



Medicaid and CHIP Engagement and Enrollment Strategies for Multi-Generational Families

Connecting Kids to Coverage National Campaign

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Gabby Duran: Welcome to the Connecting Kids to Coverage National Campaign Webinar. The topic today is Medicaid and CHIP Engagement and Enrollment Strategies for Multi-Generational Families. I'm Gabby Duran, and I work closely with the Connecting Kids to Coverage Team to support the enrollment of more children and parents in free or low-cost health care coverage. Multi-generational households, kinship care, same sex parents, single parents, and siblings living together are just some of the many diverse family structures in which children who are eligible for Medicaid and the Children's Health Insurance Program, or CHIP, live and thrive. A Pew Research Study analysis reported a record 60.6 million, or 19% of the American population, lived with multiple generations under one roof in 2014. Family structure can be influenced by cultural, financial, and situational factors. In addition to providing benefits for family members and children, family structure may also raise some challenges around health care access and eligibility. Additionally, because the caretaker role may be shared in these families, it can be difficult to identify children and families eligible for Medicaid and CHIP. Our webinar today will provide tips and strategies to connect eligible children and families in diverse family structures to Medicaid and CHIP health coverage. In just a moment, Jessica Beauchemin from the Centers for Medicare and Medicaid Services will walk us through the agenda. But first, I want to repeat a few housekeeping items to get us started. Your meeting control panel is located on the right side of your screen and will automatically minimize if you are not using it. If you need to expand the panel, click the orange and white arrow button on the control panel grab bar. There are two ways to listen to the audio of this webinar. In the Audio section, you can select either telephone or mic and speakers. And your audio line will be muted for the entire presentation. You are free to type a question in the question section at any time during the webinar. We will address them at the end during the Q& A session. With that being said, I'll pass it over to Jessica Beauchemin. Jessica?



Jessica Beauchemin: Thank you Gabby, and thank you everyone for joining this Connecting Kids to Coverage National Campaign Webinar, our first webinar of 2017. My name is Jessica Beauchemin, and I work in the Division of Campaign Management at the Centers for Medicare and Medicaid Services. Today our speakers will cover various strategies and tips your organizations can use when identifying and engaging eligible diverse families in various settings. Our speakers will also discuss how to develop messages and activities that will resonate with multi-generational families and help expand the reach of your enrollment work. Our webinar will kick off with WyKisha McKinney from the Children's Defense Fund Texas, who will discuss her organization's work advocating for quality health care coverage for all children. Next, Dr. JaNeen Cross, a Policy Fellow at the National Association of Social Workers, will share best practices for leveraging social workers to connect families and children with health care coverage. We will then hear from Alan Vietze from the New Jersey Children's System of Care who will discuss the state's integrated services and how they work with children and families to improve health enrollment and outcomes. And Ann Bacharach and Laval Miller-Wilson with the Pennsylvania Health Law Project will share how they are working to connect families to mainstream services including Medicaid and CHIP. We will then learn about the Connecting Kids to Coverage National Campaign resources that are available to strengthen your outreach efforts. We will also address questions at the end of the webinar, so please be sure to use your chat box throughout the webinar to submit your questions to our speakers. Gabby is going to get the webinar started with our first poll question. Gabby?

Gabby Duran: Thank you Jessica. So before we begin, let's answer a poll question. This question is, which multi-generational family structure does your organization see most frequently in your community? Please select one of the following responses and we will share the answers in just a bit. All right, great. So it looks like almost 63% of the attendees work primarily with single parent homes or diverse family structures. We have another quarter who are working with multiple generations living in one household in their community. So very interesting, great range of who everyone is seeing in their communities as these diverse family structures. So thank you everyone for your responses. We are excited to hear about the families that you work with and sharing more resources and tips about how to better connect them to health coverage. Next slide please. We will begin by sharing more information about these diverse family structures and how they can affect health care coverage and engagement. There have been many changes in



the American family. The structures of families and households have undergone significant changes in American society. What was historically thought of as a traditional family, two parents and children, have been represented in American culture for most of our history. But in the past few decades we have begun to see many different kinds of families being represented both on TV and the media and movies as well as in our communities. The public opinion of how we define and create families has also evolved. From the figure to the right from the Pew Research Center, we can see that in 1960, about 50% of children under 18 were living with parents in a first marriage with a stay at home mother and a working father. In 2014, that number was at 14%. In addition to other family structures that were emerging at that time or have emerged, 32% of parents were in a first marriage with other work arrangements. 26% of children were living with a single parent, and 5% of those children were living with neither parent. So as we had mentioned in the beginning of our webinar, a number of social and economic factors have led to the changes in the way that modern Americans structure their home lives and families. We see that Americans are marrying less. They are also marrying later in life, having fewer children, living alone or cohabitating more often. The divorce rate has also increased, and people are entering multiple marriages or marrying multiple times. Fewer than half, or 46% of US kids younger than 18, are living in a home with two married heterosexual parents in their first marriage. That is a big change from what we saw in earlier figures. Next slide please. To give you an idea of the breakdown of who children are living with, 50% of children are living with two parents who are in a re-marriage. 34% of children today are living with an unmarried parent, which is up from 9% in 1960 and 19% in 1980. 4% of children are living with two cohabitating parents, and this is all according to the current population survey data. 5% of children are not living with either parent, and in most cases they report living with a grandparent. The number and share of Americans living in multi-generational family households continues to rise. As 1 in 5 Americans live in multi-generational households at the moment, and a growing racial and ethnic diversity in the US population can help explain some of the rise in multi-generational living. With these diverse household structures, including kinship care, same sex parents, single parents, and siblings living together, these are just some of the many diverse family structures that people who are in outreach and enrollment with Medicaid and CHIP see children living and thriving. And Medicaid and CHIP do offer health coverage for all eligible families and children, and it is really our job to connect these families to the proper engagement channels and enrollment channels in order to get



