Florida’s State Children’s Health Insurance Program (SCHIP):

The Children’s Healthcare Access Initiative’s Florida KidCare Outreach in Hillsborough County

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Introduction

Today, it is estimated that over 500,000 of Florida’s children are without health insurance. A child without health insurance is in danger of missing critical immunizations, forgoing health treatment for common illness and injury, and is 70% less likely to receive medical treatment for medical emergencies. These untreated health conditions can lead to an uninsured child being unable to meet developmental milestones, and missing a disproportionate amount of school (4). Of the estimated 12.9% of Florida’s children who are uninsured, without the foundation to become successful students, 72% are eligible for subsidized, comprehensive health coverage, costing no more than $20 a month through Florida KidCare (6, 13). The reasons that children eligible for Florida KidCare’s free or low cost health insurance remain uninsured vary, but a survey of parents reviled that an overwhelming 55% did not know how to apply, while 45% thought their children would be ineligible (8). Florida KidCare outreach to these families is essential to insuring 100% of Florida’s children. Not only do traditional means of outreach need to be conducted, but also new, innovative strategies resulting in systematic enrollment of children in Florida KidCare must be explored.

This thesis explores not only the history of state children’s health insurance programs in Florida, but also the outreach work that has been conducted to increase enrollment in Florida KidCare programs. Specifically, it explores the organization of Florida KidCare outreach and attempts to determine effective ways to measure the impact that Florida KidCare outreach has.

![Figure 1: Florida KidCare Eligibility of Children Ages, 0-18](image1.png)

![Figure 2: Florida Child Uninsurance by Income Level, age 0-18](image2.png)

Table 1: Health Insurance Coverage Status of Children Ages, 0-18

<table>
<thead>
<tr>
<th>Source</th>
<th>FL #</th>
<th>FL %</th>
<th>U.S. #</th>
<th>U.S. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>2,061,500</td>
<td>49%</td>
<td>40,366,600</td>
<td>51%</td>
</tr>
<tr>
<td>Individual</td>
<td>212,000</td>
<td>5%</td>
<td>3,191,300</td>
<td>4%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1,125,700</td>
<td>27%</td>
<td>26,325,400</td>
<td>33%</td>
</tr>
<tr>
<td>Other Public</td>
<td>86,800</td>
<td>2%</td>
<td>1,137,900</td>
<td>1%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>756,700</td>
<td>18%</td>
<td>8,284,500</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>4,242,600</td>
<td>100%</td>
<td>79,305,700</td>
<td>100%</td>
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</tbody>
</table>
Chapter One: Florida KidCare 101

Florida KidCare History

In 1997 President Bill Clinton signed into law the State Children’s Health Insurance Program. Otherwise known as SCHIP, or Title XXI of the Social Security Act, this law was intended to encourage states to provide health insurance to uninsured, low income families who were ineligible for Medicaid (Title XIX of the Social Security Act). Under Title XXI, Florida was eligible for up to $220 million dollars of federal funding to help provide health insurance to over 250,000 uninsured and potentially eligible Florida children (2). To qualify for federal funds available through SCHIP, Florida had the option to expand their current Medicaid programs, create a separate insurance program, or to use a hybrid of both SCHIP implementation strategies. In 1998, the Florida Legislature implemented a hybrid SHIP program with the passage of the Florida KidCare Act.

Medicaid was available to some persons in extremely poor families, and families with substantially higher income purchased individual private insurance, but the “working poor” often were left with no affordable insurance option. These “working poor” are the largest number of uninsured in our country representing 38% of children who are uninsured (20). National implementation of SCHIP forced states to acknowledge the otherwise underserved “working poor” families ineligible for Medicaid, but by 1998 Florida had already been providing affordable health insurance for these families for nearly six years. Inspired by a revolutionary idea published by Dr. Steve Freedman in the New England Journal of Medicine, Florida created the Florida Healthy Kids Corporation (FHKC) in 1990, a private non-for-profit company which provided low income families health insurance (19). The uniqueness of FHKC was that it created insurance specific to children’s needs, using enrollment in public schools as the insurance grouping mechanism. Determined by the child’s eligibility for free/reduced lunch through the National School Lunch Program (NSLP) premiums were free, reduced, or the family could “buy in” to the program. Prices for FHKC families varied by county, but all participating counties used the NSLP income level requirement of 185% of the Federal Poverty Level (FPL) for subsidy eligibility. By using the traditional employee sponsored health insurance model, and defining the “employee” as a currently enrolled student in public school, Florida Healthy Kids used
schools as a grouping mechanism to negotiate coverage with health maintenance organizations.

Within the first two years of the program, Florida Healthy Kids made an important observation about the cost of children’s health care. Through the meticulous data collection and analysis implemented to provide law makers evidence to support the program, it was discovered that school age children do not utilize the types of high cost benefits which traditionally drive up the cost of premiums. This information gave FHKC the leverage they needed to negotiate lower premiums without the exclusion of benefits (2).

When FHKC was implemented in 1990, 27.7% (2) of Florida’s children were without health insurance. By 1998 FHKC had over 50,000 enrollees, and the percentage of uninsured children in Florida had dropped to 22.8% (2, 11). The FHKC experiment proved that a state sponsored children’s health care program could provide comprehensive benefits at a nominal cost to the family while remaining financially viable. Their success poised Florida Healthy Kids Corporation as a national model, and supported national children’s health reform which eventually evolved FHKC into the SCHIP program: Florida KidCare.

Federal Implementation and State CHIP Legislation

Reform of the original FHKC model first came during implementation of SCHIP, which expanded the program beyond schools and created the umbrella organization: Florida KidCare (FKC). FHKC became one of the four FKC programs offered to Florida families in addition to a Medicaid expansion program and the creation of the Medicaid look-alike program Medikids. The original FHKC model relied on the already established National School Lunch Program’s (NSLP) income requirements for free and reduced lunches to determine eligibility for subsidized coverage. The income cut off for NSLP was 185% of the Federal Poverty Level (FPL) for lunch assistance, and also 185% was the income limit for FHKC subsidized premiums. Newly enacted SCHIP laws required that the subsidy income limit be raised to 200% of the FPL, removing simple verification of income eligibility through data matching with NSLP information (2). Also, Title XIX created federally mandated limitations were put on family contribution amounts. Before national SCHIP implementation the family contributions to premiums that FHKC allowed ranged from $5-$30 depending on the county, and after SCHIP these were set to $10 or $15 per family per month depending on program eligibility(9). In addition to these changes, federal SCHIP also brought in new federal benefit requirements that improved the services offered by FHKC and lowered some co-payment amounts(2).

Both Title XIX Medicaid and Title XXI SCHIP programs are overseen at the federal level by the Center for Medicaid and Medicare Services. Unlike Title XIX funded Medicaid entitlement programs, which are federally mandated to provide specific services to children within specified
income and age requirements to qualify for federal funding, Title XXI programs provide states with more flexibility by allowing each state to determine which services, and at what income and age requirements, their SCHIP programs would offer(4). Florida KidCare is governed by Florida State Legislature, whose ability to regulate the administration of FKC has led to several notable FKC policy changes since its implementation.

Beginning with SCHIP implementation Florida’s Legislature created policy to contain costs and also to discourage “crowd out”, which is the enrollment of children who would otherwise be eligible for insurance through their parent’s employer sponsored coverage. In 1998, these limitations included capping the number of children who “buy in” at the full cost of the premium to 10% of total Title XXI funded enrollments, and placing a mandatory 60-day waiting period for families who are canceled from FKC due to non-payment or non-renewal. Aside from the provisions targeted at non-compliant accounts and the “crowd out” phenomenon, open enrollment in FKC programs allowed enrollment to steadily increase between the launch of Florida KidCare in July 1999 and July 2003. In the first year alone the number of children covered under one of FKC programs grew by over 100,000 enrollees and by October 2003 Title XXI funded enrollment was over 320,000(11, 4).

Overwhelmed by the success of FKC and the lack of legislative funds, in July 2003 the program enacted a wait list for Title XXI eligible enrollments, which grew during FY 03/04. Also, 2003 saw the cut of all federal and state funding for FKC outreach, as well as a raise in premiums and out of pocket co-pays (14). The waitlist continued without enrollment until April 2004. Shortly after children began to be enrolled from the waitlist, FKC not only rebounded to the enrollment levels seen in July 2003 when the wait list was enacted, but exceeded them. By July 2004, FKC Title XXI enrollment was at a record high of 336,689 when open enrollment periods were announced. While the creation of two optional open enrollment periods for the state eliminated the creation of any future wait lists, the limits placed on when families could enroll caused FKC Title XXI enrollments to plummet. In the months leading up to the first open enrollment period in January 2005, disenrollment due to renewal non-compliance and unpaid premiums drove FKC Title XXI enrollment down to 252,209. Since the turbulent years of FKC in 2003-2005, when many families lost coverage and were confused by successive legislative program changes, enrollment in FKC programs has never fully recovered (4). Even after continuous enrollment was reinstated in July 2005, and the return of marketing/outreach efforts in 2006, many families who have had negative interactions with FKC remain reluctant to once again navigate the program.

In 2009 the Florida Legislature made great strides in easing the application for FKC. They reduced mandatory minimum waiting periods due to non-payment from 60 to 30 days, created “Good Cause” exemptions so eligible children who voluntarily canceled coverage no longer
have to wait the 60 day mandatory waiting period, and streamlined the application process. Efforts to simply the application process have been made since THKC first began providing health insurance for children, in an attempt to create a “no wrong door” application. This means that a family who applies for health insurance with the State of Florida would be determined eligible for, and be enrolled in, the appropriate program based on age and income regardless of where the family initiated the application process. Florida KidCare applicants determined eligible for Title XIX Medicaid would (given the 2009 streamlining and subsequent efforts) be transferred to Medicaid for determination of benefits, just as applications who began the traditional Medicaid application but determined ineligible would be transferred to Florida KidCare for Title XXI eligibility determination. This process assures that a family is connected to the health insurance that they qualify for without having to make multiple applications to various agencies. The provision which allowed Title XXI and Title XIX children’s health insurance agencies to exchange information, allowing there to be “no wrong door”, resulted in over 5 thousand FKC enrollees in 2009 that were dropped from Medicaid and otherwise would not have been reenrolled in the appropriate SCHIP program (3).

Currently the 2011 Florida Legislative session is considering SB 406/HB 245, proposed by Senator Sobel and Representative Logan respectively, which includes language allowing school districts the option of remarriying the school districts and FKC. Through the proposed legislation Florida KidCare materials could be distributed through school districts, the NSLP can be modified to include language about FKC, and school districts would have the option to use currently housed school district information towards enrollment in FKC. The legislation has passed the Health Regulation’s Committee favorably, and as of March 2011 was next being heard by the Committee on Education PreK-12.

Federal CHIP Reauthorization and Health Reform

By 2007 almost 28% of children in the United States, nearly 21.7 million children, received their health insurance through traditional Title XIX Medicaid and Title XXI SCHIP coverage (15), with over 64% of the remaining nearly 9 million uninsured children eligible but not yet enrolled in either Medicaid or SCHIP (16). The success and continued need for SCHIP demanded that efforts be continued past the ten year time period of the original SCHIP legislation. However, the program cost the federal government over $48 billion dollars and was unable to gain reauthorization under President George W Bush, who in 2007 vetoed congresses’ attempts to reauthorize CHIP twice (2). Eventually in December 2007 President Bush did grant an extension to SCHIP, but simultaneously curtailed the flexibility for states to provide coverage to children over 250% of the FPL (5).

In February 2009, under the Obama administration, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) was passed strengthening and extended SCHIP through 2013. Not
only did CHIPRA give back the flexibility relinquished during the 2007 Bush administration SCHIP extension, but it also provided for new state opportunities to extend eligibility (12). Under CHIPRA states could extend coverage to illegal immigrant children and pregnant women before the traditional 5 year waiting period, and offer new options to state employees (12, 10). In every legislative session since the implementation of CHIPRA, Florida State Senator Rich has attempted to have these eligibility extensions implemented in Florida. However, he has been unsuccessful due to the cost of implementing the provisions and a particularly tight legislative budget (17). Also, CHIPRA added new citizenship and identity requirements, as well as direct citizenship verification through the Social Security Administration (SSA) (10). As of January 2011, Florida has not elected to utilize direct citizenship verification through the SSA (13), despite a reported 94% match rate in states currently utilizing the option (1).

In addition to extending eligibility, CHIPRA provides multiple funding opportunities for the improvement of children’s access to quality, affordable healthcare. The legislation allows for Medicaid “bonus payments” for states who implement “5-of-8” eligibility simplification efforts. These eight targeted simplification measures serve as an example of how the Obama administration views the future of CHIPRA applications. Florida fell short of reaching at least five of the required federal bonus targets (see the comparison below).

<table>
<thead>
<tr>
<th>Simplification Measure</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint application for Children’s Medicaid and CHIP</td>
<td>Yes for joint application</td>
</tr>
<tr>
<td>Same correspondence to request information</td>
<td>No for same correspondence</td>
</tr>
<tr>
<td>No asset test</td>
<td>Eliminated for Children’s Medicaid and CHIP</td>
</tr>
<tr>
<td>No in-person interviews</td>
<td>Eliminated for Children’s Medicaid and CHIP</td>
</tr>
<tr>
<td>Streamlined renewal</td>
<td>Yes for children’s Medicaid</td>
</tr>
<tr>
<td>Simplification in progress for CHIP (electronic verification of income)</td>
<td></td>
</tr>
<tr>
<td>Express Lane Eligibility</td>
<td>No. Florida implemented a simplified transition process for children transitioning from Title XIX to Title XXI eligibility</td>
</tr>
<tr>
<td>12-months of continuous eligibility for coverage</td>
<td>12 months for CHIP</td>
</tr>
<tr>
<td>12 months for Medicaid ages 0-5</td>
<td></td>
</tr>
<tr>
<td>6 months for Medicaid ages 6-18</td>
<td></td>
</tr>
<tr>
<td>Presumptive eligibility</td>
<td>No</td>
</tr>
</tbody>
</table>
Also, $100 million dollars of federal grants was created to be distributed through 2013 to facilitate SCHIP outreach, with $10 million being allocated for a national CHIPRA outreach campaign, and $10 million designated for Native American outreach efforts (12). A contingency fund was also created under CHIPRA to help states cope with the cost of insuring low income families if enrollment numbers exceeded state allotments, protecting against a repeat of 2003’s FKC wait list. Coupled with the expanded funding and bonus payments, CHIPRA also required benefit improvements, as well as 24 quality improvement measures, and included $225 million dollars to aid in the improvements. Under the new law mental and substance abuse benefits were required of all SCHIP programs, as well as dental benefits (1).

After the passage of CHIPRA in 2009, another success for children’s health came in March 2010 with the passage President Obama’s comprehensive health reform, the Patient Protection and Affordable Care Act, as well as The Health Care and Education Affordability Act. Collectively, this legislation provided CHIP with two additional years of funding, as well as the authority to continue Medicaid and CHIP eligibility standards until 2019. While expanding national Medicaid eligibility to 133% of the FPL, removing life time limits, and restricting annual limits on benefits, national health reform also removed the ability to deny child coverage due to pre-existing conditions, and eliminated cost sharing on preventative treatments. In addition to these changes and many other, the law also required that insurer’s dependent care coverage be extended to young adults under age 26. These immediate reforms secured coverage and quality access for vulnerable children populations, and set the stage for broader implementation scheduled for 2014. It is important to note however that these reforms to not apply universally to all types of health care plans. Some preexisting plans are eligible to be “grandfathered in” while some provisions apply only to group and/or single plans (7).

