identified included fidelity to the CHAP model, scalability, and advocacy for CHAP. Some committee members said challenges were encountered in building the virtual 2-1-1 model, establishing relationships, and data collection during MI-CHAP implementation.

- **Sustainable funding.** Developing sustainable funding for the initiative as a whole and for the local CHAPS was mentioned most often as a major challenge. Some committee members questioned reliance on foundations or health plans for funding. Others pointed out that CHAPS will need to distinguish themselves from other types of services and demonstrate what they can offer health plans and healthcare systems.

> I struggle to see how it is going to be a good choice to purposely set up a system where there is always private or foundation funding as part of the mix. It feels risky and unstable and not the way we should be building something, but some would say funding through the legislature is also unstable.

> Somewhere in the system, the cost of CHAP needs to be seen as worth the cost, either by cost-benefit analysis or the general sense that making things more accessible has value even if it is difficult to assign a dollar value. All that work needs to be done if CHAPS are to be sustainable.

> Making CHAP part of the way plans do business would be a win-win. As I understand it, and I'm learning as I go along, CHAPs were expected to be sustainable because they reduced ED utilization. Raising HEDIS scores could be an economic benefit for the plans.

- **Fidelity to the model.** After sustainable funding, achieving fidelity to the CHAP model or at least some level of consistency was mentioned most frequently as a major challenge for the MI-CHAP initiative. Committee members who raised this concern often pointed out that one of the strengths of the CHAP model is its responsiveness to the unique needs of the community, which leads to variability in structure and service delivery. But they also said definition of core elements is necessary to be able to advocate for the model as a statewide initiative. Some suggested that a core set of services should be established with flexibility to meet community needs.

> The biggest challenge has been implementation and whether all CHAPs have fidelity to the model. I don't see that as a fault; different communities have different needs. Some have been embedded in an organization, some have started a new organization. If we [representatives of our CHAP] are talking to payers—statewide payers—we can talk about core elements, but I think there are other CHAPs that are different. Whether all the CHAPS have fidelity to core elements is not clear. If we are talking about a collective and some don't have core elements of the model you're implementing, that is a challenge.

> How much local variability is a good thing and how much is a liability? Not just for problems in communicating, but for kids. Kids in different geographic areas need as much care coordination to avoid hospitalization. I'm not a huge fan of picking and choosing where services are offered. Maybe there should be standardization around a core set services, and then variability in some areas. It should be a default where we are giving you the money and you have to provide the service.

> One of the issues that has come up is fidelity to the model. The model was initially articulated as centering around PCMH. Some chapters do not have a primary care provider base, and their approach may be suitable for local conditions, but may not necessarily be the CHAP model. The challenge will be when it comes to us returning for funding. We said we'd do things one way, but now we'll have a variety of ways to explain. This creates problems with MSA (Medicaid Services Administration) and health plans. It is difficult to communicate effectively about CHAP if it looks different in different communities. We'll have to resolve the issue of fidelity to the model.

> In our area, CHAP is a different model. There are pockets where something like the MI-CHAP model exists to a certain extent, but it is not as formalized as in Kent County. There is a Federally Qualified Health Center Model that has hired individuals to do outreach and work with families. There are other clinics that offer a similar service. Instead of recreating that model, our role would be to divert people to where those resources exist. I can't argue with the concept, but we may need to think differently about how it gets done here.

- **Scalability.** Scalability is closely tied to sustainability and fidelity to the model. A few committee members commented that MI-CHAP must move to the point where it is statewide or it will become problematic politically. They said it is hard to get funding strategies in place when CHAP is not provided everywhere. And as one person put it, "If CHAP looks different in different places, it's hard to educate legislators about it."

- **Advocacy.** A few committee members spoke of the need for local CHAPs and the MI-CHAP initiative to remain visible at the state and local levels. They said the CHAP model needs to become normative for the state health department and Medicaid health plans. To reach that status, they said all committee members should continue to proactively advocate for CHAP as a valuable resource.

> When you do something new, its newness means it is outside the normal way of doing business. It requires new resources and can be seen as demanding. The CHAP needs to become normative for the state health department and the health plans.

> Another challenge is helping others understand that MI-CHAP is not a duplication of services or efforts. Clinicians, as a whole, need to understand MI-CHAP as a resource.

> The steering committee has agreed we can share the model and advocate for funding with people, but it's not a well-coordinated effort. We are all doing it, but it can get confused with other initiatives that are very similar.