themselves and their children covered. We're going to kick it off with another poll question. We'd like to know what percentage of outreach and enrollment work does your organization do with multi-generational families? You can select from the responses here, and we can share your responses in a bit. Okay, it looks like most people have voted now. It looks like about 42% of the attendees today do 25% to 50% of their work with multi-generational families, and about one third of you do a quarter of your work with them and a quarter do about 50%. So we really are engaging a lot of these families and seeing them in the enrollment work for Medicaid and CHIP. So thank you for sharing that, and we ask you to continue to share your experiences and strategies in the question section of the meeting control panel, and we can share some of these examples or success stories at the end of the presentation if we have time after the Q&A. I'm going to pass it over to our first speaker, and that is Dr. JaNeen Cross. Dr. Cross is a HEALS Policy Fellow at the National Association of Social Workers. JaNeen?

JaNeen Cross: Hello Gabby and Jessica. Thank you for having me. Thank you attendees for taking time out of your day to listen to our presentation. I am actually very pleased to be here to talk a little bit about prioritizing access to health care for children and to speak specifically about the role of the National Association of Social Workers as well as social workers in connecting children to coverage and making sure we support families appropriately. This slide too talks a little bit more about National Association of Social Workers. We are the largest organization of professional social workers in the United States. We have approximately 130,000 members, 20,000 of those members being students. 14,000 members are new members yearly. And we also have 55 local chapters, one in each state plus New York City, D.C., US territories, as well as international groups. Our local chapters provide us with our local connections to neighborhoods and communities and help us disseminate the work that we do throughout the year. The next slide talks about how we locate families. We know that social workers work directly with different types of families and diverse family structures in various settings. Our work with families provides us with our point of contacts with children and families. Some of the family engagement settings that social workers are involved in includes clinics and hospitals as well as daycare programs and schools, shelters and community, as well as agencies. Other areas that social workers work in include mental health, child welfare, and juvenile justice just to name a few. These areas provide point of contacts to our families. Social workers use broad and inclusive definitions and understandings of families and family engagement to do our



work. It is through our point of contacts that we connect with families and help assist them get coverage. The next slide talks about how NASW connects kids to coverage. A lot of focus here at NASW has to do with policy, practice, and a lot of the work that we do here helps bridge access gaps as well as address health disparities in social policies. So we monitor policy changes. And in that, some of the policies that we are currently monitoring include Medicaid expansion and family access to high quality health and behavioral health services. We also monitor and enforce mental health parity provisions to ensure that families have equal access to insurance coverage for mental health and substance use disorder services. We also work on policies that help address employment trends and opportunities related to social work. So we want to make sure that social workers are included in key policies. We also want to make sure that we promote the role of social work in terms of how they interact with patients and families in our point of contact settings. We also want to make sure that we promote the inclusion of social work and social work leaders in health care reform activities. We also make sure that we address current events in policy such as the reauthorization of CHIP in 2017 and the supplemental maternal and child home visiting services to vulnerable families. And we also make sure that we work on policies that educate not only social workers but also the public at large. And so the next slide I talk a little bit more about what are some of the direct things social workers do in order to help children with insurance enrollment. Often times in our point of contact settings, social workers identify uninsured as well as underinsured children and families. They often refer to agencies that help initiate insurance coverage, but also social workers are often trained to actually initiate insurance coverage at their settings. In addition, social workers are often trained also to provide more in depth education and insurance counseling related to eligibility, benefits and provider options. Social workers also assist families in navigating coverage options for insurances, but they also assist families when there is a loss in coverage or there are lapses in insurance and they need assistance being reinstated. The next slide talks a little bit about how social workers in general, a quick summary of how we do this related to Medicaid and CHIP. So as I stated before, we also work a lot on policies that help advance and promote social workers in their roles and settings. We want to make sure that there is proper staffing for social workers in our point of contact settings to help engage diverse families and enroll them in insurance programs. We also participate in open enrollment programs for insurances. NASW as well as social workers are also involved in health promotion and health literacy campaigns, and also they really work hard on championing overall health,



