
3 | CHI EVOLUTION, GOVERNANCE & STAFFING

CHI Evolution: The Four Stages of CHI Development

Over time local Children’s Health Initiatives transition from an informal group of stakeholders with common objectives to a coalition of aligned partners with formal policy decision-making and program oversight responsibilities. CHI evolution occurs across four developmental stages with the amount of time spent in each stage varying based on available financing, operational and systems capabilities and local conditions.

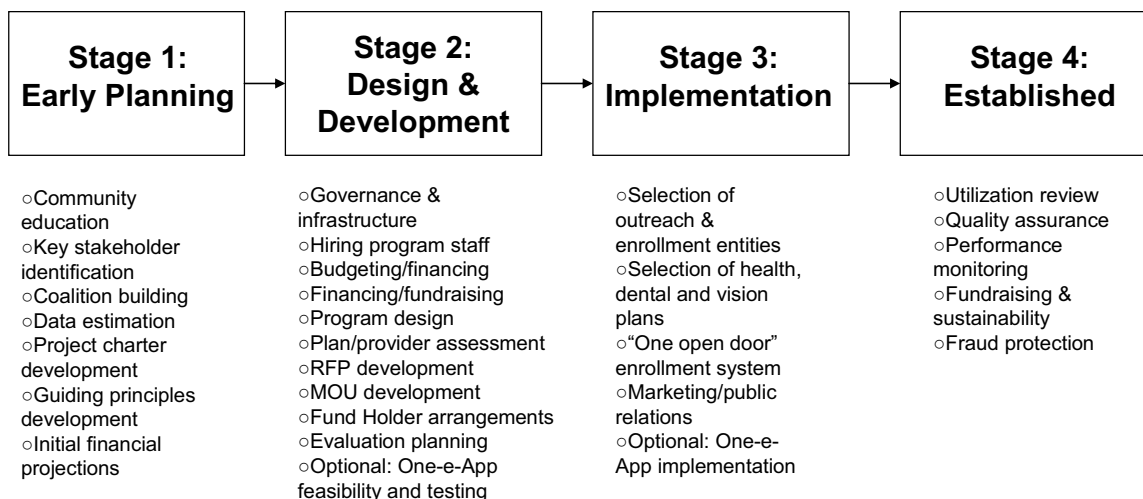
In general, while advancement through each of the four stages is sequentially ordered in the conceptual framework, some activities in the early stages may continue through subsequent CHI stages. For example, community education and coalition building are essential at each stage of a CHI’s development although the emphasis and specific activities undertaken will vary. In addition, while the framework shown in Figure 3.1 provides a general mapping of the CHI development process there is intrinsic variation across the nine CHIs. That is, CHIs may undertake certain activities earlier or later in their development than others. As of late 2004, second generation CHI counties fall within stages 1 through 3 but none are yet in Stage 4.

Stage 1: This stage consists of primary planning tasks and activities such as engaging the support of local leaders and providers, inviting stakeholder participation, building the coalition, and estimating the number of eligible children. As described in Chapter 2, activities related to the creation of a receptive environment begin and continue throughout this stage. The transition from stage 1 to stage 2 usually occurs once CHI stakeholders create and sign a project charter, or coalition partners agree to the initiative’s vision and guiding principles.

Stage 2: This stage addresses more detailed program design issues, beginning with governance and infrastructure development. It is during this stage that a CHI will embark on activities to create a governing board, recruit and hire program staff, develop an implementation workplan and timeline, establish fund holding arrangements, and establish agreement on organizational roles and responsibilities. Joint planning with the Social/Human Services Agency in the development of a single

enrollment pathway and cross-training staff within the agency and out in the community are essential activities in this stage. Other stage 2 activities include developing consensus on the scope of services and cost-sharing levels for the Healthy Kids program, developing budget and financial projections, designing outreach and enrollment strategies, and fundraising. CHI partners may also choose to conduct a feasibility assessment for the implementation of the One-e-App universal electronic application. Evaluation planning and design activities may also begin in this stage.