- **Building the V-CHAP statewide system**. A few committee members pointed out the complexity of developing the V-CHAP system within the existing 2-1-1 system. They said it required patience and collaboration between both systems, development and refinement of the online system that 2-1-1 staff would use, training of staff to work within the 2-1-1 call centers, and navigation of reporting requirements between MAUW and 2-1-1. One person noted more could be done to link primary care practices to 2-1-1.

> We still have work to do so that the healthcare sector understands the value of the 2-1-1 system and how to link that into their practice. Many practices don't have a social worker to connect people to resources, and even if they do, a social worker may not understand the system as well, and may not understand what they can get from 2-1-1. To some degree, the value of the 2-1-1 system for practices depends on the local resources that 2-1-1 can connect people to. For example, if a family has a problem getting food, I can look up the food pantries in their zip code. If the resources aren't available in a community, then what do you do?

- **Awareness/relationships.** Difficulties building awareness and developing relationships were identified by a few steering committee members as a challenge for the CHAPs. One recognized that the lag time between new CHAPs and V-CHAPs coming online and getting information to medical providers and families could be a marketing and communication issue. Another said the CHAPs that had already put groundwork in place are doing well establishing relationships and getting referrals, but the CHAPs that started from scratch have had more difficulty. Two members mentioned the development of relationships and contracts with Medicaid health plans as particularly challenging.

- **Data collection.** Another challenge mentioned by a few committee members is the lack of data to measure outcomes for the initiative. They commented that everyone has a different way of collecting data and reporting it, and suggested that one method wouldn't have been appropriate for every CHAP. However, they said it is very important to finalize negotiations between the CHAPs and MAUW, and between MAUW and MDHHS so that the data collection and analysis plan can be implemented.

> Lack of data is a huge burden. It is hard to imagine toting this to funders going forward without data.

> I haven't been provided with the quantitative data I would like to have. Qualitatively, I'm impressed with the energy and work, but I haven't seen the numbers of population served and the number served as a proportion of the eligible population.

VISION

Hope for the Future

When steering committee members were asked to describe their vision and hopes for growth and sustainability for the MI-CHAP initiative over the next five years, the similarities in their responses were striking. They spoke of complete sustainability for individual CHAPs and the initiative as a whole, diversified funding strategies, core elements for all CHAPs, expanded services at existing CHAPs, and expansion of CHAP and V-CHAP to additional communities. As one person said:

> My vision is that each one of these regions has a fully implemented CHAP supported by state, local, and philanthropic funding, with fidelity to core elements for all the CHAPs, as well as working on issues particular to their community—such as asthma, lead, and others. And I would like it to be expanded so it's everywhere. State Medicaid in particular should support CHAP. We know the initiative works. If implemented in the way they were designed, CHAPs will work.

Several committee members hope CHAPs will continue and expand their role in addressing social determinants of health. One said, "CHAPs should be seen as practical extenders of healthcare because providers do not have enough time to address social determinants." Another noted, "It is not the healthcare provider's role to go out and bring people into care." One member said pediatric practices in particular need help connecting families to community resources, and another said they hoped CHAPs would "be instrumental in bridging the gaps between the healthcare, community resource, and early childhood worlds." Another offered the following example, "The CHAPs don't have to be a home visiting program, but they have to know the resource is there. And when the home visitation program ends, they need to make sure that family is connected to the next set of resources."

A few committee members said they would like to see capacity expanded to serve additional populations, such as pregnant women and adults. One person explained, "There are potentially more savings in adult care because care for children isn't as costly; for children, CHAP is an investment. Integrated healthcare is at the forefront of everyone's planning, and the CHAP model could play a role in that."

As part of their vision for CHAP, several committee members said there must be data available on health outcomes or proof of the value proposition that would justify contracts with health plans and requests for state, local, or federal funding. As one person said, "There would be more evidence of sustainable outcomes, and reinforcement of the outcomes for families and children and importance of ties to a medical home."

Achieving the Vision

In order to achieve this vision, steering committee members emphasized the need to develop a sustainable funding model, publicize data on outcomes and cost savings, and promote understanding and support for the CHAP model. When asked if there was a particular area of responsibility on which the committee should focus, all but two of the respondents named sustainability. One of the other members said, "Insist that there has to be data," and the other said, "Put a strategy on paper so we know who and where we could reach to spread and raise awareness."

- **Develop a sustainable funding model.** To achieve diversity in funding, committee members said development of a funding model should consider all possible funding sources, including state government, health plans, health systems, philanthropy, businesses, federal government, and local sources. Several members noted that the committee has recognized the CHAP initiative can't rely on philanthropic funding forever; there will always be room for philanthropic funding, but the balance has to shift. A few members said a commitment for ongoing funding, with a two- to three-year funding plan, is important.

