2011–2013 *CONNECTING CONSUMERS WITH CARE* GRANT AREA EVALUATION

Understanding Grantee Efforts Related to Outreach and Enrollment, Consumer Self-Sufficiency, and Collaborative Problem-Solving

JULY 2014

Deborah Gurewich, PhD
Linda Cabral, MM
Laura Sefton, BA
University of Massachusetts Medical School
Center for Health Policy and Research

FOUNDATION
MASSACHUSETTS

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION

The Blue Cross Blue Shield of Massachusetts Foundation has funded the Connecting Consumers with Care grant program consistently since 2001. The program supports community health centers and community-based organizations in helping consumers enroll in and maintain publicly subsidized health insurance coverage. The program also encourages collaborative problem solving to minimize system-level barriers and enhanced education and empowerment of consumers so that they may navigate systems of health coverage and care with decreasing dependence on grantee organizations. During the October 2011–September 2013 grant cycle, the Foundation funded 13 organizations across Massachusetts. While this funding period preceded the first Affordable Care Act (ACA) open enrollment period, lessons from the outreach, enrollment, and post-enrollment work of these grantees remain invaluable to efforts to connect consumers with health coverage and care both in Massachusetts and across the country.

This report describes findings from the evaluation of the 2011–2013 grant cycle. The aims of the evaluation were to 1) assess progress made across the grantee sites on select outreach and enrollment measures; 2) describe the practices grantees adopted to reach out to and enroll consumers in insurance, increase consumer self-sufficiency, and collaborate with other agencies to minimize barriers to care; and 3) characterize barriers experienced by grantees as they worked to meet the goals of the program.

OUTREACH AND ENROLLMENT

Grantees adopted a range of creative outreach strategies, including partnering with community-based institutions such as public housing developments and places of worship; training community members to identify consumers needing assistance and refer them to grantee organizations; and building relationships with public libraries to assist visitors seeking information on health insurance coverage. All grantees had systems in place to support consumers with the enrollment process at their main sites. Several additionally utilized "virtual sites," bringing laptops with remote connections to off-site locations. This was reported to be an especially effective strategy for enrolling consumers. Closely aligned with practices aimed at reaching out to and enrolling consumers were strategies directed at avoiding gaps in coverage. Practices in this area included providing renewal reminder prompts (i.e., phone and text messages, postcards, and other mailings) and general guidance about redetermination.

QUANTITATIVE DATA: SELECT OUTREACH AND ENROLLMENT MEASURES

Grantees reported serving a median of 439 consumers per month with health insurance education and counseling, application and post-application assistance, annual eligibility review navigation, and other support. This accounted for over 335,000 encounters related to health insurance assistance across all grantees over the two-year period. In terms of the specific services provided, grantees reported assisting a median of 69 consumers with submitted applications for

MassHealth, Commonwealth Care, the Health Safety Net, and the Children's Medical Security Plan each month; a median of 87 consumers with the MassHealth eligibility annual review each month; and a median of 16 consumers with referrals to other health insurance programs including Commonwealth Choice, TRICARE, QSHIP, the Medical Security Plan, the Fishermen's Partnership, and the Insurance Partnership each month.

CONSUMER SELF-SUFFICIENCY

The Foundation defines consumer self-sufficiency as engagement whereby consumers are able to take an active role in their own health coverage and care and navigate systems with increasing independence. To advance consumer self-sufficiency, most grantees conducted one-on-one educational trainings and considered this to be the single most effective strategy. Grantees also developed and offered workshops, both on-site and at off-site community locations. Trainings and workshops focused on how to access and use the Virtual Gateway online portal, enroll in and renew insurance coverage, enhance computer skills and access, secure a primary care appointment, and more. Most grantees also developed written materials, guides, and tools (such as pictorial guides and easy-to-read handouts outlining the documents needed to enroll in insurance) as part of their strategy to facilitate consumer self-sufficiency.

COLLABORATIVE PROBLEM SOLVING

Developing relationships and collaborating with key stakeholders around policy and programmatic issues was a central part of grantees' work. Many grantees attended the Massachusetts Health Care Training Forums and developed relationships with staff at the MassHealth Central Processing Unit and regional MassHealth Enrollment Centers. These relationships, in turn, enabled grantees to better advocate on behalf of consumers and to more effectively resolve specific barriers to coverage. Grantees also reported leveraging long-standing relationships with a range of professional associations and advocacy groups. Participating in meetings sponsored by these groups provided opportunities for grantees to highlight consumer barriers to coverage, engage with stakeholders in problem solving, and create new points of contact.