Figure 3.1
The Four Stages of a Children’s Health Initiative



If a local public plan partner is available, then discussions with plan leadership should begin in this stage. For CHIs without a local public plan partner, it is expected that Requests for Proposals (RFPs) for health, dental and vision plans would be developed and released. The CHI should expect that the process for selecting and negotiating with one or more plans will take a minimum of three months. Fundraising will also commence and remain a central activity throughout stages 3 and 4. Stage 2 usually comes to a close with the development of memoranda of understanding (MOUs) or other types of agreements executed between the CHI partners responsible for the program components identified in figures 3.2 and 3.3.

Stage 3: CHI coalitions begin the implementation activities of stage 3 after the planning, design and organizational activities have been addressed. A CHI is considered as entering the implementation stage when the outreach entities or contractors have been selected and trained. In addition, the selection and execution of contracts with health, dental, and vision plans for the Healthy Kids program should be finalized. Plans for media coverage and a community event to offi-

cially “launch” the Healthy Kids program will be underway. Ideally, a CHI would be ready to implement a universal application system simultaneous to the launch of the Healthy Kids program.

Stage 4: CHIs enter the fourth and final stage after twelve months of operations. CHIs in Stage 4 typically focus on fundraising to support current and future enrollment targets and assessing their effectiveness in reaching predetermined objectives, such as appropriate service utilization and Health Plan Employer Data and Information Set (HEDIS) quality measurement. Evaluators will collect data throughout stages 3 and 4 to assist the governing board in monitoring the performance of all contractors and to gauge the initiative’s success in meeting the goals specified in the project charter.

Organizational Involvement in Early Planning

Across many first generation CHIs, the initial group of primary stakeholders included the leadership from at least four organizations: the First 5 Commission, the Health Services Agency, the Human Services Agency, and the local public plan. The support of these organizations has proven critical. First, the local First 5 Commissions have played a lead role in providing the necessary anchor funding and guiding principles for Children’s Health Initiatives. The Health and Social Services Agencies are also essential coalition partners in their role providing health and public services to the target population. In fact, because the local Social or Human Services Agencies are responsible for enrolling children and families in Medi-Cal and assisting with Healthy Families enrollment they have proven to be operationally critical to enrolling children in the new Healthy Kids programs. Finally, the local public plans, because of their unique community mission, presence, and established linkages with local providers and community-based organizations, were early CHI catalysts and continue to provide core leadership and administration of the Healthy Kids insurance product for first generation CHIs.

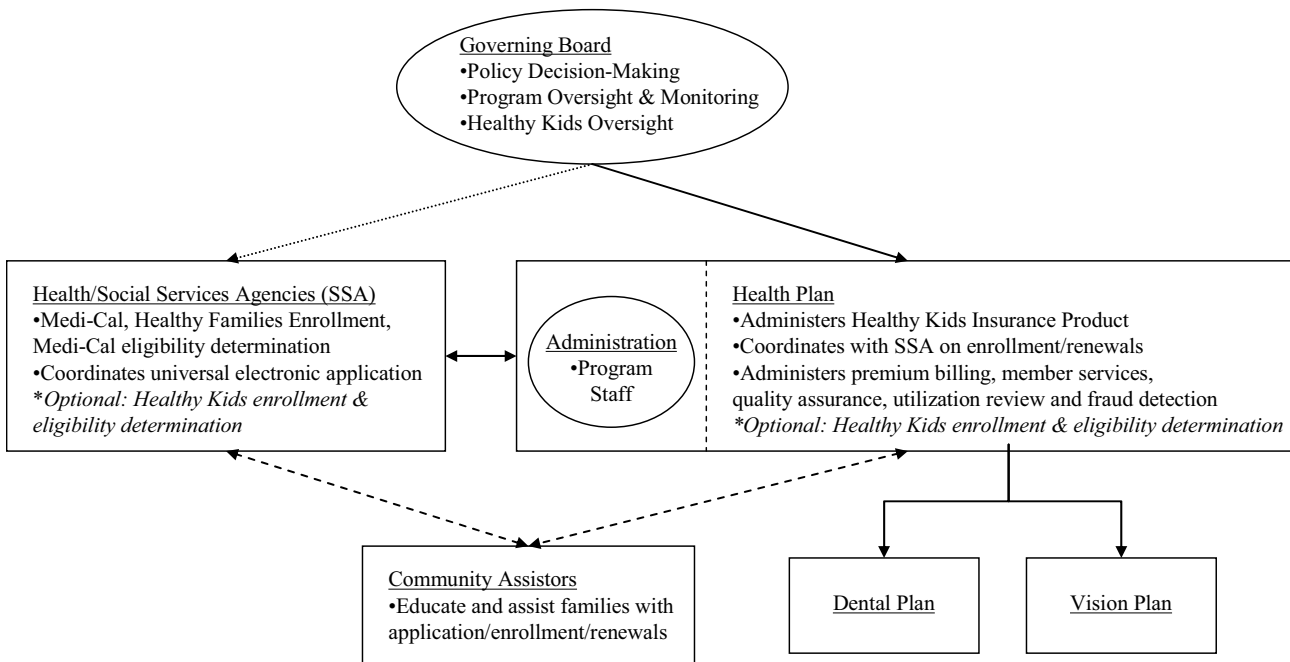
The early strategic planning phase—typically the first six to 12 months of CHI planning—is often led by a “charter” group of key decision-makers and conducted on a fairly informal basis. This group is often composed of at least two of the four key primary planning partners already discussed, but may also involve members of the Board of Supervisors, a provider champion, or an influential community leader. CHIs have typically adopted this strategy of limiting the size of the charter group to incubate the CHI and minimize opportunities for derailment early in the planning process. Over time, however, this committee may either transition or expand to a larger group of stakeholders for political and operational reasons. Eventually the CHI’s charter members must identify other essential community stakeholders to provide the hands-on leadership through each of the four stages and collaborate with the broader group of stakeholders.

