

Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage

Seven Case Studies from Local and State Health Departments

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Preface

This report summarizes findings from a project designed to highlight innovative models and best practices that leverage local health department (LHD) involvement in outreach and health insurance enrollment activities conducted as a result of the Patient Protection and Affordable Care Act (ACA). From June through October 2014, RAND and National Association of County and City Health Officials staff visited LHDs and their partners engaged in outreach and enrollment in Eagle, Pitkin, and Garfield Counties in Colorado; Tacoma-Pierce, Washington; New Orleans, Louisiana; Boston, Massachusetts; West Virginia; Houston, Texas; and Illinois. Each of these case studies was designed to capture nuanced differences in how LHDs support outreach and enrollment efforts in their communities, identify facilitators and barriers to these approaches, and develop lessons learned from these activities. In this report, we observed and identified compelling models for how local and state health departments can implement similar activities in their own communities. Given the varied approaches that public health can take and the myriad contextual differences, we sought to choose case study sites that reflect differences in expansion status, urbanicity, use of public health data, partnerships, leadership by the LHD, and involvement of public health at the state, compared to local level. This report provides guidance and insight into the role LHDs can play now, and may help redefine that role in the future, as states continue to enroll residents in health insurance coverage. We summarize the methods used in each case study and present results from each of the case studies—first providing important context for health care reform in that state, followed by a justification for selection of the study. Each case study section discusses the model of public health involvement and how they came to be in that role, activities undertaken, barriers to those activities, and future priorities. By presenting a range of case studies, all LHDs should be able to identify with one or more models, and communities may reconsider the value add that LHDs may bring to future outreach and enrollment efforts.

The case studies are included here and are also available in a series of shorter briefs designed to highlight each individual model for leveraging public health investments in outreach and enrollment.

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1. Introduction

The Patient Protection and Affordable Care Act (ACA)¹ was signed into law in March 2010, putting into place comprehensive insurance reforms designed to improve access to health care, strengthen consumer protections, improve quality, and lower health care costs. The ACA laid the groundwork for a substantial increase in the number of people who will have access to health insurance through either Medicaid expansion or the health insurance marketplaces.² In states that opt to participate in the Medicaid expansion, almost any adult with an income at or below 138 percent of the federal poverty level (FPL) will now be eligible for Medicaid. And in all states, individuals with incomes from 138 percent to 400 percent of FPL may receive tax credits to offset the costs of health insurance, and may purchase health insurance through the exchange markets. Over the first two open-enrollment seasons, millions of Americans, many of whom had never been insured, obtained health insurance coverage.³ By 2019, 13 million to 16 million people are expected to enroll in Medicaid, and 20 million people are expected to purchase insurance through the exchange markets.^{4, 5, 6}

In order to experience some of the longer-term expected benefits of the ACA, including better health and lower health care costs resulting from access to regular primary and preventive services, states first have to reach out to those who are uninsured and support their enrollment into health insurance plans.^{7, 8, 9} Failure to enroll eligible individuals will reduce the potential impact of the ACA, particularly among those with the greatest need.¹⁰

¹ Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010.

² A *health insurance marketplace*, also sometimes called an *exchange*, is a resource to help consumers choose and enroll in health insurance plans. Some states operate their own marketplaces, and others use the federal marketplace, called the *Health Insurance Marketplace*, to help their residents get coverage.

³ Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*, Washington, D.C., U.S. Department of Health and Human Services, 2015.

⁴ John Holahan, Matthew Buettgens, Caitlin Carroll, Stan Dorn, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, The Henry Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., November 2012.

⁵ Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012.

⁶ Benjamin Sommers, Katherine Swartz, and Arnold Epstein, “Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians Under Health Reform,” *Health Affairs*, Vol. 30, No. 11, October 2011.

⁷ Peter Long and Jonathan Gruber, “Projecting the Impact of the Affordable Health Care Act on California,” *Health Affairs*, Vol. 30, No. 1, January 2011, pp. 63–70.

⁸ Henry J. Kaiser Family Foundation, *Health Reform Roundtables: Charting A Course Forward—Key Issues to Consider for Outreach and Enrollment Efforts under Health Reform*, Washington, D.C.: February 2012.

While a number of state and local factors, such as financial constraints, political context, and geographic diversity, can reduce capacity for enrolling newly eligible people, outreach and enrollment are also affected by a multitude of barriers that eligible individuals face including

- lack of knowledge, including how and where to enroll, and misunderstanding of eligibility requirements
- lack of experience navigating the health care system
- difficulty completing the enrollment process, due to language barriers and low literacy levels
- fears about jeopardizing their ability to obtain permanent status and/or exposing undocumented family members or missing or incomplete documentation; and
- costs.¹¹

These barriers can be exacerbated by the other vulnerabilities that some populations may face in accessing care, such as low English proficiency¹² or mental illness.¹³

During the first open-enrollment season, states used a variety of strategies to reach out to and enroll newly eligible individuals. The success to date of these outreach and enrollment efforts was driven in large part by the collective efforts of state and local organizations that worked together to identify individuals eligible for coverage, and support them in the application process. Typically, federal and state funding was used to develop navigator programs in each state. What the models of outreach and enrollment looked like, and who the key partners were, varied considerably across the country and were tailored to reflect the population demographics, local resources and political contexts.¹⁴

While some outreach efforts across communities involved LHDs, they were, and remain, a relatively untapped resource¹⁵ in these endeavors. This is somewhat surprising, given that LHDs

⁹ Benjamin Sommers, and Arnold Epstein, “Medicaid Expansion—The Soft Underbelly of Health Care Reform?” *New England Journal of Medicine*, November 2010.

¹⁰ Laurie Martin, and Ruth M. Parker, “Insurance Expansion and Health Literacy,” *The Journal of the American Medical Association (JAMA)*, Vol. 306, No. 8, pp. 874–875. August 2011.

¹¹ The Henry J. Kaiser Family Foundation, “Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act,” June 2013.

¹² Lisa Clemens-Cope, Genevieve M. Kenney, Matthew Buettgens, Caitlin Carroll, and Fredric Blavin, “The Affordable Care Act’s Coverage Expansions Will Reduce Differences In Uninsurance Rates By Race And Ethnicity,” *Health Affairs*, Vol. 31, No.5, May 2012, pp. 920–930.

¹³ Victor Capoccia, Colette Croze, Martin Cohen, John P. O’Brien, “Sustaining Enrollment In Health Insurance For Vulnerable Populations: Lessons From Massachusetts.” *Psychiatric Services*, Vol. 64, No. 4, April 2013, pp. 360–365.

¹⁴ Enroll America, “Certified Application Counselor Program: Early Lessons,” Washington, D.C., June 2014.

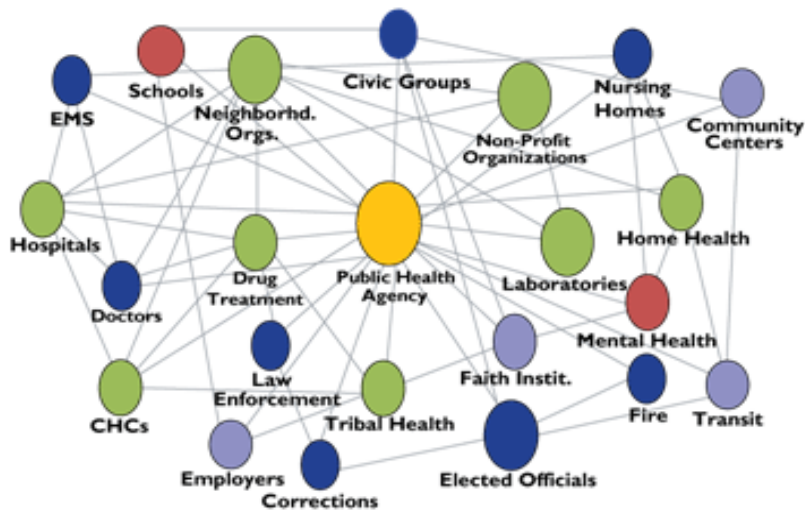
¹⁵ National Association of County and City Health Officials (NACCHO), *Role of Local Health Departments as Navigators: Findings from 2014 Forces of Change Survey*, Washington, D.C., May 2014.

serve as trusted entities in communities, can reach the most-vulnerable populations, and have access to data and resources that might facilitate ACA outreach and enrollment.

What Is Public Health?

According to the World Health Organization, “public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole.”¹⁶ To achieve these goals, public health is often structured at the local level as a network of interconnected agencies including local public health agencies. LHDs are unique within this system as they are the only organization that interacts with most, if not all, of the health-related agencies in the community (see Figure 1.1). The connecting role of public health is due, in part, to the broad activities of public health departments that monitor the health of the community, educate and mobilize individuals and communities to improve health, and ensure that health and safety standards are met. In these roles, LHDs interact with a range of community health services (e.g., clinics, hospitals), community well-being and social services (e.g., nonprofit organizations, human services organizations), other community services where health is an important but not primary mission (e.g., schools, public safety, transportation and planning, or employers), and other trusted local organizations in which health-related messages may be disseminated (e.g., faith-based organizations).

Figure 1.1. The Public Health System



Source: Centers for Disease Control and Prevention

Despite the fact that LHDs sit “at the heart” of the public health system, they do not always lead or play a central role in every public-health-related initiative. Often, they play more of a

¹⁶ World Health Organization, *Trade, Foreign Policy, Diplomacy and Health: Public Health*, web page, undated.

supporting or facilitating role, but, given their content expertise, skills, assets, community partnerships and trusted relationships with vulnerable populations, their potential value-added cannot be underestimated for the success of health-related initiatives.

Core Functions of Public Health: Relevance to Identification, Outreach, and Enrollment

Though outreach and enrollment activities under the ACA may not seem on the surface like a traditional public health initiative, increasing the number of individuals with health care coverage and access to health care and preventive services is very much in line with the core mission of public health: to prevent disease and promote the health of a population. It is also in alignment with the three core public health functions:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- The assurance that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.¹⁷

Table 1.1 summarizes how the three core functions of public health and public health services align with and may be leveraged to support ACA outreach and enrollment efforts. For example, LHDs may leverage data to identify priority populations among the unenrolled; mobilize their existing partnerships to ensure that outreach and enrollment activities are being conducted in a robust way throughout the community; develop policies to support these practices; and contribute directly to these efforts by contributing staff to enrollment efforts and evaluating progress. LHDs are also trusted entities in their communities: They are able to provide culturally competent and trusted assistance for a broad number of health related issues through various programs and supports.^{18, 19} LHDs also maintain flexible schedules to increase access to eligible uninsured populations.²⁰ Moreover, these organizations also provide sustained

¹⁷ Centers for Disease Control and Prevention, *The Public Health System and the 10 Essential Public Health Services: The Public Health System*, July 3, 2013.

¹⁸ The Henry J. Kaiser Family Foundation, February 2012.

¹⁹ Philip Chung, Tia A. Cavender, and Debbi S. Main, *Trusted Hands: The Role Of Community-Based Organizations In Enrolling Children In Public Health Insurance Programs*, issue brief, The Colorado Trust, Denver, Colo., February 2010.

²⁰ The Henry J. Kaiser Family Foundation “Covering Uninsured Children: Reaching and Enrolling Citizen Children with Non-Citizen Parents,” The Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., January 2009.

contact with individuals, helping to minimize disenrollment and drop out from existing health insurance coverage.²¹

²¹ The Henry J. Kaiser Foundation, February 2012.

Table 1.1. Core Functions and Services of Public Health

Core Functions and Services of Public Health	Potential for Identification, Outreach, and Enrollment
Assessment	
<ul style="list-style-type: none"> • Monitor health status to identify and solve community health problems. • Diagnose and investigate health problems and health hazards in the community. 	<ul style="list-style-type: none"> • Leverage public health data to identify vulnerable communities who may benefit from targeted outreach and enrollment efforts.
Policy Development	
<ul style="list-style-type: none"> • Inform, educate, and empower people about health issues. • Mobilize community partnerships and action to identify and solve health problems. • Develop policies and plans that support individual and community health efforts. 	<ul style="list-style-type: none"> • Leverage existing partnerships and strategies to inform and educate residents about available health insurance options, facilitate enrollment, and empower them to access care • Identify gaps in outreach and enrollment efforts • Work on policies that support “no wrong door” efforts for enrollment; work with human services and social services to facilitate enrollment.
Assurance	
<ul style="list-style-type: none"> • Enforce laws and regulations that protect health and ensure safety. • Link people to needed personal health services and assure the provision of health care when otherwise unavailable. • Assure competent public and personal health care workforce. • Evaluate effectiveness, accessibility, and quality of personal and population-based health services. 	<ul style="list-style-type: none"> • Leverage expertise to facilitate linkages with organizations/direct services offering enrollment services • Identify workforce needs for outreach and enrollment and work with partners to increase workforce capacity • Leverage expertise to assess and evaluate the effectiveness of outreach and enrollment strategies.

As a result, LHDs may be leveraged in a number of ways from basic sharing of institutional knowledge, to using existing public health programs for outreach, to partnering with other community organizations to design and implement outreach and enrollment approaches. Public health data may also be used to assist with more targeted and, as a result, cost-effective outreach strategies, and may offer a potential way to assess the success of certain outreach and enrollment strategies.

Despite the clear links to public health core functions, the extent to which LHDs have participated in outreach and enrollment and fulfill these roles is not clear. Though LHDs can be instrumental in identifying newly eligible populations (via other health programs) and leading outreach activities (due to other community engagement efforts), their role in outreach and enrollment has not been well-defined. The role of LHDs is particularly unclear in the context of

their relationship with other state agencies such as Medicaid and other health entities, including hospitals and community health clinics that tend to play a more-prominent role in these efforts. s

To help clarify these roles and current LHD activities, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services (DHHS) contracted with RAND and NACCHO to identify innovative models and best practices that leverage public health investments in outreach and enrollment efforts. The specific goals of the study were to:

- explore how state and local public health entities (e.g. government as well as other nongovernmental organizations such as community-based organizations) can aid in identifying those newly eligible for coverage (e.g., Medicaid or the Health Insurance Marketplace);
- assess what is known about current and previous outreach and enrollment efforts at the state and local levels in the context of using public health agencies for outreach and enrollment; and
- identify promising practices that achieve high levels of enrollment through public health agencies that can inform other states' efforts.

The central feature of the research reported herein was to engage in case studies of seven distinct communities to identify compelling models for how LHDs can implement outreach and enrollment. This research provides guidance and insight into the role LHDs can play now, and helps redefine that role in the future, as states continue to enroll residents in health insurance coverage. By comparing current practices with this framework, we can identify the ways in which LHDs contribute to identification, outreach, and enrollment efforts. We can also highlight where there may be missed opportunities for involving or leveraging public health to strengthen existing lessons learned.

In the next chapter, we discuss the methods we used to answer the questions outlined by ASPE. In particular, we lay out our process for engaging in the focus groups and analyzing the data that came out of them. In the subsequent chapters, we highlight the results of these case studies, and then conclude with an overall discussion of our findings.

2. Methods

Identification of potential case study sites

Case studies were selected using a systematic approach to ensure a diverse mix of settings and approaches to leveraging the role of state and local public health in outreach and enrollment efforts. First, RAND researchers and NACCHO staff identified state and local health departments that represented a range of models for participation in outreach and enrollment activities. An initial environmental scan, which included literature reviews, website analysis, and semi-structured discussions with national and local stakeholders, identified a range of activities. Second, to help ensure a diverse mix of case-study sites, we classified potential sites along a number of dimensions. These dimensions included the following:

- Information about the outreach and enrollment approach (including whether and how the approach targets particularly vulnerable populations)
 - Role of public health in overall effort
 - Community partnerships, number and types
 - Contracting relationships with community partners
 - Public health resources used or leveraged (e.g., data, personnel, programs, physical space)
 - Public health system characteristics and structure (e.g., PH department, PH institute, affiliations/nested within larger health systems)
 - Centralized or decentralized approach, adapted locally or uniform across state (relationships between state and local health departments)
 - Core public health functions being leveraged: assessment, assurance, policy development, or research
- Information about Medicaid and the marketplace within the states/counties under consideration
 - Medicaid expansion state or not
 - Solutions to expanding insurance to this population such as being an early adopter, timing of the implementation/roll out
 - Type of marketplace
 - Structure of Medicaid (state-run, localized)
 - Estimates of success across markets and newly eligible (current enrollment relative to uninsured)
- Community/population characteristics
 - Size
 - Urban, rural or suburban
 - Race/ethnicity (as a proportion of total population)

- Educational attainment (as a proportion of total population)
- Citizenship status (as a proportion of total population)
- Languages spoken in home (as a proportion of total population)
- Income (median income of community)
- Employment (as a proportion of total population)
- Distribution of eligible population by age (as a proportion of total population).

In addition, we considered the organization of public health in the community (e.g. department, institute, affiliations, tied to FQHC; geography such as city, county, or state; and governance type—centralized or decentralized). Using these data, we developed a list of 15 potential case study sites. Discussions with key staff at the LHDs in these communities were conducted to learn more about their specific approaches and to understand more about the community and population context. Working with staff at ASPE, we selected seven case study locations from this list. In selecting the sites, we prioritized obtaining a diversity of public health approaches and roles. In addition, we prioritized case-study sites that demonstrated not just how public health is involved, but that clearly showed the value added of public health involvement in the approach, and why public health should be involved with outreach and enrollment. Finally, we wanted to ensure that a diversity of contexts was represented (e.g., federal versus state exchange, expansion versus nonexpansion state).

Rationale for Selecting These Case Studies

In consultation with staff at ASPE, we selected seven sites that highlight a variety of models of LHD involvement and contexts in which the public health departments were operating during the second open-enrollment season (2014–2015). The sites reflect differences in expansion status, urbanicity, region, use of public health data, participation of public health in partnerships, and leadership by public health: Eagle, Pitkin, and Garfield counties, Colorado; Tacoma-Pierce County, Washington; New Orleans, Louisiana; Boston, Massachusetts; West Virginia (state); Houston, Texas; and Illinois (state and local).

The intent of the seven case studies was to build on the information learned in the environmental scan by delving deeper into specific state and local health department outreach and enrollment activities. Our aim was to design the case studies so that they adequately captured the level of detail necessary for a full understanding of the approaches that LHDs are taking. As a result, each case study highlights nuanced differences in how the LHDs implement these approaches in the context of their communities, facilitators and barriers to these approaches, and lessons learned from these activities to facilitate knowledge transfer to other public health departments looking to become more involved in such efforts or geographic regions looking to leverage the assets of public health.

In addition to providing these summaries, the case studies provide an opportunity to tell a compelling story about the value of public health in outreach and enrollment and the potential role public health may take in the future for ACA–related activities. Table 2.1 provides a high-level rationale for selecting each case study, with a more-detailed justification for choosing the seven case study sites after the table. Appendix 1 provides details on each visit.

Table 2.1: Reasons for selecting each case study

Location	Reason for selection
Eagle, Pitkin, and Garfield counties, Colorado	These LHDs serve a rural three-county area in Colorado, which is an expansion state characterized by a high seasonal worker population. In this region, all three LHDs worked collectively with human services agencies, private health care organizations, and other partners, creating an efficient model of outreach and enrollment.
Tacoma-Pierce County, Washington	Tacoma-Pierce County, Washington, led the coordination efforts for outreach and enrollment at the request of health care partners. The LHD addressed the needs of its heterogeneous population through the creative use of data, and had sufficient capacity and support for these efforts through subcontracts with partners to conduct outreach and enrollment.
New Orleans, Louisiana	New Orleans, Louisiana, had deeply entrenched partnerships with FQHCs since Hurricane Katrina and was able to leverage those partnerships as a co-leader in efforts to improve outreach and enrollment, despite being located in a state that did not expand Medicaid.
Boston, Massachusetts	The Boston LHD operated at the forefront of outreach and enrollment efforts given its highly supportive leadership and previous experience in state health care reform implementation. They worked with “fringe” population and provided lessons learned from previous health reform in Massachusetts.
West Virginia	West Virginia serves a predominantly rural population and implemented the use of fast-track enrollment in order to address the needs of its population. The Charleston, West Virginia, LHD was a prime champion and advocate for health care reform, both locally and within the state.
Houston, Texas	Houston has a large uninsured population. The LHD served as a navigator and also trained staff to become navigators (not just funded staff). The LHD set up a unique incident command structure (parallel to an epidemic) in order to organize navigators.
Illinois	The state of Illinois has a mix of both rural and urban populations and used fast-track enrollment. At the county level, LHDs are an examination of how local and state health departments can work together to coordinate outreach and enrollment efforts.

Eagle, Garfield, and Pitkin Counties Case Study

Eagle, Pitkin, and Garfield counties were selected for two primary reasons. First, they provided a model of public LHD engagement as a valued and strong partner in a coalition that includes other governmental human services agencies and health care organizations. The public health and human services departments, though now separate, were once combined as a single

health and human services agency within each community. Consequently, they maintain deep functional and relational ties.