DISCUSSION

Grantees adopted a range of practices to enroll consumers in health insurance coverage, promote consumer self-sufficiency, and work collaboratively to address system-level barriers. The evaluation identified common themes across grantees that, by extension, are suggestive of more promising practices. In this regard, critically important ingredients associated with grantee efforts were: 1) having knowledgeable and caring staff, as well as staff that reflected the linguistic and cultural backgrounds of the consumers being served; 2) building and sustaining a broad range of partnerships with external organizations; and 3) developing tools and strategies to advance health insurance and computer literacy.

Findings from the evaluation also suggest a common set of barriers that hindered grantees' efforts to connect consumers with care. System-level barriers were reported by all grantees and included long wait times for health insurance applications to be processed, long wait times for phone calls to be answered at MassHealth Enrollment Centers, and a generally complex insur-

ance enrollment and renewal process. Grantees also reported barriers related to their own organizational capacities to serve the volume and diversity of consumers needing assistance. Lastly, grantees noted consumer-specific challenges that affected the likelihood of connecting with and maintaining health insurance. These included language barriers, ability to meet documentation requirements for insurance, homelessness, and computer skills and access.

In sum, a central lesson from this evaluation is the critical role that community-based organizations and community health centers play in providing enrollment and post-enrollment services to vulnerable and hard-to-reach populations. The findings from this evaluation can serve as a guide for the specific practices associated with these efforts for other organizations doing or considering similar work, state and federal policymakers as they continue to implement components of the ACA, and other funders.

SECTION 1: INTRODUCTION

BACKGROUND

The Blue Cross Blue Shield of Massachusetts Foundation has funded the Connecting Consumers with Care (CCC) grant program consistently since 2001. The program supports community health centers and community-based organizations in helping consumers enroll in and maintain access to publicly subsidized health insurance coverage. Grantees provide culturally competent services and focus on difficult-to-reach individuals who remain uninsured or experience gaps in coverage. During the October 2011–September 2013 grant cycle,* the Foundation funded 13 organizations across Massachusetts (see Appendix). Each grantee received $40,000 per year ($80,000 over the two-year cycle), and all used the funding primarily to support staff salaries, typically for a community health worker. Among other responsibilities, the community health workers conduct outreach, strengthen relationships with community-based organizations, assist consumers in signing up for and maintaining coverage, help consumers understand how to use their insurance coverage, and connect consumers with primary care.

The Connecting Consumers with Care program also emphasizes a strong Massachusetts tradition of collaborative problem solving to support consumers in securing health coverage and services, while seeking to improve the broader systems made up of coverage programs. Grantees identify system-level barriers that create difficulty for consumers trying to access coverage or care. These might include complex notices or difficulty in connecting with state programs on behalf of clients. Grantees are encouraged to identify strategic ways to work with members of the advocacy community and implement solutions to these barriers with the appropriate state agencies.

In 2011, the Foundation refreshed the Connecting Consumers with Care program based on feedback from grantee organizations. The changes included an additional emphasis on enhanced education and empowerment of consumers so that they might better understand and navigate health coverage and care systems with decreasing dependence on grantee organizations. This component aimed to move grantee organizations away from a transactional form of assisting consumers and toward emphasizing and facilitating the role that consumers could themselves play in accessing health care and maintaining their coverage. The Foundation incorporated this concept into the expectations of grantees with the understanding that educated, engaged, and empowered consumers are critical to advancing access to health coverage and care. Grantees were further encouraged to develop strategies to advance consumer self-sufficiency that addressed the unique needs of their communities and consumer populations.

In March 2013, the Foundation contracted with the Massachusetts Area Health Education Center (MassAHEC) and the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School (UMMS) to, respectively, provide technical assistance for grantees and to

---

*The 2011–2013 grant cycle lasted from October 1, 2011, to September 30, 2013.

conduct an evaluation of the grant program. As advancing consumer self-sufficiency and promoting consumer activation was a new area of focus for the 2011–2013 Connecting Consumers with Care grant cycle, the MassAHEC technical assistance team worked with grantees to help them develop, implement, and refine their strategies. To promote learning across grantee organizations, MassAHEC and the Foundation further encouraged grantees to share strategies, lessons learned, and materials with one another. For instance, at a May 2013 in-person technical assistance meeting, grantees were asked to bring samples of their written materials, guides, and tools to share with their peers. The meeting also included an expert presentation on health literacy so that grantees might further refine their materials (e.g., understanding "plain language" principles) to better meet the needs of their consumer populations.

The aim of the evaluation conducted by the Center for Health Policy and Research (CHPR) was to assess grantee performance in the three main components of the grant program: outreach and enrollment, consumer self-sufficiency, and collaboration with external partners to identify system-level barriers and solutions. The evaluation sought to assess these components in the following ways:

- Assess progress made across grantee sites on select outreach and enrollment measures;
- Describe the practices grantees adopted to reach out to consumers and enroll them in insurance, increase consumer self-sufficiency, and collaborate with other agencies to minimize barriers to care; and
- Characterize barriers experienced by grantees as they worked to meet the goals and expectations of the program.