Federal reform called for state-based Health Benefit Exchanges, which would provide subsidies for individuals who make between 134-400% of the Federal Poverty Level. In the upcoming years, as reform mandated exchanges are implemented in Florida, it will be possible to evaluate the exchange’s effectiveness of bringing affordable, quality health care to children (10).
Figure 3: Florida KidCare Eligibility Title XXI Enrollment and Major Program Changes (4)
Programs, Eligibility, and Cost

Today Florida KidCare (FKC) serves Florida’s children under age 19 through five programs administered by three state agencies and one non-profit corporation, each having their own unique income and age requirements. All programs are overseen federally by the Center for Medicaid and Medicare Services with their own respective administrative agencies at the state level. A child’s eligibility for the various FKC programs is determined by their family size and income level, which is expressed as a percentage of the Federal Poverty Level, and the child’s age.

A product of determining eligibility for FKC programs based on age is that families with multiple children, and the same family income level, often find that each child is determined eligible for a different FKC program. In addition to each child navigating different insurance policies, the different programs utilize their own providers and so it is possible that the family is not able to have all children with the same primary care provider. However, FKC programs each provide parents with the opportunity to select their own providers from those offered under the respective plans. Therefore, a parent with children under different FKC plans can attempt to determine a provider participating in multiple FKC programs. Each FKC program has different protocols for when parents can select and/or change providers.

The five programs that comprise Florida KidCare are:

- **Medicaid for Children**: serving children from birth until the age of 19 who qualify for Medicaid. The income requirement for Medicaid for Children changes depending on the age of the children. As of January 2011, for a child to qualify for this program the income requirements are:


<table>
<thead>
<tr>
<th>Persons in Family or Household</th>
<th>100% of FPL</th>
<th>133% of FPL</th>
<th>200% of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly</td>
<td>Annual</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Income</td>
<td>Income</td>
<td>Income</td>
</tr>
<tr>
<td>1</td>
<td>$903</td>
<td>$10,830</td>
<td>$1,200</td>
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<td>2</td>
<td>$1,214</td>
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<td>$1,526</td>
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<td>4</td>
<td>$1,838</td>
<td>$22,050</td>
<td>$2,444</td>
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<tr>
<td>5</td>
<td>$2,149</td>
<td>$25,790</td>
<td>$2,858</td>
</tr>
<tr>
<td>6</td>
<td>$2,461</td>
<td>$29,530</td>
<td>$3,273</td>
</tr>
<tr>
<td>7</td>
<td>$2,773</td>
<td>$33,270</td>
<td>$3,687</td>
</tr>
<tr>
<td>8</td>
<td>$3,084</td>
<td>$37,010</td>
<td>$4,102</td>
</tr>
</tbody>
</table>
Under 185% FPL for ages birth to one
- Under 133% FPL for ages one to six
- Under 100% FPL for ages six to 19

Funding for this program comes from Title XIX of the Social Security Act, and it is administered by the Florida Agency for Health Care Administration (AHCA) (9).

- **Medicaid for Children Under One**: serving children under the age of one whose families make 186-200% of the FPL, and are otherwise ineligible for Medicaid. This is a Title XXI funded Medicaid expansion program which does not require family contributions and is administered by AHCA (9).

- **Medikids**: serving children ages one through five whose families make 134-200% of the FPL and are not Medicaid eligible. This is a Title XXI funded program administered by AHCA which uses Medicaid providers, and requires family contribution for coverage (9).

- **Children’s Medical Services Network (CMS)**: serving children with special medical and behavioral health needs from birth through age 19 whose families make up to 200% of the FPL. Funded by Title XIX, Title XXI, and a state safety net component, CMS is administered by the Department of Health. Depending on the income of the family they may or may not be required to pay a monthly premium (9). A small component of CMS is the Behavioral Health Network (B-Net), which provides health care for children with serious emotional disturbances using Medicaid providers (4).

- **Healthy Kids**: serving children from ages six to 19 whose families make from 101-200% FPL (4). This is a Title XXI funded program administered by the non-profit corporation Florida Health Kids Corporation (FHKC), and requires a monthly premium (9).

Which FKC program a child is eligible for determines if the child can receive subsidized coverage in the form of a waivered or reduced premium. Title XIX funded programs, such as Medicaid and eligible CMS enrollees; provide entire premium subsidies and families are not required to make any contribution.

Title XXI funded programs, such as Medikids, Healthy Kids, and part of CMS offer partially subsidized premiums but require family contributions which vary dependent on the family’s size and income. Title XXI subsidy eligible families making at or below 150% of the FPL pay $15 per month per family while Title XXI subsidy eligible families making from 151-200% of the FPL pay $20 per month. It is important to note that these Title XXI Florida KidCare subsidized premiums are per month, per family. A family with one child who receives subsidized coverage through Florida KidCare pays the same amount as a family with seven children.

Also, for a child to qualify for subsidized Florida KidCare Title XXI programs they must:

- Be under age 19
• Be uninsured
• Be a US citizen or a qualified non-citizen
• Not be in a public institution or in an institution for mental diseases
• Not be eligible for Medicaid
• Not be the dependent of a public employee eligible for federal or state health benefits
• Have a family income at or below 200% of the FPL

Unlike subsidized Title XXI FKC, Title XIX Medicaid allows for the child to have prior insurance, be in a public/mental institution, or a dependent of a public employee and still be eligible for Medicaid for Children. Insured children who do not qualify for Medicaid must voluntarily cancel their insurance and wait a mandatory 60-day waiting period before they become eligible for subsidized FKC Title XXI funded programs such as Healthy Kids and Medikids.

In 2009 the State of Florida passed legislation which allowed for Title XXI Florida KidCare subsidized coverage to be granted to insured children before the mandatory 60-day wait period if they qualified under any of nine “Good Cause” exemptions. Under these exemptions the child is immediately eligible for Title XXI FKC coverage if:

• The cost of the child’s participation in the family member’s health insurance benefit plan is greater than 5% of the family’s income
• The parent lost a job that provided an employer sponsored health benefit plan for children
• The death of a parent who had health insurance benefits coverage for the child
• The child has a medical condition that without medical care would cause serious disability, loss of function, or death
• The parent’s employer canceled health benefits coverage for children
• The child’s health benefits coverage ended because the child reached the maximum lifetime coverage amount
• The child has exhausted coverage under a COBRA continuation provision
• The health benefits coverage does not cover the child’s health care needs
• Domestic violence led to loss of coverage
Once a family earns over 200% of the FPL, relative to their size, they are no longer eligible for any Title XIX or Title XXI subsidized health insurance. For children over the age of one whose family income is over 200% of the FPL, Healthy Kids and Medikids offers ‘Full Pay’ coverage. This option requires that parents pay the full cost of the premium, without any federal or state subsidies. The cost per child for full pay, including dental coverage, is $133 for Healthy Kids and $153 for Medikids. While the full pay option is per child it provides Florida families with an affordable option to private health insurance. Also, unlike traditional insurance the Full Pay Medikids and Healthy Kids option has no deductible or lifetime benefit limits, includes prescription coverage, and has minimal out of pocket co-pays. At this time Children’s Medical Services Network and Medicaid for Children Under One do not offer a ‘Full Pay’ option.

An important advantage of the ‘Full Pay’ option is that for families paying the full cost of insurance premiums, without state or federal funding, many if not all previously discussed eligibility requirements no longer apply. It provides a valuable resource for undocumented children, and dependents of state employees who are ineligible for Title XXI benefits. Also an important aspect of the ‘Full Pay’ program is that it offers the same coverage for subsidized
counter parts in the same program. ‘Buying in’ to the program does not change services, and
providers are not able to tell subsidized from non-subsidized patients. Once a child is
determined eligible for FKC coverage they are then eligible for a myriad of benefits offered by
the individually contracted participating insurance providers. Medikids, CMS, B-Net and
Medicaid enrollees receive the Medicaid benefit package utilizing Medicaid contracted health
maintenance organizations (4).

Administration and the Application Process

Before discussing the application process it is important to understand the roles of all agencies
involved. As stated previously, the Center for Medicaid and Medicare Services oversees all Title
XXI and Title XIX programs. In the state of Florida the lead agency facilitating reporting,
compliance with federal regulations and distribution of federal funds to the various FKC
programs is the Agency for Health Care Administration (AHCA). All subsequent agencies operate
through their own computer networks, contracting with their respective program’s health
providers and/or health plans, as well as responding to KidCare complaints. Under the
leadership of the Governor the following state agencies operate:

- Agency for Health Care Administration (AHCA).
  o Facilitates all federal Title XXI and Title XIX activities, including distribution of
    federal funds to various FKC programs
  o Administers the Medicaid as well as Medikids program
  o Manages the contract with FHKC.
- Department of Children and Families (DCF)
  o Administers B-Net program
  o Determines eligibility for Medicaid, referring ineligible to FHKC
  o Transfers newly ineligible Medicaid enrollees to FHKC
- Department of Health (DOH)
  o Administers CMS and determines clinical eligibility
  o Chairs the KidCare Coordinating Council and prepares Annual Reporting

Operating under the leadership of the Chief Financial Officer of Florida the non-for-profit
private corporation Florida Healthy Kids Corporation serves the following functions:

- Administers Healthy Kids as well as Florida KidCare marketing and outreach
- Receives and processes applications
- Screens applications for Medicaid and when appropriate refers to DCF
- Determines Title XXI and Title XIX funding for FKC components
- Manages third party administrator and KidCare call centers (4)
Florida provides families with a “No Wrong Door” application strategy in alignment with not only current CHIPRA expectations, but also the mission that Florida Health Kids Corporation began with. If an application is too complicated, leaving too many cracks for families to fall through, they will not result in successful completions, and eventual enrollments in FKC programs. Beginning in 1997 with the implementation of CHIP, the application was streamlined to allow screening and enrollment for all programs to originate from one Florida KidCare application. However, if a family began with the traditional application to Medicaid, data transfer between DCF and Florida KidCare insures that all families reach the program they are eligible for.

Currently families are encouraged to complete the online application at FloridaKidCare.org. While paper applications are still available for families to complete, it is recommended to complete the online application as it faster and more reliable. Upon the submission of an application, the case is not complete until all supporting documents are received. A family is given written notification of any outstanding requests for documentation and has 120 day (except for Medicaid) to complete the application. If a family does not complete the application within the 120 day period, the application must be reactivated and any supporting documents must be resubmitted. The documents request not only income information for all members of the household, but also citizenship and identity verification to be considered for Title XXI or Title XIX subsidized programs. If a Social Security Number is provided, electronic verification of income may be possible. For the fastest eligibility determination it is recommended to submit all income verification as, well as citizen and identity verification, at the time of application submission.

Once families are determined eligible for a program they are provided information concerning the specific programs procedure for enrolling, including the selection of health plans and providers. After enrolling in a program, families are required to complete renewal application every twelve months to maintain continuance coverage (18).
Figure 4: Florida KidCare Application Eligibility Determination

Source: Florida Healthy Kids Corporation (2010)
Chapter Two: Florida KidCare Statewide Outreach

History of Florida KidCare Statewide Outreach

Florida KidCare (FKC) offers a valuable product for the children of Florida, but if families and caregivers are not aware of the service FKC provides, children will remain without access to quality healthcare even when it is available to them at little to no cost. Outreach to families about the Florida KidCare program was always essential to its success. While Chapter One addressed the many various components of FKC, and the many agencies it comprises, successful FKC messaging informs families that there is one program connecting Florida’s children to health insurance: Florida KidCare.

Upon implementation of SCHIP in 1998, Florida KidCare outreach coordination and administration became a required function of the Department of Health (DOH). During FFY 98/99, the first year of outreach funding, $7 million dollars was allocated to DOH which grew to its largest budget in FFY 00/01 of $9.8 million dollars. While some of the funds came from Florida’s general revenue, FKC outreach funds were largely supplemented by non-recurring Title XXI, Title XIX, and Tobacco settlement funds. Outreach funding shrank by several million dollars in the subsequent years until it was completely withdrawn in 2003, and finally in 2004 the Florida Statute requiring that the DOH provides FKC outreach was eliminated. The Florida Healthy Kids Corporation (FHKC) assumed the role of FKC outreach coordinator and administrator, and was budgeted $1 million dollars in non-recurring funds for FFY 05/06 through FFY 07/08. Since FFY 07/08, the State of Florida has not appropriated any funds specifically for FKC outreach, leaving stakeholders reliant on whatever existing resources are available (11). The state agencies that provide most of the Florida KidCare statewide outreach efforts, as well as substantial support to local outreach organizations, are the Florida Healthy Kids Cooperation (FHKC), The Agency for Health Care Administration (AHCA), The Department of Health (DOH), and The Department of Children and Families (DCF). In addition to these state agencies, the University of South Florida based Florida Covering Kids & Families provides coalition building to Florida KidCare outreach efforts statewide.
Florida Healthy Kids Corporation (FHKC) Statewide Outreach

While all FKC agencies contribute to the promotion of Florida KidCare, the Florida Healthy Kids Corporation is the lead agency administering FKC outreach. FHKC provides a free series of trainings which educate potential outreach staff. The training is comprised of several modules which include an overview of FKC programs, eligibility, and benefits in “Florida KidCare 101”, as well as “HIPAA”, “Citizenship and Identity”, and “The Application Process” training. By providing statewide training FHKC creates a consistent Florida KidCare message, which outreach staff can use as they interact with the community to help eliminate misconceptions about the program due to misinformation. In addition to a training series, which enables outreach staff to become certified FKC “experts”, FHKC requires that all printed FKC materials used for outreach purposes first be approved by FHKC. Consistent marketing of Florida KidCare through printed materials, in addition to the promotional materials which FHKC provides at no cost to local outreach projects, allows for the Florida KidCare brand to remain consistent throughout the entire state (9).