Second, this case study highlights the value of LHD outreach and enrollment efforts in rural areas. In these communities, LHDs aligned themselves with key partners to accomplish their goals. The counties highlighted in this case study—Eagle, Pitkin, and Garfield—are geographically connected and cover terrain that includes areas that are impassable during some periods of the year. Within this public health and human services structure, many services are provided across counties by one of the three county agencies, sometimes via contract or memorandum of understanding (MOU). As one discussant stated, “We smaller communities tend to band together because we don’t have many resources and we need to build off of one another’s capacity.” As a result, an existing structure for the partnership among the three counties supported outreach and enrollment efforts. A history of collaboration also supported many of the mechanisms needed to execute the ACA outreach and enrollment strategy across the three counties. The region experienced unique challenges in expanding health care coverage because the three counties are home to several major ski and recreation areas, resulting in a population that fluctuated significantly in size and in insurance coverage between seasons, with people “churning” on and off of health insurance during periods of employment and nonemployment. There was also a shared sense of community in that a resident might live in one county, work in a second, and use the public health services of the third.

Tacoma-Pierce Case Study

We selected Tacoma–Pierce County for two primary reasons. First, it provided a model of an LHD engaging as a leader in the coordination of ACA outreach and enrollment efforts. People in the local region saw the Tacoma–Pierce County Health Department as a trusted, neutral entity, and health care institutions and community organizations supported its role as a lead agency in outreach and enrollment. Through a strong network of local partnerships, the health department provided grants to community organizations to hire outreach and enrollment staff, known as in-person assisters (IPAs). The health department also conducted training for IPAs.

Second, the case study highlights the creative use of data by LHDs to address the needs of the heterogeneous population. Pierce County is a midsized region in the Pacific Northwest and is the second-most populous county in Washington. Tacoma is its largest city, and the county includes agricultural and farmland communities, Joint Base Lewis–McChord military base, the Pierce County Detention and Corrections Center, and populations who are homeless, low-income, racial and ethnic minorities, and immigrants.²² The Tacoma–Pierce County Health Department used data first to identify pockets of underserved areas and populations and then to match relevant community partners to conduct outreach in those areas or to those populations.

²² U.S. Census Bureau, *State & County QuickFacts: Pierce County, Washington*, August 20, 2014.

New Orleans Case Study

We selected New Orleans for this series of case studies for two primary reasons. First, this case study illustrates how LHDs can leverage partnerships as a co-leader of a coalition of organizations engaged in outreach and enrollment in a community. Second, New Orleans is located in a state that did not elect to expand coverage for Medicaid. As a result, there was little state support (financial or otherwise) to help coordinate outreach and enrollment efforts. The experience of the New Orleans Health Department, therefore, provides insight into how LHDs might contribute to outreach and enrollment efforts in less supportive climates.

Boston Case Study

Boston was selected as a case-study site for several reasons. First, Massachusetts had several years' experience in state health care reform implementation prior to national efforts, and public health had been instrumental in outreach and enrollment prior to implementation of the ACA. Thus, Boston was a natural place to explore the role of public health in identification, outreach, and enrollment for expanded coverage.

Second, the case study provides a model for how public health can operate at the forefront of identification, outreach, and enrollment efforts as a navigator agency. The Boston Public Health Commission (BPHC) is a locally governed LHD and operates under a strategic plan shaped by a focus on health equity and social justice principles. BPHC provides a range of direct services and supports core public health functions throughout the city. Boston is a large urban community; as a result, the LHD operates a variety of public health programs. Because of these resources, BPHC was able to build on these experiences and resources to develop a range of outreach and enrollment activities. Thus, its experience illustrates comprehensive steps that public health can take to educate consumers about the advantages of health care coverage, as well as educating newly insured people about how to use their health insurance.

Third, Boston is unique in that the city has a significant health and hospital infrastructure, including several major academic centers, which provide opportunities for frequent collaboration between health care and public health. The community health center (CHC) network in Boston is a vast and important resource that serves residents throughout the city; most neighborhoods in the city and the surrounding area have at least one CHC.

West Virginia Case Study

We selected West Virginia as a case study for several reasons. First, West Virginia serves many rural communities, and this case study examines the challenge of engaging rural populations in outreach and enrollment. Second, the state used "fast-track" enrollment, which automatically enrolls in Medicaid anyone who participates in certain public programs. Third, at the state level, West Virginia demonstrated how collaboration and public education could result in the enrollment of 85 percent of its uninsured population. At the local level, the Kanawha–

Charleston Health Department demonstrated how local LHDs could advance the ACA through public health advocacy.

Houston Case Study

Houston was selected as a case-study site because of the high rate of existing uninsured people and as a way to understand the experiences of a community that sought to increase health care coverage rates without the benefit of Medicaid expansion.

Illinois Case Study

This case study differs in that it examined outreach and enrollment activities at both the state and local levels. We based the decision to expand the scope of this one on several factors. First, it provides insight into how a state health department was involved in outreach and enrollment activities. Second, it highlights a model in which state and local health departments work together to conduct these activities. Third, it provides an opportunity to examine outreach and enrollment activities in both urban and rural settings across the state.

Site Visits

Site visits were conducted over two- or three-day periods from June through October 2014 with LHD leadership or staff and other key players in regional outreach and enrollment efforts (e.g., health care systems, social services, community-based organizations, or state or local government officials). RAND and NACCHO staff conducted four of the case studies; RAND staff alone conducted two; and NACCHO staff alone conducted one. Prior to arriving on site, RAND and NACCHO staff conducted telephone and email discussions to coordinate logistics and plan the topics to be covered in the in-person meetings. The discussions used an open-ended discussion guide that provided a consistent structure for each conversation while allowing sufficient flexibility to capture all relevant information from participants. Discussions focused on implementation strategy (e.g., outreach and enrollment activities, funding, partnerships, and resources), evaluation, sustainability, and replicability. In a few cases, follow-up phone calls were made to staff members who could not attend the in-person meetings.

The case-study discussion guide focused on nine primary topics allowing RAND and NACCHO staff to move freely among these asking questions most relevant to the community. These topics included

- details about the practice including partner roles (from the perspective of each partner) any emphasis on vulnerable populations
- development of the approach
- implementation (how the approach was implemented and organized)
- availability and content of evaluation data

- factors that help make this approach work
- barriers to implementation
- what changes, if any, in the public health workforce were needed
- changes implemented since inception and why
- details needed for replication.

Each case study is presented separately in the following chapters. The case study for Eagle, Garfield, and Pitkin counties in Colorado is in Chapter Three. Chapter Four presents the Tacoma–Pierce County, Washington, case study, and Chapter Five details findings from New Orleans, Louisiana. Case studies for Boston, Massachusetts, and West Virginia are in Chapters Six and Seven, respectively. Findings from Houston, Texas, are presented in Chapter Eight, and the case study on Illinois can be found in Chapter Nine. Chapter Ten provides a summary and conclusion, which draws from all case studies in this project.

3. A Case Study on Eagle, Garfield, and Pitkin Counties, Colorado

Context Of Health Care Reform In Colorado

Prior to the passage of the ACA, Colorado initiated health care reform efforts in 2009 by expanding the state's Medicaid program under the Colorado Health Care Affordability Act.²³ However, because of budget constraints, implementation was limited. The passage of the ACA in 2010 supported states electing to expand Medicaid for adults living at up to 138 percent of the federal poverty level. In 2012, an estimated percent of uninsured adults (258,000) in Colorado were eligible for, but not enrolled in, Medicaid. As of May 2014, roughly 179,000 Coloradans had signed up for health insurance through Medicaid.

In 2011, Colorado established a state-based health insurance marketplace called Connect for Health Colorado. Marketplaces, which are sometimes known as exchanges, are the ACA-created programs that allow consumers to shop for health insurance during open enrollment. Some states rely on the federal Health Insurance Marketplace, at HealthCare.gov; other states set up their own. Prior to enrollment, approximately 294,118 people were eligible for health insurance through the Colorado marketplace. As of April 2014, 129,000 Coloradans had signed up for qualified health plans through Connect for Health Colorado.

From 2013 through 2014, the federal government awarded the state of Colorado more than \$17 million to establish a network of navigator and IPA programs across 57 grantees, which ranged from county health departments to local clinics and community centers.

Model Of Local Health Departments' Involvement And How They Came To Be In This Role

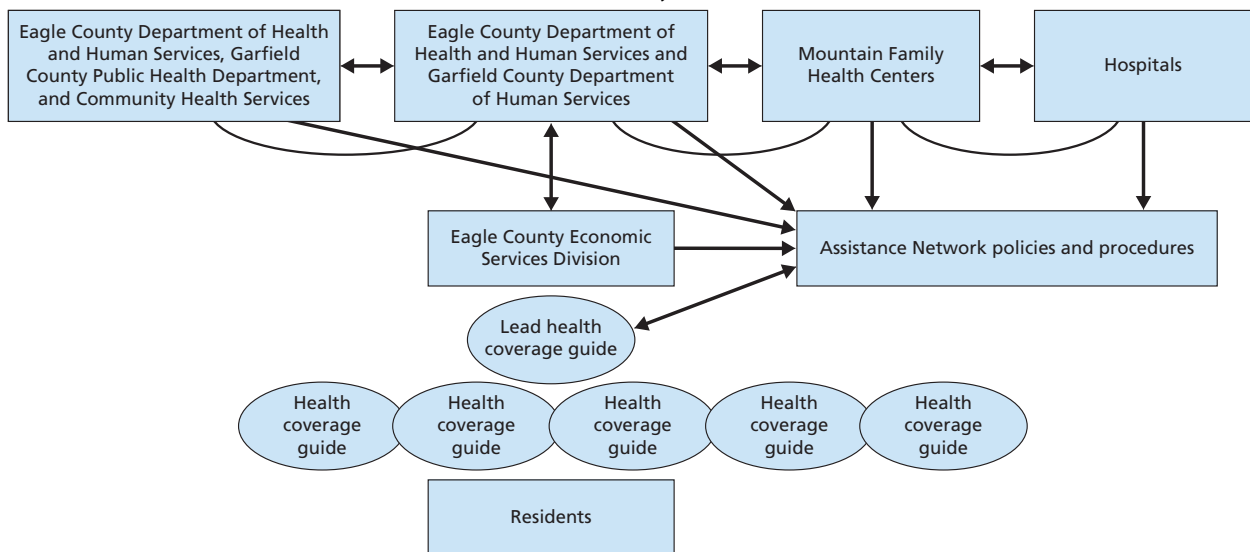
The county departments of public health and human services are part of the West Mountain Regional Health Alliance, which was formed in 2010 to address the issue of prenatal care for low-income women in the region. Other members of the alliance include health care providers, local governments, and community agencies. In 2013, the alliance received a grant from Connect for Health Colorado to establish its Assistance Network to provide outreach and enrollment services in the three-county region. Although the Eagle County Department of Human Services (Economic Services Division) took the lead role, all alliance members contributed and viewed the administration of the grant as a joint activity. The Economic Services Division led because all the partners agreed that, among the three counties, Eagle has the strongest infrastructure to manage the program and track outcomes and because Economic Services, which also houses the

²³ Colorado House Bill 09-1293, Colorado Health Care Affordability Act, Section 25.5-402.3, April 21, 2009.

Medicaid program has greater involvement in issues related to low-income families. Discussants suggested that this approach reflected the regional practice of deciding on the leadership of programs based on resources, organizational structure, and a consensus about what makes the most sense for implementation and outcomes.

Figure 3.1 illustrates the relationships between the West Mountain Regional Health Alliance members and the way they came together to support outreach and enrollment. As the figure shows, a lead health care coverage guide,²⁴ who oversaw five health care coverage guides, led the outreach and enrollment efforts. She communicated regularly with the alliance on the organization of its efforts, successes, and challenges, and she communicated changes in policy from Connect for Health Colorado and the alliance to the guides.

Figure 3.1 West Mountain Regional Health Alliance Member Relationships for Outreach and Enrollment, 2013-2014



NOTE: Pitkin County contracts out its public health services to Community Health Services. Eagle County Economic Services serves both Eagle and Pitkin counties. Mountain Family Health Centers are federally qualified health centers (FQHCs).

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Outreach And Enrollment Overview

During the first open-enrollment season (2013–2014), outreach and enrollment activities conducted by the alliance consisted primarily of certified health care coverage guides providing one-on-one support to individuals, families, and small businesses looking for health insurance

²⁴ *Health care coverage guide* is the Assistance Network’s name for certified IPAs who assist individuals, families and small businesses in evaluating health plan options, applying for insurance affordability programs, and enrolling in health care coverage.

through Connect for Health Colorado. The alliance also conducted outreach events to raise awareness about expanded insurance options. Each health care coverage guide (along with one supervisor) took responsibility for a smaller geographic area within the three counties. Although the Eagle County Department of Human Services employed the coverage guides, they met with clients at the alliance member organizations (e.g., the other public health and human services departments, local hospitals, and family health centers). Each guide was given permanent office space in one of these agencies, but he or she could enroll clients at any location because each guide was equipped with mobile equipment (e.g., phone, laptop, printer, and scanner). This provided the guides with the flexibility to meet the needs of their diverse rural population in the three counties.

The guides provided one-on-one enrollment support, often by appointment. In addition, outreach about the availability of insurance and enrollment was conducted at large sponsored gatherings. These were often shared events in which staff at all the partner agencies participated. Hospital-sponsored events involved participation by guides and staff at partner agencies. All guides were bilingual in English and Spanish in order to connect with the growing Latino population in the region.

The alliance was able to use limited grant funds to purchase newspaper and radio ads. In addition, the alliance asked for special permission to conduct outreach via bus advertisements, which was seen as an effective way to reach residents in all three counties. Staffs at the FQHCs and local hospitals were also available to enroll uninsured people who sought health care at their institutions.

One of the innovative components of the program was an electronic calendar that was used by the health care coverage guides and accessible to everyone in the county. The calendar could be used to set individual enrollment appointments and to identify where enrollment events were occurring. Staff members at all the agencies in the alliance were trained to identify people eligible for various insurance programs and to refer them to the guides. As each site identified uninsured clients, staff made a referral (and often an appointment through the calendar) with one of the guides. The electronic calendar helped the guides track demand for services across this broad geographic area. It also gave residents direct access to a guide and information about enrollment.

Local Health Department And Alliance Roles To Support Outreach And Enrollment

Case-study participants suggested that, because of the unique structure of the departments of public health and of human services, it is difficult to delineate the roles that the LHD plays relative to the other alliance members. In this sense, the relationship of the organizations represented a true partnership, not just in name but also in action. In addition, although the grant from Connect for Health Colorado supported all the outreach and enrollment activities, all

partners invested in-kind support for grant activities. In this section, we discuss these roles in more detail.

Secured Funding

The alliance's members jointly wrote and submitted the grant proposal for outreach and enrollment activities. Specifically, the alliance contracted with the former chief executive officer of Mountain Family Health Centers to write the original proposal. Although the discussants all suggested that health insurance outreach and enrollment are central to their missions as public health, health care, and human services organizations, they felt that their involvement in these activities would have been considerably less without this funding. For example, the FQHC has benefit specialists on staff who likely would have been working with uninsured patients to enroll them in the plans for which they were eligible, such as Medicaid. Likewise, the Economic Services Division is tasked with Medicaid enrollment, but case-study participants suggested that the grant dramatically increased the scale of reach into the community. As one discussant suggested, "It would have been impossible to do what we did without this funding." As the alliance considers new roles moving forward, its members will likely apply for additional funding sources jointly.

Made Hiring Decisions

Alliance members jointly hired all the health care coverage guides. The alliance felt that the only way to reach the diverse population in the three counties was to hire culturally competent health care coverage guides who understood how best to reach the different populations in the region, including the growing Latino population. However, because the guides worked closely with several different agencies (in many cases, taking office space at the organizations), each member of the alliance had a stake in hiring them. As a result, alliance members jointly interviewed and made decisions about whom to hire to fill those positions.

Provided Infrastructure

All alliance members contributed office space for the guides to conduct enrollments and space for outreach and enrollment events. Furthermore, technical support was provided to the guides while they were on site at partner agencies. Eagle County especially had the depth of infrastructure to support grant activities, including

- human resources and information technology (IT) staff to coordinate hiring and placing health care coverage guides and managing their IT needs
- legal staff to develop appropriate MOUs with the other involved agencies
- communication infrastructure to provide grant-specific messaging and marketing
- data collection and analysis to track program activities.

Provided Training and Staff Support

Staff members at each agency were trained on how to connect clients to the guides for formal assistance. This included making referrals and using the calendar to create coverage appointments. Moreover, staff time at the various agencies was used to help organize, participate in, and advertise outreach events and enrollment events. This was a very important role for the LHDs, which offer programs to many residents who lack insurance. Making the link to the health care coverage guides was important for LHDs' clients.

Facilitated Organizations' Access to Uninsured Populations

The LHDs, along with the other alliance members, all contributed to the health and human services safety nets of the three counties. As a result, they interacted with a large number of low-income and uninsured people. In some cases, these populations were eligible but had not yet signed up for insurance.

Through these contacts, the alliance was able to reach a large number of uninsured people. Although many private providers do not participate in the alliance, these providers could make referrals for enrollment either to the website or to the health care coverage guides. As one case-study participant from an LHD stated, in reference to the ability to enroll clients on site: "It's helpful when our guide is here on site; it helps if clients can easily access care. It does make a difference for clients. We provide a lot of direct services, so we are seeing the consumers [whom] we need to enroll."

Created A Broad Local Health Department and Social Service Network

Alliance members also had numerous links to other organizations in the three counties. As a result, outreach occurred through a larger network than the alliance partners alone. This was especially salient for the LHDs. As one discussant suggested, "The involvement of public health [was] important because we have links to community partners. [LHDs are] really good at linking people to people, so that was our role." Overall, the broad network of partners in all three counties supported outreach and enrollment in multiple ways, including advertising or hosting enrollment events, making referrals, and directly linking clients to the health care coverage guides through the appointment calendar.

Supplied Trusted Expertise in Health

The LHDs in particular also brought a specific understanding of the health and health care impacts of the ACA, as well as the needs of vulnerable populations. One benefit of this was in helping to shape the messaging to uninsured people based on LHDs' experience working with these clients on other issues. To address these needs, the LHDs and their key governmental partners sought to involve a trusted advocate in the form of the hired coordinator, who led

outreach and enrollment activities and oversaw the bilingual guides. Together, the LHDs and the trusted advocates were able to understand client needs and translate them effectively for the alliance to inform decisionmaking. Another benefit was that the LHD staff could help communicate more broadly about issues related to the ACA to facilitate understanding of the program.

Challenges To Outreach And Enrollment

The alliance confronted a variety of barriers to its outreach and enrollment activities. Case-study participants suggested that primary among these was inconsistency at the national and state levels around enrollment processes. For example, a major state policy change occurred just prior to open enrollment, requiring those seeking insurance through the Colorado marketplace to apply first for Medicaid. Those who were rejected because of high income could then apply for insurance through the marketplace. Accommodating this policy change meant that additional training for enrollment staff was needed. In addition, the new policy placed particular strain on Economic Services, which processes all new Medicaid applications. In Eagle County, this was an important problem because Economic Services was the lead agency for outreach and enrollment. The policy change also created delays in enrollment. During the first open-enrollment period, a determination of Medicaid eligibility could take up to 45 days. As a result, people who tried to enroll sometimes failed to return to complete the second step of the application process, or they might have been confused about where their applications stood. Because some participants felt strongly that they did not want to apply for Medicaid and might not have understood that their incomes would preclude it, the policy served as a deterrent to some participants enrolling at all.

The timing of the award from Connect for Health Colorado to the alliance was also a barrier to implementation. Although the grant was approved early in 2013, the award was not made until very close to the beginning of open enrollment. As a result, case-study participants suggested that it was difficult to implement the broader outreach strategy that had been detailed in the proposal and that this might have reduced the number of clients reached through its outreach strategy. The alliance had planned a long outreach period leading up to open enrollment and continuing through the enrollment period. However, by the time the grant was awarded and once the state policy changes were implemented, the focus became almost entirely on enrollment. Staff at the alliance also expressed concern that it was not possible to track changes in enrollment in the counties as they moved through the year. Data on enrollment and insurance rates at the state level might have been helpful in planning outreach strategies geographically but were too old to be useful for planning. Rather than rely on data to plan enrollment activities, the alliance continued to focus on the geographic regions covered by the guides.

The alliance underestimated the time needed to complete each enrollment, and staff felt that this constrained their ability to enroll larger numbers of participants. Though the two-step application process contributed to delays, low health literacy and low education, combined with

poor computer skills among some populations, also played a role because navigators had to spend more time than anticipated explaining how insurance works. In response, assistance guides changed their messaging to be as clear as possible in explaining how the process of enrollment occurs. Staff also worked to overcome challenges by helping set up email addresses and using strategies to help remind clients of important next steps. As one discussant explained: “The entire time [we’re with them in the enrollment session], we’re taking notes and giving them index cards with all their information. We’re having to write down the information for them and tell them that they have to keep track of certain pieces.”

Finally, the high cost of insurance was a shock to some participants and deterred them from completing the enrollment process. Stakeholders noted that many people would go through the process and then simply refuse to enroll in an option because of cost. Reaching people was also made difficult by both national media attention about the failures of the HealthCare.gov website at the beginning of enrollment and negative attention surrounding the ACA in general. In response, the alliance network intensified individual outreach efforts to clients who had started but not completed enrollment.