METHODS

The evaluation used a descriptive study design to characterize grantee practices and performance and to identify the barriers grantees encountered as they worked to address the three aims of the program. The evaluation relied exclusively on existing data from sources including the grantee funding proposals, monthly reports, and Year One and Year Two reports. As the staff at UMMS that conducted the evaluation was distinct from the staff that provided the technical assistance programming, other information gained in the course of providing technical assistance to grantees (e.g., phone conversations, dialogue at in-person meetings) was not included in this evaluation.

Data Sources and Collection

The evaluation relied primarily on three data sources: 1) each grantee's monthly reports; 2) each grantee's Year One and Year Two reports; and 3) notes from the Foundation's check-in calls with grantees. For all data sources, the Foundation was responsible for developing the data collection protocols and for collecting the data from grantees. The Foundation then made the data available to the evaluation team. In addition to these three data sources, the evaluation also reviewed each grantee's initial proposal for funding, which provided context for the analysis and key organizational characteristics of each grantee (e.g., mission, target population, core program components).

Monthly Reports: Each grantee submitted a report to the Foundation for each month of the funding cycle (for a total of 24 monthly reports per grantee). The evaluation used 23 of these

24 monthly reports (October 2011 to September 2013); the 24th report (October 2013) was eliminated because it was submitted after the evaluation team's cut-off date for data collection. The reports, due on the 15th of each month, captured program data and activity associated with services from the prior month. The report form, developed by the Foundation initially in conjunction with the Massachusetts Executive Office of Health and Human Services, included a total of 16 questions, of which 12 gathered quantitative data (program activity that could be counted) and four gathered qualitative data (program narratives).

The evaluation analyzed data from five of the 12 quantitative questions. These included: 1) number of unduplicated individuals served; 2) number of encounters; 3) number of individuals assisted with applying for MassHealth, Commonwealth Care, the Health Safety Net, and the Children's Medical Security Plan; 4) number of individuals referred to other insurance programs (i.e., Commonwealth Choice, TRICARE, QSHIP, the Medical Security Plan, the Fishermen's Partnership, and the Insurance Partnership); and 5) number of individuals assisted with annual eligibility review. Data from the remaining seven quantitative questions were omitted because there was substantial missing data in some cases and lack of clarity about the meaning of the data fields in other cases. The evaluation used narrative responses from all four qualitative questions. These questions solicited information about: 1) unique and effective outreach and enrollment strategies; 2) positive experiences with consumers during outreach and enrollment efforts; 3) positive experiences with state agencies and partner organizations; and 4) access barriers encountered during outreach and enrollment efforts. Seven of the 23 monthly reports were available to the evaluation team as Microsoft Excel files; the remaining 16 monthly reports were available only in hard copy.

Year One and Year Two Reports: Each grantee submitted a report near the end of Year One (July 2012) and again near the end of Year Two (July 2013) in order to demonstrate progress and also as part of its application to request renewal funding for the subsequent year. The Foundation developed a template for the reports, which included nine domains (or questions) for grantees to address in narrative form. The questions included reflections on major accomplishments, activities used to accomplish objectives and goals, measures used to determine progress, key lessons or unexpected results, and systemic changes needed to make the enrollment process run more smoothly. The annual reports were available to the evaluation team as a combination of Microsoft Word files and Adobe PDFs.

Notes from Foundation/Grantee Check-In Phone Calls: Foundation staff conducted a one-time check-in call with each grantee in January or February 2013. The purpose of the calls was to assess progress on grant activities, particularly around outreach and enrollment and consumer self-sufficiency efforts. Foundation staff wrote up a narrative summary of each call and made the summaries available to the evaluation team as Word files.

Data Analysis

Using descriptive statistics, the evaluation team examined the quantitative metrics from the grantee monthly reports. All quantitative data were entered into Excel spreadsheets and analyzed to determine the scope and scale of the entire grant program and variation across grantee sites. Using qualitative methods, the evaluation team coded all qualitative data and conducted content analysis. All qualitative data available in Word or PDF files were uploaded into Atlas.ti, software used to manage qualitative data, including content coding and analysis. An initial coding frame-

work was developed with codes representing core domains of interest: 1) adopted practices; 2) facilitators; and 3) barriers. The evaluators specified these codes for each of the three program areas (outreach and enrollment, consumer self-sufficiency, and collaborative problem solving), for a total of nine initial codes.

In the first round of qualitative data analysis, the coding scheme was independently applied to the same four documents by two members of the evaluation team. The evaluators reviewed each other's coding to ensure consistency and develop consensus on how codes should be defined and applied. For subsequent rounds of coding, two evaluators independently coded the remaining documents using the predefined coding scheme. The evaluators then reviewed each other's coded documents to assure consistent code application. Coding disagreements were resolved via discussion and additional data review until consensus was achieved. A third team member reviewed all coding and checked for internal consistency. Code summary reports were exported from the software and reviewed by the entire evaluation team to identify additional subcodes and themes.