In addition to overseeing the Florida KidCare brand and the training of FKC outreach staff, the Florida Healthy Kids Corporation also supports state wide outreach efforts. While the state still provided $1 million dollars for Florida KidCare outreach annually, FHKC was able to distribute substantial Outreach and Marketing Matching Grants. At the close of the final grant period in 2007, FHKC started the Boots on the Ground (BOTG) Program to help absorb some of the outreach efforts previously conducted by Outreach and Marketing Grantees (12). The program was launched in March 2008 to foster FKC partnerships with organizations and associations already serving populations likely to qualify for Florida KidCare (9). While reaching out to groups already serving FKC targeting populations, FHKC also sought to build BOTG Community Partnerships in areas without any existing FKC outreach. FHKC contracted the Florida Covering Kids & Families Project to provide technical assistance and coalition building to Boots on the Ground partners. FHKC offered various levels of funding for Boots on the Ground initiatives, dependent on the level of commitment partners are able make. During the first two years of operation, BOTG Community Partner membership was constructed as follows:

<table>
<thead>
<tr>
<th>Level of Membership</th>
<th>Funding</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| Level I Basic Membership    | $1,000 quarterly | • Display FKC signage and materials  
• Provide continuous FKC link on partner’s website  
• Provide FKC advertising in newsletters, distribution lists, and other communication to membership, at least once quarterly  
• Promote FKC through local schools and community partners  
• Promote FKC by either hosting or participating in one community event quarterly |

*all partnership receive $200 shipping allowance

Table 4: Florida Healthy Kids Corporation Community Partner Membership (9)
<table>
<thead>
<tr>
<th>Membership Level</th>
<th>Fee</th>
<th>Requirements</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Level II Enhanced | $2,000 quarterly | - Commit to all of Level I Basic Level requirements  
- Have staff who most frequently interact with public complete online-training provided by FHKC  
- Make trained staff available to help families complete the FKC application  
- Provide public online access to the FKC application on the premises and advertise its availability to membership  
- Develop a minimum of 4 FKC partnership with other community partnerships per quarter (9) | - Participate in meeting and conference calls as scheduled (9)  
- Submit report of FKC activities at the end of each quarter (9)  
- Have staff who most frequently interact with public complete online-training provided by FHKC  
- Make trained staff available to help families complete the FKC application  
- Provide public online access to the FKC application on the premises and advertise its availability to membership  
- Develop a minimum of 4 FKC partnership with other community partnerships per quarter (9) |
| Level III Supreme | $3,000 quarterly | - Commit to all of the Basic and Enhanced Level requirements  
- Aid a minimum of 10 families per month with the completion of a FKC application  
- Develop a minimum of 5 FKC partnership with other community partners and one school per quarter  
- Promoted FKC by either hosting or participating in at least 5 community events per quarter (9) | - Participate in meeting and conference calls as scheduled (9)  
- Submit report of FKC activities at the end of each quarter (9)  
- Have staff who most frequently interact with public complete online-training provided by FHKC  
- Make trained staff available to help families complete the FKC application  
- Provide public online access to the FKC application on the premises and advertise its availability to membership  
- Develop a minimum of 4 FKC partnership with other community partnerships per quarter (9) |

During 09/10, BOTG Community Partners reached over 500,000 people who became exposed to Florida KidCare at the over 600 attended community events, and developed 457 partnerships with local business and schools in over 36 counties (6). In 2009, in addition to the BOTG Community Partnerships, FHKC provided three other outreach opportunities including the Application Assistance Project, FKC School Based Projects, as well as PTA/PTO Mini-Grants. Through a competitive application, FHKC identified four urban and rural sites to participate in the Application Assistance Project. These partners were tasked with assisting parents applying to FKC, and providing follow up to ensure successful completion of the application. Sites participating in this project received $50 for every successfully completed application (9). Also, FHKC in collaboration with Florida Covering Kids & Families Project identified Leon County Schools and the Okeechobee County School District as partners in the FKC School Based Project (2). These school districts were tasked with overseeing application assistance sites, while promoting and distributing FKC information throughout their school district (10, 14). PTA/PTO Mini-Grant partnership allowed Florida’s Parent Teacher Associations (PTA) and Parent Teacher Organizations (PTO) the opportunity to fund Florida KidCare outreach, and gave FHKC the chance to reach an otherwise underserved population through these historically active children’s advocacy groups(9).

In 10/11, the BOTG Community Partnerships program was reorganized, eliminating Level I partnerships and adjusting Level II and Level III responsibilities. Level II partnerships no longer required application assistance, but still are responsible for providing and distributing FKC information, promoting FKC in their areas, participating in local events, and forming community partnerships. Level III partnerships had all of the responsibilities required of the Level II partnerships, and also were required to provide FKC application assistance. The Florida KidCare
School Based Projects expanded, retaining Okeechobee and Leon County School Districts and incorporating both Miami-Dade County Public Schools. Their current goals as FKC School Based Projects are to:

- Display FKC materials
- Assist 10 families applying to FKC per month
- Target hard to reach populations
- Attend five events to promote FKC quarterly
- Reach 100% of the Free and Reduced Meal Program population
- Maintain website banners at school and district websites
- Distribute FKC print and email advertisements
- Provide FKC application access at school
- Reach 100% of families on emergency cards
- Utilize report card messaging
- Target athletic professionals (3)

Also, while the PTA/PTO Mini-Grant Program and Application Assistance Project of 09/10 were not repeated, FHKC implemented the new FKC Matching Grants which require that grantees provide innovative, targeted outreach strategies facilitating FKC enrollment and retention (13). In the first two quarters of 2010 the Boots on the Ground campaign has served over 129,000 individuals at over 500 community events, and provided technical assistance to 618 families applying to Florida KidCare (3).

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Other FKC Outreach Projects*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2008 (12)</td>
<td>11</td>
<td>7</td>
<td>17</td>
<td>16</td>
<td>51</td>
</tr>
<tr>
<td>December 2008 (15)</td>
<td>12</td>
<td>6</td>
<td>16</td>
<td>16</td>
<td>50</td>
</tr>
<tr>
<td>August 2009 (14)</td>
<td>4</td>
<td>8</td>
<td>18</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>July 2010 (9)</td>
<td>7</td>
<td>10</td>
<td>16</td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td>October 2010 (16)</td>
<td>N/A</td>
<td>16</td>
<td>13</td>
<td>2</td>
<td>31</td>
</tr>
<tr>
<td>March 2011 (13)</td>
<td>N/A</td>
<td>14</td>
<td>8</td>
<td>7</td>
<td>29</td>
</tr>
</tbody>
</table>


For community partners unable to commit to a BOTG Community Partnership, FKC School Based Project, or FKC Matching grant, FHKC offers sponsorships for community events. Funding is available to help community partners cover the cost of registration and operation of a Florida KidCare booth at local community events. Seventeen events have been sponsored through this program since July 2009, and FHKC continues to take applications (9).
In addition to providing support for Florida KidCare outreach conducted by Community Partners, the Florida Healthy Kids Corporation sponsors the annual Florida KidCare “Act Out For Health” campaign. Launched in 2008, the competition targets middle school and high school students, who are most likely to be uninsured, and asks them to create a 30 second Public Service Announcement (PSA) or billboard design promoting Florida KidCare. In the spring teachers are provided with designated themes and key facts, as well as messaging and stock photos, to aid student’s design (10). The regional and grand prize winners are announced in January, and the winning PSAs are available online at actout4health.org and YouTube (9). The 09/10 application cycle received 55 PSA entries and 650 billboard designs, which was nearly double the number of entries submitted in the first year of the campaign (10).

**Agency for Health Care Administration (AHCA) Florida KidCare Outreach**

Since 2007, AHCA has contracted the Florida Covering Kids & Families (FL-CKF) Project to build business partnerships, create community based coalitions promoting Florida KidCare, and to provide training and technical assistance to successful outreach strategies. Under AHCA funding the FL-CKF program has been able to distribute over 2,100 FKC applications, and over 20,000 flyers, to community partners since July 2010. Also, the funding allows for the FL-CKF program to provide support to local coalitions (3). AHCA also incorporates the FKC message in presentations, and distributes FKC materials to local area offices as well as health care providers (9).

**Department of Health (DOH) Florida KidCare Outreach**

The DOH operates a distribution center with FKC posters, brochures, bookmarks which are available to Florida KidCare partner agencies free of cost (11). Also, DOH staff maintains FKC information in county health departments, school health programs, Healthy Start facilities, and in presentations to staff. In addition to supplying materials and promoting FKC, the DOH maintains the Florida KidCare website (9).

**Department of Children and Families (DCF) Florida KidCare Outreach**

The DCF provides materials and information about Florida KidCare to their over 30,000 community partner’s locations, which have direct contact with the Medicaid population, and participates in community events (10). Also, families with children that do not qualify for Medicaid are included in a mail out which encourages them to apply to Florida KidCare (9).

**Florida Covering Kids & Families Project (FL-CKF) Florida KidCare Outreach**

The Florida Covering Kids & Families Project, housed in the College of Public Health at the University of South Florida, began in 2002 as a Robert Wood Johnson Foundation initiative to
reduce the number of uninsured children by performing outreach for, and increasing enrollment in, Florida KidCare (9). One of the many functions FL-CKF performs is the coordination of the Florida Covering Kids & Families Coalition. By gathering resources and experience through the collaboration of state agencies, provider groups, advocacy organizations, private health plans, and businesses, the FL-CKF Coalition helps facilitate outreach efforts statewide (8).

Under contract with AHCA, FL-CKF distributes FKC applications and promotional materials to community partners, provides technical support to local coalitions, maintains business partnerships, and shares best practices from across the state. Part of the FL-CKF strategy for sharing best practices is the distribution of Innovations Reports, which highlight outreach strategies and disseminate information. Also, the development of Peer-to-Peer relationships allows coalitions to connect, addressing common barriers they face during local outreach (9).

In the six coalitions that FL-CKF works with to provide both technical and coalition building support, the focus is to ensure that all the community stakeholders are working together efficiently, with the goal of reducing the number of children eligible for FKC, yet uninsured (17, 9). Existing coalitions which receive ongoing technical support, such as Innovation Reports and Peer Matches, but not necessarily coalition building support, include coalitions in:

- Brevard County
- The Heartlands (Glades, Hardee, Hendry, Highlands, and DeSoto)
- Orange and Seminole Counties
- Palm Beach County
- Panhandle Counties (Calhoun, Jackson, Liberty, Washington, and Holmes)
- Paso County
- Pinellas County
- Gadsden County
- And Polk County

By developing the coalition’s existing business relationships, and building state business partnerships throughout Florida, the FL-CKF Project seeks to raise public awareness for Florida KidCare through in-kind advertisement opportunities, business web pages, and in business communications to their customers and employees(7). Currently, for the First Quarter of FFY10/11, FL-CKF has maintained 51 existing business partnerships, while incorporating 44 new business partnerships with such notable businesses as Publix, Children’s Movement of Florida, City of Tampa, and Wal-Mart (3).

Florida Covering Kids & Families is also contracted by Florida Healthy Kids Corporation (FHKC) to help provide technical assistance and guidance for the Boots on the Ground Community
Partners, as well as FKC School Based Projects. FL-CKF assists Boots on the Ground projects by providing templates and tools, answering FKC questions, and assisting partners as they compile Quarterly Reports. In addition to these function, Florida Covering Kids & Families provides valuable feedback back to BOTG Community Partners, and facilitates the sharing of outreach innovations across the state. In FL-CKF’s role as administrator of the FKC School Based Projects, they help provide presentations for school-based outreach, disseminate FKC information through newsletter distributions, and provide outreach materials for school-based entities (9, 5).

Florida CHIPRA Outreach Grantees

In addition to the continuous efforts of various state agencies, The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 provided over $80 million dollars to support state outreach for State Children’s Health Insurance Programs (SCHIP). The outreach efforts conducted under CHIPRA grants, administered by the U.S. Department of Health and Human Services’ Center for Medicaid and Medicare Services, are intended to target eligible but uninsured children, with a particular focus on hard to reach populations (10). The CHIPRA outreach grant opportunities do not require a match, but are not intended to replace traditional state funding for SCHIP outreach. For this reason, it is required that states receiving CHIPRA grant funds must maintain the funding provided to outreach and enrollment strategies in the previous year (19). During the first award cycle over $40 million dollars of federal outreach funding was distributed to 69 grantees in 41 states and D.C. (4). Two CHIPRA grants were awarded to Florida SCHIP outreach programs, Fanm Ayisyen Nan Miyami, Inc. (FANM) and Florida Covering Kids & Families (FL-CKF) (18).

FANM / Haitian Women of Miami, was founded in 1991 in the heart of Little Haiti as an advocacy group for low income Haitian women and families. They were awarded $69,102 dollars to target Haitian communities in the Miami-Dade County area through a partnership with the Jackson Health System and the Department of Children and Families (18).

The Florida Covering Kids & Families Project was awarded $988,177 dollars to conduct statewide outreach for Florida KidCare. FL-CKF, utilizing existing Covering Kids & Families State Coalition resources, works under the CHIPRA grant to increase FKC enrollment and retention using five unique sets of partners: ten local CHIPRA grantee FKC Coalitions, the Florida Association of Children’s Hospitals (FACH), and Human Resource (HR) departments of businesses around the state, as well as the Refugee and Entrant Project, and the ‘Get Covered. Get in the Game. Coaches Campaign’ (7, 18).

The ten local Florida KidCare coalitions funded through the FL-CKF CHIPRA grant conduct outreach and enrollment activates targeting identified hard-to-reach populations of Brevard,
Escambia/Santa Rosa, Lake, Palm Beach, The Panhandle (Holmes, Washington, Jackson, Calhoun, and Liberty), Pasco, Pinellas, and Polk, Seminole/Orange, and St Lucie/Indian River counties. Each coalition partners in strategies specific to their community to provide one-on-one application assistance for families applying to FKC (7). During the first eight months of 2010, the ten coalitions, aided over 1,700 families with application assistance, trained 182 partners, established 23 enrollment sites, and conducted over 70 enrollment events. (4)

Under the CHIPRA grant, FL-CKF is utilizing the unique outreach opportunity presented by Florida’s Children’s Hospitals. By introducing hospital staff to Florida KidCare through ten state wide trainings, and ongoing technical assistance, the project will be able to tap large populations of identified uninsured children, and provide the hospitals with the tools needed to connect eligible families to Florida KidCare. In addition to trainings provided to all Florida’s Children’s Hospitals, FL-CKF will also be administering three application assistance contracts with hospitals demonstrating the highest level of uninsured, FKC eligible families. In addition to providing training and technical assistance to Florida’s Children’s Hospitals, FL-CKF is provided similar services to the HR departments of Florida business statewide. In the first eight months of the HR initiative, FL-CKF has trained 48 representatives of West Palm Beach, Jacksonville, and Tampa Bay communities (7).

The FL-CKF Refugee and Entrant Outreach initiative works closely with five counties of Florida that house the largest Refugee and Entrant populations: Hillsborough, Pinellas, Sarasota, Lee, and Collier Counties (7). During the first eight months of the CHIPRA grant, the Refugee and Entrant outreach efforts reached over 2,000 families through events, mailing, and parent workshops, facilitated by 25 partnerships. Also, the initiative trained 14 staff, and provided 100 families with assistance (4). Also, the ‘Get Covered. Get in the Game. Coaches Campaign’ targets teenage children, who have the highest rates of uninsured, by developing over 75 relationships with athletic professionals and associations, distributing over 7,000 campaign materials, and participating in 15 events statewide (7).

Currently, the second round of CHIPRA outreach funding is being considered, proposals are due April 18, 2011 and awards will be announced in July 2011. Applicants are urged to focus their outreach on:

- Using Technology to Facilitate Enrollment and Renewal
- Focusing on Retention: Keeping Eligible Children Covered for as Long as They Qualify
- Engaging Schools in Outreach, Enrollment and Renewal Activities
- Reaching Out to Groups of Children that are More Likely to Experience Gaps in Coverage
- Ensuring Eligible Teens Are Enrolled and Stay Covered (20)
Organization and Coordination of Statewide FKC Outreach

Four councils/task forces exist which help to coordinate ongoing statewide Florida KidCare outreach, including:

- **The Florida KidCare Coordinating Council**: comprised of child advocates, representatives of health care providers, health insurers, state universities, AHCA, DCF, DOH, the Department of Education, and FHKC.
- **The Florida Covering Kids & Families Coalition**: composed of child advocates and representatives of health care providers, health insurers, state universities, AHCA, DCF, DOH, the Department of Education, and the FHKC.
- **The KidCare Outreach Team**: comprised of executive agencies, representatives of AHCA, DCF, DOH, the Department of Education, FHKC, the Agency for Workforce Innovation, Covering Kids and Families, and Volunteer Florida.

Participation in these efforts does not supplant individual agency outreach, but instead encourages communication, and collaboration between stakeholders. In addition to the councils and task forces, the Florida Healthy Kids Corporation maintains a Florida KidCare community events calendar on its website. This allows outreach partners across the state to share events, while also providing convenient tracking of statewide outreach efforts.