  Several members said an organized outreach effort to potential funders is necessary, including working with local CHAPs so they can conduct their own outreach. One member suggested approaching hospitals that are required to complete community health needs assessments because CHAPs are providing services that would help hospitals meet identified needs. Another member suggested working with the Michigan Association of Health Plans to explore development of standard contract language that health plans could use to contract with CHAPs in various counties.

  A few members mentioned Medicaid should be used to support the CHAP model by writing it into the contracts with Medicaid health plans or, alternatively, by putting expectations in the Medicaid contract for the outcomes that CHAPs could help the health plans achieve.

  A couple of members expressed their view that CHAP would be more successful going forward if there was a structure or program at the state level with requirements and a funding mechanism.

- **Publicize data on outcomes and cost savings.** Members said data are necessary on the outcomes and cost savings associated with the model to support funding requests. They said both quantitative and qualitative data are important, effectiveness must be evaluated, and savings or return on investment should be quantified. Several members expressed frustration that the data are not available yet.

  > We need that data out there, and we need to be shouting it, saying [MI-CHAP] is effective in reducing cost and improving quality.

> The words we use are not adequate to convey the reach and impact [of MI-CHAP]. It would be great to be able to state a better case.

One member would like to see measures of "things that are less tangible," in addition to information on utilization of healthcare.

> What is the effect of a CHAP program that works with a homeless family for six months and gets them into housing? How do we tell the whole story? How do we convey the complexity of each individual person's situation and that the CHAP model is set up to assist with whatever that person's barriers are? I would like a roadmap for how to tell that story five years from now.

One member pointed out that MI-CHAP needs to be talking with higher-level decision makers who care about costs of children's health, not just HEDIS measures. Similarly, another said it is very inexpensive to provide services to children and "there should be a lot of incentive at the state level to invest in children because healthy children become healthy adults."

- **Promote understanding and support for the CHAP model.** Members said it will be important to build the right relationships and stay in touch with decision makers in state government and local communities so the MI-CHAP model becomes "a household name." A few members described ways the audience could be expanded.

> Include travel to conferences and perhaps some professional writing in the MI-CHAP budget so healthcare professionals hear about [the model] and see it published.

> I hope CHAP would present at the public health association, the American Academy of Pediatrics—anything that normalizes and builds support for CHAP.

> There needs to be as much promotion to pediatric practices about the value of CHAP as there is to payers.

One committee member said more physician leadership is needed to promote the CHAP model.

> Practices listen differently when it is a physician coming in to talk to them. I'm concerned that there are not enough strong physician leaders involved in CHAP. We have some, but not enough.

Another member suggested it will be important to continually assess the "landscape"—all the opportunities and threats that exist related to the MI-CHAP model. She suggested key areas to watch are the developing community health improvement regions (CHIRs), home visitation programs, and the rules governing requirements for Medicaid matching funds. She added that MI-CHAP should be informing processes that are being developed as part of new initiatives to reform delivery and payment models.

Role of the Steering Committee

When committee members were asked what the role of the committee should be in supporting achievement of the vision they described, many noted the composition of the committee as a strength and offered a variety of ideas to build on the members' expertise and connections. One person described the role generally as "providing leadership, guidance, and advocacy." Other members were specific in their responses. A few members said the committee first needs to agree on the vision, then develop a systematic plan to reach it, and identify who will carry out specific tasks.

Several members commented that they think the "right people," with connections to many entities and networks with responsibility for children's health, are at the table. They said these members have a good understanding of the barriers and social determinants that affect a Medicaid child's utilization of healthcare and what that means later in life. With that understanding, one of the ways these members can support the vision is to "try and open some doors." According to interviewees, this has been happening to some extent, but needs to continue and involve all members. Some suggested each steering committee member should reach out to their respective network to increase understanding of and support for the CHAP model; one said members should report back to the committee on the status of their outreach efforts.

A few members talked about the "creative thinking" that members can help stimulate. They said some members, because of their position and networks, are participating in high-level conversations at the state level regarding health policy. They suggested these members might, to the extent they are able, bring information back to the steering committee to inform strategy development and communication plans. One member said the steering committee could use meeting time to "brainstorm the issues we need to address—the moving pieces at the state, federal, and local level, and then talk about how the steering committee can help MI-CHAP keep visible and viable in all those discussions."

Some members talked specifically about advocacy for funding. One said, "Steering committee members can help identify who all the partners are in various funding streams that we need to engage, and then, because they have relationships, what the best strategies will be to engage them and help them see how MI-CHAP contributes to their goals." Another said all members need to be engaged in outreach to potential funders and not leave that responsibility solely to the MI-CHAP staff.

