



Chapter Title: Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage A Case Study on Tacoma—Pierce County, Washington

Chapter Author(s): Nazleen Bharmal, Malcolm V. Williams, Laurie T. Martin and Christian Lopez

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

Book Subtitle: A Case Study on Tacoma—Pierce County, Washington

Book Author(s): Nazleen Bharmal, Malcolm V. Williams, Laurie T. Martin and Christian Lopez

Published by: RAND Corporation

Stable URL: <https://www.jstor.org/stable/10.7249/j.ctt1d9np7b.1>

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at <https://about.jstor.org/terms>



This content is licensed under a RAND Corporation License. To view a copy of this license, visit <https://www.rand.org/pubs/permissions.html>.



RAND Corporation is collaborating with JSTOR to digitize, preserve and extend access to *Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage*

JSTOR

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

A Case Study on Tacoma–Pierce County, Washington

Nazleen Bharmal, Malcolm V. Williams, Laurie T. Martin, Christian Lopez

Key findings

- The Tacoma–Pierce County Health Department led coordination of outreach and enrollment efforts for federal health care reform. It secured funding, coalesced community organizations, and leveraged its extensive network of local partnerships to connect with people in the community.
- The department established a network of in-person assisters (IPAs) and IPA organizations that were instrumental in outreach and enrollment efforts. It also created a forum for information-sharing around challenges and provided support and technical assistance to the group.
- Challenges to outreach and enrollment efforts included the Washington Medicaid renewal policy, the poor relationship between the IPAs and the Washington Health Benefit Exchange, and lack of support to address IPAs' concerns. In addition, some raised concerns about having a public health department serve as a lead agency.
- Boosts to those efforts included grant support from the Washington Health Benefit Exchange, formal collaboration with the health sector through a steering committee, the exchange grant, and the collaborative culture among organizations in Tacoma.

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

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.

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 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 in-person assistance funding provision of the federal exchange-establishment grants that were made available to states in August 2012, to create a network of in-person assisters (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. 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.

METHODS

Identifying 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.

Tacoma–Pierce County Case Study

The site visit for Tacoma, 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.

Rationale for Selecting This 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 (the IPAs referenced above). The health department also conducted training for the 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 mid-sized region located 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.⁵ 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.

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, community health centers, 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, community health centers, 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.

The figure 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

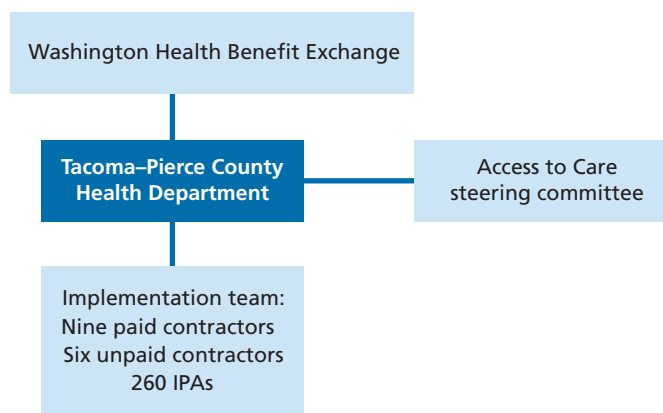
the IPA implementation through weekly meetings held at the health department. The implementation team provides enrollment numbers and on-the-ground feedback about IPA activities to the health department, which then relays the feedback to the exchange in their regular communications. The region’s health 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.

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.

Relationships for Outreach and Enrollment in Tacoma–Pierce County



RAND RR983-1

Organizations interested in becoming paid contractors not only had to describe their prior 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 Washington State, and experience delivering culturally appropriate services.

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 Improvement (OAPI)⁶ used state and local data to conduct analyses and geographic information system (GIS) 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 with which they had worked on other public health efforts or who had relevant experience and expertise working with the target populations and communities to respond to the RFQ. As part of the selection process, organizations interested in becoming paid contractors not only had to describe their prior 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 Washington State, 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 (AARTH) 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, staff 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 In-Person Assister 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,⁷ and program staff respond with workarounds or other information.⁸ 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, flyers, 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 on Saturday from 10:00 a.m. to 4:00 p.m. 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

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.

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 In-Person Assisters

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 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 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 who was 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 (CDC) associate to help with outreach and enrollment efforts in the past year. Health department staff were also proactive about securing an AmeriCorps VISTA intern to support efforts in the next year. The supervisor for the health

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.

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 IPA groups to provide services. The health department staff 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),⁹ 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

The perception that health care reform was a political issue might have limited health department advocacy on outreach and enrollment.

have limited health department advocacy on outreach and enrollment.

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 (community health centers) 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.

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.

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 Tacoma–Pierce County, Washington, the LHD is the lead institution in contracting, convening, and coordinating regional outreach and enrollment activities. As a trusted, neutral organization with community-wide 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 interviewed during the site visit 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.

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, *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 U.S. Census Bureau, “State and County QuickFacts: Pierce County, Washington,” last revised March 31, 2015; referenced August 20, 2014. As of April 27, 2015:
<http://quickfacts.census.gov/qfd/states/53/53053.html>

⁶ Tacoma–Pierce County Health Department, “Office of Assessment, Planning and Improvement,” undated. As of March 25, 2015:
<http://www.tpchd.org/resources/office-assessment-planning-improvement/>

⁷ Washington Healthplanfinder, undated home page. As of March 25, 2015:
<http://www.wahealthplanfinder.org>

⁸ Tacoma–Pierce County Health Department, “In-Person Assister Help Ticket Request,” undated. As of March 25, 2014:
<http://www.tpchd.org/health-wellness-1/health-care-reform/ipa-resources>

⁹ Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services, “Public Health in America,” last modified May 1, 2008. As of March 25, 2015:
<http://www.health.gov/phfunctions/public.htm>

About This Report

This project is a research partnership of the RAND Corporation and the National Association of County and City Health Officials. Funding was provided by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. The findings and conclusions in this report are ours and do not necessarily represent the views of the Office of the Assistant Secretary for Planning and Evaluation or the U.S. Department of Health and Human Services.

Acknowledgments

We would like to thank the many in-person assisters; staff at the health departments, clinics, hospitals; and the various social service agencies we visited over the course of this study for spending time helping us understand what they do. We would also like to thank Lois Davis, Ph.D., senior policy researcher at RAND, and Bruce Dart, Ph.D., director, Tulsa City-County Health Department, for their thoughtful insights.

Limited Print and Electronic Distribution Rights

This document and trademark(s) contained herein are protected by law. This representation of RAND intellectual property is provided for noncommercial use only. Unauthorized posting of this publication online is prohibited. Permission is given to duplicate this document for personal use only, as long as it is unaltered and complete. Permission is required from RAND to reproduce, or reuse in another form, any of our research documents for commercial use. For information on reprint and linking permissions, please visit www.rand.org/pubs/permissions.html.

For more information on this publication, visit www.rand.org/t/rr983.

© Copyright 2016 RAND Corporation

www.rand.org



The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. **RAND**® is a registered trademark.

RR-983-DHHS