For data that were available in hard copy only (i.e., 16 of 23 months of grantee monthly reports), the evaluation team reviewed the hard copy reports. Comments that described specific successes or challenges related to the coding framework described above were noted. These data were integrated into the analysis to confirm and support the themes identified in other qualitative data.

Limitations

As with any evaluation, a few limitations should be noted. First, the evaluation team did not have access to program outcomes and therefore was not able to assess the relative success of different approaches to outreach and enrollment, consumer self-sufficiency, and collaborative problem solving. Grantees did provide data on select performance measures, but it is not known if grantees specified the measures in the same way. Each grantee's performance measures were also likely mediated by factors that the evaluation could not control for (e.g., grantee size and staffing, and additional outreach and enrollment resources). A related limitation is that grantees did not approach the qualitative reporting requirements in the same way. Some grantees provided detailed descriptions of specific practices while others provided higher-level overviews. As a consequence, it is not known whether the observation of a practice or strategy at one site but not at another was a result of the two sites having different approaches or of missing data. Because of this, while the evaluators tried to give a sense of the overall frequency with which certain practices were indicated, these numbers are framed as estimates only. Finally, because this was a qualitative analysis, it was not the intent to detail every practice and every challenge but rather to identify and describe the general patterns observed across sites. As a result, some examples of grantee activities were inevitably omitted.

OVERVIEW OF GRANTEES

Table 1 lists the 13 grantee organizations funded by the Foundation in the 2011–2013 grant cycle. Grantees represent a range of service agencies operating throughout the state. Eight of the 13 grantees were community health centers (CHC), three were community-based organizations (CBO), and two were publicly funded agencies (one city-based and the other county-based). Whereas the CHC grantees' core mission is to provide primary and preventive health care ser-

vices, the CBOs and public agencies define their core missions as facilitating access to coverage and services. Almost half the grantees (six of 13) were located in suburban or rural settings; the remaining seven were in urban areas. Geographically, agencies were located across the state, with three in Greater Boston, one in the Northeast, three in the Southeast/Cape and Islands, two in Central Massachusetts, and four in Western Massachusetts.

TABLE 1: 2011–2013 CONNECTING CONSUMERS WITH CARE GRANTEES

ORGANIZATION	TYPE*	LOCATION	REGION OF MASSACHUSETTS
Boston Public Health Commission/Mayor's Health Line	Public agency	Urban	Greater Boston
Brockton Neighborhood Health Center	CHC	Urban	Southeast/Cape and Islands
Caring Health Center	CHC	Urban	Western
Community Action Committee of Cape Cod & Islands, Inc.	CBO	Suburban/Rural	Southeast/Cape and Islands
Community Health Center of Franklin County	CHC	Suburban/Rural	Western
Community Health Connections	CHC	Suburban/Rural	Central
Ecu-Health Care, Inc.	CBO	Suburban/Rural	Western
Family Health Center of Worcester	CHC	Urban	Central
Hilltown Community Health Centers	CHC	Suburban/Rural	Western
Joint Committee for Children's Health Care in Everett	CBO	Urban	Greater Boston
Lynn Community Health Center	CHC	Urban	Northeast
Vineyard Health Care Access Program	Public agency	Suburban/Rural	Southeast/Cape and Islands
Whittier Street Health Center	CHC	Urban	Greater Boston

*CHC = Community Health Center; CBO = Community-Based Organization

SECTION 2: OUTREACH AND ENROLLMENT

PRACTICES

Grantees adopted a range of outreach and enrollment strategies. This section first describes the populations targeted by grantee sites and then details the specific practices adopted for reaching out to the uninsured, managing insurance enrollment, and facilitating sustained enrollment.

Target Populations

Grantees served a diverse range of vulnerable populations at high risk for inadequate access to health insurance. Collectively, consumers served by the program included low-income individuals and families, recent immigrants and refugees, young adults, and the unemployed. Many grantees operated in communities that were disproportionately Hispanic, so this race/ethnicity was often mentioned as a core part of the target population, as well as "other cultural and linguistic minority communities." Some grantees placed special emphasis on single young males, seasonal workers, and the self-employed. Other grantees included as part of their core target population uninsured *employed* workers and residents whose primary language was not English. In sum, grantees cast a large and diverse net over the group of individuals who were thought to potentially benefit from outreach and enrollment services.