Enablers to the Local Health Departments’ Role in Outreach and Enrollment

To help overcome these challenges, the partners relied on several factors

- trust and strong communication
- complementary, not competing, interests
- strong communication
- strong community presence
- the ability to influence policy
- shared decisionmaking across the alliance.

The outreach and enrollment activities of the Assistance Network relied on the infrastructure and resources that were provided by the alliance partners. Funding was especially important because several case-study participants noted that, although many of the partners would likely have worked to identify enrollment options for their clients, the extent to which they accomplished this across the three counties depended on their grant. But navigating the hurdles of planning these activities, acquiring resources, and coordinating across agencies in both the public and private sectors also required clear communication and trust that had been honed over several years of working together on issues that included health but also extended to infrastructure, land, water, and other environmental issues. This led to contracts and formal relationships among the participating organizations, and, from the point of view of case-study participants, it resulted in a mind-set of “how do we attack this problem” rather than one of competitive interests. The alliance had been considering several health care reform–related activities, even prior to passage of the ACA, so an opportunity was created when it passed.

Strong communication (e.g., ongoing updates on activities) that, in turn, supported shared decision-making across partners was also important. The lead health care coverage guide was in constant communication with partners about their activities, and they met regularly both in person and by telephone. This meant that partners were informed about challenges as they arose and were prepared to make decisions. Working together built mutual trust in each other's capacity and commitment to overcome problems arising during implementation: In our discussions, many alliance partners said that they know whom to contact when problems arise and that they are always available to one another. For example, one of the county agencies supporting the health care coverage guides with office space was able to provide them with security badges to access the county office building despite the fact that they were technically employed by a different county. As case-study participants noted, there is a shared understanding of the value of public health and human services in the political and health care leadership of the counties and specifically of the value of health insurance. As one discussant said, "We don't have a sense of competition. Here, it is less about jurisdiction and more about, 'Are we doing this as a community?'" According to several case-study participants, these attitudes run so deep that political leaders in the counties typically follow the recommendations made by their departments of health or human services and rarely create roadblocks. Moreover, the history of prior engagement and partnership means that the alliance partners were used to working together and were often in alignment on their approach to addressing these types of issues. This made it easier for the partners to make decisions about outreach and enrollment and to solve problem as they arose. All together, the partnership reported that it helped enroll more than 9,000 lower-income Coloradans in affordable commercial insurance, Medicaid, or both.

Future Priorities: What Comes Next?

For the 2014–2015 open-enrollment season, the alliance planned to continue with outreach and enrollment pending additional funding from Connect for Health Colorado. A primary focus will be identifying methods of working more closely with consumers to provide assistance in choosing among health insurance options. The alliance is also considering adding a focus on improving utilization of services among newly insured people.

One additional area of emphasis is on further expansion of the partnership network. First, the alliance is considering how to reach small businesses to support employee enrollment in the marketplace. Second, it is examining ways to work with brokers, insurers, and private physicians to reach more uninsured people seeking care.

Discussion

Although all three LHDs in Eagle, Pitkin, and Garfield counties were instrumental in active outreach efforts, the Eagle County LHD was an especially active participant and leader in a communitywide effort to engage in outreach and enrollment. This role reflects the approach that

many health departments have taken across the country. However, one of the unique aspects of this community is the strong integrated partnership used to address outreach and enrollment across a three-county region. This case study provides useful ideas about how LHDs can participate in outreach and enrollment. Specifically, the LHD was able to leverage its network of partner organizations to implement each aspect of outreach and enrollment. The LHDs and their partner governmental agencies administered the grant in a way that made it easy to work across county lines and facilitate the work of the health care coverage guides in an efficient manner. These activities were supported in turn by a long-standing history of partners working together on a host of related health and social service activities, as well as the broad support that county leaders in all three counties had for these types of joint efforts. Other health departments might use this case study to identify how to leverage their own existing partnerships to achieve the goals of outreach and enrollment and to begin developing relationships with local social service, health, and other community-based organizations that likely take on the lion's share of outreach and enrollment activities in their communities. Notably, rural communities could learn from this approach of placing IPAs in key locations across the region (supplemented with an automated calendar for making enrollment appointments) and sponsoring enrollment events around the three-county area to help facilitate client engagement. All communities could learn from the success of centralizing the planning and implementation outreach and enrollment events around a single coordinator.

LHDs can serve as critical partners and, in some cases, as leaders of these key activities. However, some aspects of this community make it unique and could preclude exact replication of the partnership in other communities. Specifically, not all LHDs partner with one another regionally to provide services to residents like these LHDs have. Also, although many LHDs have strong working relationships with community partners, the breadth and depth of relationships evident in these three counties could not be replicated in other communities. Finally, others LHDs might not have access to the type of funding that was used in this project to support outreach and enrollment. Similarly, funding at some LHDs might preclude activities not directly covered by the grant, such as staff training. This is especially important in communities in which LHDs have faced recent and large budget cuts and have less capacity overall. Nevertheless, many facets of this partnership and its work in outreach and enrollment can be replicated.

4. A Case Study on Tacoma–Pierce County, Washington

Context Of Health Care Reform In Washington State

The state of Washington established a state health exchange as a public–private partnership in 2011 and expanded Medicaid in 2013. The Washington Health Benefit Exchange is the official state health exchange system, and the Washington Healthplanfinder serves as the online marketplace. Washington Apple Health is the state’s official Medicaid program, which is operated by Washington State Health Care Authority. In October 2013, the state consolidated the existing Medicaid system with the federal Basic Health Plan Option to create the expanded Washington Apple Health. Fifteen percent of the population was uninsured pre–ACA, with an estimated 85 percent of uninsured adults being eligible for expanded Medicaid.

Washington state received close to \$6 million through the IPA funding provision of the federal exchange-establishment grants that were made available to states in August 2012, to create a network of IPAs to help vulnerable populations enroll in Medicaid. The state contracted with ten lead agencies across the state to create a network of IPAs (i.e., coalitions, regional health networks, community organizations, and public health agencies), and four out of ten were LHD agencies. The Tacoma–Pierce County Health Department was selected to be one of the lead agencies. Of note is the fact that Washington has a decentralized public health system that features local control and partnerships, including 35 local health jurisdictions serving 39 counties and tribal partners, in addition to the Washington State Board of Health and the Washington State Department of Health.

Model Of Local Health Departments’ Involvement And How They Came To Be In This Role

Leaders in the health care system asked the Tacoma–Pierce County Health Department to apply as the lead agency to train and coordinate IPAs in the region to conduct outreach and enrollment. They saw the health department as a trusted, neutral, collaborative partner that could work with organizations focused on hard-to-reach populations.

Because of this request, the health department applied for and received a \$682,400 grant in 2013 from the Washington Health Benefit Exchange to serve as a lead agency. The health department used the grant to fund contractors for an 18-month period (August 2013 to February 2015) and to support internal staffing. As a lead agency, the health department put out a request for quotations (RFQ) to community and nonprofit organizations to receive training and funding for IPAs to conduct the outreach and enrollment activities. It selected nine organizations to be

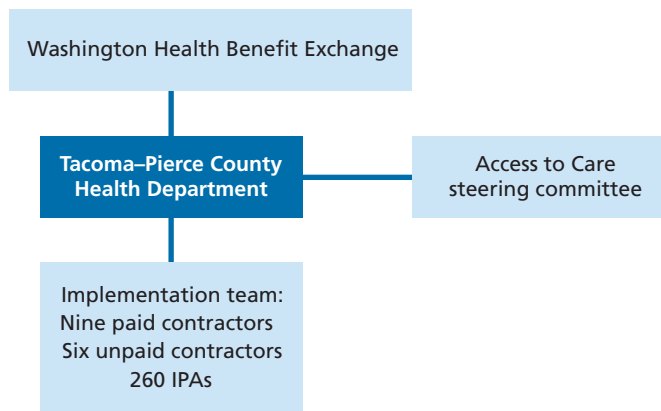
paid contractors for outreach and enrollment activities; through existing health department partnerships, another six organizations were leveraged to be unpaid contractors that would receive IPA training (but no funding from the grant) or provide in-kind resources, such as use of facilities. The next section provides information on the selection of paid contractors and motivation of unpaid contractors to participate in outreach and enrollment efforts.

This approach reflected the regional practice of deciding on the leadership of programs based on resources, organizational structure, and a consensus about what makes the most sense for implementation and outcomes. The health department's network of IPAs and IPA organizations was called the implementation team. The paid IPA organizations included cultural groups, CHCs, and organizations providing services to rural, homeless, and substance-using populations. The unpaid IPA organizations included 211 information lines, hospitals, faith-based organizations, and the library system. To serve the heterogeneous population of the county, the IPAs included speakers of a variety of languages. The implementation-team IPAs processed 24,361 new Medicaid and marketplace enrollments through August 2014.

The stakeholders in the health care community that encouraged Tacoma–Pierce County Health Department to apply as the lead agency for IPAs in the region decided to formally support the health department's efforts in outreach and enrollment and established a monthly advisory group called the Access to Care steering committee. Members of the steering committee include leaders from public health agencies, qualified health plans, hospitals, CHCs, and other community health organizations. The intention of the steering committee is to provide a forum to identify opportunities to ensure that Pierce County residents have access to affordable and needed health care.

Figure 4.1 illustrates these relationships for outreach and enrollment in Tacoma–Pierce County. Like the other state lead agencies for IPAs, the Tacoma–Pierce County Health Department is a liaison between the Washington Health Benefit Exchange and the IPAs. The exchange provides information and materials to Tacoma–Pierce County Health Department, the IPA lead agency for Pierce County. As lead agency, the health department shares this information and materials with the IPA implementation through weekly meetings held at the health department. The implementation team provides enrollment numbers and on-the-ground feedback about IPA activities to the health department, which then relays the feedback to the exchange in their regular communications. The region's health care community supports the health department's role as an IPA lead agency through the Access to Care steering committee, which wants to ensure that the health department can meet the expectations of the Washington Health Benefit Exchange's IPA grant.

Figure 4.1. Relationships for Outreach and Enrollment in Tacoma–Pierce County



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Outreach And Enrollment Overview

In addition to securing funding, the Tacoma–Pierce County Health Department serves several roles in oversight of IPA outreach and enrollment efforts.

Tacoma–Pierce County Health Department serves in a coordinator role and provides outreach and education for other service providers. Regarding outreach, the initial plans included engaging partners with planning rollout events at community locations, posting material on their websites and social media, speaking at civic-group meetings, and taking part in press releases with the state exchange. The preliminary enrollment strategy included serving as a lead agency for the county’s IPA program to help people sign up in the state exchange, in addition to training community partners and hospital staff and community health workers to be IPAs.

Selected Contractors

As lead agency, the health department put out an RFQ to community and nonprofit organizations to conduct the outreach and enrollment activities. The health department’s Office of Assessment, Planning and Improvement²⁵ used state and local data to conduct analyses and geographic information system mapping of county health indicators to identify the most-vulnerable and hardest-to-reach populations for outreach and enrollment by census tract. These uninsured groups included racial and ethnic minorities, young adults, and rural and urban community members in need of basic social services (e.g., food bank, clothes, rent or utility help, or unemployment assistance). Informed by these data, the health department staff reached out to organizations used in previous collaborations for other public health efforts or who had relevant experience and expertise working with the target populations and communities to respond to the

²⁵ Tacoma–Pierce County Health Department, “Office of Assessment, Planning and Improvement,” web page, undated.

RFQ. As part of the selection process, organizations interested in becoming paid contractors not only had to describe their past work and existing relationships with a target population or community but also had to demonstrate capacity and technology services needed to use Washington Healthplanfinder, knowledge about the ACA and its context in the state of Washington, and experience delivering culturally appropriate services.

Conducted Training

The health department arranged for and conducted training for IPAs. The health department had trained 260 IPAs at the time of the site visit, which surpassed its target number of IPAs trained (the target was approximately 100).

Leveraged Partnerships to Supplement Activities

There are three examples of how the Tacoma–Pierce County Health Department capitalized on collaboration with other organizations to support outreach and enrollment efforts. First, the health department trained additional IPAs through unpaid contractors. The health department leadership participated in the Pierce County Access to Care steering committee, which was an advisory council for outreach and enrollment work that was made up of key stakeholders from the health care community. Through this participation, some of the health systems had their personnel (financial counselors) trained as IPAs. For example, one hospital had 50 IPAs trained by the health department who then reached out to their hospital patient populations.

Second, the health department opened its implementation meeting to all groups in the county that were interested in outreach and enrollment, not just the contracted organizations. For example, the African Americans Reach and Teach Health Ministry was able to secure funding for outreach and enrollment through a mechanism other than the health department but attends the health department implementation-team meetings because the technical-assistance information is helpful and relevant to its work. In addition, staffers from the library system and 211 information line attend meetings to support regional outreach and enrollment efforts by, respectively, hosting outreach and enrollment events or providing IPA information to clients.

Third, the health department works with the University of Washington Tacoma nursing program to provide health information to the newly insured. The health department contracts with the University of Washington Tacoma nursing program's community health class, and, through this relationship, the health department helps nursing students become involved in outreach and enrollment by surveying newly insured residents and creating a health guide for those enrolled in Medicaid (Washington Apple Health).

Convened and Supported the IPA Team

The health department convenes weekly in-person meetings for the IPAs and IPA groups (that is, the implementation team). During these weekly meetings, the health department relays

information from the Washington Health Benefit Exchange, facilitates discussion on challenges to outreach and enrollment, provides workarounds for IPAs to these challenges, and provides moral support to members of the implementation team. In general, IPA team members reported that the support and responsive technical assistance by the health department staff have been instrumental in helping groups to successfully execute outreach and enrollment. For example, the health department set up an online help request system that IPAs could use to document online error codes or messages received while working on the Washington Health Benefit Exchange website,²⁶ and program staff respond with workarounds or other information.²⁷ Email communications from health department staff supplement weekly meetings. The health department staff also developed and provide spreadsheets for contractors to use to track their outreach and enrollment efforts; for some groups, this was the first time they had documented their activities and outcomes. They regularly report these data to the health department, which then reports figures back to the Washington Health Benefit Exchange. Program staff use their connections to publicize efforts through advertisements, flier, and public media, and they are responsive to the needs of the IPA implementation team.

Coordinated Outreach and Enrollment Efforts

The health department has organized at least four Super Saturday events with the support of the implementation team. At these events, IPAs are available throughout the county from 10:00 a.m. to 4:00 p.m. on a Saturday. Through various community agency locations, residents can get one-on-one support to learn how to use a website or call center to obtain information about their options and enroll in health coverage. These activities continue through bimonthly events in the county library system. The health department also coordinates its own outreach and enrollment efforts with other large-scale events, such as Project Homeless Connect, which brings together organizations and services to address the basic needs of the homeless.

Served as Liaison Between the Washington Health Benefit Exchange and IPAs

As a lead agency, the health department shares information from the exchange with the IPAs and IPA organizations. This information includes updates on state policies or enrollment information, technical assistance with the online enrollment system (i.e., Washington Healthplanfinder), and educational materials on health care reform and health insurance enrollment for constituents. In addition, the health department shares concerns from the IPAs with the exchange through its regular communications. IPA concerns include the need to tailor outreach and enrollment materials and the additional time required to enroll some newly eligible individuals into health care coverage. The exchange responded by allowing IPA organizations to

²⁶ Washington Healthplanfinder, web page, undated.

²⁷ Tacoma–Pierce County Health Department, “In-Person Assister Help Ticket Request,” web page, undated.

tailor outreach materials several months into the open-enrollment period. We do not know whether or how the exchange has responded to the time delays associated with enrollment.

Developed Outreach and Enrollment Materials

The health department also developed and shared health care–reform fact sheets and enrollment cards with the implementation-team IPAs. This was especially important early in open enrollment, when the exchange had not yet provided IPAs with health education materials for the public.

Challenges To Outreach And Enrollment

Some barriers to enrollment are beyond the LHD’s role as a lead agency, but they affect the IPA implementation team and thus require a response from the Tacoma–Pierce County Health Department. The Washington Medicaid renewal policy resulted in unanticipated demand for IPAs’ time and efforts. When the state of Washington expanded Medicaid, it decided that anyone already on Medicaid would need to reenroll through the Washington Health Benefit Exchange. IPAs now conduct renewals, which previously the Washington State Department of Social and Health Services had conducted. Contracted IPA groups reported spending a significant amount of time that had been allotted for new enrollments to unintended reenrollments, which did not count toward their target enrollment numbers.

Another barrier was the poor relationship between IPAs and the Washington Health Benefit Exchange. Staff and IPAs from both paid and unpaid contracted IPA groups expressed distrust in the exchange. Organizations felt that the exchange was not interested in the Medicaid-eligible population or in acknowledging the issues with which IPAs were dealing, such as the time-consuming process of discussing health care among groups that were less familiar with health insurance. Community organizations were frustrated to have to use Washington Health Benefit Exchange materials that were not translated into different languages, not at appropriate reading levels for their clients, and not digestible for groups who were new to health insurance; only in early 2014 did the exchange allow IPA organizations to directly tailor materials. Organizations also felt that misinformation from the exchange affected their credibility with their clients. Furthermore, IPAs found exchange staff to be unhelpful in resolving technical issues or glitches with the Healthplanfinder website. The health department recognized the exchange’s slow responsiveness to IPA concerns and therefore stepped up to answer many contractor concerns by acknowledging the challenges, providing workarounds to technical issues with the website, and supporting the use of tailored materials.

A third barrier was that decreased news coverage and publicity for health care–coverage enrollment required more word-of-mouth efforts from the IPA implementation team. Many residents were not aware that enrollment in Medicaid was ongoing and not limited to the first open-enrollment period or that a major life event (e.g., marriage, including same-sex marriage)

could qualify them for coverage. In response, the health department continues to provide twice-monthly one-on-one enrollment help at the library locations and has remained active in outreach (e.g., participation in the Tacoma Pride Festival).

Other challenges are specific to the health department. For example, the health department chose to use the Washington Health Benefit Exchange grant to support one full-time equivalent (FTE), but more personnel support was needed to address IPAs' concerns. The health department increased its capacity by bringing on a Centers for Disease Control and Prevention associate to help with outreach and enrollment efforts in the past year. Health department staffers were also proactive about securing an AmeriCorps VISTA intern to support efforts in the next year. The supervisor for the health department program staff is funded through other revenue streams and programs. Additionally, the department could have benefited from partnering with one of the hospital systems that contracted out its IPA services. However, despite numerous and strong attempts to engage this hospital, the partnership failed to materialize.

There were also concerns about the health department's lack of flexibility as a lead agency. Most of the paid contractors felt that the health department and staff were essential to the success of enrollment efforts, especially in garnering the support of the health care systems. However, health department staff and one paid contractor raised concerns about having a public health department as a lead agency. Organizational rigidity within the health department resulted in delayed contracts and late payments. Some implementation-team partners perceived that the proportion of funds used by the Tacoma–Pierce County Health Department to administer the grant was too large and resulted in less funding for contracted groups to provide services. The health department staffers involved in outreach and enrollment shared these frustrations and were transparent with the IPA groups about department bureaucracy and their efforts to address these concerns in the current system, but we do not know whether this resulted in more systematic changes. There were also contrasting views within the health department about its role in ACA–related outreach and enrollment activities. Some leadership and staff did not feel that ACA–related activities were part of the core functions of public health (assessment, assurance, or policy development),²⁸ while program staff felt that outreach and enrollment activities linked residents to care and therefore fell under assurance (“link people to needed personal health services and [ensure] the provision of health care when otherwise unavailable”). The perception that health care reform was a political issue might have limited health department advocacy on outreach and enrollment.

²⁸ Office of Disease Prevention and Health Promotion, *Public Health in America*, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services, May 1, 2008.

Enablers To The Local Health Department's Roles In Outreach And Enrollment

Despite these challenges, two primary factors were critical to enabling the LHD's roles in outreach and enrollment. First was the grant from the Washington Health Benefit Exchange, which supported the use of data to select contractors and formal collaboration with the health sector through the Access to Care steering committee. The exchange grant allowed the health department to hire an FTE for outreach and enrollment, expanding the public health department's capacity for this work. If there were no grant support, outreach and enrollment activities would likely have been limited to health systems (CHCs) and organizations that could secure funding through different avenues, and involvement of nontraditional health or social service organizations would not have been as great. The Tacoma–Pierce County Health Department has a strong epidemiologic division and, as previously discussed, was able to use data to identify vulnerable populations for enrollment and then select trusted community organizations to work with those populations and build an effective IPA implementation team. In addition, having a strong supportive relationship with the health care sector through the Access to Care steering committee facilitated the training of unpaid IPAs from other organizations and provided resources to the health department for the printing of IPA training manuals.

The second enabler was the collaborative culture among organizations in Tacoma, which helped support the health department's role as a lead agency for IPAs. The Tacoma–Pierce County Health Department has a long history of collaboration with health care systems, academic institutions, and community-based organizations. Individuals and groups working on non-ACA activities for decades had built a level of trust in the LHD as a neutral party among groups with competing interests. For example, in 2012, the Washington State Legislature passed a motion requiring nonprofit hospital systems to conduct community health assessments as part of a continuing community-improvement process, and the two major nonprofit hospitals in the county contracted with the health department to conduct this assessment.