A couple of members mentioned a role for committee members in quality assurance. One said members could help identify improvements that should be made in the MI-CHAP initiative to better meet its goals. Another said the committee can help the initiative maintain focus and "continue to do what they do very well."

The MI-CHAP Steering Committee charter lists the following responsibilities of the steering committee: foster the development of public/private partnerships; clear barriers to program implementation, especially at the policy level; promote continuous improvement of the MI-CHAP model; and identify and promote strategies for sustaining MI-CHAP through public and private funding sources. When asked how effective the committee has been in carrying out these responsibilities, the members' responses ranged from "fair" or "moderately successful" to "very successful." Some said the committee was doing particularly well given the initiative had been underway for less than two years. The majority of interviewees said the committee had been most successful in development of public/private partnerships, and some commented that those partnerships have yielded positive results in exposure for the CHAP model. Members also noted that a great deal of work had been done in identifying and promoting

strategies for sustaining the initiative, although "there is not much to show for that work yet; it is work in progress." For now, almost all interviewees said the committee's focus on sustainability should continue. One person commented that the role of the steering committee may change as the CHAPs become more stable.

Role of the Michigan Association of United Ways

Members were asked about the support provided to the committee by the Michigan Association of United Ways. All respondents said the meetings are well run and the materials provided are helpful. A few members expressed their appreciation for the responsiveness of MAUW staff and the committee co-chair to their questions or requests for information. A few mentioned the grid of funding possibilities prepared by MAUW staff as being particularly useful for the committee's discussion.

One committee member suggested that MAUW encourage identification of actionable steps that members could do between meetings. They also wondered if subcommittees focused on specific tasks, such as fidelity to the model or strategies to engage new partners, might help move items forward. Another member said it would be beneficial to have more materials available, such as the one-pagers that MAUW developed earlier in the year, so members would have them in hand when they are promoting MI-CHAP.

When members were asked where MAUW should focus its efforts in the coming year, one member summed it up this way, "The biggest thing is simple: keep it going." Another said, "MAUW has been a great home for MI-CHAP. They have been huge in keeping the momentum going, and I hope they continue in that role." Other committee members suggested focusing efforts in specific areas that could keep the momentum going—promoting the model and advocating for funding, providing technical assistance, and supporting MI-CHAP as part of MAUW's mission. One member offered a different summary statement, saying, "Collectively, between the steering committee and MAUW leadership, it depends on the vision, but they need to support where they want to end up."

One member mentioned the need to focus on the "elemental and essential things" that need to be done to assure sustainability, including honing the committee's ability to get the word out clearly and concisely about what MI-CHAP is and how it can support the efforts of different healthcare partners. Another member suggested MAUW focus on seeking multiyear funding and helping the committee bring MDHHS to the table. Yet another member pointed out that MAUW is a central partner and could continue discussions with potential funding sources and reach out to other partners who may support MI-CHAP in the future.

A few members recommended MAUW continue to convene CHAP program directors so they can build on their successes, refine their skills, and work on the challenges together. They also said it is important for MAUW to provide technical assistance to support standardization among local CHAPs. One member said she is concerned that, "Anyone could go out and call themselves a CHAP, and that hurts the infant brand of what we're calling a CHAP. Clarity is needed around what each local CHAP should deliver in terms of services."

One member suggested that MAUW's job as the host organization is to maintain focus and support CHAP as part of their total mission. In a separate interview, another member said MAUW needs to determine if MI-CHAP is consistent with its mission and then decide how they will support it. Both members said they think MI-CHAP is a departure for MAUW from usual, locally funded initiatives. They wondered aloud what potential exists to use MAUW's relationship with local United Ways to support CHAPs. One member

raised the question of whether MAUW could be a united front with the local United Ways, promoting the effectiveness of the CHAP model.

A few members talked about 2-1-1 and V-CHAP when they considered where MAUW should focus its efforts. One suggested MAUW analyze data on 2-1-1 referrals to CHAPs to determine where it is a primary source of referrals, and if it is not, why not? He said MAUW should explore whether 2-1-1 is working well, not functioning properly, or perhaps not essential in some areas of the state where CHAPs are not as dependent on 2-1-1. Another member also mentioned variability in the use of V-CHAP across the state because some areas have V-CHAP and others have a CHAP with "boots on the ground." She said this results in the need for a tailored approach to "get the word out" about V-CHAP and CHAP. Yet another member questioned whether sustaining the V-CHAP piece is what MAUW wants to do and wondered whether V-CHAP will take resources from the actual CHAP model.