Outreach to the Uninsured

Grantees adopted an impressive range of outreach strategies, including direct outreach efforts to consumers at off-site locations including homeless shelters, public housing developments, places of worship, community centers, and public schools. Grantees also targeted WIC offices, food pantries, and farmers' markets. Two grantees conducted monthly visits to a correctional facility to meet inmates scheduled for release. Several grantees hosted information booths at community events (e.g., health fairs, festivals) and posted informational flyers and posters (often in different languages) throughout the community. Some grantees recruited and trained community mem-

bers ("peers") to conduct outreach and refer consumers in need of assistance with insurance to grantee staff. In all instances, the goal was to build awareness of health insurance options and the availability of grantee staff to assist with the enrollment process. Grantees stressed that the success of these efforts depended in large part on having knowledgeable and caring outreach staff, especially workers who reflected the cultural and linguistic backgrounds of the consumers they served.

Grantees also reached out to staff at other provider and service organizations and within their own organizations (when applicable) to assist with outreach efforts, educating these staff on how to identify uninsured consumers and refer them to outreach staff for assistance. In this capacity, grantees worked with health care providers (hos-

> "Two (members) of the team set up weekly outreach posts at Open Door Social Services, Community Partners, and a local Latino faith-based radio station … Through these expanded efforts, monthly encounters have nearly doubled."

pitals and health centers), local tax preparers, and career centers. One grantee trained staff at the Boston Public Library to assist individuals coming into the library for information on how to access health insurance. Similarly, some grantees reached out to staff in other departments or divisions within their own organizations, soliciting their assistance with identification and referral. For instance, at one site, outreach staff attended community meetings hosted by the grantee organization's Rapid Testing/HIV team as an opportunity to provide guidance on insurance issues. Another grantee shadowed the organization's HIV and WIC outreach workers as a means to locate individuals who might be in need of insurance and assistance with enrollment. One grantee used incoming calls about free vaccinations as an opportunity to screen for insurance status. Having a broad range of connections with staff within and outside their respective organizations was reportedly an important factor driving the success of outreach and enrollment efforts.

> "(We) increased the number of staff members who are engaged in enrollment as patients come through different programs throughout the health center ... Staff members of different departments engage in recruiting patients and directing them to outreach and enrollment services."

Managing Insurance Enrollment

All grantees had systems in place to provide one-on-one assistance to consumers with the enrollment process at their organization's main site, through scheduled (and, in some cases, walk-in) appointments. Several grantees developed strategies for managing this process effectively and efficiently. Some encouraged consumers to complete the Permission to Share Information (PSI) form, which authorized direct communication between the enrollment worker and MassHealth and helped to expedite the enrollment process. In addition to enrolling consumers at their main sites, at least six grantees utilized "virtual sites" whereby grantee staff brought laptops with remote connections to off-site locations (e.g., other community agencies, homeless shelters, public housing) in order to enroll consumers at these locations. Several grantees noted that this was an especially effective practice for enrolling consumers.

> "(The) Access Navigator connects with people in the waiting room. They ensure that people have the right papers, reroute people, and triage people. They help people analyze the letter that came in (the mail) regarding (their) health insurance."

Facilitating Sustained Enrollment

Closely aligned with practices aimed at reaching out to consumers and enrolling them in insurance were practices aimed at avoiding gaps in coverage. Consumers may have lost coverage because they failed to submit the redetermination application on time or failed to submit missing documentation or update information about a change of address or employment. Grantee strategies in this area included providing renewal reminder prompts and education. Several grantees sent reminder letters to consumers scheduled for renewal, including guidance about the redetermination process. One grantee launched a pilot program that included

three different types of reminder prompts (phone, text message, and postcard). Another grantee implemented a redetermination campaign targeted at its current consumers. A third grantee sent mailings to consumers to educate them in general about the redetermination process.

BARRIERS

Grantees experienced three main types of barriers to their outreach and enrollment efforts. The first set of barriers reflected system-level challenges, and of these, the most commonly cited was the length of time MassHealth took to process an application. Some grantees also noted excessively long wait times to get through to a MassHealth Enrollment Center (MEC) representative by phone. Consumers were frustrated and discouraged by these long wait times; some ran out of cell phone minutes before their call got through. Long phone wait times also slowed down the work of enrollment workers who called MECs on behalf of the consumers they assisted.

Grantees also experienced challenges related to their own organizational capacity to serve the volume of consumers needing assistance, as well as the linguistic and cultural diversity of consumers. With respect to the former, the volume of demand at some sites resulted in long wait times for an appointment with an enrollment worker, with some consumers needing to make more than one visit before they could be seen. Strategies that grantees adopted to minimize this barrier included adding more staff and establishing daily cut-off times for accepting more consumers to ensure that those waiting would be seen that day. One grantee had staff available to assess the needs of waiting consumers to determine if a consumer could be assisted *without* seeing the enrollment worker, or if a consumer should return at a later date because s/he did not have the needed documentation. In addition to the volume of demand, some grantees had difficulty serving all the language needs of their consumers. One grantee reported that despite being able to serve people in 19 different languages, there remained additional languages (e.g., Karen, Kareni, and Kinyarwanda) the organization could not easily serve, a circumstance that limited its ability to reach out to and enroll consumers in this community.