The Importance of Sound Governance: Governing Board Roles and Responsibilities

Governance has become an important component of the Children’s Health Initiatives, and marks the emergence of the next generation of CHIs. Governance is the relationship between the CHI stakeholders, staff, and the governing board of a CHI. Each of these groups has different responsibilities. When the groups are able to communicate openly and independently, it is said that a CHI is exhibiting good governance.

Most CHIs transition to a more formal governance structure once the early planning process is complete. Generally, the governing boards of operating CHIs have been called steering or oversight committees. There are four primary reasons for creating a formal governance structure. First, members of the governing board will establish overall policy direction for the CHI, oversee project administration, and centralize accountability for the overall initiative. Second, the board will also be the primary entity under which financing for the CHI will be secured

Figure 3.2
CHI Organizational Roles and Relationships with a Local Public Plan Partner

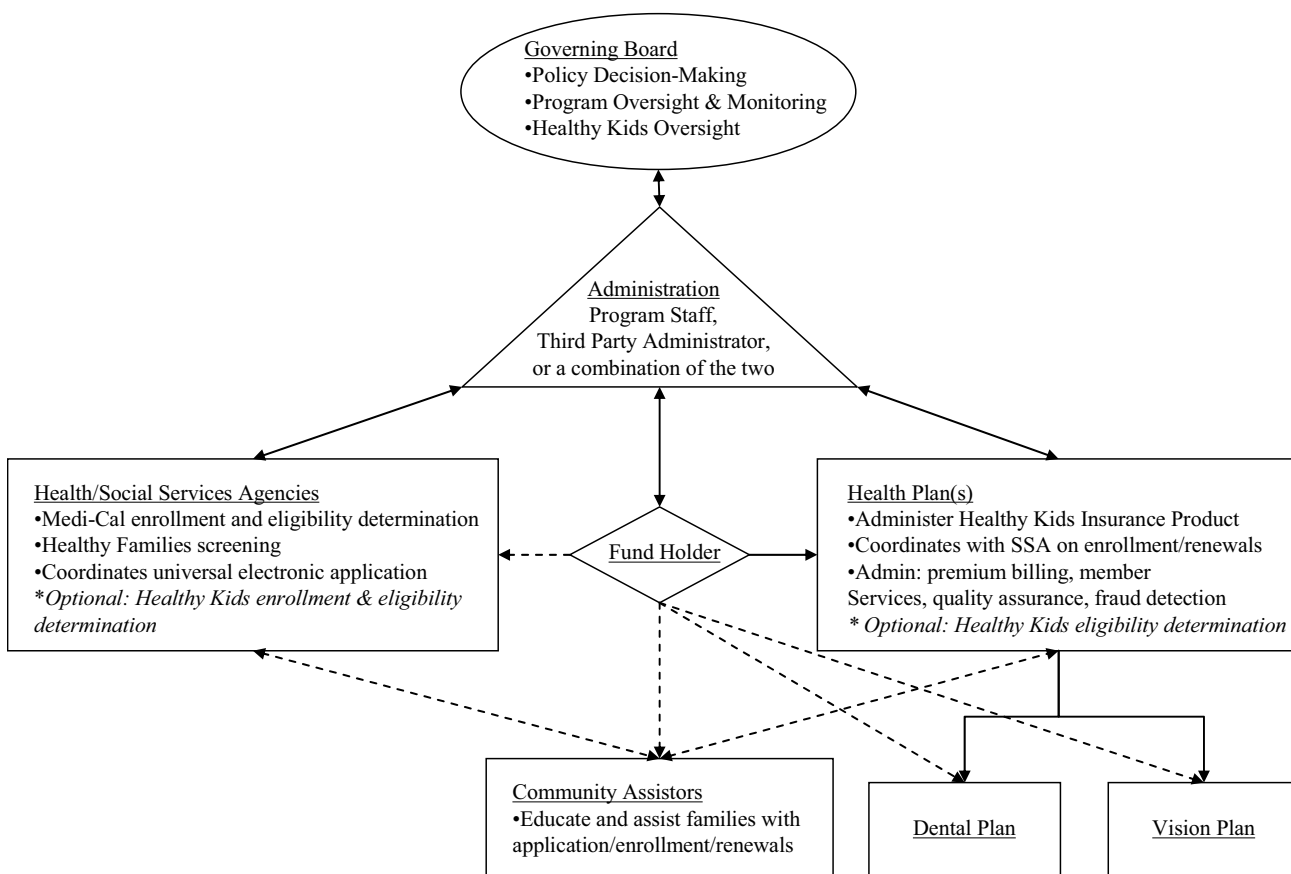


This figure illustrates the roles and relationships for most operational CHIs as of Fall 2004, which have a local public plan partner that functions as both the plan as well as the Healthy Kids program administrator. This approach requires an accountable plan partner that can largely assume the coordination and other administrative responsibilities for the Healthy Kids program.

and fundraising strategies are executed. Third, the governing board will be responsible for overseeing and monitoring the performance of the health, dental and vision plans, and presumably one or more participants on this body will contract with a health plan or plans to provide the Healthy Kids insurance product. Finally, this entity will need to direct staff and consultants hired to implement the initiative’s objectives and also assign responsibilities and tasks to the designated subcommittees.