The Florida KidCare Coordinating Council was created by the Florida Legislature to make recommendations to the Governor, Florida Legislature, and Congressional Delegates concerning the operation and implementation of Florida KidCare. Annually, the FKC Coordinating Council prepares an influential report reviewing program organization, eligibility, and benefits, enrollment trends, outreach efforts and program suggestions for upcoming legislative session. This report is made available to Florida law makers, who then can incorporate the suggestions of the FKC Coordinating Council as they analyze FKC related legislation.

As previously discussed, Florida Covering Kids & Families administers not only the FL-CKF Coalition, but also AHCA contracted coalition building and support, and Florida Healthy Kids Corporation contracted Boot on the Ground and FKC School Based Projects. In this role FL-CKF serves as a coordinator of FKC outreach statewide, providing enrollment trends and strategies for many local outreach efforts. Several examples of ways that FL-CKF disseminates information are the distribution of Innovation Reports, and coordination of Coalition Meetings, Peer Matching, and conference calls.

In conjunction with the oversight provided by FL-CKF, the KidCare Outreach Team provides an opportunity for state stakeholders collaborate together specifically on FKC outreach. In 2007, the task force was created by the Executive Office of the Governor, to help leverage resources.
and develop successful outreach strategies (11). The best example of coordinated, state wide outreach facilitated by the FKC Outreach Team is the success of Florida KidCare’s Back-to-School Campaign. A grassroots Back-to-School campaign which began in 2007 takes place annually from July 1 through September 30th. It relies heavily on existing resources that the more than 20 partner agencies participating in the KidCare Outreach Team leverage to promote Florida KidCare. By coordinating outreach efforts and collectively utilizing the ability of schools to help us reach the FKC targeted populations, enrollment continues to be its highest in the fall as a result of the Back-to-School Campaign (10).

The 2010 Back-to-School Campaign saw Florida KidCare outreach expand beyond existent FKC partnerships, with over 3 million applications distributed through state school systems, and over two million Florida KidCare post cards distributed to both school sites and VPK providers (1). In addition to material distribution, over 336 community events and health fairs participated in promoting Florida KidCare (3). The number of applications made to FKC can be used as an indicator of success for the 2010 Back-2-School FKC outreach efforts, which showed an average of 2,000 additional applications per month during the campaign (1).
Chapter Three: Hillsborough County Florida KidCare Outreach

- DOH: Department of Health
- CHIPRA: Children’s Health Insurance Program Reauthorization Act
- FERPA: Family Educational Rights Protection Act
- FKC: Florida KidCare
- FKOP: Florida KidCare Outreach Project
- FK-CKF: Florida Covering Kids & Families
- FPL: Federal Poverty Line
- FHKC: Florida Health Kids Corporation
- HCHSS: Hillsborough County Health and Social Services
- HCPS: Hillsborough County Public Schools
- HCSB: Hillsborough County School Board
- HIPAA: Health Information Portability and Accountability Act
- MA: Medical Assistant
- SCHIP: State Children’s Health Insurance Program
- SJCAC: St. Joseph’s Child Advocacy Center
- TKHF: The Kids Healthcare Foundation

History of Florida KidCare Outreach in Hillsborough County

Hillsborough County began its initial Florida KidCare outreach under the guidance of the Department of Health (DOH) contract with Hillsborough County Health and Social Services (HCHSS). Hillsborough County, then home to an estimated 79,100 uninsured children (20), 72% of which would be eligible for free or subsidized Florida KidCare (FKC) coverage (19), had an initial FKC outreach budget of $89,078. HCHSS used the funds to employee two full time staff who attending community events, educated community leaders, and distributed applications and promotional materials (2). From the beginning of FKC local match requirements, until the 2008 elimination of local match by the Florida Legislature, HCHSS supported Hillsborough County Florida KidCare with over $1.2 million dollars of Match Funding (3). Since the elimination of legislation both requiring the DOH to conduct FKC Outreach and requiring FKC local match, HCHSS has continued to support FKC in Hillsborough County by providing information at their service centers, and websites.

In the absence of DOH’s leadership as FKC outreach coordinator in Hillsborough County, several local organizations have worked under the Florida Healthy Kids Corporation’s Outreach and Marketing Grants, funded under state general appropriations from FFY 05/06 through FFY 07/08. Hillsborough county organizations working to promote Florida KidCare have worked together on these initiatives to leverage resources and expand their impact in the community.

During FFY06/07 St. Joseph’s Children’s Hospital Child Advocacy Center (SJCAC) partnered with The Kids Healthcare Foundation (TKHF), as well as Florida Covering Kids & Families (FL-CKF), to implement a community based, innovative strategy focused on increasing awareness and enrollment in the non-Medicaid component of the Florida KidCare program. This marked the
beginning of partnerships which would provide the foundation for Hillsborough County Florida KidCare outreach leadership.

St. Joseph’s Children’s Hospital Child Advocacy Center (SJCAC) educates the community about preventative children’s health, and serves as the lead agency for FKC outreach in Hillsborough County. SJCAC’s parent organization, St. Joseph’s Children’s Hospital of Tampa, is Tampa’s first dedicated children’s hospital. The 174-bed facility meets the unique needs of children and their families, providing high-tech care in a family friendly environment. St. Joseph’s Children’s Hospital has a long history of advocating for the preventive and primary care of the children of Tampa, and is a charter member of the Kids Health Care Foundation (5).

The Kid's Healthcare Foundation, Inc. (TKHF) was established in 1998, to improve the health of children in Hillsborough County by increasing their access to quality health care. The Foundation membership organizations are involved in providing health and social services to children throughout the Tampa Bay area. The original role of the TKHF was to act as the Hillsborough County point of contact for the Florida Healthy Kids Corporation, the state’s precursor organization to Florida KidCare. In the early years, TKHF organized community efforts to provide the local match for state-subsidized insurance for low-income children. In collaboration with SJCAC, TKHF has focused its efforts on finding and enrolling children eligible for KidCare (3).

SJCAC and TKHF collaborated with the University of South Florida’s Covering Kids & Families Project (FL-CKF), which began in 2002 as a Robert Wood Johnson Foundation initiative to reduce the number of uninsured children by performing outreach for, and increasing enrollment in, Florida KidCare. Together these partners formed a highly successfully pilot program that increased awareness of Florida KidCare in Hillsborough County. Serving as fiscal and administrative agent for the project, St. Joseph’s Children’s Hospital subcontracted with TKHF to mobilize its member organizations to establish enrollment sites and conduct the outreach/marketing activities. Customized training for community based outreach and marketing teams, including the production and dissemination of the Florida Healthy Kids marketing tools, and program performance tracking tools will be provided by the FL-CKF (5).

During the project, 67 enrollment sites were established within existing community organizations (clinics, managed care plans, civic associations) to offer applications and assistance to families. Materials developed in partnership with FL-CKF were used to train individuals from these community organizations, to serve as resource persons for families in the community and disseminate outreach and marketing materials. In addition to training staff of community organizations, the partnership recruited and trained 15 Parent Ambassadors. Parent Ambassadors contributed over 400 hours, participating by disseminating accurate information
about Florida KidCare, referring parents to enrollment sites, and assisting parents at enrollment sites and community events. They were compensated for their time with gift cards (7).

Using the Train-the-Trainer model, which educated key members of existing community organizations working with Florida KidCare eligible populations, the project initially trained 55 people. Those 55 trained outreach staff then trained an additional 123 people to conduct FKC outreach and marketing activities, with a total of 178 people trained in Hillsborough County from over 28 partner organizations (6). These trained FKC ‘experts’ then participated in over 210 community events completing 623 applications, and assisted in disseminated more than 26,000 FKC applications, and 10,000 FKC promotional materials county wide (5). Funded by the Florida Healthy Kids Corporation (FHKC) and the Children’s Board of Hillsborough County, the partnership’s success provided a model for successful Florida KidCare outreach, emphasizing the need for coordination between the stakeholders of a community, and the high yield impact of training key members of community organizations working with FKC populations. During this time period, SJCAC also participated in a Back-to-School Mini-Grant funded by FKHC which enabled Florida KidCare outreach in seven events reaching nearly 17,000 people (9). Overall, during the project Hillsborough County applications to Florida KidCare increased by 19% and enrollment by 14% (6).

The success of the SJCAC/TKHF/CF-CKF Florida KidCare outreach project was so impressive that the Hillsborough County Board of Commissioners agreed to match the FHKC grant for FFY 07/08. The successful strategies from the first year were replicated again during the pilot’s second year, with an emphasis of maintaining current community partnerships and developing new ones. To achieve this goal the project held a Kickoff Event in November 2007, inviting both current partners as well as unaffiliated community stakeholders, allowing them to gather for additional training and to publicly acknowledge partner’s contributions to the project’s success. At this event roll was taken, and organizations which attended but where not currently partners were invited to join the project (7). Also, during year two the project continued to recruit and train not only new Parent Ambassadors, but also newly funded program staff positions (7). The project was also associated with a FHKC Mini-Grant, which SJCAC obtained to assist in Head Start Round Up Florida KidCare outreach, which reached approximately 500 families (8).

Once again the outreach project was highly effective, exceeding their grant deliverables with over 266 community events attend by over 70 trained Florida KidCare outreach workers, nearly 15,000 FKC applications distributed, and 65 online applications completed with families (10, 4).

**The Children’s Healthcare Access Initiative**

With the success of Florida KidCare outreach efforts in Hillsborough County made evident during 2006-08, The Kids Healthcare Foundation (TKHF) sought out additional funding to
continue their goal of providing children with access to quality health care. Allegany Franciscan Ministries awarded TKHF a grant for $397,000 based on their Children’s Healthcare Access Initiative proposal, starting December 2008 and ending November, 2011. The grant not only supported the successful outreach with St. Joseph’s Children’s Hospital’s Child Advocacy Center (SJCAC), but aimed to demonstrate the potential of large organizations implementing system wide enrollment of eligible children into Florida KidCare. The primary partners representing large organizations, with potential to create mass enrollments, were the Bay Care Health Network and Hillsborough County Public Schools (HCPS). In addition to increased number of children enrolled in FKC, the initiative wanted to track the access that children had to healthcare after enrollment in one of FKC’s insurance programs by developing a “passport”. This “passport” would allow for analysis of access to care across FKC programs, in addition to providing a tool to measure the quality of care children receive. Lastly, the Children’s Healthcare Access Initiative sought to answer the pivotal question posed by those seeking to enroll children in FKC: where are the uninsured children of Hillsborough County, and where are the uninsured children of Hillsborough County who are eligible for subsidized Florida KidCare?

Two projects worked to provide Hillsborough County Florida KidCare outreach under the Children’s HealthCare Access Initiative, SJCAC’S Hillsborough County Florida KidCare Outreach Project and HCPS’s Hillsborough Healthy Students (3).

Hillsborough County Florida KidCare Outreach Project (FKOP)

The Kids Healthcare Foundation (TKHF) has contracted with St. Joseph’s Children’s Hospital’s Child Advocacy Center (SJCAC), a partner in the Children’s Healthcare Access Initiative, to achieve the following objectives:

1. Increase the number of KidCare enrollments and retentions
2. Design strategies for promoting and measuring retentions.
3. Enhance parental participation in design and evaluation of the program.
4. Train TKHF member organizations to increase enrollment and retention (11).

Using strategies from FKC outreach in Hillsborough County from 2006 to 2008, the SJCAC Florida KidCare Outreach Project facilitates these objectives while finding families of uninsured children, and helping them to apply for coverage through Florida KidCare. In addition to helping families complete a Florida KidCare application, their project also attends numerous community events to inform families about the Florida KidCare Program and how to apply. Following is a description of the outreach strategies the Florida KidCare Outreach Project uses, many of which they have been perfecting since 2006.
The cornerstone of the Florida KidCare Outreach Project (FKOP) is their network of Community Organizations which have partnered with the project to promote Florida KidCare. Ranging from schools, local churches, businesses, and health care providers, these organizations play the role of liaison to populations of uninsured, and potentially eligible for FKC, children. These partners not only advocate for Florida KidCare, educating families and community leaders about the program, but also collect information from interested families on data cards provided by the FKOP. These data cards collect the contact information of families, as well as the names and ages of children in the family. Staff of FKOP then follows up with the families, answering their questions and assisting their application to Florida KidCare. These cards serve as a tool not only to measure the number of families receiving the FKC message through the project, but also to determine the demographics of families that are served.

Each organization that agrees to partner with FKOP is asked to sign a letter of agreement which outlines the expected activities of a partner with FKOP, and the resources that will be given to help the organization’s efforts. The FKOP Community Organization agreement is similar to the Florida Healthy Kids Corporation’s Community Partners agreement, in that they both have different levels of commitment which correlate to different incentives. The commitment levels and incentives for the Florida KidCare Outreach Project are as follows:

<table>
<thead>
<tr>
<th>Levels of Partner Involvements</th>
<th>Partner Commitments by Level</th>
<th>Partner Compensations by Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>• Be a distribution site for the paper applications</td>
<td>• Free KidCare applications</td>
</tr>
<tr>
<td></td>
<td>• Provide/make available data cards for families to report information to help complete application</td>
<td>• KidCare outreach materials</td>
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<tr>
<td></td>
<td>• Return data cards within one week of receiving them to the project coordinator for follow-up</td>
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<tr>
<td></td>
<td>• Display approved Florida KidCare outreach materials such as posters, brochures, and applications in prominent public locations</td>
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<td></td>
<td>• Include a link to the Florida KidCare website, <a href="http://www.floridakidcare.org">www.floridakidcare.org</a>, in a prominent and pre-approved location on the organizations website (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>• All responsibilities of Level I</td>
<td>• Free KidCare applications</td>
</tr>
<tr>
<td></td>
<td>• Allow the Florida KidCare Outreach Project to use their facility for an enrollment event which is planned and marketed by the PARTNER</td>
<td>• KidCare outreach materials</td>
</tr>
<tr>
<td></td>
<td>• Allow the Outreach Project to use their computers, fax machines, copy makers, and printers for the enrollment</td>
<td>• $5 per completed</td>
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</table>
In addition to the Community Organizations efforts, FKOP staff and Parent Ambassadors also attend community events promoting and assisting applications to FKC, as well as collecting data cards from parents. FKOP developed a checklist for applications the project assists with, allowing for consistency and making sure that applications are competed properly. Also, whether with a Community Organization partner or FKOP staff, parents completing an application with FKOP are given the same follow up instructions. A one page follow up letter explains the necessary next steps, the FKC phone number to call, a list of documentation that must be provided, and a FKOP contact number if the parent has any problems or concerns. The assistant who completed the application with the family is also required to complete a tracking. The tracking form allows FKOP not only to claim credit for assisting the family, but also provides a tool to track the application once it is submitted to Florida KidCare. These universally used forms within the county wide project, allow families to receive the same quality assistance as they apply to Florida KidCare regardless of where they are encountering FKOP, be it at a school event, doctor’s office, or immunization bus.

In addition to Florida KidCare outreach funded directly through the Children’s HealthCare Access Initiative, SJCAC’s Florida KidCare Outreach Project (FKOP) also participates in grant opportunities offered by the Florida Healthy Kids Corporation (FKHC). Since the onset of the Children’s HealthCare Access Initiative in January 2009, FKOP has been a participant of FHKC’S

| Level III | • All responsibilities of Level I and Level II  
• Help families to complete the Florida KidCare application online  
  - This can be done by holding a monthly online event and staffing it with at least 1 trained application assistant from your organization  
  - Allowing the Outreach Project to use their computers, fax and copy machine, and printers for enrollment event (if available)  
  - By individually helping families apply online with the assistance of the trained application assistant from your organization  
• Provide a minimum of 1 trained application assistant to assist families with the Florida KidCare application (application assistant must complete and pass an online training)  
• Complete the Application Assistance Tracking Form for every application completed and return that form and other pertinent documents to the Program Coordinator within one week of completing the application | • All materials provided for Level I  
• $10 per completed application with documents sent to Florida KidCare |

(20)
Application Assistance Project, Boots on the Ground Program, and was recently awarded a FHKC Matching Grant. The outreach performed under these initiatives contributes to the goal of the Children’s HealthCare Access Initiative, and is one of the many ways the Florida KidCare Outreach Project has contributed to its success (12).