A final set of barriers reflected complexities in the lives of consumers served by the program. In addition to language barriers, some consumers are challenged by the documentation needed to complete the MassHealth enrollment process: some do not have copies of their birth certificate; some work in cash-only jobs with no proof of income; some lack housing security and do not have a permanent address. Two grantees allowed consumers to use their site's or a partner site's address as a "home" address; other grantees provided funds to obtain new birth certificates. Some consumers also had limited means of transportation, which made getting to a MEC and, in some cases, the grantee site a challenge. For this reason, almost all grantees made themselves available in different community locations. One grantee made home enrollment visits in order to overcome the geographic isolation experienced by some consumers.

SECTION 3: QUANTITATIVE DATA: SELECT OUTREACH AND ENROLLMENT MEASURES

TABLE 2: NUMBER OF CONSUMERS SERVED AND NUMBER OF ENCOUNTERS
Monthly Reports (October 2011–September 2013)*

SITE	NUMBER OF CONSUMERS SERVED (MONTHLY AVERAGE)	NUMBER OF ENCOUNTERS (MONTHLY AVERAGE)	NUMBER OF ENCOUNTERS (TWO-YEAR TOTAL)
Site 1	2,196	2,492	57,321
Site 2	102	135	3,114
Site 3	178	266	5,595
Site 4	269	277	6,360
Site 5	586	1,612	33,843
Site 6	608	684	15,741
Site 7	285	4,044	93,006
Site 8	1,330	1,378	31,703
Site 9	35	44	933
Site 10	321	400	8,407
Site 11	1,360	1,881	43,255
Site 12	997	1,025	23,573
Site 13	439	597	13,724
Total	–	–	336,575
Median	439	684	15,741

*Some sites did not report data for every item for every month.

Table 2 provides select outreach and enrollment measures for the program overall and for each grantee. Each month, grantees were asked to report an unduplicated count of the number of consumers served with the support of Foundation dollars. Grantees were instructed to count each consumer only once, even if multiple services were provided or if there were multiple encounters over the course of the month. Sites are de-identified (and randomly ordered) to minimize cross-site comparisons. Variation across grantees by consumer demographics, community character-istics, geography, and outreach and enrollment strategies (among other factors) and the evalu-ation's inability to adequately control for these differences makes cross-site comparisons not indicated for this evaluation.

Grantees reported serving a median of 439 consumers each month (Table 2/Column 2). Grantee organizations varied substantially on this measure, with Site 9 reporting an average of 35 con-sumers served each month and Site 1 reporting an average of 2,196 consumers served each month. Some of this variance may reflect different measurement methodologies across grantees. Some grantees may have counted only consumers served via one-on-one encounters, while others may have included consumers served in group settings (e.g., health fairs). This points to a

need for the Foundation to add more clarity to the reporting questions to achieve greater consistency in the data reported across grantees.

Variance across sites may also reflect differences in overall resource capacity. While grantees were asked to report only on consumers assisted under the Connecting Consumers with Care program, it is possible that some sites were unable to isolate Foundation-funded activities from outreach and enrollment activities funded by other resources. As a consequence, organizations with more non-Foundation resources for outreach and enrollment would be associated with higher numbers of consumers served. Finally, geography and consumer characteristics might also explain some of the variance. For instance, grantees that operate exclusively in rural regions or specifically work with homeless persons may report helping fewer consumers due to smaller target populations or higher intensity of services provided.

Grantees collectively reported 336,575 encounters for assistance related to health insurance over the two-year period (Table 2/Column 4). Here, too, there was substantial variance across sites. The average number of encounters each month across the grantees ranged from a low of 44 to a high of 4,044 (Table 2/Column 3), while the average number of consumers served each month ranged from 35 to 2,196. While it is not possible to calculate an encounter rate for each grantee site (as the number of consumers served is not an unduplicated count over the two-year period), Site 7 appears to provide a higher intensity of services than other sites. Variation in measures related to the number of consumers served and number of encounters could be explained by the same rationale described above: different measurement methodologies, resource capacities, geography, and consumer characteristics. For instance, a grantee that largely serves refugee and immigrant communities might have more encounters per consumer in order to address potential language, cultural, or documentation barriers to securing health insurance coverage.