Not only did organizations involved in outreach and enrollment efforts share strong professional relationships with the Tacoma–Pierce County Health Department; health department staff also had a deep understanding of the on-the-ground realities of daily operations of health systems and community organizations. Although the IPA implementation team and Access to Care steering committee provided the first occasions for some groups to work together, the culture of work in Pierce County is collaborative (i.e., very few groups work in silos), and the health department intentionally supported that camaraderie (e.g., parties, food, in-person meetings, active listening, and providing solutions). Some stakeholders attributed the collaborative spirit in Pierce County to the size of the county: “It is not too big for competing interests among community organizations, not too small with too few resources to help residents, but ‘Goldilocks’ medium-sized.” Almost universally, IPA groups discussed the dedication,

creativity, and hard work of the health department staff as critical to the success of outreach and enrollment efforts.

Future Priorities: What Comes Next?

The future role of the health department in outreach and enrollment is not clear and will depend on both grant funding and health department leadership interest to continue to participate in these activities given the political climate around health care reform. The health department leadership explained that, if the health department's current role as lead agency is successful, IPA groups will have capacity and experience to conduct future outreach and enrollment activities without the need for the health department to serve as a lead agency. At the time of the site visit, the Access to Care steering committee was interested in continuing to meet and was considering changing its role to focus on health education and navigation for the newly insured.

Discussion

In Washington state's Tacoma–Pierce County, the LHD is the lead institution in contracting, convening, and coordinating regional outreach and enrollment activities. As a trusted, neutral organization with communitywide partnerships and relationships with diverse groups and populations, the Tacoma–Pierce County Health Department was seen as the natural leader for these efforts, so much so that a coalition of health organizations encouraged the LHD to serve as a lead agency and then continued to support the LHD in its role. Furthermore, the Tacoma–Pierce County Health Department and its partners have a shared goal of doing what is needed to help county residents. Some stakeholders felt that this model of an LHD's role in outreach and enrollment could be replicated in communities that are receptive to working together and that have champions for those efforts.

The discussants felt that Tacoma–Pierce County might be unique in its history of having a collaborative spirit among agencies and individuals, as well as the health department's strengths in epidemiology, data collection, and surveillance. The case study illustrates a model of the LHD as a community convener and relationship builder that actively collaborates with health care institutions and diverse community organizations serving individuals newly eligible for health care coverage. Public health agencies can create or repurpose existing coalitions and focus them on a common goal: to effectively reach vulnerable populations and support their enrollment in health insurance coverage. In addition, this case study shows how LHDs can be creative with limited resources and in a charged political climate and serve as an important liaison between state agencies and community organizations or residents.

5. A Case Study on New Orleans, Louisiana

Context Of Health Care Reform In Louisiana

The ACA provided an opportunity for Louisiana to extend coverage to roughly 866,000 uninsured residents. People meeting certain income thresholds became eligible for tax credits on health insurance premiums for plans purchased through the marketplace. The ACA also gave states the option to extend Medicaid eligibility up to 138 percent of the FPL. However, in 2013, Louisiana decided not to expand Medicaid; as a result, about 242,000 adults (28 percent of the uninsured in the state) would have to purchase insurance through the marketplace or remain uninsured.

Prior to implementation of the ACA, some uninsured residents in and around New Orleans paid for part of their primary care through the Greater New Orleans Community Health Connection (GNOCHC), which is a Section 1115 Medicaid waiver for the four-parish region that includes Jefferson, Orleans, Plaquemines, and St. Bernard parishes.²⁹ It covers primary and mental health care (but not hospital services) for low-income residents (up to 200 percent of the FPL) who are otherwise not eligible for Medicaid. Under the expectation that expanded Medicaid would better serve the low-income uninsured population living from 100 percent to 138 percent of the FPL, the waiver was scaled back to cover people at only up to 100 percent of the FPL upon ACA implementation. When Louisiana elected not to expand Medicaid, a gap in coverage larger than the pre-ACA landscape was created.

The federally facilitated marketplace is the primary pathway to obtaining coverage under the ACA in the state of Louisiana; to help uninsured people enroll in health care coverage, the federal government awarded four local organizations \$1,767,175 to establish a network of navigator and IPA programs:

- Southern United Neighborhoods, serving north, southeast, and southwest Louisiana
- Martin Luther King Health Center, serving Bossier and Caddo parishes
- Southwest Louisiana Area Health Education Center, serving the entire state
- Capital Area Agency on Aging, serving southeastern Louisiana.

At the start of the first open-enrollment season, nearly 298,000 (more than one-third) of uninsured people in Louisiana were eligible for premium tax credits under the ACA to help purchase insurance in the marketplace. During the first open-enrollment period, 101,778 Louisianans signed up for qualified health plans.

²⁹ Section 1115 of the Social Security Act “gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP [Children’s Health Insurance Program] programs” (Centers for Medicare and Medicaid Services, “Section 1115 Demonstrations,” web page, undated).

Model Of The Local Health Department's Involvement And How It Came To Be In This Role

According to some discussants, the New Orleans Health Department has a very strong focus on improving access to health care services for the region. Originally, then-LHD director Karen DeSalvo fueled this focus; through her work both inside and outside the LHD, DeSalvo made improved access to care in the city at a particularly important point of focus in the aftermath of Hurricane Katrina. This commitment led in part to the development of 504HealthNet, a private not-for-profit membership organization for the region's CHCs. That organization is charged with growing and supporting the health care safety net through CHCs.

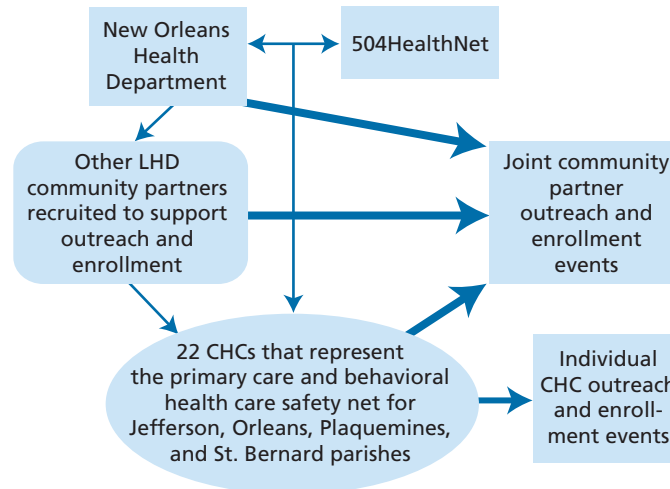
In 2012, the New Orleans Health Department, with support from the DHHS, undertook an effort to assess the capacity of the health care safety net and design strategies to strengthen it. Through this work, the LHD and the Louisiana Public Health Institute (a statewide nonprofit organization that coordinates and manages public health programs designed to support the public health system) developed a partnership of key health and health care stakeholders from nonprofit hospitals, local health systems, other government agencies, and insurance organizations and brought them together to develop a comprehensive strategy. As a result of that work, the Greater New Orleans Primary Care Safety Net Access Plan was developed. As one participant explained, the goals of the strategy support the LHD's outreach and enrollment efforts and its partnership with 504HealthNet. Among the broader goals of that plan are building safety-net capacity to meet growing demand and strengthening the viability of existing CHCs, expanding coverage options for uninsured residents, and public outreach about the availability of public health and health care services.

Although the Greater New Orleans Primary Care Safety Net Access Plan fosters the LHD's role in implementing the ACA, the LHD's participation in outreach and enrollment also grew naturally out of its historical efforts to improve access. As the figure depicts, the LHD's current primary role in these activities was to partner with 504HealthNet to coordinate the efforts of the many CHCs that are engaged in outreach and enrollment. In addition, the LHD engaged other community-based organizations to participate in outreach and enrollment specifically in its efforts to reach specific populations, such as small-business owners, and the Latino and Vietnamese populations..

A grant from the Health Resources and Services Administration (HRSA) supported some LHD activities. This funding created the outreach coordinator position in the department. One of the critical factors that brought the LHD and 504HealthNet together was the gap in access created by the loss of GNOCHC for those living from 100 percent to 200 percent of the FPL. This change in GNOCHC eligibility not only affected people's ability to access care; it also affected the health clinics that served these people as those clinics, in turn, lost a large component of their payment system because people could no longer afford care. As a result, outreach efforts focused on identifying and informing former GNOCHC participants about the

change in their insurance status and, where possible, enrolling them in other programs. In short, the primary goal of the LHD access efforts with respect to ACA implementation was to “strengthen and sustain the health safety net.” LHD outreach and enrollment activities were viewed as a way to accomplish this goal, which, in turn, would support the financial health of local CHCs.

Figure 5.1 New Orleans Health Department Participation in Outreach and Enrollment



NOTE: The smaller arrows indicate relationships between organizations. The larger arrows indicate activities that the organizations sponsor. For example, the LHD partnered with other community organizations to engage in joint events, participated in these events as an independent organization, and partnered with 504HealthNet to work with community health centers to put on the events.

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Outreach And Enrollment Overview

One discussant shared that a motto for the city of New Orleans is “facilitate, link, leverage.” The LHD operationalizes this motto by building on existing community resources to accomplish outreach and enrollment. According to several discussants, the LHD realized that, in order to have an impact, it would need to connect with partners that could extend its reach into high-need communities. From its perspective, the grant that it had received was not enough to enable it to reach every resident. So its strategy was to facilitate the work of community-based and health care organizations in outreach and enrollment and participate directly when possible. As one LHD staff person suggested, “We knew we couldn’t do this by ourselves; we had to work through other agencies.” In this section, we describe specific activities that the LHD undertook in support of outreach and enrollment efforts.

With 504healthnet, LHD Outreach And Enrollment Work Group

With 504HealthNet, the LHD cochaired a work group that was made up of CHCs that had received grants from HRSA for outreach and enrollment along with the support of other community-based organizations. The LHD and 504HealthNet were closely aligned and played a similar, often shared role in supporting the work group and the outreach and enrollment activities in the community. Work-group members conducted outreach and enrollment with their own patients and clients, and they organized and participated in communitywide outreach events. The work group coordinated the timing of these activities with a central calendar and wiki that contained information on all coalition members' activities. The wiki is hosted by 504HealthNet, and the calendar is hosted on both the LHD and 504HealthNet websites. Both organizations took responsibility for updating the calendar. 504HealthNet was responsible for making sure that clinic events were listed, and the LHD was responsible for its own information. Each week, 504HealthNet would reach out to the work-group members to find out about their events. This process made it easier for work-group members to track all the activities and made it easier for them to refer clients to any ongoing events.

Work-group member organizations worked together to ensure that each event was well staffed and had the resources it needed to be a success. In addition, the LHD planned major communitywide outreach and enrollment events in which all the agencies participated. These were planned to occur all over the city and depended on the space and calendar availability of partners, such as libraries.

From the point of view of the individual health centers, the coordination that the LHD and 504HealthNet provided was critical to helping them achieve their mission. According to discussants, the large planned events were very good resources for them. Sometimes their individual events would not net as many enrollees as they wanted, but these larger events attracted more people. As one discussant stated, "The LHD set up the events, and all we had to do was show up. They were [organized] in places we had not thought about going, but, when we would arrive, there would be lines outside the door." The work group also served as a learning collaborative, in which work-group members shared information on lessons learned and promising practices.

Specific supports that the LHD provided to the work group included providing the basic infrastructure to support work-group activities, providing thought leadership on potential outreach and enrollment activities and strategies, and directly supporting the enrollment events with staff and other planning and coordination support. In addition, the LHD developed press releases and supported the development and translation of educational materials for use in outreach and enrollment activities. The LHD also coordinated messaging by local public officials, which garnered a great deal of attention.

Used Public Health Data And Mapping To Support Outreach

The Bureau of Health Services Financing provided the New Orleans Health Department data on the locations of people who lost coverage under the change in eligibility for GNOCHC. By compiling these data and producing maps that highlighted the concentrations of populations adversely affected by the loss of GNOCHC health insurance, the LHD and the work group could target their outreach strategies more efficiently in their communities. In particular, they sought to set up enrollment events in communities with higher concentrations of these people.

Conducted Direct Outreach To And Enrollment Of Residents

The LHD did engage in outreach enrollment directly with clients and residents. Some staff were trained as certified application counselors, and they participated as enrollers at the large enrollment events, as well as enrollment days sponsored by the LHD. Staff would focus specific attention on enrolling clients in relevant programs, such as Healthy Start. The LHD also sponsored enrollment days on which residents could come into the LHD to enroll.

Leveraged Its Network To Increase Enrollment Opportunities

One of the LHD's key roles was to leverage its broad network of partners to increase the reach of outreach activities. Although the work group was made up almost entirely of health care clinics, the larger network of the department included insurers, brokers, and organizations from other sectors, such as faith-based institutions, increasing the number of organizations that could participate in and support outreach and enrollment activities. For example, the LHD partnered with Puentes New Orleans, a community development organization that supports the inclusion of Latinos in public, political, and socioeconomic life. The LHD asked Puentes to help sponsor a large enrollment event targeting Latinos. Puentes led outreach efforts to inform Latinos of this event, and Spanish-speaking staffers from the work group were on hand to facilitate enrollment. That event garnered substantial participation by Latinos in and around New Orleans. It is important to note that this was not the first time the LHD and Puentes worked together. In 2013, the LHD funded Puentes to conduct a survey of Latino health needs in New Orleans. The experience of working on that issue built trust and established a working relationship between the two organizations. In addition, it helped increase knowledge of the need for outreach and enrollment activities among Latinos in the city.

Individual Barriers To Outreach And Enrollment

The LHD and its partners encountered a variety of individual barriers to outreach and enrollment. These ranged from the difficulty that some populations have had in trying to understand and engage in the enrollment process to the policy barriers that made coordination of activities more difficult. We describe these in more detail in this section.

Health, Computer, And Insurance Literacy

One of the more difficult issues the LHD and its partners had to overcome was related to literacy. Those helping with outreach and enrollment activities found that some populations had difficulty accessing information electronically and navigating the online enrollment process. According to some discussants, some consumers did not have email addresses or Internet access. Others had access to the Internet but struggled to understand the information that was presented. In particular, many people did not understand the basics of how health insurance worked. For them, understanding terminology and comparing cost-related information beyond premiums, such as deductibles, copayments, and coinsurance, was particularly difficult. Thus, the discussants with whom we spoke suggested that it was difficult to help clients make choices among these elements when the clients lacked a fundamental understanding of what they were. Lack of experience with insurance and the enrollment process, coupled with insurers dealing with a larger influx of newly enrolled populations, also created communication gaps. For example, not all clients understood that they needed to pay their premiums on time each month in order to stay insured, or their insurers never contacted them with bills or follow-up information about next steps. As a result, some clients dropped coverage.

Lack of knowledge about available options also posed a barrier to outreach. According to some of the discussants, many clients had heard of the ACA or “Obamacare” but did not know how it worked. According to several discussants, misinformation about how the ACA worked meant that clients did not necessarily understand how to enroll, what they were enrolling in, or how to use insurance after they received coverage. Part of the problem was related to the way in which the new options were communicated. Although the focus in New Orleans was on educating people about where they could enroll, not all uninsured people were convinced of the insurance’s utility, relative to that of other financial needs. As one discussant put it, “We were selling health insurance, but that’s not a sexy product. Unless the person is sick, insurance is not a top priority, especially not with lower-income populations.”

Affordability Of Insurance

Cost was perceived as a critical barrier. Those who were not eligible for Medicaid but with incomes up to 100 percent of the FPL were eligible to enroll in GNOCHC to help cover the cost of primary care, and those with incomes from 138 percent to 400 percent of the FPL were eligible to purchase subsidized marketplace plans. However, because Louisiana did not elect to expand Medicaid, there was little financial support for people in 100 percent to 138 percent of the FPL. This meant that, for some, the cost of the marketplace plan was very high. However, even among those with subsidies, the monthly premiums were more than they expected or could afford.

As noted earlier, some discussants reported that many of the people they were working to insure had never had insurance and did not necessarily see the value of it. When they were

confronted with premium costs that were high or higher than expected, some residents refused to complete the enrollment process. As one discussant stated, a question she heard multiple times from clients was, “Why would I buy insurance when I can go to your clinic and just pay \$10?” Furthermore, as some discussants described, because not everyone understood how their health or utilization patterns might result in different out-of-pocket costs under different plans, many chose “bronze” or the lowest-cost plans based on premiums alone without fully understanding differences in coverage and financial risk. Thus, discussants voiced a concern that some clients might drop their insurance because of dissatisfaction and high overall cost.

Enrollment Time

Given the literacy and cost barriers noted above, discussants found that enrollments took longer than expected. Staff needed to spend more time explaining the process and helping clients make decisions. In some cases, a discussant had to stop the enrollment process to create an email account for the client and then show the client how to use that email. Many participants showed up without all the necessary paperwork required for enrollment. In some cases, the process would take so long that it had to be stopped and concluded on a different day. However, when the enrollment effort stopped, clients were often confused about how to follow up to complete the enrollment process. The technical glitches on HealthCare.gov and the fact that, at some events, many more people turned out than had been anticipated exacerbated these problems. Given the time required to enroll, fewer people could be enrolled at these events than work-group members would have liked.

Policy Barriers To Outreach And Enrollment

Two key policy concerns in New Orleans affected outreach and enrollment efforts. The first was the change in GNOCHC eligibility upon implementation of the ACA. When Medicaid was not expanded in Louisiana, a gap in coverage occurred for some people who had previously been able to access GNOCHC. To fill this gap, the work-group members started an education campaign to fully reinstate the GNOCHC waiver. But they also made reaching out to this population a key component of their access-to-care campaign. As part of this effort, the LHD created maps of the locations of this group and then worked with the work group to concentrate outreach around the available ACA options.

The second policy issue was the lack of Medicaid expansion. For the work-group members, Louisiana’s failure to expand Medicaid was a very important concern. According to estimates made by work-group members, about 40 percent of the uninsured would have been eligible for Medicaid under expansion; many of these people seek care primarily through CHCs. Thus, finding alternatives to coverage for this population was critically important. However, the lack of expansion created not only a gap in coverage but also confusion for some people about whether health insurance was available to them. Although national attention was placed on the expansion

of health insurance options to low-income people, in states that have not expanded Medicaid, the perception is still that there will be free or greatly reduced-cost insurance options. When New Orleans residents were not presented with these free or low-cost options, they blamed the LHD and other agencies involved in outreach. According to some of the discussants, the lack of Medicaid expansion also resulted in lower levels of trust in local entities that led enrollment efforts.

Lack of Medicaid expansion also affected the work-group partners' capacity to engage in outreach and enrollment because there was no state-level involvement in outreach and enrollment. This meant that there was no state-sponsored outreach campaign, and the state did not fund local enrollment activities. Several of the discussants suggested that the result of this was that local organizations took on more roles with limited funding. They also felt that, compared with communities in expansion states, local communities in Louisiana experienced

- limited coordination of outreach and enrollment activities
- no clear media strategy to educate the public about the availability of enrollment opportunities
- fewer trusted messengers to convey information about outreach and enrollment
- less clarity about the more-complicated aspects of the ACA, such as the availability of tax credits.

One other impact that discussants mentioned was a lack of positive messages about enrollment locally to combat national media stories that were weighted toward failures. During the final outreach and enrollment push in 2014, the news in some states focused on the positive stories of people waiting in line to enroll, floods of enrollment, and good stories about newly insured across the state. However, this did not occur in Louisiana, making communication about the ACA an uphill battle—in essence, there were fewer positive pieces about enrollment in the statewide news cycle, likely because of the political climate of the state.

Strategies For Overcoming Barriers

To account for both the individual and policy barriers, the LHD and its partners implemented a variety of activities. First, they adjusted their outreach and enrollment model to deal with HealthCare.gov website difficulties. The LHD and its partners focused instead on developing and implementing outreach and awareness events in October and November 2013 in order to generate interest in enrollment rather than try to do enrollment directly. Second, to address concerns clients raised about costs, they focused on developing materials that were as transparent and open as possible about the costs associated with insurance and the plans among which enrollees were choosing. As one discussant stated, “Even though we’re essentially selling health insurance, we didn’t want to push someone into something that doesn’t make sense.” Thus, to aid in transparency, they developed conversations to answer questions about how this fit into an individual’s budget, what the likely out-of-pocket expenses would be, and how much someone

could afford to spend if he or she did end up in a high-cost scenario (e.g., in the hospital). Third, to address some of the literacy issues, they adjusted the reading level and content of the materials they used with clients. This included working with a health literacy consultant to redesign materials to account for enrollees' lower levels of health literacy. What they found in this process was that their materials were too dense and detailed about how the ACA worked. Rather, what they needed was a simple, positive message about the marketplace. Their rewrites focused on making materials clearer, simpler, and more interesting. Their strategy then was to provide more details in face-to-face interactions.