While continuing successful strategies from SJCAC’s past FKC outreach, the Florida KidCare Outreach Project has also worked to develop large organization’s systematic enrollment to FKC, which the Children’s HealthCare Access Initiative intended to demonstrate. As a part of the Bay Care Health Network, the FKOP has worked to help train Medical Assistants (MAs) at all eleven of the Bay Care Health Network’s hospital locations. The goal of this partnership is to take advantage of the large volume of uninsured children that pass through the multiple hospital sites of the Bay Care Health System. MAs have been trained by FKOP staff about the FKC programs, as well as how to make an application, and how to contact the Florida KidCare Outreach Project with additional questions.

When uninsured children are identified in the hospital, MAs visit each family and make an application for that child to Medicaid. If the child is approved for Medicaid the hospital will be reimbursed for the cost of the child’s stay. If the child is determined ineligible for Medicaid they may still be awarded Medicaid Share of Cost. While this is not the comprehensive health insurance the uninsured child needs, Medicaid Share of Cost provides some reimbursement to the hospital for the child’s treatment. Because it is in the best interest of the hospital to have some of the bill covered, it is necessary that the child first apply for Medicaid so that the hospital is able to receive the most money possible for the visit. What FKOP’s partnership with the Bay Care Health Network allows, is for a report to be generated of the children who were either denied for Medicaid or awarded Medicaid share of cost. The MAs can then either follow up with families directly, or refer the list of children to the FKOP staff member. This data transfer to the Florida KidCare Outreach Project is made possible only because project staff is employed by St. Joseph’s Children’s Hospital, a member of the Bay Care Health Network. Without having a member of the outreach team able to access healthcare files, the information would be inaccessible due to the Health Information Portability and Accountability Act (HIPAA). FKOP then uses that list to generate letters to the families who did not qualify for Medicaid, making sure they have the information they need to follow up with FKC and complete an application.

**Hillsborough Healthy Students (HHS)**

When The Healthy Kids Corporation first began to deliver affordable, quality health insurance to the families of Florida’s children in 1990, school involvement was integral to its success. Schools not only sent home applications in the beginning of the year, but also kept applications in the nurse, guidance, social work, and principals office’s year round. New students received
applications to Florida Healthy Kids during their first day of school, and staffs were aware of the programs benefits, quickly sharing the resource with families of uninsured children (18).

Schools are well-known not only as a place of education, but also as a community gathering where parents seek guidance and support. In this role, school staff develops a personal, intimate relationship with families. This insight into the lives of the children can often be the fastest way to determine if a child is uninsured, and in need of Florida KidCare services. Because of the trust that school staffs develop with parents, the staff endorsement of Florida KidCare can make a large difference as to whether or not a family in need makes a FKC application.

Today, school liaisons play many diverse roles that are unique to each school. Some schools provide applications and distribute FKC materials, while others are able to individually assist parents in completing a FKC application. Regardless of the resources that a school is able to contribute towards FKC outreach, providing a familiar face to families as they try to find health insurance for their children is the most valuable asset FKC liaisons in schools can give. Consistently, from the launch of Florida KidCare in 1999 until today, families have indicated that one of the most frequent ways they hear about Florida KidCare is from their schools (14, 13). These results occurred throughout periods of time when very little formalized FKC outreach was taking place in schools, indicating that educators have always known the importance that health insurance plays in learning.

School staff is committed to the roles that they play as educators. If school employees believe that Florida KidCare is going to help the children of their school, they will work to educate families about FKC. Not only must families be educated about how they can obtain affordable, quality health insurance, they must also be educated about the benefits of preventative health care for their children. If families do not believe that it is important to receive regular, timely healthcare it will not be a priority to have their children insured. Without this piece of education in outreach, children will be enrolled in health insurance, but not utilize the benefits the coverage provides. Educators with a relationship with families are perfect advocates for obtaining, and utilizing health care for the simple reason healthy students are better learners (18).

The Kaiser Foundation Commission on Medicare and Medicaid documented the impact that health insurance had on children with asthma. In the study, those with insurance were less likely to have asthma attacks, E.R. visits, and hospitalizations compared to their uninsured counterparts (15). For a school aged child, fewer medical episodes translate into fewer absences from school. Children who miss more than 10 days of a 90 day semester have a difficult time staying on grade level (17). A study of the effect enrollment in SCHIP has on students, found that children enrolled in SCHIP, with access to health care, had improved attendance, greater ability to pay attention in class, better reading scores, and were more
active in school activities (16). Knowing that access to health care improves a child’s ability to succeed, and that health insurance is the single more important attribute in determining whether or not a child has access to health care, makes enrolling children in Florida KidCare a priority for Florida’s schools (15).

For that very reason, Hillsborough County Public School agreed to partner with the Children’s HealthCare Access Initiative, and launched their own Florida KidCare outreach project: Hillsborough Healthy Students (HHS)The partnership between TKHF and HCPS sought not only to encourage traditional methods of outreach, but also to use one of the largest school districts in the nation to make systematic enrollments. Because uninsured children are one of the largest groups of uninsured, and of the uninsured those enrolled in public schools are the most likely to be eligible for Florida KidCare, system wide enrollment using HCPS information had the potential to enroll thousands of uninsured children (3, 18).

The memorandum of agreement between the Hillsborough County School Board (HCSB) and The Kids HealthCare foundation (TKHF), called for the identification and enrollment of children into FKC (Title XXI funded programs specifically) by district staff members who had been trained to provide application assistance (1). To facilitate the programs development and implementation an Outreach/Enrollment/Retention specialist .5FTE was hired by Hillsborough County Public Schools, whose salary was funded by both the HCSD and TKHF. The duties for the Outreach/Enrollment/Retention specialist included:

- Act as liaison to and collaborator with The Kids Healthcare Foundation programs and projects.
- Maintain a working relationship of all Hillsborough KidCare/Medicaid partners and the services they provide.
- Maintain a working knowledge of available health care plans in the community.
- Maintain a working knowledge of the application process for all programs under Florida KidCare.
- Train and update Hillsborough County School appropriate staff in the online and paper application processes for KidCare
- Maintain a working relationship with the school district human resource administration.
- Track and follow-up on applications initiated through Hillsborough County School’s process, in conjunction with the Hillsborough Kids Healthcare Foundation.
- Create of a process to document and track outreach activities in the district.
- Assist with the development a server based system for relevant data collection.
- Collect and control all documentation of outreach activities in the district.
- Compile data for monthly reports to The Kids Healthcare Foundation.
- Assure the maintenance of a supply of informational brochures, posters, and applications at each Hillsborough County School site.
- Other duties as required to assist the overall efforts in getting students and employees children insured for health care and to connect children and families that will improve the health and well-being of the family (21).
Evaluation of Hillsborough Healthy Students was to be based solely on the number of applications made to FKC by district staff, and was set at a goal of no less than 2,000 enrollments. Like SJCAC’s Florida KidCare Outreach Project, which benefited from having a hospital employee outreach worker who could satisfy HIPAA regulations, an employee of the school district is able to access information generally restricted due to the Family Educational Rights and Privacy Act (FERPA) as well as HIPAA. In both cases, the system wide enrollments that the Children’s HealthCare Access Initiative aimed to demonstrate, was made possible by the strategic placement of outreach employees within the institutions in which enrollments would be generated.
Chapter Four: Hillsborough Healthy Students

The goal of the Hillsborough Healthy Students (HHS) program contracted between FHKC and HCPS was to target uninsured students likely to be eligible for Florida KidCare (FKC) Title XXI programs, enroll them in FKC, and also implementing systematic enrollment using existing school information. The goal of HHS is to identify uninsured students within Hillsborough County Public Schools (HCPS) by utilizing school data and personal relationships with families. To complete FKC applications for the identified uninsured students, a FKC liaison would be identified at every school site. This FKC liaison would be trained, using the Florida Healthy Kids Corporation FKC Online Training, as a FKC application assistant. This district staff person would then receive referrals of uninsured students who need to complete a Florida KidCare application, and help the child’s family complete the application. This strategy of using school resources to target and enroll potentially eligible uninsured children into Florida KidCare requires both system wide implementation as well as school specific outreach. When working within a school district, especially one as large as Hillsborough County which has over 230 school sites, it is important to cater outreach efforts to the specific needs of schools. Each school site has dramatically different demographics which need to be taken into context in order to successfully reach uninsured children.

Hillsborough County Public Schools represent a large number of site, students, staff, and administrators. Therefore, outreach in HCPS will require different strategies than those of smaller school districts. The desire for district wide impact, limited by school sites requiring individually crafted outreach approaches, inspired the HHS ‘Top Down, Bottom Up’ strategy. A Florida KidCare culture incorporating the ‘Top Down’ support of school district leadership, and the ‘Bottom Up’ support from school site staff, is essential to successful FKC outreach in a school district.

Creating a Culture: Top Down Hillsborough Healthy Students (HHS) Strategies

Every school district has its own unique political environment. Some school districts have a very lose organizational structure, while others have a clear leader calling the shots. In Hillsborough County Public Schools (HCPS), a very large organization requiring very clear leadership to maintain operations, there is a very strong leadership system. Before the project officially began it was necessary to obtain the support of key district leaders:
1. District Superintendent
2. Assistant Superintendent of Student Services and Federal Programs
3. School Board Members

Key executive administrative leaders support the program by shaping its design, championing its cause, and facilitating its impact. In Hillsborough County Public Schools, it is essential to gain the blessing of these leaders when conducting FKC outreach. HHS's goal is to use the support of key executive administrative leaders for Florida KidCare and Hillsborough Healthy Students (HHS) to encourage district "buy in". The hope is that the support of FKC from school leadership will encourage members of the district (teachers, coordinators/supervisors, principals) to participate in Hillsborough Healthy Students. To demonstrate the support of the most influential leaders of Hillsborough County Public Schools, the project has set the following goals:

1. Have leadership support and facilitate the creation of a .5FTE in HCPS to conduct Florida KidCare outreach
2. Create a video of the superintendent supporting Florida KidCare and HHS
3. Have leadership include HHS in presentations to district staff and community
4. Support systematic identification of uninsured children, and their automatic enrollment into Florida KidCare

Hillsborough Healthy Students recognizes not only executive administrative leaders of the school district, but also the operational leaders who oversee the implementation of Florida KidCare outreach. These leaders include:

1. Student Health Services Coordinator
2. Social Work Supervisor
3. Guidance Supervisor
4. Medicaid Billing Specialist
5. Student Nutrition Services Supervisor

Whereas executive administrative leadership provides an example of support for the entire school district, the operational leaders encourage “buy in” from their staff of the Florida KidCare program. Also, just as every school has a unique culture, each group of student support staff has unique resources to contribute to FKC outreach, as well as specific limitations. Working with the operational leaders allows HHS staff to understand the realistic abilities, and challenges, each student support group faces when asked to take on the additional role of FKC advocate. This sensitivity is absolutely essential when working with already over-worked staff, and is made possible by relationships with staff leadership. Hillsborough Healthy Student’s goal in working with operational leadership as FKC advocates is:

1. Have Supervisors and Coordinators include FKC information at staff meetings
2. Have operational leaders ask for volunteers willing to work with HHS, and train to become application assistants.

3. Have operational leaders encourage staff to refer any uninsured children to the HHS district employee for FKC application assistance.

Whether working the executive administrative leaders or operational leaders, it is important to provide them with the information necessary to understand the program and communicate its benefits. With this in mind HHS developed speaking points to help spread an accurate message within the school district including the following points:

- Florida KidCare is affordable insurance available to all of Florida’s Children!
- Florida KidCare provides comprehensive health insurance including vision, dental, immunizations, and sick visits!
- Florida KidCare applications can be made online at Floridakidcare.org, and take only 20 minutes to complete!

Creating a Culture: Bottom Up Hillsborough Healthy Students (HHS) Strategies

In addition to engaging HCPS leadership to support and promote Florida KidCare outreach, HHS developed a “Bottom Up” campaign which works with school sites individually. Whereas the focus of working with district leadership is to encourage the participation of district staff, the goal of “Bottom Up” is to reach parents and encourage enrollment in FKC by word-of-mouth. To accomplish this goal, HHS targeted 13 pilot schools and identified key staff within the schools that were most likely to have contact with a child, and their family. The targeted school personnel include:

1. Principals
2. Guidance and Social Work Professionals
3. Nurse/ Health Professionals
4. Front desk staff
5. PTA/PTO members
6. Teachers

The pilot schools are targeted based on their levels of Medicaid enrollment and Free and Reduced Meal Program Eligibility. The procedure used to select the schools which would have the most uninsured children potentially eligible for Title XXI Florida KidCare (children with families whose income is 101% of the Federal Poverty Level, FPL and higher) was designed as follows:

1. Starting with all the school sites with reported Medicaid eligibility data, eliminated school sites with over 50% of the student body eligible for Medicaid.
2. Eliminate schools without a bilingual paraprofessional. This was done because initial outreach efforts will attempt to have bilingual staff trained to provide Florida KidCare application assistance.

3. Schools then organized by type (elementary, middle, high) and arranged by % of students enrolled in Reduced Lunch Programs. This statistic was used as a marker because those receiving reduced lunch all qualify for Florida KidCare Title XXI insurance (5 years old or older, 101-200% FPL) as they are school aged children whose family income is 134-185% FPL.

4. Redundancy was removed by reducing the presence of multiple "feeder schools", retaining the school of each feeder pattern with the highest number of reduced lunch students, lowest number of Medicaid eligible students, and largest student body.

5. Reduced selection by geographic location, trying to cover as much of the district as possible and eliminating overlap.

6. Lastly, members of the community and school district were asked their professional opinion concerning the ability of each remaining school to support the pilot.

At the end of the pilot school selection process the 13 selected schools represented six of the seven HCPS areas, and 23 feeder schools. The pilot schools selected had an average of 13.59% of the student body eligible for Reduced Lunch, with a high of 17.77% and a low of 9.21%. The average percent of the student body eligible for Reduced Lunch in HCPS was 10.6%. Families eligible for Reduced Lunch represent only families 134-185% of FPL while Florida KidCare programs provide Title XXI funding to families earning 101-200% of the FPL, therefore the given percentages of children eligible for FKC are low estimates. The pilot schools selected for HSS’s ‘Bottom Up’ strategy, identified to have the largest body of potentially eligible students, are:

1. Grady Elementary
2. Maniscalco Elementary
3. Rampello Ele/Middle
4. Valrico Elementary
5. Barrington Elementary
6. Hill Middle
7. Liberty Middle
8. Mann Middle
9. Williams Middle
10. Alonso High
11. Brandon High
12. East Bay High
13. King High

Within each pilot school the HHS Outreach/Enrollment/Retention Specialist will identify a FKC liaison to be the contact person at the school site for HHS. This person is selected not only for their relationship with families, but also their energy and enthusiasm for the project. Eventually, it is the HHS’s goal that the FKC liaisons will become application assistants trained by Florida Healthy Kids Corporation, and assume the role of helping families in their school become familiar with the FKC program and its application process.
As discussed previously, every staff person in a HCPS who will participate in HHS already has a full time job. It will require someone who understands the benefits of FKC, and the impact health has on student’s learning, to go above and beyond what is required of them to become the FKC liaison for their school. For this reason the project has asked the principals of the pilot schools to identify someone they feel is willing and able to perform the task, as they know their own staff better than anyone else.