not just for families but also our vulnerable children. Next slide please. Even though NASW is very successful in their policy and practice outreach, they are strengthened by their community partnerships. There are many areas and partners that NASW collaborates with. Some of the government agencies that they collaborate with include the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, and the National Institute of Health as well as key contacts at the White House. Our government collaborations help NASW educate and work on health care policies that support families. NASW also connects with professional organizations. Some of them are social work specific, and other agencies are interdisciplinary. Some of the professional organizations that NASW works with include the Society for Social Work Leadership and Health Care, Association of Oncology Social Workers, National Association of Perinatal Social Workers, as well as the American Psychological Association. And it is through our professional organizations that we are able to disseminate information and resources as well as galvanize support and momentum related to policy, policies and practice. Another area that we forge community partnerships is through our education. The Council for Social Work Education and Society for Social Work Research are professional organizations that focus on education. But we also use our schools of social work as well to forge programs to help us with outreach in the community. Next slide please. Back one more, thank you. So again. Some of the areas that we use in terms of community outreach that helps us really address Medicaid and CHIP policies and practice. One of them is the Health Education and Leadership Scholars, the HEALS program. And this program helps us improve our outreach in the community because it strengthens the health care service delivery by training social work policy and practice leaders and have them conduct a lot of outreach work and support in their respective communities. We also take part in what we call Health Care Champions. And this is where we have public or private organizations and businesses that promote health care coverage within their own communities. And this includes engaging in various educational and outreach efforts, leveraging materials and resources. It also includes in person or virtual educational events, social media campaigns, and distributing materials to their consumers as well as providing space and resources for enrollment events. We also have Social Work Day on the Hill, and this is one of our educational partnerships with some of the partners that you saw on the prior slide. But also it is a collaboration with the Congressional Social Work Caucus to advance policy and education priorities, particularly related to health care policy with social work students. The day also includes congressional visits to



address health care policy with our representatives of Congress. And in this role, students are able to visit their congressional members and discuss any health care policies that are of particular concern as well as present asks to their local congress members. NASW also has a Grassroots Toolkit, which is located on their website, and it provides an overview of grassroots activities and a step by step guide on how individuals can take action locally. That includes meeting with their representatives, doing letter writing, or op-ed submissions. So as we see in terms of the social work role and working with diverse families and helping enroll and connect children to health care, we see the social work role as very important. As our CEO states, social workers will continue to make sure that our country works, specifically related to health care for everyone. And we also want to make sure that we use our strength in numbers in order to organize and advocate as well as educate on behalf of families and also help advance policies and practice that helps promote and support oppressed and vulnerable families. Thank you. And I also included a couple of additional resources on the next slide, can you move forward? These resources can be found on our website, it's open enrollment resources as well as the ACA website information. Next slide please. Also it provides other resource tools that we provide, some are to members and some are open to the public such as our practice perspectives and smart briefs. Also here are some websites that are population specific that provide available and additional resources to families. Thank you very much.

Gabby Duran: Thank you JaNeen for sharing the important work that social workers conduct with families around Medicaid and CHIP and for the work that your organization does as well. We appreciate the additional resources. You can find also, this will be recorded so you can find it on the webinar but also on the NASW website. Our next speaker today, we have WyKisha Thomas-McKinney. WyKisha is the Program Director at the Children's Defense Fund in Texas. WyKisha?

WyKisha McKinney: Hi and thank you, thank you all so much for joining in today. As mentioned, I am the Program Director here in Texas with Children's Defense Fund. I am very excited to be on today and sharing some information and best practices related to our work with schools. Next slide please. Children's Defense Fund's mission is to ensure every child a healthy start, a head start, a fair start, and a safe and moral start in life and successful passage to adulthood with the help of caring families and



communities. So we do have several offices around the country, one here in Texas specifically. Our Texas offices are located in Austin, Houston, and also in McAllen Texas in the Rio Grande Valley, as well as satellite staff out in some of the East Texas counties that I'll talk about in a second. Next slide please. So in ensuring children a healthy start, our health outreach and enrollment project ensures that every child has access to affordable and comprehensive health coverage and mental health coverage and the care that they need to grow and thrive. We want to make sure that every child has access to a doctor to get a proper checkup, to medications if necessary to try to avoid any type of health problems or issues that may arise that would interfere with their ability to become successful adults. And we do this by meeting families where they are. We collaborate with schools, businesses, media and community partners as well. And we provide education and training about affordable coverage options for children and families. In meeting children where they are, I always like to share with the team is the nature of outreach is that we are out reaching. We don't wait for families to come to us, we try to figure out where they are, where they are getting their needs met at, whether it be at school or libraries or the local WIC clinic, and how we can make contact with them. And in addition to that, we provide education and training not only to the families of uninsured children where we help them to disseminate how to apply for coverage, what to expect next. Also, how to make sure that they are fully utilizing their coverage. We also provide education and training to those community gatekeepers who would come into contact with families with uninsured children. So for those gatekeepers, whether it be school nurses, small businesses, child care centers, we want to make sure that they are well educated on CHIP and children's Medicaid coverage and where they can refer their families to for help. So we try to leverage those partnerships and relationships throughout the community so we are able to find every contact point that we can to reach our families. Next slide. So with our school based health outreach work, CDF Texas has worked with more than 35 Texas school districts for a little over 15 years. We've also worked with other organizations who have taken part in our campaign. One of the things that we ask our schools is to add a health insurance question to the school enrollment form or other health documents or even sports physical forms or other documents that they would need to register a child in school. Then we ask that we collect that data to identify the need. And we don't necessarily want to know specifically the names or contact information, we are definitely very careful about confidentiality and HIPPA and all those other rules that protect the identities of families and children. So we are just looking for