The inclusion of influential leadership in the governance structure creates a level of accountability for decision-making that is critical to a

Figure 3.3
CHI Organizational Roles and Relationships with One or More Commercial Plan Partners



This figure illustrates the various roles and relationships likely to exist between a CHI governing board, Healthy Kids program administration activities, health plan contractor(s), the fund holder and local agencies for CHIs without a strong local public plan partner. In this scenario, the administrative/program staff component resides outside of the contracted plan(s) and assumes much of the oversight and coordination responsibility for the program. Dedicated program staff will be integral to this approach because of the high degree of coordination required. This approach may be seen in second generation CHIs pursuing a regional CHI and/or those contracting with commercial health plans.

program's ultimate launch and sustainability. Governing board participation reduces the possibility that an initiative will become mired in ongoing "processing and reporting" without progress toward actual implementation. The governing board should meet regularly to discuss such issues as the ongoing health and sustainability of the CHI, the plans and their performance, and the overall impacts of the program. If problems arise, it's the board's responsibility to address them before they become serious.

Without leaders setting an expectation for accountability within their organizations, facilitating inter-organizational collaboration, and working to raise the necessary financing, the CHI is likely to stall or never come to fruition. Most CHIs have designated clear organizational roles and responsibilities prior to program operationalization. They have created memorandums of understanding (MOU) to designate the responsibilities of key agencies for enrollment and eligibility determination, fund holding, provision of the Healthy Kids insurance product, outreach and administration (see Appendix C). Figures 3.2 and 3.3 depicts the inter-organizational relationships that some counties have formed.