HHS focuses efforts on the pilot schools, and developed a menu of ways the pilot schools could participate in promoting Florida KidCare in their schools. HSS also offers assistance to any school who requests FKC information. Schools are informed that if they chose to participate in any of the suggested options, that their efforts would be completely supported by the Children’s Health Access Initiative, including both St. Joseph’s Child Advocacy Staff as well as HHS staff. District schools are not required to contribute staff or resources to conduct FKC outreach, they are asked only to provide the opportunity to reach families through their school site. Events, trainings, and printed materials all are provided by the Children’s Healthcare Access Initiative staff. The options given to pilot school included:

- Distribute Flyers
- Include Florida KidCare in School Newsletters
- Have FKC Enrollment events
- Accept FKC Referrals
- Train Staff/PTA/PTO to be application assistant
- Allow FKC Presentations to Staff/PTA/PTO
- Allow FKC information to be presented at School events
- Display FKC information on school Marquee or website

To demonstrate the collaboration between the ‘Top Down, Bottom Up’ partners, HHS will orchestrate a Florida KidCare Week. Florida KidCare Week is intended to be collaboration between the HCPS, St. Joseph’s Child Advocacy Center, and The Kids Healthcare Foundation. Events for this week are intended to raise public awareness for uninsured and underinsured children, promote education of families currently in need of healthcare for their children, and culminate in at least one enrollment event at one of the HHS Pilot Schools. HHS will also attempt to make “Florida KidCare Week” an annual event within the Hillsborough County School District. To implement this objective:

1. Representatives from partners must collaborate to develop appropriate week as “Florida KidCare Week”
2. Each partner must adequately advertise and promote “Florida KidCare Week” within their respective organization as is appropriate
3. Each partner must contribute resources to staff and organize “Florida KidCare Week”

4. Prior to the launch of “Florida KidCare Week” a detailed report to include timeline, budget of events, individual partner commitments, significant advertisement/promotion of event, intended measures of outcomes, and all other concerns, must be presented to partners.

5. Procedure for installing “Florida KidCare Week” as a permanent Hillsborough County School District event must be identified and pursued.

Target Uninsured Children in Hillsborough County Public Schools (HCPS)

With over 190,000 students enrolled in Hillsborough County Public Schools (HCPS) and an estimated 12.7% of Florida Children uninsured, HCPS is home to over 20,000 students in need of health insurance (6). Using estimates for the number of uninsured over the age of five, and the estimated 72% of uninsured children eligible for subsidy under Florida KidCare, the target audience of HHS is roughly 16,000 children uninsured and eligible for FKC in Hillsborough County Public Schools (7). While it is easy to estimate the number of children HHS is targeting, it is much more difficult to determine where these uninsured children eligible for FKC are, and how to reach them.

HHS outreach targets the student population whose family income is over 100% FPL, and therefore do not qualify for Medicaid, with an emphasis on families whose income is between 101-200% FPL who are traditionally covered by FKC Title XXI subsidized health insurance. The Student Nutritional Services program ‘Free and Reduced Meal Program determine eligibility by using income requirements similar to Florida KidCare’s. Traditionally, Free Lunch was provided to families who up to 133% FPL, and Reduced Lunch provided to families who earn 124-185% FPL. Reports of the number of children who received Free and Reduced Meals are available by school and by district. Using the number of children who are on reduced lunch, and families earn between 134-185% FPL we have an estimate of children in the district eligible for Florida KidCare, assuming that there is 100% enrollment in the Free and Reduced Meal Program. This does not, however, include families who earn 101-133% FPL or 186-200% FPL who also would be eligible for Florida KidCare Title XXI benefits.

To determine a goal for the project I used the available Hillsborough County KidCare enrollment data. In September 2009 the total Florida KidCare Title XXI subsidized enrollment for Hillsborough County was 12,601. The Reduced Lunch Program had 19,141 students participating during September 2009. This leaves a difference of 6540 students that qualify for FKC subsidized health care and are not currently enrolled. This number represents the children enrolled in Free and Reduced Meal Program, whose income is between 134-185% FPL. Therefore this is a low estimate of the number of children potentially eligible and uninsured.
With a target of 6540 students, 100% enrollment of the target would be a 51.9% increase in Hillsborough FKC enrollment, and a 2.64% increase FKC statewide enrollment.

From the current Florida KidCare School Pilot Project in Leon County Schools we know that crossing data from Student Nutritional Services, collected from Free and Reduced Meal Program applications, with the school district’s Medicaid Eligibility Roster can enable us to determine who is eligible for FKC, but not eligible for Medicaid. In theory, this list will remove Medicaid eligible children whose families earn up to 100% FPL, and leave the information of FKC eligible children whose families earn between 101-185% FPL. This allows a targeted population to be identified within the district so that school staff can then focus outreach efforts without sharing confidential information with outside agencies. With the assistance of Leon County we know that this can be implemented quickly with programs already used by the district. This strategy may provide a list of potentially eligible uninsured children that still includes some children eligible for Medicaid but not enrolled, so they would not be removed during the data match. Also, this strategy does not data match with the list of children currently covered by FKC, so redundancies may occur.

In addition to utilizing school data to determine the number of uninsured children, HHS strategies include:

- Referrals from staff
- Information from emergency cards
- Data cards from school events
- Parent inquiries

**Completing a Florida KidCare Application**

The goal of HHS is to identify uninsured students within Hillsborough County Public Schools (HCPS) by utilizing school data and personal relationships with families. To complete FKC applications for the identified uninsured students, a FKC liaison would be identified at every school site. This FKC liaison would be trained, using the Florida Healthy Kids Corporation FKC Online Training, as a FKC application assistant. This district staff person would then receive referrals of uninsured students who need to complete a Florida KidCare application, and help the child’s family complete the application. This is the long term goal of the program, with the immediate needs for FKC application assistance being meet by the HHS .5FTE, the Outreach/Enrollment/Retention Specialist. Until a school site has a specific FKC liaison, all referrals of uninsured students are collected by the HHS Outreach/Enrollment/Retention Specialist, and followed up on. In a school district with more than 190,000 students, and over 16,000 children estimated to be uninsured and eligible for FKC, this is not a realistic solution. It is only the temporary means by which families receive the help they need during the development of HHS. The HHS staff member completing the FKC application will follow the
procedure used by St. Joseph’s Child Advocacy Center’s Florida KidCare Outreach Project, utilizing the same follow up page, tracking from, and data cards.

Another method of enrollment, available to HHS Pilot Schools as well as any district event, is a Florida KidCare Enrollment event. Enrollment Events are opportunities for schools to advertise to parents that FKC application assistance will be made available. The Enrollment Events can either be created solely for the purpose of having parents attend and complete FKC applications, or they can be associated with a school event such as a school fair, Back-to-School event, or open house. If a school feels that they have enough families willing to participate in an enrollment event, HHS will help to help coordinate their efforts to make the most successful FKC event possible. Strategies that HHS will use to maximize enrollments as FKC are:

- Distribute literature advertising the enrollment event
- Use school ‘Robo Calls’ to encourage parents to attend
- Advertise the needed documentation to complete a FKC application
- Provide banners, printed materials, staff, and training for event
- Arrange the needed computer equipment, including internet access

In addition to knowing that they are helping students gain access to affordable, quality healthcare, Hillsborough Healthy Students have the ability to provide financial incentives to organizations completing FKC applications. The Children’s HealthCare Access Initiative which providing funding for HHS, has offered $20 dollars per completed FKC application for the first 200 applications, and $25 dollars per completed FKC application for every application after 200. In addition to incentives per application, the Children’s HealthCare Access Initiative provides a $500 bonus upon the 100th completed FKC application, and a $750 bonus upon completion of the 200th FKC application.

**Innovative System Wide Enrollment Strategies**

Florida KidCare Enrollment events, collecting family information on data cards at schools functions, and presenting FKC information to school leadership are all FKC outreach strategies that have been implemented in the past. They are valuable methods which connect families with the resources available to them, however, they represent tremendous amount of effort that traditionally result unknown numbers of enrollments. A family who gets a Florida KidCare flyer from HHS at a school fair is able to go home and, if they chose, complete an online FKC application without assistance. If their application results in an enrollment in one of the FKC programs, HHS remains unaware of their impact on the family’s decision. Utilizing the tools that large organizational systems have available, HHS can not only track their outreach and its impact in the community better, but also more accurately target who they provide outreach too, and potentially enable mass enrollments into Florida KidCare. The following strategies are ways that HSS hope to utilize these systems:
1. **Florida KidCare Icon**: HCPSs use the email suite IDEAS to manage the district email. IDEAS provides a function called ‘conferences’ or icons, which allow specific departments to share resources. For example, ‘School Health Services’, ‘Guidance Services’, ‘School Social Work’ are all different ‘conferences’ or icons available only to users allowed to access them. A school nurse will be on the list able to access ‘School Health Services’ but not necessarily able to access ‘Guidance Services’. HHS will develop a FKC Icon which will include basic information FKC such as eligibility, contacts, applications, and how to reach HHS. The FKC Icon will be made available to all district staff. The FKC Icon will have the ability to create ‘FKC Referrals’, allowing staff to complete a simple online form, and send information of a student in need of FKC assistance to the HHS Outreach/Enrollment/Retention Specialist for follow up.

2. **Florida KidCare Online**: HSS will create a web page associated with the HCPS main web page which will contain information about FKC including eligibility, contacts, and HHS staff information. The site will also have a FKC Referral similar to the referral located in employee’s FKC Icon. Also, the number of people viewing the web page will be an indicator of outreach impact. The FKC webpage will be accessible through a link on the main HCPS webpage.

3. **HCPS Employee Benefits**: HHS will coordinate with HCPS Employee Benefits to make sure correct FKC information is provided to all employees.

4. **Student Packets**: HHS will pursue the inclusion of Florida KidCare applications/information in both the annual first day packets, as well as in new student registration packets. The FKC application will be voluntary for families enrolling a child in school, but will serve as an important point of contact for new students.

5. **Medicaid and School Lunch Data Match**: as previously discussed, a data match between Student Nutrition Service’s ‘Free and Reduced Meal Program’ application and Medicaid eligible roles will provide a list students potentially eligible for Title XXI Florida KidCare. Current Medicaid and SCHIP enrollment numbers indicate at least 6,540 children enrolled in the Free and Reduced Meal Program in HCPS, are potentially uninsured despite the fact that they qualify for low or no cost health insurance through FKC (2). It is reasonable to conclude that by obtaining the eligibility information contained in Free and Reduced Meal Program applications we can identify, contact, and enroll these remaining families.

6. **Data Match with Florida KidCare**: As of October 1, 2000 schools can share information regarding a child’s eligibility for the Free and Reduced Meal Program with persons directly connected to the administration of State Medicaid and SCHIP. This amendment to the National School Lunch Program, allowing the sharing of information between schools and Medicaid/SCHIP, was designed for the purpose of identifying and enrolling eligible children. It requires that
a. The State agency and School Food Authority elect to disclose eligibility information to the health insurance program

b. There is a written agreement between the school and health insurance program stating the eligibility information will be used to enroll children in Medicaid/ SCHIP

c. Parents are notified of the potential release of information and given an opportunity to elect not to have their child’s information released (3)

Many state programs have successfully used this opportunity to collect information on uninsured families including Colorado Covering Kids and Families (4) as well as Express Lane in California (5) By using school Medicaid Eligibility Roles and Free and Reduced Meal Program applications to determine a child’s Medicaid status, then crossing students uninsured by Medicaid with FKC enrollment status’, uninsured children who would qualify for SCHIP are identified. These names may or may not be used for direct outreach, and may only be used to determine the number and location of uninsured children in HCPS.
Chapter 5: The Children’s Healthcare Access Initiative’s Outcomes

The primary goal of The Children’s Healthcare Access Initiative (TCHAI) is to increase the number of children enrolled in Florida KidCare (FKC). To achieve this goal TCHAI funded Hillsborough Healthy Students (HHS) housed in Hillsborough County Public Schools (HCPS), and Florida KidCare Outreach Project (FKOP) housed by the St. Joseph’s Child Advocacy Center. These projects conducted outreach both individually and collectively. To effectively increase FKC enrollments the project sought to increase FKC awareness in Hillsborough County, creating a ‘Florida KidCare Culture’. Also, FKOP and HHS targeted uninsured families with the goal of assisting their completion of a FKC application for their children. Throughout their work both projects collected data, and recorded outreach efforts for future analysis.

Creating a Florida KidCare (FKC) Culture

HHS and FKOP worked together to deploy a ‘Top Down, Bottom Up’ strategy of promoting FKC in Hillsborough County. Because HCPS rely heavily on the guidance of key district leadership, the ‘Top Down’ strategy concentrated primarily on key leaders whose endorsement allowed for the creation of a .5FTE Outreach/Enrollment/Retention Specialist. The HCPS superintendent provided HHS with a 4 minute video emphasizing the importance of health insurance, stressing that a student’s health is paramount to their academic success. In this video the superintendent endorsed FKC as a “great program” and provided HHS staff contact information. The superintendent’s video was shown to HCPS staff and leadership, helping to create district ‘buy in’ and showing that HHS is a priority of HCPS leadership. HHS presentations were made during professional training days, school board workshops, staff meetings, and district area directors meetings, reaching over 650 HCPS staff members. In addition to HHS presentations to HCPS staff, FKOP presented to community partners such as insurance companies, hospital staff, and health center staff to promote the utilization of FKC, and provide general information about its programs and application process. In 2009 FKOP made 22 presentations to over 500 community partner’s staff, and in 2010 they made 134 presentations to over 600 community partner’s staff. While key district leadership publicly endorsed FKC and HHS, operational leaders championed HHS to their staff and requested for volunteers to support the project. Their
request resulted in 8 Florida Healthy Kids Corporation (FHKC) trained Application Assistants who serve as certified HCPS volunteers during HHS events.

While the ‘Top Down’ campaign focused on gaining leadership support of FKC, the ‘Bottom Up’ strategy focused on forming partnerships with community organizations who had direct contact with families potentially eligible for FKC. Through these community organizations HHS and FKOP provided FKC information and application assistance to families. In these partnerships 149 community/school events were attended in 2009, and 134 were attended in 2010. During these events thousands of parents where given the opportunity to talk to a trained FKC application assistant who could inform them about FKC, and answer any questions they might have about the application process. Staffing these events were one of the 52 community partners who had completed the Florida Healthy Kids Corporation (FHKC) Application Assistants training through TCHAI during the first two years of the project. In addition to FHKC certified Application Assistants, TCHAI gave presentations which provided information about FKC and the applications process to 44 community partners in 2009 and 93 partners in 2010. ‘Community Partners’ include HCPS staff (social workers, guidance staff, health professionals, certified volunteers) as well as the staff of FKOP community partners (community resource centers, YMCAs, churches). By training key members of the community who frequently interacted with families, both HHS and FKOP exponentially increased their outreach capabilities. HHS and FKOP are facilitated by staff that is employed less than full time, limiting the time they are able to devote to staffing community events, completing applications, and conducting parent contact follow up. Trained community partners are able to accomplish these roles in lieu of HHS/FKOP staff, and are in some cases compensated for their efforts. For example, FKOP’s parent ambassadors are compensated for their time with gift cards. In addition to fostering relationship with community organizations and attending events, FKOP distributed FKC information by producing informational flyers and brochures which were distributed during events, and to local community organizations. In 2009 FKOP printed and distributed approximately 6,000 FKC flyers, while in 2010 they printed and distributed 10,000 English project brochures and 7,000 Spanish project brochures. They also sent information to 500 preschools, 50 churches, and 30 clinics in 2010.