aggregate data that shows us where the need is within those school districts. From that data, it helps us to identify the most appropriate strategy for reaching those families and encouraging them to apply for coverage. Then we follow up with information about how to apply, use and renew CHIP and Medicaid. The important part, you know, once we get families on board, we definitely keep up with them and try to maintain contact with them over time to make sure that they maintain their coverage and that they are actually utilizing it. As many of you may know, the renewal time is a time where we lose a lot of our families and a lot of children lose their coverage. And so our outreach team here at CDF Texas has made it a point to reach out to families close to their renewal time and remind them to apply and schedule time to provide assistance in that arena as well. And then for those who do not qualify, we do provide them with education and referrals for [healthcare.gov](https://www.healthcare.gov) or other community health clinic options. So we do try to build a network of referrals and resources for every individual to receive some type of health care. Next slide please. One of the things that we've done, based on our years of school based health outreach work, we have developed a toolkit which is accessible online. You can also download a hard copy from this website, www.insureallchildren.org. This website is based on the work that we've done with local school districts here in Texas as well as school districts in California and some other states that we've worked with in the past. And we've included in here some very detailed information about how to establish your own child health outreach program within the school district, how to develop a partnership with the school district, what are the things to look for, and what community partners and what are some key community partners that are available there, how to keep the family engaged and also how to sustain the project within the school district. It's a wealth of knowledge and information and I encourage you all to visit the website and grab some good information and definitely keep in contact with us and let us know how it works for you. Next slide. Now, we have recently expanded our work. We have moved into six rural counties across Texas, and those counties include Hidalgo, Willacy, Cameron, Nacogdoches, Smith and Shelby Counties. So we are currently working with schools, community partners, and businesses and those partners that I mentioned before in these local counties. So if there is an opportunity to expand our work and to really make our work more effective, please feel free to reach out. Next slide please. Now, specifically in reaching multi-generational families through the schools. The schools provide an ideal opportunity to reach multi-generational families, specifically for us at CDF Texas we definitely do come into contact with quite a few grandparents or relatives that are raising children. So even



like Grandparents' Day, Donuts with Dad, Muffins with Mom, school enrollment and different large events that the schools are putting on offer an opportunity for us to reach out to those multi-generational families. Also if there are multiple families within the home, this is the time where we may come into contact with children that are cousins or that are living in the same home with each other but may not necessarily be siblings. So we definitely take advantage of those opportunities to connect with our families. As I mentioned, new student enrollment and orientations are also an ideal time for reaching out to these families as well. This is a time where the kids are on their mind and the things that they need for school and to enroll in school is on their minds. So if there are vaccinations needed or anything like that, then they would be referred to us from school staff or administrators and nurses in order to get them the health coverage they need in order to receive those. Next slide please. So as you are working with the schools, it's important to keep in mind that some key players within the schools are going to be your health and nursing leads. We find that the school nurses are usually our first point of contact with referring families for assistance with CHIP or children's Medicaid, particularly because children who don't feel well, whether they have ear infections or problems with their vision or toothaches will go to the nurse more often. So this is a time where we can provide outreach and education for the nurses so they can refer those families to us. We definitely want to get the buy in from administrators, principals, and teachers, the more folks in the schools that are aware of what you're doing and the work that you're doing the better. That way, the families can be educated and they can be referred properly. Parent involvement representatives as well in some school districts, particularly one of the school districts that we've worked with in the past, Edinburg Consolidated in the Rio Grande Valley. Their parent involvement reps are responsible for maintaining contact with the parents. And so if they notice that there is a child that is having problems with absenteeism or some other issues that are taking place, they will make contact with that family and try to problem solve to make sure that the child is in school. That is a great representative and a great group of folks who can offer the referral and provide some outreach for CHIP and children's Medicaid coverage. Different community partners like communities and schools here in Houston. School health clinics as well are also great partners. And also think outside of the box, what type of partnerships can you establish that may provide additional resources? For instance, AARP is a great resource for grandparents raising children, so it is a great relationship to have in order to make sure that we can help grandparents with applying. And finally, parents and students are