Governing Board Composition

Governing board members are integral to the program's successful implementation. Thus, the board membership should be comprised of major funders, participating providers and other participants in a county-wide leadership role. All governing board members should have decision-making authority for their organization, or possess sufficient influence in the broader community in order to effect change. Board members should also be independent, and not in any way stand to personally benefit from the CHI or its activities.

Examples of local leaders and organizations participating in the stewardship of CHIs include: the local Board of Supervisors and their staff; Health and Human Services Agency leadership, hospital and health system leadership, community clinic leadership, pediatricians and private physicians, the local medical society, local philanthropy, education, and business. Community-based organizations, such as the labor-affiliated Working Partnerships USA (WPUSA) in Santa Clara County or the faith-based Fresno Metro Ministries in Fresno County, are also likely candidates for participation on the governing entity. A children and families advocacy group, such as the Family Action Network in Sonoma County, is another example of a likely community-based participant in overseeing and monitoring CHI activities. It is also highly advantageous to select members who will champion the CHI to local policymakers and other key stakeholders.

The model for emerging CHIs will likely change with regard to the health plans' involvement in the early stages of planning and governance when there is no publicly administered health plan. If a competitive bidding process is anticipated (see Chapter 8), then a conflict of

interest could arise in identifying one or more health plans to participate on the governing board. For this reason, boards should be broad and require potential conflict disclosure and processes by which board members can recuse themselves. Any insurance carrier that may ultimately compete for the Healthy Kids product may need to recuse itself from a CHI's governing board. However, health plans should be invited to participate in subcommittees where their input is essential to program design and improvement.

CHI governing board members in the operational CHI counties have had many affiliations, as indicated in Table 3.4.

Table 3.4
Potential Governing Board Members

Funders	Implementing Agencies	Partners
Board of Supervisors Local First 5 Commission Community and Other Foundations Hospitals Health Systems	Health Services Agency Social Services Agency Health Plans Clinics (community and county) Health Systems Community-based Organizations	Education Labor Faith-based organizations Physicians Medical Society Dental Society Hospitals Health Systems Child Care Providers Other Community-Based Organizations Business

The governing board is not the same as staff and does not have the same responsibilities. Staff may make day-to-day operational decisions, but major strategic issues require the board's participation and approval. A governing board should provide careful oversight of the CHI and draw on its members' expertise in areas such as outreach and enrollment, financing, quality improvement, plan performance monitoring and program evaluation.

An important balance to strike in designating members for the governing body is both the desire to be representative and the need to be able to make decisions effectively. The board should be equipped with an effective system to monitor staff and contracted plans and vendors. Board size generally varies between seven and fifteen voting members and generally only one member per organization sit on the board. Too large a board can be unwieldy, whereas too small a board doesn't allow for the variance of perspectives and skills that are required for sound governance. Although there may be strong political reasons to establish a large and fairly informal governing entity, generally this approach is not recommended. Decisions are generally made by consensus among board members, however, an odd number of participants allows for a tie-breaking vote if votes are split between governing board members.

However, as on most other dimensions, each CHI differs in number of coalition participants, level of health systems integration, and collaboration history—all of which may influence a CHI’s governance structure options. An informal governance structure has been adopted by the Santa Clara CHI because of the unique conditions in which the CHI operates: a well-integrated public health and hospital system, a relatively small group of key stakeholders, and a multi-year history in collaborating on children’s coverage issues. The Los Angeles CHI, which is relying on internal structure to provide functional, representative governance, exemplifies another CHI governance alternative. In contrast to Santa Clara and Los Angeles, San Mateo’s Board of Supervisors has formally passed a resolution naming the county’s oversight committee as the decision-making body for the CHI. San Mateo’s oversight committee members include the Health and Human Services Agencies, the First 5 Commission, the local public plan, the hospital consortium, a community foundation and the local labor council.

Subcommittee Composition and Structure

Most boards are divided into subcommittees, each of which focuses more directly on specific components of the CHI. Some of them, such as a governance committee, may be short term or optional. Most CHIs have at least three to four subcommittees. Subcommittees focus on specific task areas of the CHIs, including but not limited to financing, outreach/enrollment/retention, health plan and provider participation, marketing and communications, governance, and evaluation and performance monitoring (which may include quality and utilization review). Their focus is to research options and operationalize activities identified by the governing body. Examples of CHI subcommittees are included in Table 3.5.