Table 3 details consumers assisted by type of application across the program overall and by each grantee over the two-year period. Again, sites are de-identified to minimize cross-site comparisons. In terms of the specific services provided during this grant cycle, grantees reported assisting a median of 69 consumers each month (Table 3/Column 2) with submitted applications via the Virtual Gateway, Real Benefits, and the Medical Benefits Request (MBR) form (including MassHealth, Commonwealth Care, the Health Safety Net, and the Children's Medical Security Plan). In addition, grantees assisted a median of 87 consumers each month with the MassHealth annual eligibility review process (Table 3/Column 3). For consumers who were not eligible for MassHealth or Commonwealth Care, the grantees assisted with referrals to other health insurance programs including Commonwealth Choice, TRICARE, QSHIP, the Medical Security Plan, the Fishermen's Partnership, and the Insurance Partnership (Table 3/Column 4).

TABLE 3: CONSUMERS ASSISTED BY TYPE OF APPLICATION/PROGRAM
Monthly Reports: October 2011–September 2013*

SITE	NUMBER OF CONSUMERS INCLUDED IN SUBMITTED APPLICATIONS** (MONTHLY AVERAGE)	NUMBER OF CONSUMERS ASSISTED WITH ANNUAL ELIGIBILITY REVIEW (MONTHLY AVERAGE)	NUMBER OF CONSUMERS REFERRED TO OTHER INSURANCE PROGRAMS*** (MONTHLY AVERAGE)
Site 1	51	100	9
Site 2	48	25	16
Site 3	64	111	18
Site 4	58	87	14
Site 5	52	9	1
Site 6	73	153	23
Site 7	87	201	0
Site 8	207	441	17
Site 9	23	8	1
Site 10	69	35	25
Site 11	261	623	63
Site 12	238	27	0
Site 13	150	75	16
Median	69	87	16

*Some sites did not report data for every item for every month.

**MassHealth, Commonwealth Care, the Health Safety Net, and the Children's Medical Security Plan

***Commonwealth Choice, TRICARE, QSHIP, the Medical Security Plan, the Fishermen's Partnership, and the Insurance Partnership

SECTION 4: CONSUMER SELF-SUFFICIENCY

PRACTICES

The Foundation defines consumer self-sufficiency as engagement whereby consumers are able to take an active role in their own health coverage and care, and navigate systems with increasing independence. Grantee practices related to consumer self-sufficiency took the following forms: one-on-one trainings, workshops, peer-to-peer trainings, and development of written materials, guides, and tools.

One-on-One Trainings

Most grantees conducted one-on-one trainings, and several reported that this was the most effective method for facilitating consumer self-sufficiency. One-on-one education, often provided during the enrollment process itself, allowed grantee staff to show a consumer how to access and use the MassHealth website and, most importantly, the My Account Page (a feature of the Virtual Gateway that allowed members to view and makes changes to their account status).

These sessions were also an opportunity to walk a consumer through each step of the enrollment process, and to inform and educate consumers about the redetermination process. One-on-one sessions provided consumers privacy in discussing their situation and needs, which, in turn, allowed staff to customize their education and assistance to the unique needs of each consumer. Several grantees noted this to be especially valuable. Grantees recognized that most consumers would not be able to navigate the enrollment process on their own and emphasized resources available for assistance as part of these trainings.

> "… Training participants all expressed appreciation for the understanding they came away with concerning what is contained in the body of the (MassHealth) letters, why they need to hold on to them for future reference, and what will make them eligible to apply successfully in the future."

Workshops

A majority of grantees (an estimated nine in total) conducted educational workshops. Some offered workshops at their main site; others offered workshops mainly at off-site locations (often at the same locations where they conducted outreach). Workshops focused on topics similar to those noted in the one-on-one trainings: how to navigate the MassHealth website and how to apply for and retain insurance. Additional workshop topics included computer skills training and information about where consumers could access publicly available computers, as well as education about MassHealth letters sent to consumers—both how to understand them and the importance of responding to them in order to retain coverage. Community health center grantees were also likely to incorporate into trainings information about the health care services and programs they provide. Most grantees scheduled workshops at standing, frequent times, allowing consumers to return with questions or draft MassHealth applications needing review. Importantly, workshops were also used to educate consumers about where and how they could seek ongoing assistance with health insurance and care, both in the community and at grantees' main sites.

Peer-to-Peer Trainings

At least two grantees adopted a peer-to-peer (or "train-the-trainer") model, training volunteer community members to conduct outreach and assist consumers with learning to access health care and maintain insurance with increasing independence. This approach followed the community health worker (CHW) model of patient navigation that uses peers to conduct outreach, insurance enrollment, health education, communication, and service referral. One grantee recruited patients who had been diagnosed with specific health conditions, who were then trained (as part of a 12-week curriculum) to share their experience with treatment, adherence, and prevention. In this sense, the model went beyond insurance and enrollment self-sufficiency to additionally assist consumers with how to manage their own health and health care service needs. One grantee used peer trainers to conduct both formal (workshops) and informal (one-on-one outreach to a neighbor) trainings.