APPENDIX A: MI-CHAP EVALUATION FRAMEWORK

Goals and Objectives	Evaluation Questions	Data Sources and Measures

GOAL 1: Improve the health of Medicaid-enrolled children in MI-CHAP.
• Improve by 25 percent the score of asthma clients on the Pediatric Asthma Caregiver's Quality of Life Questionnaire (PACQLQ)
• Reduce by 30 percent school days missed due to asthma among MI-CHAP asthma clients
 	
GOAL 2: Improve the quality of and access to medical homes in MI-CHAP communities.
• Increase by 15 percent the number of Medicaid children aged 3-6 assigned to CHAP practices who are up to date on their well-child visits
• Increase by 10 percent the number of Medicaid children ages 0-2 assigned to CHAP practices who are up to date on their immunizations
• Increase by 25 percent the number of CHAP practices who meet the HEDIS target for Medicaid children assigned to their practice who have been tested for lead
	1. To what extent does CHAP improve health outcomes (asthma, immunizations) for children on Medicaid?
	2. To what extent does CHAP improve school attendance among participating children with asthma?
	3. To what extent does CHAP improve access to care and medical homes for children on Medicaid?
	4. How do healthcare providers and community partners work together to address CHAP goals?
	5. How were opportunities created and challenges overcome?
	6. How are providers engaged in CHAP (peer discussions, others)?
	7. How are parents engaged and involved in their children's health and well-being through CHAP? How did this involvement contribute to improvements in health and well-being?
		CHAP team CRM/database:
		• Direct services provided by CHAP team, including number and type
		• Client demographics
		
		Asthma data (CRM/CHAP database/asthma provider):
		• Asthma services delivered, including number and type
		• Changes in client asthma outcomes (PACQLQ/Juniper scores, missed work and school days, tobacco smoke exposure in the home, Asthma Control Test scores)
		• Number of asthma clients with asthma action plans
		
		Focus groups with parents:
		• How they learned about CHAP services
		• Perceived value of CHAP services
		• Comfort/confidence in using the healthcare system
		• Level of engagement in children's health
		
		Survey of healthcare providers/practices:
		• Changes in accessibility
		• Whether and how CHAP has supported patient care
		• Changes in patient no-show rates, HEDIS measures
		• Integration with other providers and community partners
		• Participation in/usefulness of CHAP provider meetings
		
		Interviews with CHAP team directors:
		• Strategies for communicating about CHAP
		• Strategies for engaging providers in CHAP
		• Strategies for engaging parents and involving them in their children's health and well-being
		• Challenges encountered and strategies used to overcome them
		
		MDHHS Data Warehouse:
		• Encounter data for MI-CHAP clients:
		  • Well-child visits
		  • Immunizations
		  • Lead tests

GOAL 3: Lower the total cost of care by reducing ED visits and inpatient hospital admissions among children on Medicaid.
• Reduce by 50 percent inpatient admissions due to asthma among MI-CHAP asthma clients
• Reduce by 35 percent ED admissions among MI-CHAP clients
• Reduce by 40 percent preventable inpatient hospital admissions among MI-CHAP clients
	1. How does CHAP affect healthcare costs?	**MDHHS Data Warehouse:**
		• Encounter data for MI-CHAP clients:
		  • Hospital inpatient admissions
		  • ED visits
		  • Preventable inpatient hospital admissions
		PSC calculations:
		• Cost benefit analysis
		• Savings related to good health

GOAL 4: Innovate efficiencies and scalability by delivering components of the CHAP model statewide through a new virtual strategy.
• Screen 115,000 families with children with Medicaid for healthcare navigation needs and link them with community resources to address social conditions affecting their health
• Refer 38,000 families with children to a medical home (follow up with 7,600 to find out whether services were utilized)
	1. How do 2-1-1, state and local CHAP staff, volunteers, and the technical assistance provider (HNWM) contribute to the expansion and success of the program?
	2. How were opportunities created and challenges overcome?
		2-1-1 MI-CHAP/RiverStar database:
		• Number of callers *screened* for CHAP services
		• Number of callers *referred* to a CHAP team
		• Number of callers *referred* for other health-related services (primary care provider, Medicaid enrollment support, Medicaid health plan)
		• Data from follow-up with one in five CHAP-related referrals
		  • Whether child/parent accessed/received services
		  • Barriers to receiving services
		  • Potential solutions identified and/or executed
		Interviews with 2-1-1:
		• Successes and challenges related to MI-CHAP screening and referral

APPENDIX B: PARENT FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

The Michigan Association of United Ways has a two-year grant from the Michigan Health Endowment Fund to implement the Michigan Children's Health Access Program, known as the MI-CHAP initiative. MAUW has provided funding in eight regions to either expand or set up local CHAP teams that are working with primary care providers and families to help strengthen connections between providers and families. Public Sector Consultants has been hired by MAUW to conduct an evaluation of MI-CHAP.