While these activities promote FKC in a myriad of ways, they provide limited methods of evaluating the impact made on families of uninsured children. Community events are largely educational and generally do not provide onsite application assistance. Therefore, applications that result from the information provided by either HHS or FKOP are untracked and TCHAI has no way of reporting the outreach results. Additional tracking may provide further insight to the outcomes of outreach efforts. For example, if event staff routinely recorded the number of data cards collected, the project could determine which events produce valuable contacts and allocate resources accordingly. Also, the number of applications resulting from a person
becoming a trained application assistant would be a valuable tool for accessing the productivity of trainings.

Goals of HHS that would have contributed to the creation of a Florida KidCare culture that did not come to fruition were the development of pilot schools, and the establishment of Florida KidCare Week. Each pilot school principal was asked to identify a FKC liaison who would work with the HHS Outreach/Enrollment/Retention Specialist to develop a FKC outreach plan for the school. The plan could include anything from distributing flyers and putting FKC in their school newsletter, to having enrollment events. Initial feedback from the 13 pilot schools selected as those with the highest number of potentially eligible students was very weak.

<table>
<thead>
<tr>
<th>Table 7: Hillsborough Healthy Students (HHS) School Pilot Initial Response</th>
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<tr>
<td><strong>Grady ES</strong></td>
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<tr>
<td>Maniscalca ES</td>
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<tr>
<td>Rampello ES/MS</td>
</tr>
<tr>
<td>Valrico ES</td>
</tr>
<tr>
<td>Barrington MS</td>
</tr>
<tr>
<td>Hill MS</td>
</tr>
<tr>
<td>Liberty MS</td>
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<tr>
<td>Mann MS</td>
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<tr>
<td>Williams MS</td>
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<tr>
<td>Alonso MS</td>
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<tr>
<td>Brandon HS</td>
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<td>East Bay HS</td>
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<td>King HS</td>
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One reason for the weak initial response from pilot projects was the fear that school staff could not take on the additional responsibilities of performing and/or coordinating FKC outreach. Attempts were made to reassure the school staff and leadership that HHS/FKOP would support all FKC outreach providing staff, training, printed materials, and event planning but the response did not change. Few of the schools have attempted to foster a partnership with HHS, those who have agreed to provide FKC services have chosen to include FKC at their health fairs and parent conference nights. Given the reluctance of individual schools to commit to participating in HHS, it was unlikely that Florida KidCare Week would be a priority of HHS or HCPS. While it would have represented district support of FKC, its implementation would have required district wide coordination that HCPS was not interested in pursuing. HCPS leadership was concerned that district wide implementation of HHS would have created a volume of interest that the project was not ready to accommodate. This was a valid concern because the designed referral system was not yet operational, schools were not interested in FKC liaisons, and there was only one .5FTE HHS staff to conduct parent contact follow up.

FKOP organized a successful ‘Florida KidCare Kickoff’ event at the end of the second year to engage the community for the final year of TCHAI. Over 50 HCPS staff and leadership, community advocates for KidCare, local and state representatives, as well as partner community organizations were given a presentation covering FKC updates and the progress of TCHAI. This event was a unique opportunity for the various FKC stakeholders in the Tampa Bay area to share resources and outreach strategies. Also, community organizations who were not currently affiliated with TCHAI were invited to learn more, and become partners.

Uninsured Children In Hillsborough County

Identifying the number and location of uninsured children in Hillsborough County was not only one of The Children’s Healthcare Access Initiative’s (TCHAI) goals, it was also essential to conducting targeted, effective FKC outreach. Throughout the project, data cards, tracking forms, and outreach databases were maintained by all outreach participants in an attempt to create an accurate depiction of the uninsured children in Hillsborough County.

When the databases were compiled TCHAI had recorded contact with 656 families in 2009 and 626 families in 2010, with a total of 1216 parent contacts during the first two years of the project. Approximately 40% of the contacts were made by Hillsborough Healthy Students (HHS) staff and 60% of the contacts were made by Florida KidCare Outreach Project staff (FKOP). The main source of parent contact information was data cards collected from interested parents at community and/or school events. Information collected included the parent name, address, phone number, and email address, as well as the names and ages of children in the family. Parents completing the data card did so to gain information on FKC as well as application assistance, and are likely to have children who are uninsured. We used the information
collected to help illustrate the demand for FKC information by zip-code, and to provide an idea of where higher populations of uninsured children may be. Of the 1216 contacts made, 171 zip codes were represented, and 13 zip codes occurred more than 20 times.

Using parent contact information gathered in the database, outreach staff from both HHS and FKOP conducted outreach follow up. The primary form of follow up on parent contacts who indicated they were interested in Florida KidCare (FKC) was done by phone. Also, HHS conducted some follow up using email addresses families provided on data cards. The rate of follow up with interested parent contacts whose information was collected was 62.9% for FKOP and 52% for HHS, with the Children’s Healthcare Access Initiative having an overall 53% average for follow up with parent contacts. The low percentages of follow ups on parent contacts were due in part to lack of man power. Follow up by phone is a time consuming task which, during the 2009-2019 time period, staff was not available to perform. FKOP hired additional outreach assistants for 2011 who have begun to make progress towards having 100% parent contact follow ups. Also, a letter is being developed which will be mailed to families providing information on FKC and how to contact either HHS or FKOP for additional questions. In the future, clear communication of follow up goals between the various outreach staff of HHS and FKOP could help coordinate 100% parent contact follow up. In addition to clear communication of follow up expectations, TCHAI projects in the future should track the outcome of parent contact follow ups to determine if it is a valuable, productive method of FKC outreach.
Aside from data cards which relied on the parent to identify their child as uninsured and/or potentially eligible for FKC, several other ‘self-identification’ options existed to find uninsured children. Many of HCPS collect student health insurance information on their emergency cards. This was pursued as a potential source for identifying uninsured children but several barriers existed. Not all schools used the same emergency card, and the method of storing information on the emergency card varied. The variations among schools would make systematic identification of uninsured children very difficult, and asking school staff to comb through all emergency cards to identify potentially uninsured children would be a time intensive task. Given that schools where unable to designate staff time for HHS, this would ultimately leave the .5FTE HHS employee responsible for filtering through emergency cards, which would not have been an effective use of their time.

Student ‘self-identification’ also existed through parents who called the .5FTE HHS Outreach/Enrollment/Retention Specialist in response to HHS advertisements and flyers, requesting application assistance. A final method of individually identifying uninsured students within HCPS was through referrals to HHS by school staff. A reason for building FKC partnerships within schools is that school staffs are able to identify students who are uninsured through intimate relationships with children and their families. By providing families with FKC information or giving their contact information to the .5FTE HHS Outreach/Enrollment/Retention Specialist, school staff served as a link between uninsured children and the coverage they need. TCHAI took advantage of this resource by presenting FKC information to various school staffs, allowing them to give accurate FKC information to families, and also distributed HHS and FKOP staff contact information. Developing a more formal referral process for families and staff members, both within HCPS as well as any community organization, would increase the number of identified uninsured children in need of FKC programs. If an online service was provided in the Tampa Bay Area as a tool for both partner organizations and parents to request FKC information and application assistance, TCHAI would not only have an organized, streamlined referral process which could be easily advertised, it would also have a way to accurately measure the project’s impact.

As discussed in Chapter Four, HCPS Free and Reduced Meal Program enrollment numbers were used to target specific schools. Those with the highest number of students enrolled in the Reduced Lunch Program (RLP) had the largest target audience, due to the fact that the RLP and FKC had comparable income requirements. FKC’s income eligibility is more lenient than that of the RLP, so estimated numbers of uninsured represented low estimates. While this generated a list of schools with the most students potentially eligible for FKC, it did not provide information on the number of uninsured, or the names of uninsured students. However, using data from the Free and Reduced Meal Program, maps were made illustrating the areas of HCPS which would have the most need for both Title XIX and Title XXI FKC programs. The Children’s Board
of Hillsborough County produced maps using October 2009 Free and Reduced Meal Program enrollments for elementary school, middle schools, and high schools (2). These maps illustrate the findings of the highest frequency zip code trends, and also mirror similar maps produced by the Urban Institute (1). An interesting observation about the Free and Reduced Meal Program enrollment by elementary, middle, and high schools is that the high percentage enrollment areas shrink from elementary to high school. It would be expected that the level of enrollment would remain the same throughout the school levels, because the demographics of the families in those areas remain constant. However, as the maps show, parent participation decreases as children move from elementary to high school, therefore the number of families completeing the Free and Reduced Meal Program application also decreases. This provides misleading maps if they are taken out of context. The most accurate representation of the income levels of families is the map depicting the Free and Reduced Lunch enrollment by elementary schools.
Figure 5: Free and Reduced Lunch Enrollment In Hillsborough County Public Schools (HCPS) Elementary Schools (2)
Figure 6: Free and Reduced Lunch Enrollment in Hillsborough County Public Schools (HCPS) Middle Schools (2)
Figure 7: Free and Reduced Lunch Enrollment in Hillsborough County Public Schools (HCPS) High Schools (2)

High School Students Eligible for Free/Reduced Lunch

- 75.0% to 80.7% Eligible (2)
- 50.0% to 74.9% Eligible (9)
- 25.0% to 49.9% Eligible (11)
- 14.4% to 24.99% Eligible (2)

Values inside parentheses in legend represent the number of school catchment areas within a given range.
Figure 8: Map of Uninsurance Rates in Tampa Bay Area (2)

Black Stars indicate an area of high insurance corresponding to a high frequency zip code from Table 8
Innovative Strategies

Understanding that traditional methods of outreach were both difficult to evaluate and time consuming, TCHAI pursued several innovative systematic methods of identifying and enrolling uninsured children into FKC programs. Using the internet presence of HCPS and St. Joseph’s Children’s Hospital, FKC information was made available through the partner organizations’ main web sites. These displayed not only FKC program information, but also HHS and FKOP staff contact information. In addition to online information available from the main HCPS website, HCPS guidance and student services staff had access to the ‘Florida KidCare Icon’ through their email suite IDEAS. Using this service, accessible to them anywhere there is an internet connection, approximately 1,200 HCPS staff could review FKC program and contact information, as well as complete FKC referrals to the .5 FTE Outreach/Enrollment/Retention Specialist for uninsured students. Development and implementation of both FKC information on HCPS’ web site and the ‘Florida KidCare Icon’ took a significant amount of time given the size of the school district. The ‘Florida KidCare Icon’ was implemented December 2009, but the referral feature was not completed until February 2011.

Innovative strategies that did not come to fruition during the first two year of TCHAI include the medical “passport”, distributing FKC information in HCPS’ student packets, as well as data matching. TCHAI determined that the medical “passport”, proposed to allow the analysis of the quality and accessibility of children’s health care, would not be feasible due to lack of implementation of electronic health records among health care professionals. CHAI pursued data matches internally between HCPS Medicaid and Free and Reduced Lunch enrollees; however progress towards this goal has been slow. Similarly, data matches between HCPS and FHKC have been hindered by the need for matching information by Social Security Numbers. The Department of Children and Families as well as FHKC use Social Security Numbers to identify children, however HCPS does not require that families provide Social Security Numbers, nor are they willing to release the numbers they do have to an outside agency. TCHAI provided HCPS with both the laws explicitly allowing the information of student information with state agencies for the determination of state health insurance benefits, as well as language that could be included on the Free and Reduced Lunch Program application to comply with the stipulations of the law, however the current opinion of the HCPS attorney is that it is not advisable to pursue data matching.

In addition to attempting large systematic enrollment within HCPS, TCHAI also attempted to utilize St. Joseph’s Children’s Hospital association with Bay Care Health Networks. The original strategy was to have hospital staff complete FKC applications for families whose children were uninsured and potentially eligible for FKC. As was experienced with HCPS, implementing change of a large organization is both time consuming and difficult. While staff was trained on the FKC
program, and how to complete a FKC application, TCHAI did not receive the large system wide application volume they had anticipated.

**Applications to Florida KidCare**

The focus of TCHAI outreach is to inform families about FKC and encourage them to complete FKC applications, increasing Hillsborough County FKC enrollment and reducing the number of uninsured children. All applications made by both FKOP and HHS were done by FHKC trained application assistants working individually with parents. Only one school incorporated the use of a FKC Liaison who acted as the application assistant for Woodbridge Elementary School, which was not one of the targeted pilot schools. Because of the limited number of people performing application assistance and FKC outreach, the number of completed applications was not as high as the project would have anticipated had large systematic enrollments been made. Through the project it has become clear that evaluation based on the number of applications made is not a sufficient indicator of outreach impact. FHKC provides application reports of outcomes upon request, based on a child’s date of birth and social security number. If FHKC application reports are received within 120 days of the application being completed, they can be used to ensure parents successfully complete their applications. If FHKC application reports are received after the 120 application period, they can be used for follow up and outcomes evaluation.

During 2009, FKOP assisted 186 parents in completing FKC applications. In 2010, HHS assisted 13 FKC applications and FKOP facilitated 141. Collectively, TCHAI application assistants facilitated 340 FKC applications, which were monitored via the tracking form. FHKC provided TCHAI with application reports giving the outcome and status of 71.47% of completed FKC applications. Overall, 61.32% of the applications made to FKC resulted in children becoming enrolled in a FKC program. A total of 260 children gained insurance through the 149 applications that resulted in FKC enrollments, at a rate of 1.74 children enrolled per successful application. Using this data, we can estimate that the number of applications resulting in enrollment from the total 340 applications made by TCHAI is approximately 208 FKC enrollments. We can further estimate that from 208 enrollments, at a rate of 1.74 children enrolled per successful application, TCHAI facilitated the enrollment of 362 children to FKC programs. The results of the 243 applications reported on by FHKC are illustrated below, as well as the reasons for denial and ‘other’ outcomes. The most common ‘other’ outcome of FKC applications was that the application expired. This does not describe the status of the application before expiration, and likely was due to one of the other four ‘other’ outcomes.
The largest contributing factor to why FKC applications were not completed was that the application was missing documentation such as income, social security, and identity documentation required by either FKC or Medicaid. These application statuses account for 26% of cases that do not successfully complete the FKC application. The second most common reason that applications did not result in enrollment was that a premium payment was needed to begin coverage. This indicates that families successfully completed the application but did not pay the determined premium for whatever reason. Of the sixteen cases that were waiting on premium payments, ten were $133 or more, with the highest premium at $399. It is possible that some families did not receive the notification requesting premium payment, allowing the case to eventually expire. It is more likely however, that families found the cost of the premium to be prohibitive. The last reason that FKC applications were not completed was that FKC determined that the child/children were already enrolled in a FKC program. This information illustrates the need for FKC educational outreach. The families applied for FKC without being aware that they already were a recipient of the benefits, illustrating the general public’s confusion about what FKC is.

Reasons for denial to FKC programs further illustrate both the need for more accurate FKC educational outreach, helping the public understand the roll of FKC, and also the fact that families determined ineligible for subsidized premiums are prone to discontinuing the FKC application process.
Two of the twelve children denied for FKC programs were already enrolled in FKC, and began a new application instead of completing the renewal process. Also, two children were denied FKC benefits because they were of the age 19 or older. Both of these applications would have been avoided with proper education about the FKC programs facilitated FKC outreach education. All TCHAI applications were conducted by trained FHKC application assistants, and still these 4 children in addition to the two cases discussed previously, completed a FKC application while either already enrolled in a FKC program or too old for benefits.

