



Chapter Title: Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage A Case Study on Houston, Texas

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

A Case Study on Houston, Texas

Laura Runnels, Kate Heyer, Courtney Armstrong, Malcolm V. Williams, Laurie T. Martin

Key findings

- Through an incident command system–based model, the Houston Department of Health and Human Services contributes to outreach and enrollment efforts. The department leverages its reputation in the community to gain quick buy-in for a coordinated strategy, provides a strength-based framework for response, and coordinates the efforts of the Gulf Coast Health Insurance Marketplace Collaborative.
- Outreach and enrollment efforts face challenges, such as the notices of award and timelines for funding differing from partner to partner, the collaborative not always having access to accurate and timely data from state and federal agencies, and some people remaining uninsured because they know that the hospital will provide comprehensive care at a cost that is lower than insurance premiums or potential tax penalties.
- Some factors help local health departments' efforts. 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 incident command system to maximize resources and reach a shared goal has been readily accepted. 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.

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 briefs 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 HOUSTON, TEXAS

In 2013, 20 percent of Texans did not have health insurance, the highest rate in the nation.⁵ Most of the uninsured in Texas are low-income workers, and 40 percent live below the poverty level.⁶ 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.⁷

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 the state 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.

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, 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- to 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.

Houston Case Study

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.

Rationale for Selecting This Case Study

Houston was selected as a case-study site because of the high rate of existing uninsured persons 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.

MODEL OF PUBLIC HEALTH DEPARTMENTS' INVOLVEMENT AND HOW THEY CAME TO BE IN THIS ROLE

In the autumn of 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,

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personnel, procedures, and communication.⁸ An incident commander leads it and oversees the coordination of operations, planning, logistics, and finance and administration.

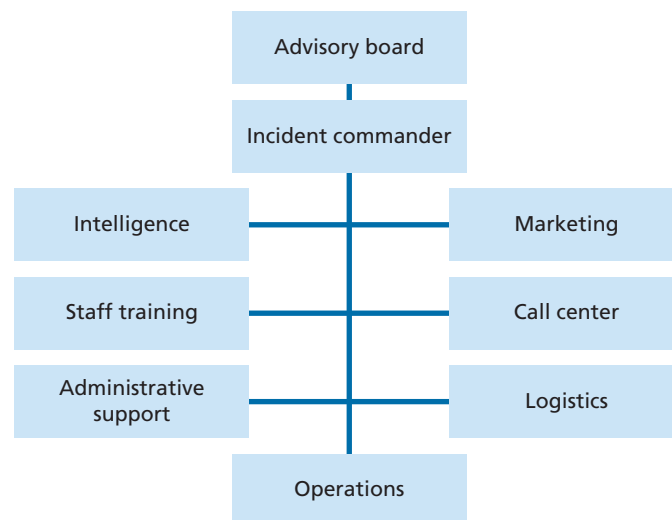
The collaborative's system includes an advisory board made up of agency executives, an incident commander from HDHHS, and seven branches (i.e., working groups) dedicated to specific activities: intelligence, staff training, marketing, a call center, logistics, administrative support, and operations (see the figure). 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 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.⁹

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. Also, 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 the 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, and Children clinic waiting rooms; and utility-bill inserts), an informational phone line to provide information to the public, and a public website.¹⁰

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

Houston's Incident Command System for Outreach and Enrollment



RAND RR986-1

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.

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.

The 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.

Leverages 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 Response

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 emerging community needs. Through their responses to emergency situations, such as hurricanes, HDHHS staff 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 rapidly serve a large number of people. 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 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 community-wide 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 is 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 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 incident command system to maximize resources and reach a shared goal has been readily accepted. 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 differs from others’ interpretations, 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,

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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 enrollment, staff 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 eligi-

ble persons 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.

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 23, 2015: <http://www.naccho.org/topics/research/forcesofchange/upload/Navigators.pdf>

⁵ Henry J. Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," undated. As of March 23, 2015: <http://kff.org/other/state-indicator/total-population/>

⁶ 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. As of March 23, 2015: <http://kff.org/uninsured/report/the-uninsured-population-in-texas-understanding-coverage-needs-and-the-potential-impact-of-the-affordable-care-act/>

⁷ The act is Public Law 111-3, Children's Health Insurance Program Reauthorization Act of 2009, February 4, 2009. As of March 23, 2015: <http://www.gpo.gov/fdsys/pkg/PLAW-111publ3/content-detail.html>

⁸ Federal Emergency Management Agency, *ICS Review Document*, May 2008. As of March 23, 2015: <http://training.fema.gov/emiweb/is/icsresource/assets/reviewMaterials.pdf>

⁹ Stephen L. Williams, Beverly L. Nichols, M. Katherine Barton, Maria De LaCruz, 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.

¹⁰ Enroll Gulf Coast, undated home page. As of March 23, 2015: <http://www.enrollgulfcoast.com/>

About This Report

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