As the second program year draws to a close, we are talking with parents of children who have received CHAP services to learn how you became involved in CHAP services, whether –the services are helpful, and whether you think there has been any change in your use of healthcare services. By talking with you, we hope to help MAUW learn the stories behind the numbers and better understand the family experience with CHAP services.

Your responses to these questions will be kept confidential. We will prepare a report that summarizes the key themes we hear across all eight focus groups. We may include quotes to represent an important point, but we will not tie any individual names to those quotes.

QUESTIONS

1. How did you first learn about Kent CHAP? (Probe for primary care provider, 2-1-1, or other.)
2. What types of services have you and/or your children received from Kent CHAP?
    a. Probe: Services might include information about when to use an emergency department, information about well-child visits and immunizations, importance of having a medical home for your children, coordination or provision of transportation, interpretation services if needed, referral to community services, help navigating the healthcare system, asthma education and case management, help navigating the behavioral health system, or childhood obesity programs. Have you or your children received any of these services from Kent CHAP?
3. Have the services you received from the CHAP agency been helpful to you and your family? Please give me an example of how Kent CHAP has helped you and your family. What has been the most helpful/useful aspect of CHAP services for your family?
    a. Probe: Did Kent CHAP help you find a medical home for your child or children?
4. Has Kent CHAP helped you learn more about your children's health, given you tools you need to help them be healthy, or suggested questions to ask their doctor? If so, please tell me how they have helped you, or give me an example.
5. How did you feel about using healthcare services (for example, using your health coverage, finding a doctor for your child, or visiting your child's doctor) before you started working with Kent CHAP? How, has that changed, if at all, since you began working with Kent CHAP?
6. Is there anything you wish Kent CHAP would do differently? Any other services you would like them to provide? Anything they could do to improve how they deliver services?
7. If you had a concern about your children's health, would you reach out to Kent CHAP again? Why or why not?

8. Would you recommend Kent CHAP to others? Why or why not?
9. Is there anything else you would like to share about Kent CHAP and the services they offer?

APPENDIX C: INTERVIEW GUIDE FOR CHAP PROGRAM DIRECTORS

INTRODUCTION

As the second year of the MI-CHAP initiative draws to a close, PSC is conducting interviews and surveys with a variety of program stakeholders to learn more about the successes and challenges they have experienced in planning and implementation. Your participation in this interview will help PSC and MAUW gain a better understanding of how the program has unfolded for local CHAP teams, including the staffing model being used by your site, how your site is working with local healthcare providers, your strategies for promoting CHAP services, community supports and barriers, successes and challenges related to service delivery, the helpfulness of technical assistance and support from the MAUW program team, and data collection.

Your responses to these interview questions will be kept confidential. While quotes may be used to illustrate key themes in a summary of the interviews, the quotes will not be attributed to individuals or CHAP sites.

QUESTIONS

1. Please tell me the number and types of staff who work at your CHAP site. What other or additional staff positions would be helpful? Are you seeking to fill any positions in the near future? If so, which ones?
    a. Does your current staffing model reflect what you initially proposed? If not, what has changed and why?
    b. If your CHAP site is operated within a larger organization, do you share positions with other areas of the organization? If so, how has this helped or hindered delivery of CHAP services?
2. With how many healthcare practices does your site have BAAs or MOUs for delivering CHAP services to patients? About how many physicians does this represent?
    a. What challenges did you face in setting up agreements with the practices? How did you overcome them?
    b. What has worked well to establish connections and relationships with providers?
    c. Did the size of the practice have any effect on your ability to establish agreements?
3. What other types of organizations refer clients to your CHAP? What strategies are you using to share information about CHAP with agencies that might refer clients?
    a. What's working well to share information?
    b. What has been less successful?
4. Are you receiving client referrals from 2-1-1? How well has the referral process worked?
    a. Please rate the appropriateness of referrals received from 2-1-1 on a scale of one to five, where one means nearly all of the referrals are inappropriate and five means that nearly all of the referrals are appropriate.

b. What do you think could be done to improve the appropriateness of the referrals or the referral process?