always a key player, word of mouth is always the best form of marketing. We get many of our families to us because they have heard from a friend or a sister in law or a sister about the help that we provided to them, and so they come to us as well. So just keep in mind that, you know, there are definitely some key players within the schools that could help you with identifying and reaching those uninsured children. Next slide please. When assisting the families, always make sure that you are taking time to learn about them. Who lives in the home, who takes care of the children. A key example, we had an outreach worker who went to assist a family, she actually met with them and went to their home because transportation was limited. There were a number of children living in the home. So when she went to meet with them within the home, she discovered that there was not one but three families living in the home. So she was able to provide application assistance for CHIP and Medicaid for all three families and all children received health coverage because of her work. So it's important that you take the time out to learn about the family. Make home visits when necessary. Just take a few minutes to find out who is responsible for the children and what the makeup of the home is. Always ask if the family, or if they know of anyone else who needs health coverage. Include resources specific to multi-generational families. So if you have resources for grandparents or if you have resources for single parent homes or families with multiple generations, it's more helpful for them. So if you can offer those referrals and information to those families that would be helpful. Also make sure that it is in a variety of languages. As we saw on the slide earlier, there are definitely many families who may speak different languages, so we want to make sure we have the right resources available to them. And remember that many families have limited experience with technology and online processes, and therefore it may take more time with taking them through the application process online if you are accessing Your Texas Benefits or wanting to complete the application online. And some families may just be more comfortable with using a paper application, and those can definitely still be downloaded at yourtexasbenefits.com. Next slide please. That concludes my presentation, and I thank you all for listening and joining in today. I can be reached at my email address here, and you can definitely find out more information about our project at cdf-texas.org. Thank you.

Gabby Duran: Thank you for sharing those insights on connecting children and families to health coverage through school based partnerships and initiatives. We appreciate all the helpful information that you shared and some of those tips for how to best reach families and engage them. Our next



speaker is Alan Vietze. Alan is the Deputy Director for the New Jersey Children's System of Care. He'll be speaking with us today about service linkage through family engagement. Alan?

Alan Vietze: Good afternoon. I'm going to discuss the Children's System of Care Initiative, which began in 2001. I hope this is of consequence to those listening. So Children's System of Care was initially instituted as a wraparound process to address the needs of youth with behavioral and emotional challenges. As it's grown over time, it has become an initiative that addresses the holistic needs of children, youth and families. The structure in our department, which is the New Jersey Department of Children and Families. We have five different units: Children's System of Care, which provides services; Division of Child Protection and Permanency, which is our child welfare division; Division of Family and Community Partnerships, which is an opportunity for families to go to Family Success Centers and obtain services that they need to support themselves; Division on Women, that relates to women's issues including domestic violence; and the Office of Adolescent Services that relates to youth in transition and homelessness. So I'm going to address the issues from the Children's System of Care. Next slide please. We try to provide services at home and keep kids in school and in the community. This is done by development of a care management organization, we have 15 of them across the state, and they are responsible for functioning within a child family team. Our services are youth and child focused and family driven. And included in the child family team process are people who the family would like to have and are able to address the complex needs of our children. Included in our complex needs are accessing health care services for youth as is needed and all the children are screened, there is a priority eligibility done for Medicaid and if youth are not eligible for Medicaid they receive a state only insurance, there is CHIP and then there are other services that we pay for in the state. So no youth, no family of any sort is turned away from the Children's System of Care. They all can receive services. And we base it on need. We have an elaborate evaluation process. Next slide please. So one of the things we like to do is we like to set the stage, we feel that language, how we describe children and youth, we like to describe them as children, youth and young adults, not clients, cases or consumers. We talk about parents and caregivers, not mom and dad. We talk about treatment, not placement. We talk about engagement, not motivation. We talk about transition, we don't close or terminate youth. And we talk about missing children, not runaways. And when a youth is in out of home care, they go on home visits, not on therapeutic leave. Next slide