A final strategy they undertook to address some of the barriers they encountered was to adjust enrollment events to account for the larger number of low-income but ineligible attendees. They were finding that people with low incomes were showing up to find low-cost or free insurance. But some did not qualify or simply did not have the right paperwork to apply and were being turned away after long waits, which exacerbated their frustration. To account for this (and to respect everyone's time), they adjusted the screening procedures so that everyone was prescreened quickly and redirected if they were not going to be able to successfully apply for insurance that day so that people did not have to wait a long time just to find out they were not eligible. They created a half sheet that had a few questions for sign-in to help triage attendees. Those who did not qualify were provided information on where they could go for free or reduced-price health care. They received a list of federally qualified health centers, and then they were directed to the closest one. As one discussant stated, the goal was to convey to clients that, "even if you can't sign in today, you can go to [this] health center [for care]."

Enabler To The Local Health Department's Role In Outreach And Enrollment

The primary facilitator of these activities is the large network of partnerships on which the LHD could draw to enhance outreach and enrollment. Not only was the LHD leveraging its relationships with partners from its early access-to-care work; it extended this reach into other partnerships. Prior to outreach and enrollment, the LHD focused on building a network of partnerships with other local community-based organizations to develop a health assessment and community improvement plan. According to one discussant, the LHD wanted community input on what the strategy should be and created a steering committee of organizations that would participate and could come together for this purpose. Puentes and other community-based organizations that participated in this network were called on in outreach and enrollment as well. For example, the LHD recruited both Mary Queen of Vietnam Church and the Vietnamese American Young Leaders Association to identify and enroll residents from the growing Vietnamese population; and Agenda for Children, a nonprofit advocacy and service organization that focuses on early child development, agreed to host outreach events within its network of child care centers. Leveraging existing partnerships and organizations that had a history of

working together and already had built trust between each other helped facilitate the success of these larger activities.

Within the department, the ACA outreach was linked to other LHD activities, such as behavioral health care, because it was a good fit with these other initiatives. To accomplish this, staffs in these programs were trained to do in-reach among their own clients to identify uninsured people. Doing this enhanced sustainability of the LHD's outreach efforts. According to several discussants, although the state did not support expansion of the ACA, residents of New Orleans were generally in favor of the ACA. As one discussant explained, the city is generally "pro-Obama" and, as a result, supported implementation activities, such as the enrollment events. This manifested itself through the support of key political figures who participated in outreach events, helped plan press events that provided information on enrollment, and helped set the stage for positive stories about their outreach efforts.

Future Priorities: What Comes Next?

The New Orleans Health Department will continue to provide these services as long as there is grant funding to support the network. It plans on producing more public service announcements and seeking more earned media on its activities. It also plans, for the 2014–2015 open-enrollment period, to have more dedicated office hours for enrollment, as well as more-simplified materials, in order to attract more clients. It is also looking to alleviate the concern that many people who seek care at the CHCs have: continuity of care once enrolled. The LHD will be looking to work with health plans to ensure that the CHCs are in the networks of newly insured plan members and to educate consumers about their ability to continue to seek care at the health center once enrolled. It is also working on specific information campaigns to help people better understand how to access care, including covering such topics as how to use health insurance and choosing a primary care provider.

Discussion

The New Orleans Health Department plays a role in outreach and enrollment that is similar to those of its peers around the country. In this model, the LHD has partnered with another key agency to coordinate a larger group of agencies that collectively engage in outreach and enrollment around the region. In so doing, it participates in a broad communication campaign; it produces and distributes educational materials; it leverages its data and network of partners to support outreach and enrollment; and it plans large events for enrollment. But it does so without a substantial state infrastructure to support these activities. This means that, although federal funding is available, the department receives only limited financial support for these activities. It does so because it has a strong commitment to ensuring access to care in the community and there is a robust CHC network available to conduct enrollment activities. Not only does this case study illustrate how LHDs in communities with less outreach and enrollment infrastructure can

participate in these activities; it also highlights how this particular LHD overcame a variety of barriers to enrollment. Primarily, it focused on ensuring that its outreach efforts reached residents by relying on trusted community partners and by evaluating the strength of its outreach materials. It also worked specifically to overcome the challenge of working with resource-poor populations by helping each client engage in the process. In order to gain greater reach into two harder-to-reach populations, Latino and Vietnamese populations, it partnered with local agencies to develop materials and an approach tailored to these audiences. In this way, it models how LHDs can leverage their broad networks of partners to engage in outreach and enrollment across the community. The department might have had access to resources for outreach and enrollment that other LHDs lack, but its plan to leverage its existing community partnerships to engage stakeholders in these activities can be replicated anywhere.

6. A Case Study on Boston, Massachusetts

Context Of Health Care Reform In Boston And Massachusetts

In 2006, Massachusetts became the first state in the United States to pass comprehensive health care reform, which required most residents to obtain health insurance. Prior to the state health care reform efforts and continuing through implementation of the ACA, Massachusetts operated an expanded state Medicaid program, MassHealth, under a series of Section 1115 Medicaid waivers.³⁰ The waivers allowed Massachusetts to expand MassHealth eligibility and coverage to low-income pregnant women, parents or adult caretakers, infants, children, and individuals with disabilities and provide premium subsidies to some individuals enrolled in qualified health plans that meet the minimum standards set by the ACA. As a result of these policy changes and financial support for the state Safety Net Care Pool program, by 2013, Boston had a 95.2-percent insurance rate among residents, and there were high levels of awareness of the legal requirements for and benefits of health coverage.³¹

Model Of Local Health Departments' Involvement And How They Came To Be In This Role

For many years, BPHC has dedicated significant resources to connecting residents with health care coverage and services. Since 1986, BPHC has operated the Mayor's Health Line, which is a toll-free phone line monitored by trained LHD staff that connects residents to information about available services in the community. The Mayor's Health Line promotes a variety of resources, including health insurance coverage, primary care, housing, energy assistance, and access to translation and interpreter services. The Mayor's Health Line is one of the key ways in which residents connect to enrollment assistance and, in many cases, makes the first health care appointment for newly enrolled individuals to begin connecting with care.

In 2013, BPHC applied for and was awarded funding from the Massachusetts Health Connector to become a navigator agency, training nine LHD staff to be certified application counselors. The \$304,690 grant partially funded salaries for nine navigators, who worked through the Mayor's Health Line and supported marketing and coordinated efforts to outreach to

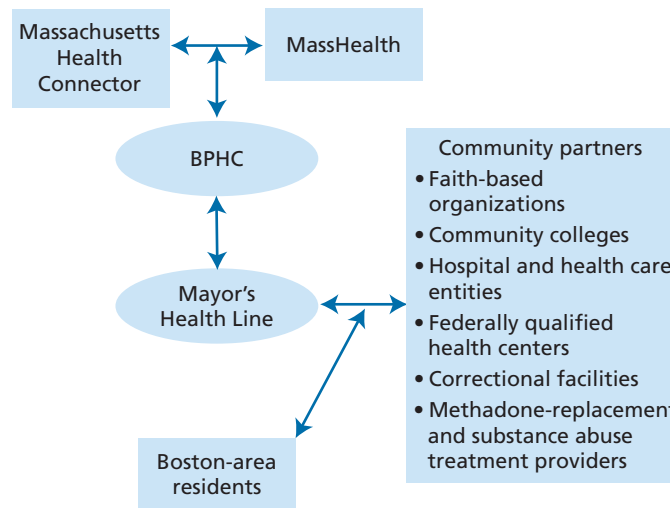
³⁰ Social Security Act "gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP [Children's Health Insurance Program] programs" (Centers for Medicare and Medicaid Services, undated).

³¹ Centers for Medicare and Medicaid Services, "Massachusetts Section 1115 Demonstration Fact Sheet," October 30, 2014.

hard-to-reach populations during the 2013–2014 open-enrollment period.³² The LHD applied for additional funding to continue its outreach and enrollment work for a second year, although the focus for the 2014–2015 grant year was adjusted to meet the population and geographic needs of those who were eligible but have not yet enrolled in health coverage.

As Figure 6.1 shows, this existing infrastructure supported BPHC’s identification, outreach, and enrollment efforts and allowed consumers to have access to multicultural, multilingual, and responsive staff who were prepared to assist with their health insurance questions during the 2013–2014 open-enrollment period. The Mayor’s Health Line was influential in connecting individuals with the resources available to them as they investigated and enrolled in health coverage. The Mayor’s Health Line also served as an important connection between BPHC and community partners. When Mayor’s Health Line staff visited community partners and provided enrollment assistance or gave presentations about health insurance, the navigators became the “public face” of the resource, and BPHC found that consumers recognized the service they offer and provided word-of-mouth advertising about the enrollment assistance available through the LHD.

Figure 6.1 Boston, Massachusetts, Public Health Infrastructure



NOTE: Boston residents can apply for health insurance coverage through MassHealth, which is the commonwealth’s Medicare and State Child Health Insurance Program, or they can apply for a health plan for the Massachusetts Health Connector, which is the state’s health insurance exchange. BPHC works to reach out to and educate residents about coverage for both the Health Connector and MassHealth. The Mayor’s Health Line operates through BPHC to connect residents to community services, including health insurance. The Mayor’s Health Line works with a variety of community partners to conduct outreach to Boston-area residents.

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³² Massachusetts Health Connector, “Health Connector Announces Awardees of Massachusetts Navigator Grant Program,” July 22, 2013.

Public Health Roles To Support Outreach And Enrollment

As a result of both the navigator grant and BPHC's existing outreach and enrollment infrastructure, BPHC contributed to identification, outreach, and enrollment as a navigator agency in Boston through a variety of mechanisms, which we describe in this section.

Provided Direct and Indirect Enrollment Assistance

Given the high insurance rates in Boston, BPHC targeted outreach during the 2013–2014 open-enrollment period to people who remained uninsured following state health care reform and those who were newly eligible for coverage. To accomplish this, BPHC provided both direct enrollment assistance and referrals to community agencies that can provide direct enrollment assistance. The navigator staffers at BPHC are multilingual and multicultural and have established the trust with the community necessary to successfully reach people who might not otherwise have frequent contact with the public health and health care systems. A staff member from the Mayor's Health Line said, "We started noticing that what allowed our outreach to be effective was to work with people [who] already had an established trust in the community. This helped us get the information out there in an effective and timely way."

Because Massachusetts had high levels of insurance coverage prior to the implementation of the ACA, the direct enrollment assistance provided by BPHC differed from assistance in other jurisdictions in that plan selection was a less significant component of the enrollment experience than in other jurisdictions because most people were newly eligible for MassHealth coverage, for which there is only one plan. Additionally, because the marketplace website was inoperable, consumers who otherwise would have qualified for plans in the marketplace could not do so. As a result, people were granted temporary MassHealth coverage during this period.

To leverage the grant funding and support the LHD's existing outreach and enrollment efforts, navigator staff from the Mayor's Health Line developed a strategic plan to target and reach out to uninsured or underinsured populations by leveraging existing relationships. Priority populations included newly unemployed people, the long-term unemployed, people recently released from incarceration, select immigrant communities, the homeless, and substance-abusing populations. The Mayor's Health Line staff initially conducted stand-alone presentations about outreach and enrollment at community events. They found that, although consumers were interested in learning about coverage options, they could reach more people by pairing presentations about health insurance with existing community health activities.

Leveraged Partnerships

To reach the target populations during the 2013–2014 open-enrollment period and throughout the year, BPHC leveraged partnerships with both new and existing community partners. Those with whom it worked closely during the first open-enrollment period included Bunker Hill Community College, South Bay House of Correction, CHCs, homeless-serving

agencies, faith-based organizations, a methadone-replacement and substance abuse treatment clinic, and the local needle exchange.

Bunker Hill Community College served as an important partner for BPHC's identification, outreach, and enrollment efforts targeted toward young people, many of whom previously relied on student health insurance plans with limited coverage scopes. The two-year local community college enrolls more than 14,000 students, 67 percent of whom are people of color and older than the typical college student. BPHC and Bunker Hill identified the need to partner to provide enrollment assistance through a meeting focused on college affordability. Prior to ACA implementation, students were required to carry some form of health insurance through family or an employer or purchase the student health insurance plan (SHIP) upon registering for a full course load; however, since the implementation of the ACA, many students, depending on family income, are now eligible for subsidized coverage and do not have to opt for SHIP. The ACA also extended the age to which students were allowed to stay on their parents' insurance to 26, which increased coverage and helped students save on health care costs in order to remain enrolled in school.

BPHC and Bunker Hill partnered to provide enrollment assistance through a meeting focused on college affordability. Recognizing that many students might now be eligible for other health care coverage options, BPHC and Bunker Hill identified an opportunity to pair course registration with health insurance enrollment. To accomplish this, Bunker Hill developed an electronic message for the class registration portal to inform students about the need to enroll in health insurance and included informational materials in new-student folders.

BPHC also provided periodic on-site enrollment assistance, and Bunker Hill referred students to staff at the Mayor's Health Line to connect with navigation assistance. This partnership allowed BPHC consistent access to young people who are often eligible for insurance coverage and has supported Bunker Hill in helping its students obtain affordable coverage and remain enrolled in classes.

BPHC also worked with the South Bay House of Correction, a county correctional facility for inmates serving sentences of 2.5 years or less that integrated MassHealth enrollment into discharge planning for people as they prepared for release from jail. By initiating the enrollment process prior to discharge, the House of Corrections helps incorporate health and wellness into the transition from incarceration to the community which is particularly useful for inmates who require care for chronic diseases, substance abuse, or psychiatric care.

Additionally, BPHC partnered with the local methadone-replacement clinic and needle-exchange organization to provide outreach and enrollment referrals for people accessing care at those sites. Some of the discussants indicated that this is a key partnership because the staffs at the methadone-replacement clinic and needle-exchange program have frequent (often daily) contact with people who are disenfranchised from the health system.

Used Data to Identify Populations and Provided Education

BPHC has access to data that helped in identifying eligible uninsured people and facilitating outreach and enrollment. During the first grant year, the Mayor's Health Line utilized existing zip code-level census data to identify the populations that were likely uninsured to target for enrollment assistance. The LHD has planned to compare those same data with enrollment data to target and plan outreach for the 2014–2015 open-enrollment period.

BPHC also plays an important role in the community by providing education on a wide range of health topics, including the importance of health coverage. With the expansion of MassHealth and the changes that arose as a result of the requirements of the ACA, BPHC staff and partners served as educators to the community to explain the details of comprehensive health care coverage to consumers and describe the differences between the federal health care reform efforts and previous state-level reforms. Because the Massachusetts Health Connector website experienced significant challenges throughout the 2013–2014 open-enrollment period, staff from the Mayor's Health Line also provided troubleshooting assistance to consumers who could not successfully enroll in coverage online.

Challenges To Outreach And Enrollment

BPHC and its partners experienced a variety of challenges to its outreach and enrollment activities. Case-study participants indicated that a primary challenge was the unreliability of the Massachusetts Health Connector website, which was not functional during open enrollment. The subsequent communication from the Massachusetts Health Connector about the status of improvements and approaches to developing “workarounds” to facilitate enrollment during the time that the website was not operational, was not timely, and was insufficient to address the problems the navigators were experiencing. BPHC staff indicated that, although the Massachusetts Health Connector frequently provided feedback about the challenges the website was experiencing, it encouraged people to continue attempting to enroll through the portal, without providing guidance as to how to do this successfully. LHD staff, including from the Mayor's Health Line, ultimately shifted to enrolling people using paper applications, resulting in a slower process and more staff time spent per application.

The inoperable website created an additional challenge that affects open enrollment in 2014–2015. Those people who enrolled using paper application forms during the 2013–2014 open enrollment needed to reenroll through the electronic portal in the 2014–2015 open-enrollment period.

Initially, one of the key areas of focus for the Mayor's Health Line strategic plan was to work with small-business owners to educate them about enrollment and coverage options for their staff. However, BPHC found that the small-business owners had many questions about the technical and financial implications of the coverage choices that went beyond the navigators' training. As a result, it scaled back direct outreach with groups until it could train staff on how to

answer these questions. Additionally, the small-business component of the connector, SHOP, was not functional during this grant period, and the federal government delayed implementation of the small-business-owner coverage requirement, which reduced the urgency from employers to sign up.

Enablers To The Local Health Department's Role In Outreach And Enrollment

BPHC has a large research division, which was able to use census-level data to identify people and neighborhoods most likely to be eligible for insurance coverage and benefit from enrollment assistance. This allowed the Mayor's Health Line staff to target their outreach activities and has set the stage for planning their work for future open-enrollment periods to support continued outreach to eligible but unenrolled individuals and to facilitate reenrollment. The availability of CHCs, which provided culturally and linguistically appropriate health care, was an especially important resource for LHD staff as they connected newly insured people with primary health care.

Additionally, several discussants described the connections between neighborhoods in Boston and the ways in which those neighborhoods facilitate residents' engagement with the health care system. Case-study participants noted that, because people are connected at the neighborhood level to the organizations and services that exist in their neighborhoods, these connections helped to facilitate the word-of-mouth information sharing and trust needed for effective outreach and enrollment.

Future Priorities: What Comes Next?

BPHC received continuation funding to support its work providing navigators for the 2014–2015 open-enrollment period.³³ The funding, although less than what was awarded in the 2013–2014 open-enrollment period, was used to support salaries for enrollment staff, as well as communication capacity to reach the populations who were not connected to health care coverage during the first open-enrollment season. For the next open-enrollment period, staff will be using the updated zip code-level data compiled during last year's enrollment activities to facilitate outreach and reenrollment processes. By coordinating reenrollment activities according to zip code of residence, the LHD believes that it will streamline the process while providing a high level of customer service to residents.

³³ Boston Public Health Commission, "Health Connector and BPHC Urge Residents to Connect with Local Navigators to Access Health Insurance," October 21, 2014.

Given the existing infrastructure for health care in Boston and the comparatively low numbers of people who do not have access to health coverage, BPHC's work will continue as the populations who are not currently covered and who might lose coverage are identified. BPHC is also focused on assisting people as they use their health insurance, with a focus on health literacy and encouraging new health care usage patterns that support medical homes.

Discussion

In Boston, public health is a leader in a community-wide effort to engage in outreach and enrollment. This role reflects the approach that many LHDs have taken across the country. But one of the unique aspects of this community is the coordinated nature with which the LHD engaged partners to address outreach and enrollment across the city. This case study provides useful information on several aspects of how LHDs can participate in outreach and enrollment, including focusing on harder-to-reach populations. Primarily, public health was able to leverage its network of partner organizations to implement each aspect of outreach and enrollment. Next, public health administered the navigator grant in a way that made good use of existing LHD resources while hiring new staff to support the outreach and enrollment activities in their communities.

These efforts were facilitated by a variety of factors. BPHC and its partners had a history of working together on a host of related health care and public health activities, and outreach and enrollment received broad support of city and LHD leadership for the shared goal of increasing health insurance coverage in the community. According to some case-study discussants, given the robust public health and health care infrastructure in Boston, BPHC was well positioned to lead many of the outreach and enrollment activities occurring in response to the ACA. A visible executive director supported BPHC and sought to capitalize on the LHD's work by issuing a press release to announce the award of the navigator grant and raise awareness in the community and to state and local politicians that the LHD was engaged in helping people apply for health insurance coverage. Several discussants suggested that, although the navigator grant was not one of the largest monetary grants the LHD received, it was important for providing a needed community service. In addition, Boston might have a unique political environment given its own health care reform efforts.

Other LHDs might use the example of Boston's experience and leadership to identify how to leverage their own partnerships to achieve the goals of outreach and enrollment. In Boston and other communities, public health (and LHDs in particular) can serve as a critical partner and, in some cases, as leader of key outreach and enrollment activities. However,

Boston had the advantage of being able to build on experiences, relationships, and lessons learned from the earlier health care reform efforts in the state. As a result, the uninsured rate in the city is very low, and BPHC was able to concentrate on the hardest-to-reach groups. It might be many years before other LHDs gain the experience that Boston has had; as a result, some of

these activities might not be replicable today. Nevertheless, the Boston case study provides a view into how LHD outreach and enrollment efforts might evolve over time.

7. A Case Study on West Virginia

Context Of Health Care Reform In West Virginia

West Virginia began exploring health care reform before the passage of the ACA. In 2006, a grassroots effort began in the state to pass health care reform legislation similar to those already enacted in Vermont and Massachusetts. Although the state legislature and governor did not support health care reform at that time, these early efforts established a foundation for education, advocacy, and partnership that have informed West Virginia's efforts to implement the ACA, including outreach and enrollment.

According to discussants, the ACA is a polarizing issue in West Virginia, and decisions about whether and how to implement it were politically sensitive. After the ACA was passed, administrators in the West Virginia state government researched different options for expanding health care coverage. After an actuarial study was conducted and state administrators, state legislators, and the governor debated the options, West Virginia created a partnership exchange model and expanded Medicaid in 2013. Many political decisionmakers in West Virginia considered a state exchange too costly and politically difficult to support because it was affiliated with the ACA, which has low overall support in the state. However, state elected officials and administrators supported Medicaid expansion because, according to the actuarial study, the expansion promised a \$14-to-\$1 return on investment.

In a partnership exchange, the federal government manages the exchange but the state coordinates plan management and consumer assistance, which, in West Virginia, the Office of the Insurance Commissioner conducted. The Office of the Insurance Commissioner received a \$1 million planning grant and two level 1 establishment grants totaling approximately \$20 million.³⁴ The Office of the Insurance Commissioner convened stakeholder meetings to inform West Virginia's partnership exchange and IPA program. The Office of the Insurance Commissioner also contracted with MAXIMUS to oversee the IPA program.