5. How has your CHAP team worked directly with physicians or other providers in the primary care practices to identify ways to improve delivery of services to families in the practice (e.g., to improve accessibility, coordination of care, or cultural effectiveness and sensitivity)? Do you think your efforts have had an impact? Why or why not?
6. What role has your medical director played in establishing and/or building your CHAP's relationship with physicians?
7. How has your site engaged health plans? How, if at all, have they helped connect you with providers and families? What other aspects of CHAP services are health plans helping with or providing support for?
   a. What challenges have you run into in connecting with health plans?
   b. What has worked well for engaging them?
8. How well is service delivery going? What has been most challenging? How have problems been addressed?
9. How has your CHAP team engaged parents to involve them in their children's health and wellbeing?
10. How well have you been able to collect data on CHAP clients and services provided? What challenges have you faced related to data collection? How, if at all, has your collection of data improved since you began delivering services?
11. Please tell me about your advisory committee. What types of stakeholders are represented on the committee? How often does it meet? How has the committee supported your CHAP? (i.e., What activities do they perform as a group or individually to help advance your CHAP?)
12. What have you done to lay the foundation for sustaining CHAP services when funding from the Michigan Health Endowment Fund is gone?
13. How would you describe the overall state of your CHAP?
   a. Do you feel confident that things are moving in the right direction?
   b. Are you on target to meet goals you have established?
   c. What do you look forward to doing with your CHAP team in the coming year?
14. What types of technical assistance would be most useful in the coming year?
15. What type of support from MAUW would be most useful in the coming year? What types of statewide activities, if any, would it be helpful for MAUW to spearhead to promote support for CHAPs and the services they provide?
16. What has been the most challenging aspect of implementing a CHAP?
17. What has been the most positive aspect of CHAP implementation?
18. Is there anything else you would like to share about MI-CHAP implementation?

APPENDIX D: INTERVIEW GUIDE FOR 2-1-1 STAFF

INTRODUCTION

In 2015, the Michigan Association of United Ways received a two-year grant from the Michigan Health Endowment Fund to implement the Michigan Children's Health Access Program. MAUW has provided funding in eight regions to set up local CHAP teams that are establishing relationships with primary care providers and working directly with families to help strengthen their connections with these and other healthcare providers in their regions. MAUW has also been working to establish a connection between 2-1-1 and CHAP services. Public Sector Consultants has been hired by MAUW to conduct an evaluation of MI-CHAP.

As the second program year draws to a close, PSC is conducting interviews and surveys with a variety of program stakeholders to learn more about the successes and challenges they have experienced in planning and implementation. Your participation in this interview, will help PSC and MAUW better understand how implementation of MI-CHAP has unfolded in 2-1-1 agencies and how well the MI-CHAP screening and referral process is working.

Your responses to these interview questions are confidential. PSC will prepare a summary of key themes, but will not attribute any quotes or ideas to individual respondents.

QUESTIONS

1. How were you prepared to begin screening callers for MI-CHAP eligibility and referring them to a local CHAP or to a V-CHAP specialist? How was the MI-CHAP program presented to you? How well did you understand the program?
2. Tell me about the training and TA you received for the screening and referral process. What was most helpful? What was missing? What types of training and ongoing support would be most useful in the coming year?
3. How well has the screening and referral process worked from your perspective? (Probe for caller receptivity to screening and referral and transfer of information to CHAP team or V-CHAP agent.)
4. How has the use of the RiverStar data system for screening and referrals gone? Is there anything that should be done to improve it?
5. Approximately how many screenings do you conduct on any given day? Does this feel low, high, or about right?
6. What, if anything, prevents you from screening more callers for MI-CHAP? What would motivate you or help you screen more callers?
7. What suggestions do you have for reducing the number of callers who turn down the opportunity to be screened for CHAP eligibility?
8. What has been the most challenging aspect of implementing the MI-CHAP screening and referral process? What might be done to address these challenges?
9. What has been the most positive aspect of implementing MI-CHAP screening and referral?
10. Is there anything else you would like to share about the MI-CHAP screening and referral process?

APPENDIX E: INTERVIEW GUIDE FOR V-CHAP SPECIALISTS

INTRODUCTION

The Michigan Association of United Ways has a two-year grant from the Michigan Health Endowment Fund to implement the Michigan Children's Health Access Program. MAUW has provided funding in eight regions to set up local CHAP teams that are establishing relationships with primary care providers and working directly with families to help strengthen their connections with these and other healthcare providers in their regions. MAUW has also been working with the state 2-1-1 organization to establish a connection between 2-1-1 and CHAP services. Public Sector Consultants has been hired by MAUW to conduct an evaluation of MI-CHAP.

As the second program year draws to a close, PSC is conducting interviews and surveys with a variety of program stakeholders to learn more about the successes and challenges they have experienced in planning and implementation. Your participation in this interview will help PSC and MAUW better understand how well the virtual CHAP aspect of the project has unfolded and what could be done to improve it over the coming year. We want to know more about your role as a V-CHAP specialist, how well the referral process has worked, and how well-equipped you are to handle client needs.