please. This pyramid gives us some sense of the type of services we provide. We have a 24/7 access to services, someone can call at any time. A family can call, a care manager can call, our juvenile justice system can call, the police can call, a hospital can call to access services through what we have is a contracted systems administrator who is a third party. It is a no-risk model of managed care. And they will be reviewed and have access, we do triage, we may do some evaluative work, and we always do information and referral. So that's open 24/7. Bottom line is we are going to do a comprehensive assessment of a child's needs, and if they are referred to the care management organization, the care management organization holds team meetings at the outset to address the needs and the strengths of the youth and family and assigns a care manager and a family support partner. So all the youth who come into our care management organizations have access to a family support partner. Those people are usually folks who have had children who have gone through the system. They are a separate organization that the state funds. So we try to put, like I said, it is family driven services, and we want to support the families in this process. They can have access to outpatient treatment, and that includes not only behavioral health or mental health outpatient treatment but if they need medical care we link youth to the medical care. In the last two years, we've developed what we call a behavioral health home, so that links, that provides the care management organization with medical staff, nursing staff, and health professionals to be able to address the needs of youth who have medical issues, not only behavioral health issues, and link them to services in the community and follow those services in the community. In addition, in the last four years we added to our scope of services working with intellectually and developmentally disabled youth as well as youth who have co-occurring or substance use services as well. So we are covering a broad cross section of services for youth. We've also developed services that can go into the home, you see the intensive in-home services for developmentally disabled youth, intensive in community services or behavioral health services that go into the community, work with the family, and behavioral assistance that supports some of the behavioral plans. As I said before, we have a family support organization that is linked to every family. They also provide a center for families to come for groups, supports, to have someone to talk to, and to understand how to navigate the system. In case of an emergent issue, any family in the state can access, 24/7, a mobile response and stabilization service. It's a service that can go out within one hour at any time and will go to any family who needs services. They will provide support for 72 hours and then they will do an evaluative



process, develop a crisis plan if need be, and they may continue to provide services in the home and/or linkages in the community for up to 8 weeks. At the end of that time, they probably, if they continue to need services will be referred to the care management organization. As I said, we have 15 care management organizations across the state. They manage with a very low ratio of care managers to families, child family teams, and as I said before, they evaluate what services are needed and how they can be accessed. Aside from using Medicaid and CHIP, the care management organizations have flexible funds to pay for other types of services that they might need. If indeed a youth needs to have out of home treatment, we are able to provide that. Over the last 12 years, we have reduced utilization of out of home treatment by 50%. At the same time, in New Jersey, utilization of juvenile detention has been reduced 67% because we have developed a good linkage between the juvenile justice system and our system of care rather than incarcerating youth or functioning with them in the penal system, they get services through the Children's System of Care, thus part of the reduction of utilization of incarceration. Last of all, and least favorite, we do provide in-patient treatment if the youth needs very intensive care. Next slide please. So as I've already alluded to, the child family team has family team members, professionals, community residents identified by the family, and it's organized by the care management organization. And they develop this individualized service plan which drives all the care, both medical and non-medical, for the youth. We try to get a broad cross section of folks to be part of the child family team. All treatment decisions, be it behavioral, developmental disability, medical, all issues are driven by the child family team. And family members are certainly encouraged to participate in all aspects of the treatment. We work with a myriad of types of families, and in New Jersey a tremendous number of different cultures. Next slide please. Here we have the presumptive eligibility process. So much of our system is based on a Medicaid platform. As I said, if the youth is not eligible for Medicaid, he or she can receive those services through state only funds, but it is blind to the provider, no one knows the difference. Granted, if a youth appears eligible for our services based on assessed clinical need, they are going to get services. We also start, we provide services before the whole eligibility process goes through, so there is presumptive eligibility. We don't want our children and families to go without services if they need them. We have all our services are authorized and linked to billing if need be based on third party by our contracted systems administrator. It is a no-risk agency, so they don't get paid extra to say no. They are paid to say yes. And so we have what's called the 3560, and that's the non-Medicaid coverage, but we



call it a Medicaid lookalike card for services only. Medicaid coverage, and then we are doing more Medicaid with the recent Medicaid waiver. So our services are covered by care management, family services, out of home, intensive in community mobile response, IDD services, and substitute services, and access to any medical services. Every care management organization has a PE, a presumptive eligibility coordinator. And we manage all our work through an electronic health record. Next slide please. Some of the outcomes we've had. We have less children in institutional care by having this model, less children accessing inpatient treatment, closure of state psychiatric hospitals and many of the residential treatment centers. We don't send kids out of state any more for services. Children in out of home care have more intense needs than prior to the System of Care development. So youth who go into out of home services are only those who have intense needs. Kids without intense needs we're keeping in the community. We see that the wraparound model, the holistic approach is successful. I said before, less youth in detention centers for a variety of reasons in the community, but we have been able to manage their care. And so we also access federal funding support under Title XIX. Next slide. So this is, you can access, you can see more about our system at this website that I have here and also at the PerformCare Member Services, that's our contracted services system administrator, PerformCare. They give a list of services and how to access services. Thank you very much for your time. I hope what I had to say was consequential to your work.

Gabby Duran: Thank you so much Alan for sharing the highlights of your work and the positive impact it has had on the children and families in New Jersey. We appreciate you being on today.

Alan Vietze: Thank you.

Gabby Duran: Our next speaker is Ann Bacharach, and she is going to speak about comprehensive case management for children and families. Ann is the Special Projects Director at the Pennsylvania Health Law Project. Ann?