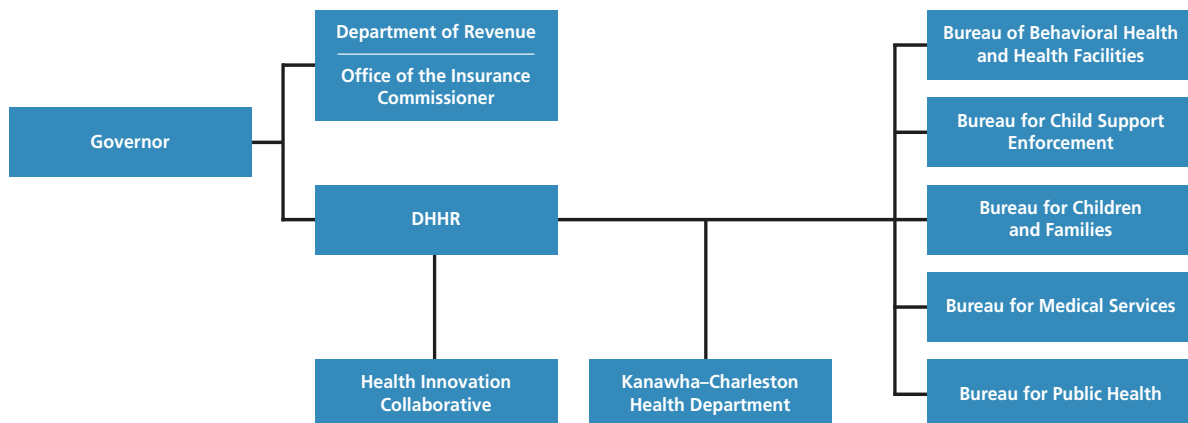
West Virginia's outreach and enrollment efforts have been very successful. In one year, 147,000 out of 175,000 uninsured people enrolled in health insurance. About 86 percent of newly covered people received health insurance through Medicaid. Approximately 20,000 people enrolled in the partnership exchange. The state greatly exceeded its initial estimate of enrolling 63,000 uninsured people.

³⁴ The Henry J. Family Foundation, "State Marketplace Profiles: West Virginia," updated October 24, 2013.

Model Of Local Health Departments’ Involvement And How They Came To Be In This Role

The West Virginia Department of Health and Human Resources (DHHR) provides public health services at the state level, and 49 local LHDs serve counties throughout the state. DHHR is made up of the Bureau of Public Health, Bureau for Behavioral Health and Health Facilities, Bureau for Child Support Enforcement, Bureau for Children and Families, and Bureau for Medical Services (Figure 7.1). DHHR created the Health Innovation Collaborative, which consisted of partnerships with groups that supported ACA implementation, outreach, and enrollment. These major players included the West Virginians for Affordable Health Care (WVAHC) advocacy group, the Office of the Insurance Commissioner, hospitals, health plans, CHCs, the West Virginia Primary Care Association, and LHDs, such as the Kanawha–Charleston Health Department. Only a few of the local LHDs across the state, including the Kanawha–Charleston Health Department, had the capacity, leadership, and resources to support outreach and enrollment.

Figure 7.1 State and Local Organizations Involved in Outreach and Enrollment in West Virginia



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West Virginia had IPAs, certified application counselors, and navigators, all of whom helped people enroll in qualified health plans.³⁵ The Office of the Insurance Commissioner received funding from the Centers for Medicare and Medicaid Services (CMS) to develop an IPA program. The office placed IPAs at the DHHR county offices. The DHHR county offices are

³⁵ IPAs, certified application counselors, and navigators help consumers determine their eligibility for and enroll in marketplace insurance. The three types of roles differ in terms of how they are funded (e.g., state or federal grant), how they are trained, and whether they are located in states with federally facilitated partnerships, state partnerships, or state-based marketplaces. (Centers for Medicare and Medicaid Services, “Assistance Roles to Help Consumers Apply and Enroll in Health Coverage Through the Marketplace,” Product 11647–P, July 2013.)

extensions of the state DHHR and provide human services to counties. CHCs received funding from the DHHS's Health Resources and Services Administration (HRSA) for certified application counselors. The federal government placed navigators in 105 organizations across the state,³⁶ including the Kanawha–Charleston Health Department. Although the partnership did not choose the grantees, it did work to ensure that these organizations coordinated their activities.

Outreach And Enrollment Overview

DHHR, which includes public health at the state level, developed and led the use of fast-track enrollment and engaged in market research, cross-sector collaboration, and advocacy efforts that resulted in high enrollment. The Kanawha–Charleston Health Department, an active LHD in the state, was a key partner in advocating for public health and supporting outreach and enrollment.

Support For Outreach And Enrollment

Supported Fast-Track Enrollment

DHHR developed and managed Medicaid expansion using the CMS-approved fast-track enrollment, which allowed the state to quickly enroll people receiving Supplemental Nutrition Assistance Program (SNAP) and Children's Health Insurance Program (CHIP) benefits. DHHR manages an online system, inROADS, that assesses individual eligibility and enrolls people in such programs as SNAP, CHIP, and Medicaid. Because SNAP, CHIP, and Medicaid all fall under DHHR and inROADS already existed before the Medicaid expansion, West Virginia was able to quickly institute fast-track enrollment for those eligible for Medicaid under expansion. The DHHR fast-track process involved employees identifying people through inROADS, mailing letters to people informing them about their Medicaid eligibility, and calling eligible people and reminding them to enroll. Consumers then indicated whether they wanted to enroll in Medicaid. Fast-track enrollment resulted in approximately 70,000 new Medicaid enrollees.

Conducted Market Research

DHHR conducted market research on ACA implementation, which informed outreach and enrollment communication strategies. The research led decisionmakers to conclude that they should frame outreach and enrollment in terms of increased coverage and access to care and that IPAs should not reference "Obamacare" or the ACA. IPAs experienced instances in which people declined coverage even though they needed health insurance because they learned that it was associated with "Obamacare."

³⁶ West Virginia Hospital Association, "WV Health Insurance Navigators Helping Uninsured Explore Their Options," WVU Health News, November 19, 2013.

Collaborated in Partnerships to Support Outreach and Enrollment

Representatives from DHHR and the Kanawha–Charleston Health Department actively participated in WVAHC and were key members of WVAHC’s Implementation Coalition. As one discussant stated, “Public health here has always been part of the safety net. We see ourselves as complementary and not competitive with others.” The Implementation Coalition worked to ensure that the ACA was successfully implemented across the state. The Kanawha–Charleston Health Officer also chaired the WVAHC Public Health Committee. WVAHC provided education to the public on the ACA through town meetings and training in communities across the state. WVAHC also created a citizen’s guide to enrollment. Furthermore, WVAHC pooled \$150,000 from four foundations, which it used to provide mini-grants to 31 nonprofits that were working on outreach and enrollment. WVAHC provided grantees with technical assistance and resources.

DHHR and the Kanawha–Charleston Health Department engaged in partnerships to support outreach, enrollment, ACA implementation, and overall improvements in health. DHHR created the Health Innovation Collaborative, which it structured around the triple aim of improved population health through better patient care at lower cost. The Health Innovation Collaborative created forums for experimentation and pilot-testing of ideas. The forums also improved knowledge exchange among different sectors, such as hospitals, health plans, Medicaid, public health, and primary care providers. A representative from the Kanawha–Charleston Health Department participated in the Health Innovation Collaborative. DHHR and Kanawha–Charleston Health Department representatives also worked closely with the Office of the Insurance Commissioner and participated in stakeholder meetings that informed the design of the exchange. In all these state forums, the Kanawha–Charleston Health Department ensured that public health was represented and brought attention to health care reform as a public health issue.

The Kanawha–Charleston Health Department often hosted collaborative activities to support outreach and enrollment. The LHD hosted partnership meetings, WVAHC trainings, navigators, and celebrations involving Senator Jay Rockefeller. Because the LHD is independent from state governance, the Kanawha–Charleston Health Department was able to host events that would be politically sensitive at the state level.

Educated Policymakers About Supporting ACA Implementation

The Kanawha–Charleston Health Department played a strong role in educating state policymakers about the importance of supporting ACA implementation. Even before the ACA became law, the Kanawha–Charleston Health Department worked on health care reform with DHHR, the Office of the Insurance Commissioner, Senator Rockefeller, and other stakeholders.

As one participant stated, “We’ve been able to be proactive because we are out front. You can’t lead from behind.” In 2010, the LHD was a formal member of the committee charged with exploring a state-based exchange. The Kanawha–Charleston Health Department ensured that a public health officer would be eligible to serve on the board of the state health care exchange if

such an exchange were created. When the state decided not to create a state-based exchange, the Kanawha–Charleston Health Officer wrote an op-ed piece in the local newspaper encouraging the governor to expand Medicaid.

Challenges To Outreach And Enrollment

Medicaid expansion in West Virginia resulted in a large number of new enrollees; however, the partnership exchange did not meet the state’s expectations because of four major challenges. Discussants shared that describing the exchange to consumers was difficult. Communication about the exchange was not as straightforward as explaining Medicaid expansion. Second, navigators, certified application counselors, and IPAs spent only a few hours each week out in the community and instead spent most of their time at county DHHR offices, hospitals, or community health centers. As a result, hard-to-reach populations were difficult to enroll. Third, only one qualified health care plan was offered through the exchange, and many consumers felt that it was not affordable. Perceived affordability could have been related to the reputation of the only qualified health care plan provider, Highmark, which is considered a high-quality and expensive health care plan in the state. People who were not eligible for Medicaid under expansion did not feel that they could afford Highmark’s high premiums and cost-sharing. Finally, according to several discussants, “Obamacare” is unpopular in the state, which discouraged people from enrolling. Discussants described people working for the coal industry as particularly unsupportive of “Obamacare.” In the first year, only 20,000 West Virginians enrolled in the exchange, not the expected 40,000 to 60,000 enrollees.

Although the Kanawha–Charleston Health Department played a strong advocacy role in ACA implementation, other LHDs in the state did not have the capacity, resources, or leadership to actively support outreach and enrollment. Only two of the 49 LHDs had full-time health officers, and many LHDs had only two or three employees. IPAs were housed in county departments of health and human services rather than LHDs because the county offices are considered “one-stop shops” for beneficiaries.

Enablers To The Local Health Departments’ Role In Outreach And Enrollment

The dire health conditions in West Virginia motivated leaders from different sectors to work together to support outreach and enrollment. Even before the ACA became law, West Virginia explored health care reform to address the ill health of residents across the state. Discussants noted that West Virginia is fifth in health care spending in the United States³⁷ but second to last

³⁷ United Health Foundation, “Public Health Funding: West Virginia—Rank: 5,” web page, undated.

in health outcomes in the country.³⁸ Members of the DHHR-sponsored Health Innovation Collaborative expressed their commitment to work together to improve the health of West Virginians.

Strong interpersonal relationships further supported outreach and enrollment. As one person noted, West Virginia is a “person-driven state.” Most people in West Virginia have known each other for years and in diverse settings, thus forging strong bonds of trust. People involved in outreach and enrollment feel accountable to one another. A representative from the West Virginia Primary Care Association commented on how fast and responsive DHHR was in helping health centers determine the eligibility status of individual cases. DHHR employees also followed up by phone with each person who qualified for Medicaid. Many outreach and enrollment efforts involved one-on-one interactions with consumers either by phone or in person. Coordination between DHHR and the Office of the Insurance Commissioner, and therefore between Medicaid and the partnership exchange, also succeeded because of strong relationships between leaders at various agencies.

The Kanawha–Charleston Health Department effectively advocated for public health’s role in health care reform because of its reputation in the community and in the state capital. Local health officials are seen as well-informed, credible, and trusted sources of information. Leaders at LHDs are well-connected with state elected officials and are the main players involved in ACA implementation.

Future Priorities: What Comes Next?

West Virginia will work to enroll the hardest-to-reach people and to improve utilization of health care services. About 30,000 people in the state are uninsured and difficult to reach and enroll. New strategies will have to be used to enroll these remaining uninsured. State and local leaders also focus efforts on helping people use health care. For instance, there are efforts to reduce emergency room use and to encourage healthy behaviors. As one person noted, “Access to care [alone] will not improve horrible statistics.”

Discussion

This case study illustrates the role of public health in a rural state and the challenges and facilitators to enrollment. The case study also describes how state and local public health used existing resources, collaboration, and advocacy to achieve success in outreach and enrollment. The state succeeded in enrolling 85 percent of its uninsured in the first year by leveraging DHHR’s existing inROADS system to identify people eligible under Medicaid expansion. When challenges in outreach and enrollment arose, partnership organizations worked together to solve

³⁸ United Health Foundation, “All Outcomes: West Virginia—Rank: 48,” web page, undated.

problems. Moving forward, the state faces the challenge of enrolling the hardest-to-reach uninsured people into qualified health care plans that many consider to be too expensive.

8. A Case Study on Houston, Texas

Context Of Health Care Reform In Houston, Texas

In 2013, 20 percent of Texans did not have health insurance, the highest rate in the nation.³⁹ Most of the uninsured in Texas are low-income workers, and 40 percent live below the poverty level.⁴⁰ Houston is the largest city in Texas and the fourth-largest city in the United States. The federal government projected that 138,000 people in Houston would enroll in health coverage during the 2013–2014 open-enrollment period. Ultimately, 197,000 people acquired health coverage through the insurance exchange, and 60,000 people enrolled in Medicaid through Children’s Health Insurance Program Reauthorization Act–related efforts conducted during the same period.⁴¹

Two state agencies have rule-making authority related to ACA implementation: the Texas Department of Insurance and the Health and Human Services Commission. In 2011, after considering the implications of compliance with the ACA, the department determined that it did not have statutory authority to enforce regulations related to the ACA and opted into the federally run health insurance exchange rather than create a state exchange. The commission has historically asked for flexibility and reform for Medicaid to permit states greater authority for controlling costs. In 2013, Texas chose not to expand Medicaid. Both Houston and the state of Texas received a lot of attention for their uninsured population when Vice President Joe Biden and then–Secretary of Health and Human Services Kathleen Sebelius challenged leaders to meet enrollment goals. Although state leaders in Texas largely oppose the ACA and its implementation, several local leaders emerged as vocal supporters of outreach and enrollment efforts.

The Houston Department of Health and Human Services (HDHHS) provides traditional public health services and seeks to use innovative methods to meet the community’s needs, including developing partnerships with the community to promote and protect the health and social well-being of all Houstonians. HDHHS is an established, safety-net provider in the community with longstanding efforts to coordinate complex, collaborative initiatives.

³⁹ The Henry J. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” web page, undated.

⁴⁰ Katherine Young and Rachel Garfield, *The Uninsured Population in Texas: Understanding Coverage Needs and the Potential Impact of the Affordable Care Act*, Henry J. Kaiser Family Foundation, July 11, 2014.

⁴¹ Public Law, 111-3, Children’s Health Insurance Program Reauthorization Act of 2009, February 4, 2009.

Model Of Public Health Departments' Involvement And How They Came To Be In This Role

In fall 2013, three agencies in the Houston area (Change Happens, Houston Area Urban League, and the Harris County Area Agency on Aging, an agency of HDHHS) received navigator funding through federal grant funds to assist consumers with enrollment in health insurance and to provide outreach and education about the Marketplace. Federally qualified health centers received enrollment contracts, and Gateway to Care received funding to train in-person assistance personnel, who generally perform the same duties as the navigators, but are funded through state contracts or grants. Enroll America, SRA International, and Cognosante also received funding. Many of these organizations already worked together in other health care-related coalitions. Through these relationships, the agencies became aware of each other's funding status and roles in the effort and decided that effective and efficient enrollment would require a coordinated and collaborative strategy.

HDHHS proposed that the partners coordinate their efforts across Houston and 13 counties of southeast Texas to maximize the impact of their individual grants. Their approach to accomplishing this was to treat lack of health coverage as an emergency situation and use a proven disaster response-management framework to coordinate resources, skills, and activities. They created the Gulf Coast Health Insurance Marketplace Collaborative and modeled it after the Incident Command System (ICS), a national disaster response framework, to coordinate the outreach and enrollment strategies across the 13-county target area. The collaborative aims to ensure that all residents are aware of their health coverage options, know where to enroll, and have access to assistance, if needed.

Structure Of The Outreach And Enrollment Strategy

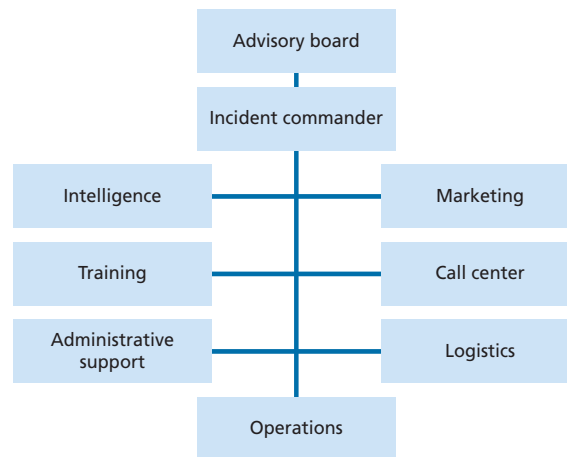
ICS is an emergency response framework designed to enable effective and efficient incident management through a common organizational structure that integrates facilities, equipment, personnel, procedures, and communication.⁴² An incident commander leads it and oversees the coordination of operations, planning, logistics, and finance and administration.

The collaborative's system includes an advisory board made up of agency executives, an incident commander from HDHHS, and seven branches (i.e., working groups) dedicated to specific activities, including intelligence, staff training, marketing, a call center, logistics, administrative support, and operations (see Figure 8.1). Fourteen partner organizations (e.g., advocacy groups, health care systems, service providers, and information technology specialists) serve on branch teams based on their resources, assets, skills, and, in some cases, the requirements of their organizations' grant funding. In addition to the funded agencies mentioned

⁴² Federal Emergency Management Agency, *ICS Review Document*, May 2008.

above, partners include Texas Organizing Project, Harris County Healthcare Alliance, Memorial Hermann Health System, Texans Together, One Voice Texas, and Vecino Health Centers. The collaborative meets monthly, the incident commander meets with branch team leads every two weeks, and branch teams meet as needed. In addition, the team uses a wiki to coordinate and monitor all of the collaborative’s activities and provide access to resources. More information about HDHHS’s role in the collaborative and its strategy is described in a *Journal of Public Health Management and Practice* article.⁴³

Figure 8.1 Houston’s Incident Command System for Outreach and Enrollment



RAND RR986-1

The collaborative’s strategy is made up of four major activities. First, a subset of the partner agencies receives funding to train the outreach and enrollment navigators and certified application counselors (CACs). These trained people are available to staff outreach and enrollment events to help people understand their coverage options, apply for financial help, and enroll in private plans. In addition, partner-agency staff and volunteers, such as the Medical Reserve Corps, are trained as champions for coverage. These people promote health coverage and the benefits of health insurance but do not enroll people. In addition, insurance agents and brokers play a large role in enrollment efforts. Second, HDHHS, Enroll America, and Texas Organizing Project gather information about residents without health care coverage, geocode data to identify areas of need, and determine access points in each of the high-need areas (e.g., apartment complexes, community centers, churches, schools, and libraries). Third, the collaborative coordinates enrollment and educational events and sites across the community and within the high-need areas. Finally, it communicates with partners and the public about health coverage and enrollment opportunities through grassroots outreach, traditional marketing (e.g., radio campaign, videos played in Special Supplemental Nutrition Program for Women, Infants,

⁴³ Stephen L. Williams, Beverly L. Nichols, M. Katherine Barton, Maria De La Cruz and Benjamin Hernandez, “Local Leadership and the Affordable Care Act,” *Journal of Public Health Management and Practice*, Vol. 21, No. 1, January-February 2015, pp. S87-S92.

and Children clinic waiting rooms, and utility-bill inserts), an informational phone line to provide information to the public, and a public website.⁴⁴

HDHHS created an online wiki dashboard to help monitor activities and track progress. The wiki provides partners with easily accessible, up-to-date information and implementation guidance and tracking for contractual obligations. Navigators and CACs complete standardized reporting forms to collect data about outreach and enrollment efforts, including the location of the events, the projected and actual attendance, the number of face-to-face interactions, the number of materials distributed, and the nature of the interaction. The intelligence branch uses the data to benchmark actual outcomes against projected targets. These near-real-time data allow the collaborative to alter strategies and target its resources more effectively in order to improve performance. In addition, one discussant noted that the dashboard permitted each partner to see how its efforts contributed to the collective goal.

Role Of Public Health In Outreach And Enrollment

Through the ICS model, HDHHS contributes to identification, outreach, and enrollment efforts in Houston in a variety of ways, ranging from garnering community buy-in for the proposed strategy to implementing it.