All interview responses are confidential. PSC will prepare a summary of key themes from the interviews, but will not attribute quotes or ideas to any individual respondents.

QUESTIONS

1. How long have you been in your current position as a V-CHAP specialist? How would you describe the role of a V-CHAP specialist?
2. Describe the training and technical assistance that you received to prepare you to work as a V-CHAP specialist. Were the training and technical assistance adequate? Why or why not? What types of training and technical assistance would be most useful in the coming year?
3. How well has the 2-1-1 screening and referral process worked from your perspective?
4. We have found that the vast majority of callers who are eligible for V-CHAP choose to schedule a callback rather than be transferred immediately to a V-CHAP specialist. We've also learned that only 39 percent of callers who choose to receive a callback are ever reached by a V-CHAP specialist, compared to 82 percent of those who receive a warm transfer.
    a. Do you have any suggestions for increasing the number of live transfers?
    b. Do you think two callbacks is adequate to connect with a V-CHAP client? If not, how many callbacks do you think should be attempted before removing the client from the system?
5. On average, V-CHAP specialists speak with five V-CHAP clients in a week.
    a. Does this feel like too many, not enough, or about the right amount? Why did you give the answer you did? (Probe for what should be done to address the problem of too many or not enough clients.)

6. On average, V-CHAP specialists spend about seven minutes on the phone with a V-CHAP client.
    a. Does this feel like it is too long, not long enough, or about the right amount of time? Why did you give the answer you did? (Probe for what should be done to address the problem of too long or not enough time.)
7. Do you have the information and tools you need to appropriately address the needs of V-CHAP clients?
    a. What tools and information have been most helpful?
    b. What additional tools and information do you need?
8. How has the use of the RiverStar data system for capturing data on client interactions gone? Is there anything that should be done to improve it?
9. What has been the most challenging aspect of working as a V-CHAP specialist?
10. What has been the most positive aspect of working as a V-CHAP specialist?
11. Is there anything else you would like to share about the V-CHAP screening and referral or service-delivery process?

APPENDIX F: INTERVIEW GUIDE FOR CHAP STEERING COMMITTEE MEMBERS

INTRODUCTION

As the second year of the MI-CHAP initiative draws to a close, PSC is conducting interviews and surveys with a variety of program stakeholders to learn more about the successes and challenges they have experienced in planning and implementation. Your participation in this interview will help PSC and MAUW gain a better understanding of how you view the challenges faced and successes achieved by the MI-CHAP initiative and the role of the steering committee in supporting the growth and future success of the initiative.

All interview responses are confidential. PSC will prepare a summary of key themes from the interviews, but will not attribute quotes or ideas to any individuals.

QUESTIONS

1. How has your understanding of the CHAP model increased as a result of your participation on the steering committee? Has it improved your ability to explain the model to others?
2. How would you describe the importance of MI-CHAP in addressing the healthcare needs of Medicaid-eligible children and their families?
3. To what degree does the MI-CHAP initiative align with or have the potential to strengthen the work you do?
4. What is your sense of how well the MI-CHAP initiative is doing overall? Why did you answer as you did?
5. What do you think have been the initiative's greatest challenges?
6. What have been the initiative's key successes?
7. What is your vision for the MI-CHAP initiative over the next five years? Where do you hope it will be in terms of growth and sustainability?
8. What needs to occur to realize that vision? What should happen in the next year? Three years?
9. What is the role of the steering committee in what you just described? How can the steering committee best support the achievement of that vision?

The steering committee charter lists the following responsibilities of the steering committee:

   a. Foster the development of public/private partnerships
   b. Clear barriers to program implementation, especially at the policy level
   c. Promote continuous improvement of the MI-CHAP model
   d. Identify and promote strategies for sustaining MI-CHAP through public and private funding sources

10. Thinking of these roles and responsibilities, how effective has the committee been in carrying out these responsibilities? Why did you answer as you did?

11. Is there a particular area of responsibility on which the committee should focus to help the MI-CHAP initiative achieve the vision you laid out?
12. How well do steering committee meetings and the materials provided to the committee support you and your colleagues in carrying out committee responsibilities? What additional support or information would help the committee fulfill its roles and responsibilities?
13. Where do you think the Michigan Association of United Ways should focus its efforts in the coming year to build on successes and address challenges?
14. Is there anything else you would like to tell me about your thoughts on the MI-CHAP initiative?

230 N. Washington Square
Suite 300
Lansing, MI 48933