Ann Bacharach: Thank you. We can go to the next slide. So in our project, under this particular grant, we have been focusing on vulnerable adolescents. We describe adolescents as being between 13 and 25. We've looked at two particular groups: adolescents in alternative education sites and youth involved in the juvenile justice system in one form or another. For the alternative education sites, we looked at alternative high schools, which



are sometimes those facilities where within a school district disruptive youth are sent rather than being in a regular high school. And the other focus, which has been sort of prime in our activities, has been in looking at GED to community college programs, where youths who have left high school but are still under 21 can come back into a program, and usually that program has a site rather than just an online approach, get their GED, and then either then get support to community college entry or get some vocational training, building trades, food service, home health services. And then we also looked at youth involved with the juvenile justice system, looking at in some ways what Alan was talking about, the opportunities that are presented at intake. A youth may be arrested and warned, and that is an opportunity to ask about health insurance. Youth on probation who are not necessarily adjudicated delinquents, which means they do not go before a judge for determination but are supervised for a period of time. And then an opportunity also at discharge, when youth are leaving supervised care, will lose their justice involved Medicaid under Title 4E and need to get Medicaid through their own system. Next slide please. So we have learned, as families are diverse, that an adolescent between 13 and 25 can be living with a parent, grandparent, aunt, uncle, siblings, nieces, nephews, their children or on their own. Most applications have been for the adolescents in these settings, but some have included other family members, parents, siblings, nieces. Most applicants are citizens but the project has assisted lawfully present immigrants, one refugee, one asylee and one family with suspended deportation. So we needed to know our immigration rules pretty clearly. Next slide please. Youth under 21 who are returning to school after leaving high school has been the focus of one of our projects. They have to be over 18 but under 21. They are all full time students. Some of them are also working in addition to being full time students. The school requires health coverage, and part of that is because these are youth getting their GED and some vocational training, so there is some risk to their day to day activities. The case managers in this particular high school have identified the youth without proof of some form of health coverage, and we worked in terms of engaging them in the application process. You can also self-refer. I spend my time sitting in a classroom in the building, and they often self-refer themselves or their friends. We've done one application over the phone for the boyfriend of a student just to get them involved. Next slide please. This is a big step for these young people. These are the first steps on their own in their transition to adulthood. Many of these are not aware of their lack of coverage or they don't know their status or they don't know how to go about applying. The navigator, in this case me, sets up regular times to be onsite,



varying to meet attendance needs. Some of these youth spend a week in the building and then spend a week out in their vocational training and then rotate back into the building for their GED courses. We learned that we need to provide food at lunch time. We work with the case managers as I said to identify those youth without health insurance. One of the things that we have access to because we are a non-traditional provider of services within the Medicaid system here in Pennsylvania is that we can check the Medicaid enrollee database and know whether this young person is really uninsured or just unaware of his or her status on Medicaid. Next slide please. As we said, we also use this state's web portal for applications, which has the capacity to upload documents. And when we do the applications in person, we are also empowering the young person sitting next to us, we share the screen and complete the application together. So they know where these questions come from, why they are being asked. They also help me correct my typing. So it's nice to have a right handed proof reader while I'm doing this work. We also do applications over the phone. Generally we try to start the process in person, but if the young person has to run to class or their job we can then finish the process over the phone. We use text messaging, most of these young people have a phone, as reminders to complete particularly the verification or to give the heads up, I'm going to call you in five minutes and we can finish the application if that's still okay. And then they use their cell phones to take photos of the proof, their ID, their social security cards, pay stubs if they have them. And then we can use that to upload into the state's web portal. So a photograph is a handy thing. Next slide please. This project has really involved YouthBuild Philly, which is an alternative high school as I said for young people getting a GED and vocational training. Their goal was to have 100% of their students with health coverage, and as I said we have done this assistance. We began last August when they first started their year. As of the end of December, of the 100 students in this particular yearlong program's cohort, only 11 students remain uninsured, and half of them had insurance recently. So they lost their coverage at the end of December or the end of November. We are reapplying rather than necessarily starting a new application for the 11 that remain. Next slide please. The other half of this project is really outreach to the juvenile justice system. Two juvenile probation officers and their staff, so their financial counselors and case managers within the probation system. Public defenders who are helping these young people navigate this system in one form or another. And then child welfare staff if these young people actually do end up in a supervised setting. We've had interest from multiple counties. We've done a great distribution of outreach materials. We have used the CMS



materials and customized them, particularly the skateboarder which you'll see I think in a little bit. We've done that through palm cards, through posters and flyers in both English and Spanish. So far we haven't seen a strong need to translate into other languages, though that capacity remains. We've done presentations to juvenile probation staff. We've worked with the Pennsylvania Juvenile Court Judges' Commission doing both newsletters and trainings through their conferences and webinars. This has been an interesting project, can we go to the next slide and I can explain a little bit more why. So there are some persuasive reminders about Medicaid that resonate with the juvenile justice system itself. Medicaid covers all medically necessary services for youth up to age 21. It can be secondary coverage when there is employer based or individual market coverage. It covers Multi-Systemic Therapy, a common treatment recommendation for youth in the juvenile justice system but it's not usually covered by private insurance. It's as you can imagine not a traditional form of therapy. So by getting that covered through Medicaid, the Medicaid payments can offset the juvenile justice costs in each county. Then Medicaid coverage provides continuity after the youth leaves that particular system in terms of their physical and behavioral health medications, ongoing therapy, and regular health services and family planning services for young women, etc. Next slide. And that would be it. Thank you so much. This has been an interesting project, and I'm happy to answer questions about it.