Subcommittees typically meet on a bi-weekly or monthly basis depending on their charge, status of specific activities under their purview and the stage of the initiative. Throughout the early planning phase, for example, the outreach/enrollment/retention subcommittee may need to meet twice a month until the outreach plan has been completely formulated. In a similar vein, the program evaluation subcommittee may only meet once or twice in the early planning and design phases, but ramp up meetings once the CHI moves into actual implementation. CHI planners should exercise flexibility in setting forth meeting schedules and agendas for the subcommittees, as they are likely to change over the course of the initiative.

Developing a Project Charter and Implementation Timeline

CHIs have found that program momentum may slow after establishing a governing board due to a lack of clear consensus about program goals, activities and timelines. Several first generation CHIs have acted to avoid this by creating a charter document that defines the vision, princi-

Table 3.5
Sample CHI Subcommittee Functions

Subcommittee	Role/Function
Financing/Fundraising	<ul style="list-style-type: none"> • Determine core operating budgets and financial projections • Develop plan for financing the CHI from public, private and philanthropic sources • Meet with and/or make presentations to potential funders • Ensure program sustainability over the long term
Outreach, Enrollment & Retention	<ul style="list-style-type: none"> • Ensure program enrolls targeted eligibles • Ensure families learn how to use the program • Ensure enrollees stay enrolled as long as eligible • Make recommendations regarding eligibility criteria, application forms, required documentation • Examine outreach, enrollment and retention issues for Healthy Kids, Medi-Cal and Healthy Families
Health Plan Participation	<ul style="list-style-type: none"> • Draft and review RFP to select health, dental and vision plans to provide Healthy Kids coverage product • Evaluate submitted bids and provide recommendation to steering committee
Marketing/Community Relations	<ul style="list-style-type: none"> • Develop and recommend communication strategies, including messages and materials to reach various target groups, e.g., donors, community members, providers, policy leaders, community organizations, and low-income families with children • Help to broaden coalition membership and insure adequate communication to all community stakeholders
Program Evaluation	<ul style="list-style-type: none"> • Oversee and design the evaluation process • Design key research questions and components that will guide the evaluation • Develop RFP to solicit evaluation proposals • Select the evaluator • Review the evaluation’s progress • Conduct performance monitoring • Quality assurance and utilization review

ples and goals of the initiative. In some counties this document is called a project charter. This charter is a living document that defines the intent, scope, and breadth of the local children’s health initiative, and may change at the recommendation of the governing board as the initiative unfolds (see Appendix D). Other CHIs, such as Sonoma and San Luis Obispo, have agreed to a set of guiding principles for their programs.

The project charter or statement of principles serves as an “anchor” for the initiative over the course of its development and implementation. These documents set the framework under which individual organizations go back and secure the broader organizational buy-in and commitment of resources to the CHI. For CHIs where there may be some difficulty in achieving clear consensus on the breadth and scope of the initiative, the process for creating and adopting a charter document will assist in alleviating potential misunderstandings as the initiative moves

forward. In creating the project charter, it is recommended that the group realistically identify key challenges and opportunities in the initiative's implementation. The charter may also include a statement about participation in the governance structure, and a general timeline for program launch. The timeframe for actual implementation will vary based on the availability of resources and a provider for the Healthy Kids product, but the average time to implementation generally ranges between nine and eighteen months. A sample implementation plan is included in Appendix E.

Staffing and Technical Assistance Considerations

With the governing board in place and poised to begin Stage 1 tasks, leadership should carefully consider specific staffing and technical assistance needs. The work includes, but is not limited to, staffing committee meetings and community forums, developing numerous technical papers, preparing budgets and cost estimations, and managing contracting processes for outreach, health plan administration and other services. While the governing board members or staff from their respective organizations may take responsibility for some of this work, many CHIs have solicited expertise from outside technical consultants.

