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

A Case Study on New Orleans, Louisiana

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Key findings

- The New Orleans Health Department's history of improving access and partnering with community-based organizations helped outreach and enrollment. With 504HealthNet, a private not-for-profit membership organization for the region's community health centers, the New Orleans Health Department led an outreach and enrollment work group. The department also made use of public health data and mapping to support its outreach efforts. It conducted both direct and indirect outreach and enrollment, and it leveraged its network to increase enrollment opportunities.
- Outreach and enrollment efforts face challenges at the individual and policy levels. Individual barriers included the population's low levels of health, computer, and insurance literacy; the cost of insurance; and the time and effort required to enroll. When Medicaid was not expanded in Louisiana, a gap in coverage occurred for some people who had previously been able to access coverage through a Medicaid waiver program. Also, about 40 percent of the uninsured would have been eligible for Medicaid under expansion but are not, and their incomes are too low to qualify for health insurance marketplace subsidies.
- Some factors help those efforts. The primary facilitator of these activities is the large network of partnerships on which the health department could draw to enhance outreach and enrollment. Also, although the state did not support expansion of the Patient Protection and Affordable Care Act, residents of New Orleans were generally in favor of the act. The city is generally "pro-Obama" and, as a result, supported implementation activities, such as the enrollment events.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)[1] laid the groundwork for a substantial increase in the number of people who have access to health insurance through Medicaid expansion or health insurance marketplaces.[2] During the first open-enrollment season, states used a variety of strategies to reach out to and enroll newly eligible people. Typically, federal and state funding was used to develop navigator programs in each state. The design of these programs differed by location,[3] and, although many stakeholders were involved in these efforts, state and local health departments (LHDs) were, and remain, a relatively untapped resource.[4] This is somewhat surprising, given that LHDs 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.

This is one in a series of reports designed to highlight innovative models and best practices that leverage LHD involvement in ACA outreach and enrollment and to facilitate knowledge transfer to other geographic regions looking to leverage the full range of roles for LHDs in ACA outreach and enrollment. Potential roles include serving as a coordinator for community activities, being a trusted source of health care information for consumers, and leveraging community partners to increase capacity for outreach and enrollment. These reports identify compelling models for how LHDs can implement similar activities in their own communities. Further, they provide guidance and insight into the role LHDs can play now, and help redefine that role in the future, as states continue to enroll residents in health insurance coverage. Each case study

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was designed to capture nuanced differences in how health departments support these efforts in their communities, identify facilitators and barriers to these approaches, and develop lessons learned from these activities.

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 health insurance marketplace. The ACA also gave states the option to extend Medicaid eligibility up to 138 percent of the federal poverty level (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.[5] 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 between 100 and 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 health insurance 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 in-person assister (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.

METHODS

Identification of Case-Study Sites and Activities

RAND researchers and National Association of County and City Health Officials (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 semistructured interviews with national and local stakeholders, identified a range of activities. Discussions with key staff at 15 health departments were conducted to learn more about their specific approaches and to understand more about the community and population context. In consultation with staff at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), we selected seven sites that highlight a variety of models of LHD involvement and contexts in which the public health departments were operating. 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: Boston, Massachusetts; Eagle, Pitkin, and Garfield counties, Colorado; Houston, Texas; Illinois (state and local); New Orleans, Louisiana; Tacoma and Pierce County, Washington; and West Virginia (state).

Site Visits

Site visits were conducted over two- or three-day periods between June and 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 to each interview 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 who could not attend the in-person meetings.

New Orleans Case Study

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.

RATIONALE FOR SELECTING THIS 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 coleader 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.

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 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 community health centers (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 U.S. Department of Health and Human

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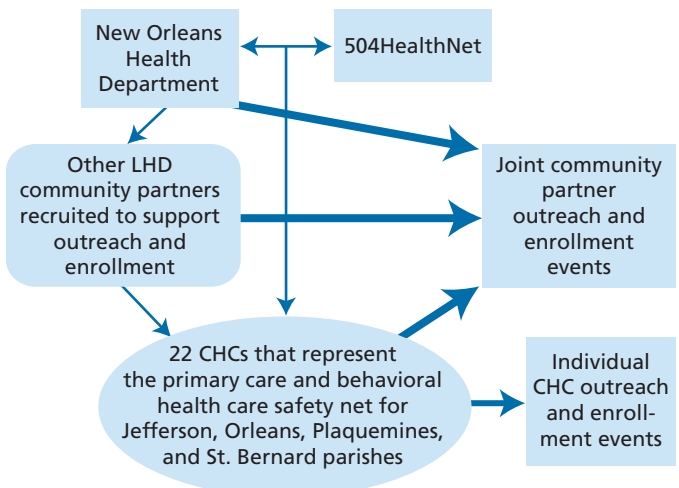
Services, undertook an effort to assess the capacity of the health care safety net and design strategies to strengthen it. Through this work, the LHD and the Louisiana Public Health Institute (a statewide nonprofit organization that coordinates and manages public health programs designed to support the 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, the Latino population, and the Vietnamese population.

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 between 100 and 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

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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> Work-group member organizations worked together to ensure that each event was well staffed and had the resources it needed to be a success.

accomplish this goal, which, in turn, would support the financial health of local CHCs.

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, Led Outreach and Enrollment Work Group

With 504HealthNet, the LHD cochaired a work group that was made up of community health centers 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 community-wide 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 community-wide 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 and 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 staff 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.

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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 when 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 between 138 and 400 percent of the FPL were eligible to purchase subsidized health insurance marketplace plans. However, because Louisiana did not elect to expand Medicaid, there was little financial support for people falling in between 100 and 138 percent of the FPL. This meant that, for some, the cost of the health insurance 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?" Further, 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, an IPA 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.

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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

Three key policy concerns in New Orleans that resulted from the lack of Medicaid expansion 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.

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.

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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

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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 health insurance 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]."

ENABLERS 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 had already 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, staff 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 (PSAs) 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.

NOTES

[1] Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010. As of February 13, 2015: http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html

[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] Enroll America, "Certified Application Counselor Program: Early Lessons," Washington, D.C., June 2014. As of February 13, 2015: http://www.enrollamerica.org/certified-application-counselor-program-early-lessons/

[4] National Association of County and City Health Officials, *Role of Local Health Departments as Navigators: Findings from 2014 Forces of Change Survey*, Washington, D.C., May 2014. As of February 13, 2015: http://www.naccho.org/topics/research/forcesofchange/upload/Navigators.pdf

[5] 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," undated. As of April 2, 2015: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html).

About This Report

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