Leverage Its Reputation In The Community To Gain Quick Buy-In For A Coordinated Strategy

According to discussants, HDHHS is an established, trusted safety-net provider in the community with a proven ability to coordinate complex, collaborative initiatives in a forward-thinking manner (e.g., hurricane response and community assessments). HDHHS is committed to ensuring that all residents have access to the care they need. This includes providing health care services to fill gaps in the community (e.g., dental care and family planning). One partner noted that he contacted a local health official prior to the announcement of the navigator grants because HDHHS was a “trusted community partner with creative vibrant leadership and a lot of top-down support,” and he looked to HDHHS for leadership and coordination on outreach and enrollment efforts. HDHHS has leveraged this history of collaboration and action to mobilize partners quickly. When HDHHS offered ICS as a structure for outreach and enrollment, there was little to no opposition from likely partners because they trusted HDHHS to serve in a coordinating capacity.

Provides A Strength-Based Framework For Responses

HDHHS routinely utilizes ICS for nonemergency response purposes to allow HDHHS staff opportunities to practice and feel confident in their roles within the structure and to meet

⁴⁴ Enroll Gulf Coast, web page, undated.

emerging community needs. Through their responses to emergency situation, such as hurricanes, HDHHS staffers demonstrate their proficiency with the system, which enables partners to understand the model and their roles in the structure quickly during their “just-in-time” training.

A key advantage of an incident command system is that it permits a network of partners to extend their capacity, maximize finite resources, and serve a large number of people rapidly. Partners of all capacities can leverage their strengths and assets, ranging from civic engagement and community mobilization to data analysis and interactions with residents. Partners with previous recruitment experience (e.g., voter registration and Children’s Health Insurance Program and Medicaid enrollment) provide practical knowledge. As a result of the ICS approach, the collaborative has created a cadre of navigators, CACs, and champions who can be mobilized based on need, not agency affiliation. Partners can focus on meeting needs of specific areas without concern that efforts have been duplicated or communities were overlooked. As one discussant mentioned, “The ICS method helped maximize everyone’s contribution and brought out the value of each organization in a collaborative way.” In short, the process coordinates the efforts of staff at multiple agencies, which creates an efficient response.

Coordinates The Collaborative Effort

As one discussant stated, “public health has a strategic role to play. Sometimes you are the convener; sometimes you are the catalyst.” HDHHS serves a coordinating role for the collaborative because HDHHS has the experience and clout to quickly mobilize and coordinate outreach and enrollment activities.

However, HDHHS does not emphasize its leadership role publicly. It views outreach and enrollment as a communitywide effort and values the contributions of all participating agencies. One partner noted, “The culture [of the collaborative] was more inclusive. We did everything as a collaborative, not just as the health department. There was a spirit of camaraderie.”

Facilitators And Barriers To Outreach And Enrollment

Although state-level political support in Texas for the ACA was limited, some local and national entities are quite vocal in advocating for more state and local attention to outreach and enrollment in Texas. One discussant observed, “Publicly recognized leadership in a state where we have so much opposition was important.” The mayor of Houston, Annise D. Parker, has indicated her support for outreach and enrollment in ways that enable the collaborative to access residents in previously untested ways. For example, her support facilitated the inclusion of a notice in water bills that reached about 400,000 residents. Additionally, her support lends great credibility to the work that HDHHS does to engage partners and support identification, outreach, and enrollment functions.

Because many public health– and health care–oriented partners in Houston have long histories of collaboration and a commitment to ensuring access to health care for all residents, the concept of using an ICS to maximize resources and reach a shared goal has been accepted

readily. Likewise, partnerships with grassroots organizations are essential in encouraging people to enroll, particularly in a state that strongly values individual autonomy and in which many residents mistrust the government.

Although the collaborative's efforts are widely regarded as successful, partners described a variety of barriers to implementation. First, the notices of award and timelines for funding differ from partner to partner. In the beginning stages, it was difficult for HDHHS to determine who received navigator funding to ensure that they were engaged in the collaborative. In addition, some funders' interpretations of enrollment restrictions and guidance differ from others' interpretation, which contributes to confusion for tracking metrics and application of regulations. For example, project officers have provided conflicting interpretations to navigator grant recipients about their ability to coordinate with insurance companies or broker agents to enroll eligible people.

An incident command system functions best when the data needed to direct operations—in this case, training, outreach, and enrollment—are updated frequently. The collaborative does not always have access to accurate and timely data from state and federal agencies, which makes it difficult to ensure accuracy when determining areas of highest need.

Discussions with potential enrollees highlighted additional issues. If hospitals provide high-quality no- or low-cost care, some people will remain uninsured because they know that the hospital will provide comprehensive care at a cost that is lower than insurance premiums or potential tax penalties. Because Texas did not expand Medicaid, insurance is still relatively expensive for those who did not qualify for subsidies in the marketplace. At enrollment events, to allow people to make decisions about whether to pursue the sign-up process, staffers try to screen people to give estimates of the final costs. Some organizations have also been engaged to connect people to low-cost care resources in the community.

Next Steps

Enrollment and reenrollment will remain priorities for Houston for the next several years. The high rates of uninsured and eligible people and reenrollment needs will require that the public health and health care system collectively engage in identification, outreach, enrollment, and education for years to come.

The collaborative recognizes that there are opportunities for improvement. To increase their reach into certain subpopulations, for example, partners hope to engage more agencies that work with Hispanic residents. Likewise, data showed that the people who were least likely to enroll often had high school degrees or less. The collaborative plans to tailor materials to these populations and identify appropriate access points in the next outreach and enrollment phase. Finally, collaborative partner agencies are developing strategies to work with newly enrolled people to support health literacy, specifically related to utilization of health coverage. The

collaborative is also exploring ways to connect residents who do not qualify for Medicaid or for coverage through the exchange to gain access to affordable care.

Discussion

This case study emphasizes the collaborative role that LHDs play in outreach and enrollment in their communities. HDHHS not only implemented an innovative approach to enrollment through the operationalization of its incident command system; it did so collaboratively with a variety of community-based organizations. There are, however, some limitations to replicating these activities. First, not all LHDs will have the experience or capacity to implement an ICS approach; and many might not be able to integrate the community-based organizations into such an approach to the degree that Houston has. Second, these activities have been accomplished with federal funding, and it is not clear that HDHHS will be able to continue these activities without that support. Nevertheless, HDHHS provides many of the same services that other LHDs provide regardless of size and is leveraging its partnerships with the community to promote and protect the health and social well-being of residents by connecting them to health insurance, which is a common goal for LHDs.

9. A Case Study on Illinois

Context Of Health Care Reform In Illinois

The state of Illinois expanded Medicaid coverage to adults in households earning up to 138 percent of the FPL and offers health coverage through a state-partnership marketplace. In this model, the state can coordinate in-person assistance efforts, and the federal government administers the marketplace through Healthcare.gov.⁴⁵ The Illinois marketplace is called Get Covered Illinois.

Model Of Health Departments' Involvement And How They Came To Be In This Role

In 2013, Get Covered Illinois created the in-person counselor program. Its purpose was to provide grants to community-based organizations and coalitions across the state to create a network of organizations with trained in-person counselors to educate community members about new insurance options under the ACA, assist them in sorting through the coverage options, and help them complete the application and enrollment process.

The federal navigation grant was awarded to the Illinois Department of Insurance, which partners with Get Covered Illinois. Get Covered Illinois is housed within the office of the governor. However, neither the governor's office nor the Illinois Department of Insurance had direct experience with making grants to community-based organizations. To augment their grant-making capacity, Get Covered Illinois and the Illinois Department of Insurance partnered with the Illinois Department of Public Health (IDPH) because IDPH already had a rigorous grant-monitoring system in place and IDPH's mission to promote health through the prevention and control of disease and injury was a strong fit with the goals of the ACA to promote wellness and increase access to health care. Moreover, IDPH's director at the time, LaMar Hasbrouck, had an established record of serving as a spokesperson for public health issues, including the ACA.

Outreach And Enrollment Overview

IDPH's primary functions were in coordinating the grant, ensuring the delivery of grant information and support, and ultimately making payments to grantees to engage in outreach and enrollment services. IDPH worked with Get Covered Illinois on other program-related activities, such as policy updates related to enrollment goals, documentation of activities, and program processes, as well as statewide outreach activities and providing technical support to the

⁴⁵ The Henry J. Kaiser Family Foundation, "State Health Marketplace Types, 2015," June 2015.

grantees. In addition, the organizations hired ten regional outreach coordinators to support all of the regional activities across the state.

In-Person Counselor Grant Program

In July 2013, IDPH and Get Covered Illinois released the in-person counselor program request for applications. They received more than 160 applications from hospitals, community clinics, other community-based organizations, and LHDs, as well coalitions made up of these organizations. To ensure adequate coverage of the state and key vulnerable populations and to ensure that outreach activities were relevant to the needs of Illinois' diverse local communities, IDPH and Get Covered Illinois divided the state into ten outreach regions based on geography and population size and awarded grants within each region. According to several discussants, IDPH's primary goal was to fund trusted established organizations in each region. To evaluate the grant applications, IDPH created a scoring team made up of leadership from several different state agencies and awarded 44 grants to applicants that included approximately 260 different organizations. All of the scorers had expertise on statewide program implementation and community-based outreach, but some were not ACA subject-matter experts. However, they all received training on the ACA. In addition, some organizations that were not funded directly were offered information on how to access certified application counselor training because IDPH wanted to ensure that as many organizations as possible were included in the enrollment process. In addition, some organizations that were not selected for state funding did receive federal navigator funds. IDPH and Get Covered Illinois included these organizations in all general in-person counselor grant communications sent to all grantees.

IDPH and Get Covered Illinois encouraged all grantees within each region to network with one another, share lessons learned, and update one another on progress. To facilitate this, they employed regional outreach coordinators to work with all of the funded coalitions and organizations. Get Covered Illinois hosted weekly webinars so that grantees could create a "learning laboratory" in which they shared best practices and asked questions. Coordinators also hosted in-person meetings or calls to share their weekly outreach calendars and, in some cases, jointly plan outreach events. Coordinators also met one-on-one with staff in each region, as well as through in-person meetings that brought together all of the regional grantees. In addition, coordinators used partnered events, such as outreach, educational, and enrollment events, to meet with grantees. According to discussants, preliminary evidence suggested that, in those regions where grantees worked well together, the grantees exceeded their goals for outreach and enrollment.

Links Between The State And Local Health Departments

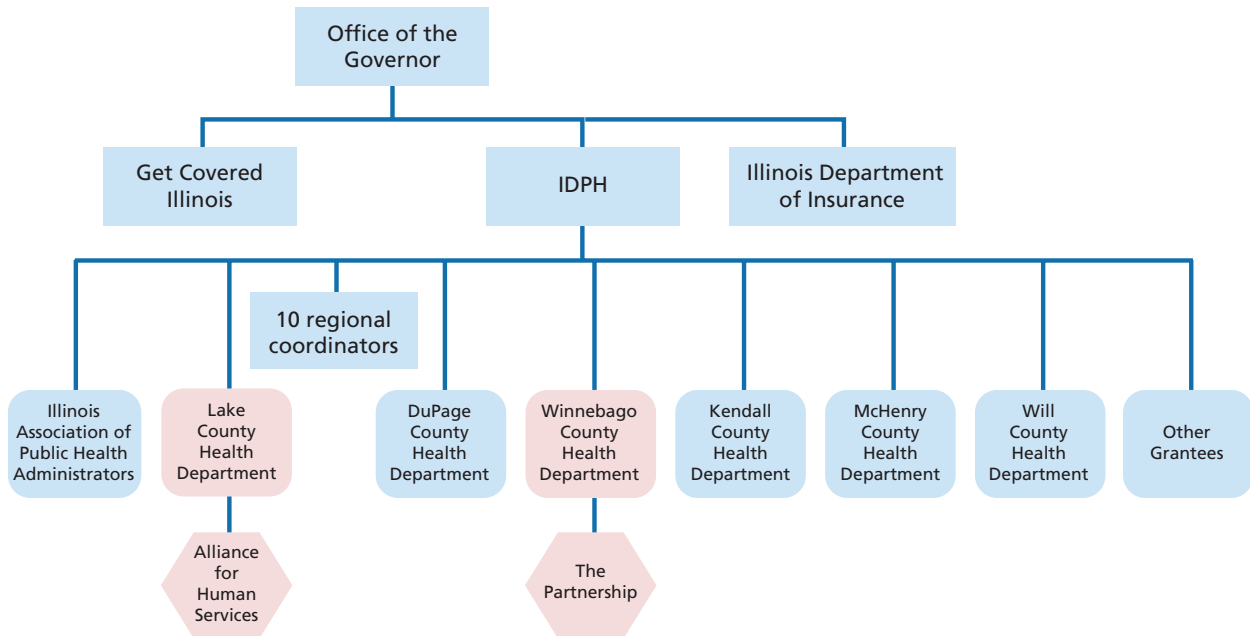
IDPH funded LHDs in two different ways. First, IDPH made direct grants to six LHDs—DuPage County Health Department, Kendall County Health Department, Lake County Health Department, McHenry County Health Department, Will County Health Department, and

Winnebago County Health Department. These were typically larger LHDs in the state with greater infrastructure for engaging in larger-scale outreach and enrollment efforts. Second, IDPH funded the Illinois Association of Public Health Administrators to administer grants to the other LHDs across the state. The purpose of this grant was to fund smaller LHDs that had less capacity for writing their own proposals. In this way, most health departments in the state received funding to participate in local outreach and enrollment efforts.

IDPH emphasized funding to LHDs for several reasons. First, according to several discussants, both IDPH and Get Covered Illinois recognized that LHDs have demonstrated a history of being trusted organizations in many of these communities, especially with respect to health issues. Second, LHDs serve all communities in Illinois, and, by funding these organizations, IDPH and Get Covered Illinois leveraged this reach into every community. This is especially important in rural communities, where the LHD is often the only organization providing services to residents. According to one discussant, the LHD in these cases serves as the “on ramp” to health and social services for populations in need. Third, LHDs have existing capacity that can be leveraged for outreach and enrollment. Many see clients that lack health insurance and so have a direct link to vulnerable populations. Others have long-standing relationships with community-based organizations with which they can partner for outreach and enrollment efforts. Finally, IDPH had previous successful experiences funding LHDs to engage in other public health initiatives.

In Figure 9.1, we illustrate the relationships between IDPH and other state agencies with which they partner for outreach and enrollment and their link to LHDs through the in-person counselor grant program. As the figure shows, Get Covered Illinois and IDPH work together to administer grants to local organizations for their outreach and enrollment activities in ten different regions of the state. During the case study, we visited two LHDs, in Winnebago and Lake counties, both of which applied for funding jointly with other local partners. In this section, we provide more detail on how the relationship of the state and local health departments is structured and on the activities of the two LHDs.

Figure 9.1. State and Local Organizations Involved in Outreach and Enrollment in Illinois



RAND RR988-1

Outreach And Enrollment Implemented In Lake County, Illinois

Lake County is situated along Lake Michigan just north of Chicago. To the north, it is bordered by the state of Wisconsin. The county has a diverse set of communities; the suburbs of Chicago are to the south, but the county becomes increasingly rural as one travels north. The Lake County Health Department and its community partner, the Alliance for Human Services, applied for and received a grant from the state for their outreach program, which they called Enroll Lake County. The Alliance for Human Services is a coalition of 37 member organizations that seeks to improve the delivery of human services in Lake County.

Enroll Lake County largely focused on three target cities within the county that Get Covered Illinois identified as having the highest proportions of uninsured populations in the county: Waukegan, Round Lake, and Antioch. Enroll Lake County is a partnership of 27 community-based organizations, faith and civic groups, library networks, schools, business representatives, hospitals, and primary care providers funded to engage in outreach and enrollment in these communities. Among these agencies, 15 were funded specifically to hire and train enrollment specialists to assist consumers through the enrollment process. In addition, five local hospitals helped to enroll uninsured patients, and the Lake County Health Department hired and trained five navigators to support outreach and enrollment activities in that county.

The consortium also includes seven community- and faith-based organizations that served as awareness and referral partners. Although these organizations did not receive any funding, they nevertheless contributed by communicating about outreach events, referring uninsured people to in-person counselors, and hosting public events.

The LHD and its partners engaged in several activities that highlight the roles that LHDs can play in outreach and enrollment. We describe these in the next section.

Outreach And Enrollment Events in Lake County

Because each agency received separate funding from Enroll Lake County, each implemented its own plan for outreach. As a result, the agencies reached people at various locations across the county, including libraries and churches. They also held outreach events at various community events, such as street cleanups and Halloween festivals. The focus of these events was to share information with people who did not know much about the ACA.

Early in the enrollment period, outreach and enrollment were separate activities. First, funded organizations across the county would plan and host an outreach event, during which appointments for a later date would be scheduled to conduct the enrollment process. The outreach presentations were phased out over time because attendance waned. According to the discussants, focus then turned to one-on-one informational sessions and enrollment. This revised model also helped to address barriers in more-rural areas of the county related to transportation. To better serve these populations, Enroll Lake County contracted with one community-based organization that already provided services to this population to assist in outreach. Its staff then focused on door-to-door outreach and enrollment. Although Enroll Lake County did not specifically target outreach by race, ethnicity, or other characteristics, such as English-language proficiency, the different funded agencies had various reach into these subpopulations. Each navigator tracked his or her enrollment figures daily and adjusted his or her approach according to these data. If, for example, a navigator learned that the team was successful in enrolling a larger number of people in an area, the navigators would extend their stay longer than originally planned.

Outreach And Enrollment Implemented In Winnebago County, Illinois

Winnebago County is about 90 miles northwest of Chicago. Like Lake County, it borders the state of Wisconsin. Rockford, Illinois, is the largest city in Winnebago and the third-largest city in the state. During the 2013–2014 outreach and enrollment period, Winnebago County Health Department served as the lead agency for outreach and enrollment. It partnered with several local social service and health care organizations to apply for the grant from Get Covered Illinois and IDPH. The Winnebago County Health Department led this initiative to engage in outreach and enrollment by engaging in a variety of key activities, each of which is described in more detail in the rest of this section.

Partnerships in Winnebago County

The Winnebago LHD chose to form a partnership with a diverse set of social and health care organizations because it believed that it would be able reach more uninsured patients by working with a strong set of community-based organizations. The partners were drawn from social services and health care institutions and included the University of Illinois at Chicago College of Medicine, OSF Saint Anthony Medical Center, Rockford Health System, Swedish American Health System, Rock Valley College, Lifescape Community Services, United Way of Rock River Valley, Rockford Health Council, YWCA of Rockford, City of Rockford Human Services Department, La Voz Latina, and Treatment Alternatives for Safe Communities (TASC). According to several discussants, the hospitals were key partners because they had staffing and an existing outreach and enrollment process that could be leveraged for ACA–related enrollment. For example, prior to the implementation of the ACA, hospitals had employed patient financial navigators to connect uninsured patients to Medicaid or charity care programs. As part of ACA outreach and enrollment efforts, these same navigators received training to enroll uninsured patients in either Medicaid or one of the marketplace plans.

Reaching Hard-To-Reach Patients

Given the high number of uninsured individuals (about 24,000, or 14.5 percent of the county population in 2012),⁴⁶ the county knew that reaching everyone with in-person assistance would be difficult. In order to use its resources as efficiently as possible, it targeted broad public outreach about how to use the marketplace website to populations it thought would be better able to enroll on their own with less support (e.g., people with higher levels of reading, computer, and health literacy). But, among harder-to-reach populations, such as people with low literacy, Latinos, and recently released inmates, it leveraged its partnerships to conduct more-focused outreach and in-person assistance.

To support low-literacy populations, the partnership reduced the reading level of written materials and created new processes, such as asking enrollers to provide simpler explanations and, in some cases, reading the consent forms out loud to ensure that clients understood what they were signing. In addition, the LHD created a computer lab in its office and hired enrollment specialists to support uninsured residents to walk in during specified hours and use the computers to research and choose insurance plans. The LHD also funded other subgrantee organizations to conduct outreach activities in other harder-to-reach communities. For example, TASC provides reentry case-management services across Illinois that help parolees successfully transition to their communities. TASC set up outreach and enrollment events at libraries to reach homeless people, and it educated parole officers about enrollment opportunities so that they could refer parolees to TASC for enrollment. La Voz Latina is a nonprofit resource center for the Latino

⁴⁶ Stephani Becker, *Landscape of Illinois' Uninsured and Underinsured: What Do We Know and What Else Do We Want to Know Before 2014?*, Illinois Health Matters and Health and Disability Advocates, October 23, 2012.

community of Rockford. It served as the primary organization reaching eligible immigrants broadly, with specific emphasis on the Latino population. The LHD partnered with La Voz Latina because it had a history of working with this community by providing interpretive services for the county court. La Voz Latina hired two navigators who focused their efforts on providing information about enrollment at community restaurants and grocery stores. La Voz Latina also provided educational presentations to help people understand the importance of health insurance and how to choose among their different options.

Generating Media Attention

One goal of the LHD's plan was to focus specific attention on encouraging higher-income residents to purchase insurance through the marketplace. According to discussants, this meant that the LHD had to generate significant press coverage about its efforts. To accomplish this, it hosted more than 180 media events. It also created English- and Spanish-language commercials that ran for six months, and it made continuous announcements of its efforts through social media. In the Latino community, its outreach strategies also included television advertisements; however, staff suggested that radio advertisements appeared to reach more Latinos than television or promoting open enrollment at health fairs.