CHIs also vary in their decision to hire dedicated full time staff to the program. Ideally, funding can be secured through the key partners to hire a dedicated, full-time project manager for the initiative prior to commencement of subcommittee activities. This staff member can be housed in any of various organizations, including the Health or Human Services Agencies, the First 5 Commission, the health plan or a key community-based organization participating in the coalition. The decision of where full-time staff are located will depend on a number of factors, including the salary structure and benefits the fiscal agent would provide, and the extent to which the staff member would be accountable to both the fiscal agent and the governing board. A CHI project manager should understand the relationships between key participating entities and have the ability to facilitate inter-organizational relationships. S/he may also be asked to staff one or more subcommittees in addition to the governing board in order to provide a central linkage between all the committees.

The funding source or sources for CHI staff will depend on which organization has available resources or the flexibility to underwrite staff support. In the Santa Clara and San Mateo CHIs, the local public plan and the Health and Human Services Agencies provided full and part-time staffing for the CHI. Other CHIs, including San Francisco, San Joaquin, Riverside, Los Angeles and Santa Cruz relied heavily on staff from the local public plan. Several second generation CHIs have received grant support to cover the costs of dedicated full-time staff or consultation for their planning process. Finally, a combination of sources including a regional community foundation, the First 5 Com-

mission and the local United Way are supporting a full-time project director for the Sacramento Cover the Kids by 2006 initiative.

Because a range of technical issues will need to be addressed during stages 1 and 2, most CHIs have utilized the combined support of staff and outside consultation. The issues and topics requiring expert research, writing, and technical guidance include:

- *Estimates of uninsured children:* This addresses the scope of uninsured children in the county and/or region and to the degree possible, breaks down the estimates by demographic characteristics. These estimates not only serve as the basis for financial projections, but also serve as a rallying point for developing community support.
- *Budget projections:* This will be based on the estimated number of children for a Healthy Kids product, benefits selected, premium costs and other factors. The budget may also include estimating costs based on enrollment projections by month and by year. The projected premium costs for children covered by the Healthy Kids product may need to be modeled in advance by outside experts.
- *Financing sources:* Research will be needed into the various state and local financing sources that may be available to fund the CHI. This assessment would include a feasibility study of tapping into each potential source and the particular requirements associated with each source.
- *Health plan solicitation, evaluation and negotiation:* Covering children ineligible for Medi-Cal and Healthy Families with public or commercial health plans will require expert knowledge of the managed care environment, Request for Proposals (RFPs) development and review, health plan negotiation and contracting arrangements, and third party administrator (TPA) functions and contracting arrangements.
- *Local provider capacity:* Achieving the goal of improving children's access to care in the county or region will require sufficient provider capacity (physicians, specialists, dentists, clinics, hospitals, mental health providers) to serve them. This assessment often precedes the health plan contracting phase and utilizes both existing data and some additional interviews and surveys. This can also be addressed in the health plan RFP process.
- *Outreach, enrollment and retention infrastructure:* Creating a "One Open Door" outreach and enrollment system first requires an assessment of the existing infrastructure and all of its complexities. This may also include a feasibility study of implementing a One-e-App electronic enrollment system.

- *Legal and actuarial issues:* Legal issues may arise around governance, financing and fund holding, and contracting with health plans. In the case of First 5 Commissions, issues may arise relative to the 0-5 funding restrictions. It is also highly recommended that an independent actuarial valuation of the scope of services be included in the start-up budget for a CHI.

Each county with a CHI will address the staffing and technical assistance needs differently and a number of options should be considered. As discussed earlier in this chapter, CHI staff and external technical expertise may also be provided by local community-based organizations and the Health and Social Services Agencies. In Fresno County, for example, the staffing to the CHI coalition is provided by Fresno Metro Ministries, a community-based organization. In San Luis Obispo, dedicated CHI staff will be housed at no charge at the Human Services Agency. In several of the first generation CHIs, staff have been hired as part of the local public plan. In addition, local agencies and community-based organizations may also address some of the specific technical assistance needs discussed above. In particular, county counsel offices may play an important role in addressing legal issues around the use of First 5 funds, governance and contracting with commercial managed care plans.

Finally, the relationships between the governing board, staff members and consultants should be clearly identified and communicated prior to implementation. The various staffing and technical needs are likely to be identified in the implementation workplan, with specific activities or tasks assigned by expertise area. It should be expected, however, that certain responsibilities between staff and consultants will evolve over time as local technical expertise is developed.