Gabby Duran: Thank you Ann for sharing all of your engagement strategies and enrollment as well as your successes including YouthBuild Philly. We really appreciate you being on and we'll follow up with a question and answer session. Thank you. And now we're going to quickly go over some of the Connecting Kids to Coverage National Campaign resources before we open up our Q&A session. The campaign has a number of downloadable resources to help enhance your outreach and enrollment work. These include tip sheets, eNewsletters, and ready-made article templates as well as PSA radio scripts and more. We also have a range of digital media tools, including social media graphics and guides, web buttons and banners for different topics, and sample social media posts as well. They cover a wide variety of material topics. They cover year round enrollment, we talk a little bit about oral health especially around February which is Dental Care Month. We also have materials around vision, teens, and sports. This is what Ana had referenced before. We do customizable materials including posters, flyers, palm cards and tear pads. The materials that are available for your outreach efforts are provided both in English and Spanish and in additional



languages as well. So the process to customize these materials takes approximately two weeks. We also have all of our videos and webinar archives on our outreach video library and webinar archives, so please feel free to look at those and check them out with the various topics that we do during the year. Next slide please. There are several ways you can stay up to date with the latest Medicaid and CHIP outreach strategies and stay connected to the Connecting Kids to Coverage Campaign. To expand your outreach, connect with the campaign on social media and follow @IKNGov on Twitter for campaign updates and share resources across your social media channels. You can also tag messages using the hashtags #Enroll365, #KidsEnroll, #Medicaid, and #CHIP. And we would love to see what you are doing in your communities, so please tag us using those hashtags. You can also sign up to receive our campaign eNewsletters. They are distributed throughout the year and provide updates on campaign activities. And if you want to share anything about the work that you are doing in your community, please email us at connectingkids@cms.hhs.gov. So we have been monitoring your questions throughout the webinar. We wanted to take the opportunity to address some of those questions. I think we had one come in for WyKisha. An attendee wanted to know if the downloadable application is just for Texas coverage.

WyKisha McKinney: There are, excuse me. You can download the application, on Your Texas Benefits it is for Texas coverage. I believe that there are two applications. So you have one if you want to apply for all state benefits, so that's Medicaid, SNAP, TANF. Or if you just want to apply for health coverage, that is the Federal Health Care Marketplace application.

Gabby Duran: Great. Thank you for that. And I will open it up for all of our speakers today. What types of questions do you receive from the families you are working with about eligibility?

Ann Bacharach: This is Ann. One of the trickier questions that we have to get answered in the process is, what is your tax household? And that invariably will prompt a call from the young person back to whoever claimed them last just to make sure that they are not going to be claimed. If clearly they are going to be claimed by somebody, we then need to get additional information from the head of that household. So that's one of the more intricate pieces that we get, which is so, if I want to apply I have to have my mother's information? And the answer is, sometimes, not all the time, but yes.



Gabby Duran: Great, thank you for sharing that Ann, that's really an important piece of information that definitely comes up along eligibility lines. Is there anyone else that has, any other speaker that has frequently asked questions to share?

JaNeen Cross: Yes, this is JaNeen Cross speaking. When I was doing direct practice work, I would get a lot of questions related to income and eligibility. I would always direct families to experts in the area, either their local county assistance office or the hospital billing department to speak with a representative to go over more specifically what their income is as well as to assess to see if they are in their household size to determine that they are eligible for insurance. I also often times worked with younger head of households, specifically teenage mothers who were concerned about their ability to be able to establish health insurance not only for themselves but for their newborn child as well. And this is just mainly supporting and encouraging them to also go through the local county assistance office because they were eligible for benefits, but a lot of times there was a fear.

Alan Vietze: This is Alan. One of the things we find ourselves doing is allaying people's fears in terms of eligibility. So we work very assiduously up front to let people know that that is not a concern, that we actually are able to manage it. And our care management organizations are experts in necessarily linking families to services as they need them and also getting them the way to support those services.

Gabby Duran: Great, thank you all for chiming in here. I think those are some really important takeaways for definitely approaching families where they are in the process and really as Alan had mentioned assuaging fears about eligibility and income as well. I appreciate you all being on the webinar today, and thank you all for attending the webinar. Remember that the campaign resources are available for download on the website. Also, this webinar will be available on the website in about two weeks. So if you missed any part of the webinar, please check the webinar archives on insurekidsnow.gov. Thank you all for joining today and we look forward to seeing you on our future webinars. Thank you.

Jessica Beauchemin: Thank you everyone.