Challenges To Outreach And Enrollment

According to discussants across the three sites, one of the most-significant barriers to enrollment during the first open-enrollment period (2013–2014) was the failure of the Healthcare.gov website launch. Although both the state and county levels focused on directing people to use the website for enrollment in the marketplace, when that resource was unavailable, residents stopped the enrollment process. The discussants with whom we spoke were concerned that many residents never returned to complete enrollment. In their view, this, combined with confusion created by the changes in the actual program enrollment deadline, negatively affected the number of people who would have participated early in the program.

A second significant hurdle was the amount of information in-person assisters had to convey during enrollment appointments. New clients' low levels of literacy and lower understanding of insurance surprised some discussants. In addition, discussants mentioned that many residents they encountered had little experience with computers. Grantees and program planners at IDPH and Get Covered Illinois expected that an in-person counselor would be able to complete an enrollment during a one-hour appointment. In reality, however, many appointments took several hours and, in some cases, could not be completed in one sitting. This then meant that residents needed follow-up appointments to complete their enrollments. This increased the time that in-person assisters spent with clients and, as a result, reduced the number of enrollments they could complete. In some communities, enrollment staff simply could not accommodate the increased numbers of hours necessary to enroll residents given these delays. Residents were also less likely

to complete the process if enrollment required more than one appointment session. In addition, some in-person assisters reported that many people signed up primarily to avoid paying a penalty; as a result, they would sometimes choose the plan with the least-expensive premium. Discussants were concerned that this was not always the best decision because it can result in higher out-of-pocket costs overall.

A third challenge was enrolling eligible immigrants and people living in families with mixed legal status. Discussants highlighted that the early process of applying for coverage through the ACA was very confusing for people who had been legal permanent residents with five years of residency, and this might have resulted in fewer residents with this status enrolling. Although some did not apply, Healthcare.gov incorrectly denied coverage to other legal permanent residents because of errors on enrollment materials. This meant that navigators and enrollees had to dedicate time to tracking down reasons for the errors and work toward correcting them, but not always successfully. This confusion was fixed in July 2014 for the second open-enrollment period by adding a question about legal permanent residency to the marketplace enrollment application. Discussants also pointed out that a common concern was that some immigrant residents live in households with multiple families and completing their applications was difficult because assessing the number of people in the family for income and other calculations was difficult. In addition, many had difficulty navigating the Spanish-language telephone line because of confusing instructions and, in some cases, poor interactions with operators.

Discussants at the state level observed that grantees across the state, including some of the LHDs, had varying degrees of experience. Some had little experience with the basic outreach and enrollment tasks and, as a result, had to learn from their peers or contract out these activities to accomplish them. For example, some LHDs had less experience providing direct education to residents, while others had experience providing educational services but not outreach activities (e.g., advertising, networking with other organizations, and hosting outreach events). Although many LHDs collaborated with different agencies in their communities, not all did, and some LHDs had difficulty developing and maintaining relationships with other organizations when working on these efforts. State- and regional-level discussants also noted that many consumers could schedule their enrollment appointments only for the evenings, and, although some LHDs could accommodate the staffing necessary to stay open later and offer a range of working hours, not all could do so. This left some imbalances in the experiences of residents of different communities.

There were also barriers specific to the local communities we visited. Some discussants at the local level thought that the in-person counselor grant program had a lot of administrative and reporting requirements. At the height of outreach and enrollment activities, some suggested, they were having difficulty striking a balance between spending time doing outreach and reporting their activities to stay compliant.

In Lake County, discussants noted some confusion among residents about the ACA. They suggested that the negative media attention resonated more with residents than positive coverage

that promoted open enrollment. As a result, in-person assisters felt that they had to continuously remedy misinformation while refraining from appearing political. This made discussions about enrollment more complicated and difficult. In addition to challenges around consumer perception, another barrier in Lake County was that, even though some residents spoke only Spanish, there was insufficient capacity to translate materials and messages that had been developed locally.

In Winnebago County, discussants stated that Get Covered Illinois provided media advertising until later in the enrollment period than expected, so, as a county, they had to ramp up their own media efforts. Discussants were also concerned that the Get Covered Illinois advertising always guided consumers to the website for enrollment, but many in the region's target populations did not have access to the Internet. Others noted that some national media describing the ACA were present in Rockford but did not promote Medicaid expansion, which was a critical access lever for residents. Once open enrollment in the marketplaces ended, discussants noted, media coverage about enrollment dropped, even though Medicaid enrollment is year-round.

Enablers To Outreach And Enrollment

Despite the barriers faced by organizations working to enroll residents into various options under the ACA, several factors in Illinois facilitated enrollment. The primary facilitators were trust, partnership, and the availability of federal resources for enrollment.

Trust was particularly important. IDPH and Get Covered Illinois chose to work with LHDs across the state in part because they saw them as trusted institutions in many local communities. They also valued the capacity that some LHDs had to communicate information about health and health care issues authoritatively and in a way that residents trusted. As one discussant described, a range of organizations discussed enrollment in this community. But, because of the sensitive information that was needed to complete the enrollment process, some residents were concerned about sharing this with organizations they did not know and that did not have an obvious connection to health and health care. In particular, residents were concerned about whether these organizations could protect their private information. As a result, they believed that some residents simply felt more comfortable coming to the LHD because they perceived that that organization had experience with collecting and protecting private health-related information. In one of the communities we visited, the partnership between the LHD and several local hospitals that were also trusted agencies bolstered this perception of trust.

Despite some variation across the state, LHDs were a key component of the outreach and enrollment plans of IDPH and Get Covered Illinois because these institutions could leverage their existing partnerships with other community-based organizations to increase their outreach to residents. Discussants at the LHDs we visited described how their efforts relied on relationships with key partners that jointly applied with them for the grant. In Lake County, they

further expanded their network of partners by funding a variety of community-based organizations to conduct outreach and enrollment and reached out to additional partners by sending letters to local ministers, public officials, and schools to advertise enrollment events and highlight options for enrollment in insurance under the ACA. Some of the discussants with whom we spoke who were subgrantees of the LHDs attributed their commitment throughout enrollment in part to maintaining their strong working relationships with the LHD.

Discussants also cited existing federal resources produced as part of the CMS From Coverage to Care initiative as facilitators to outreach. Discussants in both communities noted that some residents lacked understanding of what health insurance is and how important it is to maintaining health. The CMS materials provided this guidance, and both health departments modeled some messaging around these materials to overcome confusion about the ACA, increase resident understanding of how to use health insurance, and help them understand how to choose among options.

In Winnebago County, one discussant noted that they received a great deal of positive media attention about their enrollment efforts, ranging from television interviews to print and radio coverage of their outreach events. This differed remarkably from Enroll Lake County, which received relatively little media attention about its activities. This was likely due to differences in proximity to Chicago. Lake County is, in part, a suburb of Chicago, and, as a result, ACA coverage focused on larger national and state issues or Chicago-specific activities when local outreach and enrollment was covered. Winnebago County has its own media in the city of Rockford. So all local outreach and enrollment events were covered, and the enrollment staff at the LHD often served as local media experts for interviews and discussion.

Future Priorities: What Comes Next?

Get Covered Illinois and IDPH expected to make several changes in policy based on feedback from the grantees. Software and systems were being developed that would provide a method for scheduling the work of the in-person assisters in the different regions. Get Covered Illinois aspires to be a data-driven effort. Some discussants suggested that grantees had been able to work with communities that have the highest need for outreach and enrollment, but no agency was able to track in real time how efforts are going across the state without the infrastructure and capacity to collect and analyze data. Moreover, Get Covered Illinois and IDPH would like to be able to produce estimates about whether grantees' efforts are reaching benchmarks, especially to share with media and policymakers. In addition, Get Covered Illinois and IDPH found that those working full time exclusively on this work provided a better return on investment than those in-person assisters who spent half their time on this work and half their time on other projects. For the 2014–2015 open-enrollment period, the organizations required that the in-person assisters hired by grantees spend a minimum of 37.5 hours per week on outreach and enrollment activities. Get Covered Illinois and IDPH also considered the feedback from consumers about

extending their office hours and are requiring some locations to stay open later to meet the needs of residents. In addition, Get Covered Illinois was making efforts to simplify its outreach and enrollment materials in order to be more accessible to lower-literacy populations.

Because both counties projected fewer enrollments in 2014–2015, they each reduced the number of funded staff and altered hours to have more full-time than part-time positions. In Winnebago County, they are considering focusing more on the messages about how to use health insurance in order to generate greater interest in enrollment.

Discussion

IDPH's involvement as the centralizing entity was a unique model for public health's involvement in outreach and enrollment. In other communities, LHDs typically participate in or lead outreach and enrollment efforts independently of state health department efforts. However, IDPH was considered the best fit to lead the state's outreach and enrollment efforts because it had the infrastructure and experience to operate a sizable grant program. Because LHDs serve every community in the state, IDPH and Get Covered Illinois leveraged this reach by funding LHDs to engage in outreach and enrollment. IDPH made training and supports available to LHDs and other organizations in order to sustain efforts statewide. LHDs directly funded by IDPH were responsible for implementing local outreach and enrollment activities and eliciting support from organizations and assistance from subgrantees they contracted. These LHDs secured funding for themselves and for their partners and made hiring decisions based on need and adjusted to meet demand. They tapped into their broad local networks to reach uninsured populations and even provided support and resources to organizations that were not being funded to do this work. Overall, public health's lead added a level of trust to a new system in which consumers faced multiple and significant hurdles to understand and secure health coverage. Although not every state can have greater involvement of the state health department in outreach and enrollment activities, this case study highlights the unique relationship between state and local health departments and how this relationship was leveraged in one state for greater LHD participation in outreach and enrollment.

10. Conclusions

From these seven case studies, we can draw several important conclusions about the roles of local and state health departments in outreach and enrollment, the barriers they faced in addressing these activities during the second open-enrollment season, and the actions LHDs took with their partners to overcome these challenges. These case studies provide a window into how LHDs leverage their unique roles with significant impact as community-based service providers to engage in outreach and enrollment activities. In particular, the case studies illustrate the specific skills, approaches, and resources that health departments can provide in support of outreach and enrollment efforts within their communities. The diverse approaches suggest that there are different models for public health involvement in outreach and enrollment activities with, in some cases, LHDs playing a larger (or central) coordinating role; or, in other cases, LHDs playing a supportive role.

The LHDs highlighted in these seven case studies also encountered many common challenges to outreach and enrollment including poor understanding of the importance of health insurance coverage, technical glitches in federal and/or state enrollment systems, and miscommunication about the availability and affordability of insurance coverage. Further compounding these problems was the fact that they and their partners didn't fully realize how much time it would take to enroll each person. In this section, we summarize the different approaches (some developed to overcome these challenges). These approaches highlight the potential value of public health for outreach and enrollment efforts specific to developing partnerships, building trust, leveraging existing policies and practices designed to support the public's health, and use of data.

Partnerships

LHDs **leveraged their partnerships to develop and coordinate local efforts** as a key activity of engagement. In some communities, the LHDs worked to unite the different agencies already engaged in enrollment in order to coordinate these efforts across the area. In some cases, the large network of LHD partnerships was a primary facilitator in enhancing outreach and enrollment. LHDs are uniquely suited to leverage partnerships for this purpose because of their varied relationships in the community and, in some cases, the long histories of collaboration. In Colorado's Eagle, Garfield, and Pitkin counties, for example, the LHD in each county worked with the county Department of Social Services to lead a coalition that included private sector health care and social service agencies. This coalition applied for a navigator grant from the state to support their outreach and enrollment activities. Their partnership was facilitated by a long

history of working together on other related health and social service issues in the region. In New Orleans, on the other hand, no single agency received a state or federal grant to lead outreach and enrollment activities, but the LHD nevertheless jointly led (with 504HealthNet) a coalition of CHCs that each received their own navigator grants. The LHD and 504HealthNet sponsored large enrollment events, supported coalition members with information and materials, and leveraged their broad partnerships to further support outreach and enrollment by advertising events, generating volunteers, and uncovering communities with concentrated proportions of people uninsured or at risk of losing insurance coverage who are eligible for enrollment. The LHD's specific mission to address access to care in the region facilitated this partnership.

Trust

Trust is critical when working with the hardest-to-reach and vulnerable populations in a community. Each of the seven LHDs we visited provided health care or other public health services directly to community residents. Often these residents face substantial barriers to accessing services because of high poverty, low education, and disenfranchisement from other public services. **Given the trust that had been established, LHDs were able to reach out to residents facing barriers to identify opportunities for them to enroll in health insurance.** Case study discussants suggested that LHDs are well suited to play this role for two main reasons. First, many have longstanding roles communicating with the public about the availability of health services and have the staff available to engage with harder-to-reach clients. Second, other LHDs are skilled at contracting with local community-based organizations that have reach into specific communities and are able to leverage these relationships for outreach and enrollment. For example, in Rockford, Illinois, the LHD funded La Voz Latina, and Treatment Alternatives for Safe Communities (TASC) to reach the Latino community and the prisoner reentry population, respectively—two locally defined populations of interest that also were more difficult to reach without community expertise and trust. This was facilitated by the commitment of the Illinois State Department of Health to fund LHDs to engage each community in outreach and enrollment. Discussants in West Virginia suggested that their overall approach relied on strong interpersonal relationships. As one person put it, West Virginia is a “person-driven state and thus has strong bonds of trust.” From residents' perspective, the LHD was effective due to its strong reputation in the community. LHD leadership is also often seen as well-informed, credible, and a trusted source of information. This is particularly true in Houston, for example, where the LHD is considered a trusted safety-net provider in the community and was able to leverage that reputation to gain buy-in for coordinated outreach and enrollment efforts across the city.

Policy and practice

LHDs are one of the few organizations in local communities that have a broader understanding of health care service delivery, population health, and policy. **The diverse perspective of LHDs is critical to understanding the ACA, for successful outreach and enrollment efforts, and for helping to shape the dialogue around health insurance within the community.** Some LHDs, for example, played a substantial role in educating the public and policymakers about the importance of having insurance coverage. Several LHDs in West Virginia participated in a statewide coalition aimed at expanding access to insurance in the state. This coalition then focused on outreach and enrollment when the ACA was passed into law and Medicaid was expanded in West Virginia.

In other states, LHDs found creative ways to apply the practice of public health to outreach and enrollment. One of the more-unique approaches occurred in Houston, where the LHD treated the lack of health insurance coverage as a “public health emergency” and stood up to its ICS to address outreach and enrollment. The ICS is an approach to emergency management that incorporates a common organizational structure that integrates facilities, equipment, personnel, procedures, and communication. The HDHHS acted as the incident commander, which lead the approach and oversaw the coordination of operations, planning, logistics, and finance and administration with input from an advisory board comprised of core partner organizations. To accomplish this, HDHHS brought in community-based organizations to participate at all levels of the ICS as partners in planning and executing outreach and enrollment. These partner agencies also lead different aspects of the ICS. The resulting outreach and enrollment activities leveraged multiple LHD core activities such as partnership, data analysis, and outreach to vulnerable populations.

Other states leveraged existing grant-monitoring systems of public health departments. In Illinois, for example, the state health department partnered with the Department of Insurance to lead the state-based Marketplace called Get Covered Illinois. Because the state health department already had a rigorous grant-monitoring system in place, they coordinated the grant, helped develop enrollment goals, and documented grantee activities and program processes, as well as statewide outreach activities and technical support.

Use of Public Health Data

LHDs’ access to census-level data helped inform enrollment targets and strategies. While several LHDs had relevant data, not all leveraged these data as an explicit part of their outreach and enrollment activities. Among our case studies, Tacoma–Pierce, New Orleans, and Boston analyzed data to identify locations of concentrations of populations that were uninsured or at risk for losing insurance so that they could target outreach activities to these communities.

Conclusions

These case studies report on activities developed during the first open-enrollment period. It is not clear how LHDs will remain involved in future years. But moving forward, there may be fewer local, state and federal resources devoted to outreach and enrollment. Simultaneously, the populations in need of outreach will become increasingly harder to reach. LHDs have the skills and experience to be important partners in these efforts in many communities.

Case-study discussants identified a number of future roles for public health, including being a key messenger on the importance of health insurance and tailoring messages or approaches to reaching vulnerable populations in their communities that weren't enrolled during initial outreach activities. Furthermore, they expressed a desire to leverage data to inform their approaches in real time. However, a number of discussants expressed that LHDs and their partners could use support from national and federal agencies including

- improved dissemination of state and national messaging to illustrate the importance of insurance and how it can be used
- NGO, state and federal funding and education to support LHD participation in outreach and enrollment; especially needed in nonexpansion states
- education among potential funders and other stakeholders about the important roles public health can play
- real-time information on enrollment
- support for new staffing models that are created by the employment of navigators across the country; these staffs form an important new LHD link to help consumers take next steps in accessing care after ACA enrollment.

One of the primary limitations of this study is that LHDs are not all organized in the same ways. Differences on factors such as financing, political structure, and organizational structure mean that some LHDs are freer to engage in outreach and enrollment than others. Because relatively few received navigator grants (unlike many of the LHDs at our case study sites) some LHDs would have difficulty shifting resources away from other core activities toward outreach and enrollment. We are only aware of one state (Illinois) in which every LHD received funding or had access to funding for outreach and enrollment. It's likely that this is unique because the state health department had a much larger role in ACA implementation than other states and it had a specific interest in funding local health departments.

As these case studies show, there are many different ways for LHDs to engage in these efforts despite such differences in organization and financing. For example, New Orleans and Houston were unique in that they were not funded specifically to engage in outreach and enrollment by a state agency, but nevertheless carved out the capacity to coordinate and participate in such engagement. This helped ensure that different agencies were not duplicating services or concentrating in some areas while ignoring others. They used staffing and existing funds in innovative ways to accomplish these goals. The New Orleans Department of Public Health, for example, directed a series of externally funded fellowships toward staffing their

enrollment activities. They also leveraged the strengths of the community clinics to increase resources in the management of their outreach and enrollment coalition.

The findings in this report are also limited by a small sample size. We engaged only seven communities across the United States, and there are many more models that we did not explore in depth. The circumstances in these communities may be unique, so the conclusions we draw here can't necessarily be generalized to all LHDs. The diversity of LHDs' roles suggests that this is true. In some cases, we saw that the model with the public health as the lead agency for outreach and enrollment worked well; however, a supportive role for public health worked better in other cases.

Finally, there are challenges to integrating LHDs into outreach and enrollment activities. The field of public health is not always seen as relevant, adequately resourced, or sufficiently apolitical by all stakeholders to play a role. As a result, what works effectively for a particular community will depend on population, context, resources, etc.

Despite these limitations, the case studies provide different ways to think about the potential value and roles of public health moving forward. Information from this research will be useful to LHDs interested in learning how to engage in outreach and enrollment in their communities, and to funders and policymakers interesting in expanding state and local health departments' efforts to engage newly insured people. The lessons learned illustrate how LHDs carved out roles in outreach and enrollment, and overcame difficult challenges to implement these activities.

11. Appendix

Table A.1. **Site-specific information**

Eagle, Garfield, and Pitkin counties, Colorado	The case study for Eagle, Garfield, and Pitkin counties took place in June 2014. Our team, which included staff from both RAND and NACCHO, conducted eight meetings with representatives of the health departments' network involved in outreach and enrollment activities
Tacoma–Pierce County, Washington	The site visit for Tacoma–Pierce County, Washington, took place on July 15–16, 2014. Our team of RAND researchers conducted nine meetings with representatives of the LHD network who were involved in outreach and enrollment activities. The team also attended an outreach and enrollment implementation-team meeting held at the Tacoma–Pierce County Health Department office.
New Orleans, Louisiana	The case study for New Orleans took place in August 2014. Our team, which included staff from RAND, conducted nine meetings with representatives of the health departments' network involved in outreach and enrollment activities.
Boston, Massachusetts	RAND and NACCHO conducted the site visit to Boston on September 9–10, 2014. Our team conducted five meetings with the LHD's network involved in outreach and enrollment activities, including partners at Bunker Hill Community College; the South Bay House of Correction; and the Bureau of Addictions Prevention, Treatment and Recovery Support Services at the BPHC, which administers the local LHD's needle-exchange and addiction treatment programs.
Charleston, West Virginia	For West Virginia, the site visit took place September 17–18, 2014. Our team conducted seven meetings with representatives involved in outreach and enrollment activities, which included people from WVAHC, DHHR, the DHHR-sponsored Health Innovation Collaborative, Office of the Insurance Commissioner, West Virginia Hospital Association, West Virginia Primary Care Association, and Kanawha–Charleston Health Department. On September 17, 2014, the team also attended a meeting of a coalition made up of local and state entities that were engaged in outreach and enrollment across the state.
Houston, Texas	The case-study research for Houston took place in October 2014. Our team, which included staff from both RAND and NACCHO, conducted five meetings with representatives of the health departments' network involved in outreach and enrollment activities.
Illinois	Unlike other case studies in this series that focused on LHDs alone, the case study for Illinois was unique in that it included discussions with staff at the state level, as well as with staff and partners at the LHDs in Winnebago and Lake counties. In September 2014, our team, which included staff from RAND, conducted 11 meetings with representatives of the health departments' networks involved in outreach and enrollment activities.

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