The denial summary also illustrates the difficulty of working within large organizations. As any large organization, the state as well as HCPS and Bay Care Health Networks, require time to implement change and train existing staff to incorporate new habits to their daily duties. In 2009 Florida Legislature provided good cause exemptions which allowed children who are currently insured to apply for FKC and be determined eligible for immediate benefits. The application and determination of benefits process took time to adjust to the new change. As a result, families who may be eligible for FKC and are currently insured were unjustly denied FKC benefits. While the system was making adjustments to their internal processes, it was necessary for families to call FKC and speak with a representative to indicate that they will be terminating current benefits to enroll in FKC. This was needed to ensure that the child would not be covered by two separate insurance providers at the time that FKC benefits were instated. It is important to note that this process was required for families determined eligible for Title XXI benefits only, as it is not a requirement of Title XIX that the child be uninsured to receive Medicaid. As a result of rule change and implementation, six children were denied FKC benefits on the basis of indicating that they already had insurance.
Evaluating Project Outcomes

An example of TCHAI events which tracked outreach and outcomes was a series of H1N1 vaccinations in HCPS. During November and December 2009, HHS and FKOP staff attended over twenty HCPS H1N1 vaccination events, providing FKC information and collecting parent contact information on data cards. Because parents were using the school as a source of routine care, vaccinations, it was concluded that the children were likely uninsured. It was estimated that over 15,000 people attended the events, during which TCHAI staff collected 307 parent contacts. The follow up conducted on the 307 parent contacts was done by sending FKC information to the 52% of parent contacts which included an email address. Of the 160 emails sent from contacts made during H1N1 vaccination events, 8 resulted in a completed application to FKC through TCHAI. This represents a 2.6% enrollment rate of all parent contacts made, and a 5% enrollment rate of all follow ups made to parent contacts. It is important to note that the results we are able to report as being facilitated through TCHAI are only those who completed the application process with either FKOP of HSS, resulting in a tracking form being produced. Families who received FKC information from FKOP/HHS and then continued the application process independently cannot be measured at this time. Therefore, while the total number of families applying to FKC from the contacts made during this series of events is only estimated to be 2.6% of families contacted, it is not possible to evaluate to total impact that FKC outreach achieved. One way to analyze the impact of the FKC outreach conducted during the HCPS H1N1 is to compare Hillsborough County FKC enrollment trends to Florida FKC enrollment trends for the months during, and immediately following outreach. When comparing Title XXI enrollments from the H1N1 event time period (November 2009 to February 2010), Hillsborough County enrollment increased 4.29% while Florida enrollment increased only 1.8%. Comparing Hillsborough County and Florida’s Title XIX enrollments, the results are more similar with 3.00% and 2.92% respectively. This is an expected outcome representing the uninsured population we are targeting, which is the uninsured ineligible for Medicaid but eligible for FKC Title XXI programs.

<table>
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<tr>
<th>Time Period</th>
<th>Hillsborough County Title XXI enrollment</th>
<th>Florida Title XXI enrollment</th>
<th>Hillsborough County Title XIX enrollments</th>
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Table 9: Comparison of Hillsborough County and Statewide Florida KidCare (FKC) Enrollment During H1N1 Targeted Outreach (4, 5)
A weakness of the tracking system was that outreach staff each used their own database format; therefore compiling information for result analysis was time consuming. Also, the occurrence of Spanish speaking families was not uniformly reported by outreach workers. This information would have been useful in determining the need for bilingual outreach assistants.

Another example of coordinated outreach resulting in FKC enrollments was the 2010 Back-to-School Campaign. HHS and FKOP staff participated in 6 Back-to-School Immunization events providing not only FKC information but also FKC application assistance. Using wireless internet cards, laptops, and printers TCHAI partners were able to complete FKC applications for parents at all Back-to-School events. Instrumental to the success of the project was the distribution of information to parents about the FKC outreach events. HHS included a flyer promoting the FKC application assistance being offered in the mail out of Free and Reduced Meal Program applications. The mail out distributed FKC information as well as event details to every household in HCPS, representing over 190,000 students. The flyers listed all the Back-to-School events, and also included information on what documents would be needed to complete a FKC application at one of the Back-to-School events. Parents attended the Back-to-School events with the flyer they had received in the mail, all needed documentation, and with the intention of completing a FKC application. Over the 5 week Back-to-School schedule 50 FKC applications were completed at Back-to-School Events. Like all FKC outreach, if a family receives FKC information and independently completes the FKC application, TCHAI is unable to document the impact it made on FKC enrollments. As was done earlier to gauge the impact of TCHAI outreach on FKC enrollments, Hillsborough County FKC enrollment trends can be compared to

<table>
<thead>
<tr>
<th></th>
<th>Jan-10</th>
<th>Feb-10</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15,129</td>
<td>15,401</td>
<td>237,180</td>
<td>239,046</td>
</tr>
<tr>
<td></td>
<td>118,241</td>
<td>119,593</td>
<td>1,510,810</td>
<td>1,516,208</td>
</tr>
</tbody>
</table>

Figure 12: Comparison of Enrollment in Hillsborough and Florida During H1N1 Targeted Outreach (4, 6)
Florida FKC enrollment trends. The results of this comparison do not indicate that the Back-to-School campaign had a large impact on FKC enrollments in Hillsborough County. Title XXI enrollment in Hillsborough County declined by 1.5% during what is considered to be the “Back-to-School Season”. While this is discouraging, state wide Title XXI enrollments during what FHKC characterizes as their “highest application volume”, decreased by .5% (3) Title XIX enrollments in Hillsborough County and Florida during the same period of time decreased by 5.3% and 7.6% respectively. For a period of enrollment which experiences higher than average applications but a decrease in overall enrollments, outreach projects must modify Back-to-School efforts to include both follow ensuring that applications are completed, as well as retention strategies to avoid a loss of overall FKC enrollments. It is possible that the impact of Back-to-School outreach campaigns was not seen until December of 2009 and later, as enrollment began a steady increase at the beginning of 2010. However, given the 120 day application lifespan, it is unlikely that results from July through early September would be surfacing more than 5 months later. The Back-to–School campaign of 2009 was more successful, with Title XXI enrollments increasing 2.5% both in Hillsborough County and Florida as a whole.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Hillsborough County Title XXI</th>
<th>Florida Title XXI</th>
<th>Hillsborough County Title XIX</th>
<th>Florida Title XIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-10</td>
<td>16,365</td>
<td>255,742</td>
<td>122,320</td>
<td>1,574,521</td>
</tr>
<tr>
<td>Aug-10</td>
<td>16,449</td>
<td>256,758</td>
<td>123,343</td>
<td>1,580,722</td>
</tr>
<tr>
<td>Sep-10</td>
<td>16,224</td>
<td>256,062</td>
<td>123,352</td>
<td>1,588,706</td>
</tr>
<tr>
<td>Oct-10</td>
<td>16,138</td>
<td>255,451</td>
<td>124,785</td>
<td>1,605,276</td>
</tr>
<tr>
<td>Nov-10</td>
<td>16,117</td>
<td>254,436</td>
<td>125,489</td>
<td>1,623,750</td>
</tr>
</tbody>
</table>

Table 10: Comparison of Hillsborough County and Statewide Florida KidCare (FKC) Enrollment During Back-to-School Season (4, 5)
To evaluate the impact of THCAI outreach performed from November 2008 until December 2010 on FKC enrollments, comparisons between Hillsborough County and Florida Title XXI and Title XIX FKC enrollments can be made. These comparisons showed that Title XXI, Title XIX, and overall FKC enrollment in Hillsborough County were very similar to enrollment trends statewide. During the project Hillsborough County Title XXI enrollment increased 15.6% while Florida enrollment increased 14.28% and Title XIX enrollments statewide increased 23.2% while in Hillsborough County they increased 22.09%. Overall FKC enrollment increased in the state of Florida by 20.8% while Hillsborough County FKC enrollment increased by 21.3%. The following graphs illustrate the similar trends of Florida and Hillsborough Title XXI, Title XIX, and overall FKC enrollment (4, 5).
Figure 14: Comparison of Hillsborough County and Statewide Florida KidCare (FKC) Title XXI, Title XIX, and Overall Enrollment from December 2008 to December 2010 (5,6)
While these graphs depict Hillsborough County enrollments during TCHAI, they do not illustrate the impact that FKC outreach as a whole has had on Hillsborough County FKC enrollment numbers. During 2003 and until August 2005, FKC Title XXI enrollment statewide plummeted by 61% due to legislative changes which included wait list enactment and lack of FKC outreach. Similarly, Title XXI enrollment in Hillsborough County fell 62%. Title XIX enrollment remained consistent statewide as the wait list impacted only Title XXI eligible families, and Hillsborough County’s traditionally high percentage of Title XIX families was 18.6%. In the period of time since the reinstatement of FKC outreach (August 2005 onward), beginning with Back-to-School campaigns, FKC Title XXI enrollment increased 21% statewide, while Hillsborough County FKC Title XXI enrollment increased 30%. The graphic representation of the two year period that TCHAI operated in represents these maintained efforts which have allowed FKC Title XXI, Title XIX, and overall FKC enrollment to rebound from the turbulent 2003-2005 time period at a rate higher than the rest of the state.

Another way to analyse the data from TCHAI is to look at the percent change in Title XXI FKC enrollment compared to Florida FKC Title XXI enrollments. This shows that Hillsborough County FKC Title XXI enrollments were equal to or higher than state averages until May of 2010 when enrollments in Hillsborough County dropped suddenly. The reason for this sudden decrease in enrollment, relative to state trends, is unknown. Upon further research into the socioeconomic trends similar to both Hillsborough County and the State of Florida, it was discovered that not only do Florida FKC enrollment patterns resemble each other, but also Hillsborough County and Florida unemployment rates (7). As the graph illustrates, both Hillsborough County and Florida began at 7.8% unemployment in December 2008 and ended with 11.7% unemployment in December 2010, making both of their unemployment growths 33%. Also, enrollment in Hillsborough County during November 2009 to May 2010 was above the state FKC Title XXI enrollment average, as was their percentage of unemployment. If a correlation between area unemployment and enrollment in FKC programs could be proved, perhaps it would allow for outreach outcomes to be measured by comparing FKC enrollment to unemployment rates.

Table 11: Comparison of Statewide and Hillsborough County Florida KidCare (FKC) Title XXI, Title XIX, and Overall Enrollment from August 2005 until December 2010 (5,6)

<table>
<thead>
<tr>
<th>FKC Programs</th>
<th>Florida FKC Enrollment</th>
<th>Hillsborough FKC Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title XIX</td>
<td>+7.7%</td>
<td>+27.2%</td>
</tr>
<tr>
<td>Title XXI</td>
<td>+21%</td>
<td>+30%</td>
</tr>
<tr>
<td>Overall FKC Enrollment</td>
<td>+22.8%</td>
<td>+27.6%</td>
</tr>
</tbody>
</table>
Thesis Conclusions

Florida KidCare outreach is a commitment to the larger policy initiative which began in 1990, the desire to provide quality affordable health insurance to all of Florida’s children. This policy initiative began as a private corporation and grew exponentially into a state mandated program encompassing over 3 state agencies and countless local entities, overseen by both the state and federal government. As the number of organizations implementing the policy goal of insuring all of Florida’s children grew, responsibility for various aspects of policy implementation became divided between state agencies and non-for-profit organizations. The fragmentation of power between these various organizations added to the amount of time spent navigating bureaucratic processes while attempting to accomplish the policy initiative, making the coordination of efforts and outcomes between participating entities difficult. This phenomenon continued from state level FKC organizations, to community level FKC outreach, with unclear relationships among outreach organizations perpetuating unclear outcomes objectives.

Coordinating multiple large organizations, each with different FKC responsibilities, requires constant interface between organizations’ software, procedural requirements, and administration. Also, all organizations, with the exception of FHKC, have missions that included much more than administering Florida KidCare. Just as HCPS was primarily focused on running schools, and Bay Care Health Networks was primarily focused on running hospitals, the state organizations responsible for FKC primarily run other, larger state programs.

The compartmentalization and continual redistribution of FKC responsibilities among various organizations has added to public confusion about the role of Florida KidCare. Such a complicated network of bureaucratic processes takes focus away from the policy initiative of enrolling children in health care. TCHAI’s decisions to implement systematic change through partnerships with large organizations necessitated that TCHAI work within the guidelines of the larger entities, and required that TCHAI compromise about which project goals be pursued. The limited ability to determine what strategies would be implemented, in conjunction with the immense amount of time required to create system wide change, did not justify the number of applications made through partnership with Hillsborough County Public Schools and Bay Care Health Networks. Overall, TCHAI spent an estimated $300,000 dollars to facilitate approximately 362 enrollments, at a cost of $828 per enrolled child. During the next year of the project, if systematic enrollments result from the work completed so far, navigating the bureaucracies will be well worth the large number of enrollments that would be expected.

The most important lesson TCHAI learned during its first two years of operation, was the need for frequent and effective Florida KidCare outreach evaluation, and that methods for accurately measuring outreach efforts have not been identified. While TCHAI gathered information contained in data cards, information distribution, application tracking forms, and applications outcomes, a clear indicator of TCHAI’s impact was not distinguishable. The number of events attended and flyers distributed does not measure the impact that was made. Without a clear and effective methods of evaluating FKC outreach, the project cannot be declared successful or unsuccessful. Also, because different outreach projects across the state have varying methods of evaluation, outcome comparisons across projects are difficult to make. If Florida Healthy Kids Corporation developed and implemented FKC outreach outcomes measures, used to evaluate all FKC outreach statewide, meaningful results could be achieved, and best
practices from the most effective projects shared throughout the state. As was discovered in TCHAI, tracking the number of applications made by outreach project staff does not accurately measure the wide impact FKC outreach has. Therefore, different information must be considered in conjunction with reports on the number of applications completed by each project. In this report, the enrollment trends of Hillsborough County were compared with those of the State of Florida. Measuring FKC enrollment trends within a county due to specific outreach events also proved effective when compared to FKC enrollment trends statewide. If these methods of evaluation are determined to be the best way to indicate project outcomes, TCHAI must reevaluate its outreach strategies for the final year of the project.

The reported application outcomes, as well as Back-to-School enrollment results, indicated that follow up and partner education needs to be reevaluated. When a parent inquires about FKC, TCHAI partners need to educate parents about FKC programs and eligibility requirements, the renewal process, and the steps necessary to complete applications. These opportunities to educate parents would eliminate application denial due to parents applying for children too old to qualify, and applications from parents who are already enrolled in a FKC program. The fact that these were outcomes of project applications illustrates the need for increased parent education by project staff. Data showing that Back-to-School season’s FKC application volume is the highest of the year, but does not result in increased enrollments, could be a result of families ineligible for FKC making applications, or lack of follow up by both outreach workers and parents. As discussed, parent education could decrease the levels of ineligible applications being made. Providing information to families, such as ‘follow up’ handouts, as well as outreach follow up with parents could decrease the number of families who do not successfully complete FKC application. The lesson learned is that our focus should not be on helping families submit FKC applications. Instead, FKC outreach should focus on helping families successfully complete an application with Florida KidCare. This subtle shift in program focus, placing more emphasis on parent education and follow up, has the potential to change the outcomes of parent’s applications to Florida KidCare.
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Chapter Two Sources

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Chapter Five Sources