Written Materials, Guides, and Tools

Most grantees developed some type of educational materials as part of their strategy to facilitate consumer self-sufficiency (11 grantees described activity in this area). In most cases, these materials supplemented and reinforced what grantees reviewed with consumers individually and in groups. For instance, grantees created consumer-friendly guides in different languages to explain the MassHealth application process. Some grantees developed fact sheets with step-by-step instructions on the insurance enrollment and renewal process, as well as an overview of MassHealth letters, and one grantee described developing an "easy-to-read" handout outlining the documents needed to enroll in insurance. In addition to written materials, one grantee developed an electronic tutorial (in four languages) about insurance, enrollment, and the redetermination process, which played on television monitors in the site's main lobby.

Grantees also developed "toolkits" and "guides," often in more than one language; in at least one instance, materials were translated into as many as five different languages. Toolkits and guides similarly provided information about how to enroll in and retain insurance. At one site, a toolkit additionally included diagrams of sample MassHealth letters as well

> "We developed and adapted written materials on the MassHealth/Commonwealth Care application and enrollment process. These materials are specific to our community and reflect certain local facts that general statewide materials do not."

as guidance on letter content, so consumers would know what to look for in the mail and be better equipped to understand the information and take next steps. At another site, an instructional guide included information on upcoming open-enrollment dates and other ACA health coverage information. This same site also designed tools to help consumers understand tax penalties, subsidies, and other cost-sharing opportunities. In at least two cases, materials about insurance were provided to consumers as part of a larger packet or folder that included additional information about how to navigate health care services (within the grantee organization as well as outside it), general health information (e.g., blood types, vaccination schedules, frequency of dental exams), guidance on how to prepare for medical appointments (e.g., how to make an appointment, what to bring, how to cancel an appointment, how to manage referrals), important contact phone num-

bers, and more. In two instances, grantees sought consumer feedback on the content and format as part of the guide/toolkit development process, thereby ensuring that these materials better met the needs of the intended users.

BARRIERS

Grantees identified four main factors that limited efforts to further consumer self-sufficiency. One barrier was similar to that described in relation to outreach and enrollment practices: challenges related to effectively serving a population that represented enormous linguistic and cultural diversity. Grantees stressed the critical importance of having outreach and enrollment workers who linguistically and culturally reflected the populations they serve. Yet this was not always possible, especially for locally rare languages and cultures. This, in turn, created barriers to educating and empowering these populations.

Language barriers also limited some consumers' ability to navigate the health care delivery system. Of particular note, MassHealth letters are available in English and Spanish and contain important information about action steps needed to initiate enrollment or retain coverage. Grantees adopted strategies to assist consumers whose first language is not English or Spanish and/or who have limited literacy skills (i.e., educating consumers about the importance of these letters and how to understand their content), and they also encouraged consumers to seek out grantee staff for assistance with any formal communication from MassHealth that they did not understand.

> "Many individuals who were given the steps were people who don't usually use a computer or who don't understand English well and find the computer experience challenging … We began to develop a picture instruction sheet to give the client more of a photographic view of each step as they used the computer to check their status or fill out a form."

Another essential component of accessing and maintaining coverage is consumers' ability to navigate the online Virtual Gateway. Many consumers lacked computer skills and/or access to computers or the Internet. Grantees took steps to minimize this barrier, including providing computer trainings and guides as part of the workshops and one-on-one trainings; providing information about publicly available computers; and, in at least two cases, giving consumers access to computers at their main sites. Regardless, limited computer skills and access were identified as significant barriers for some consumers.

A final barrier described, and also relevant to outreach and enrollment efforts, was that some consumers were overwhelmed with immediate and pressing demands (relating to, e.g., housing, child care, and food) and consequently had difficulty prioritizing health care access and insurance. Some grantees described consumers who worked multiple jobs and thus did not have time to attend meetings, workshops, or trainings; others described consumers who had time but were challenged to elevate health care over other competing issues. For these reasons, some consumers preferred that grantee staff manage the enrollment process for them, rather than learning how to enroll in and retain insurance on their own.

SECTION 5: COLLABORATIVE PROBLEM SOLVING

PRACTICES

Developing relationships and collaborating with key stakeholders around policy and programmatic issues was a central part of grantees' work under the Connecting Consumers with Care program. Activity in this area included working closely with MassHealth and other state agencies, attending meetings and forums sponsored by professional associations and advocacy groups, and working with local organizations.

> "(We have) developed ongoing collaborative relationships with supervisors at the MassHealth Central Processing Unit … with these relationships we are able to address challenges that consumers encounter when accessing or maintaining health coverage."

MassHealth and Other State Agencies

Many grantees attended the Massachusetts Health Care Training Forums (MTFs), quarterly state-sponsored events held in five regions of the Commonwealth, which provide information on MassHealth and other public insurance programs. In addition to providing useful materials and information, these meetings were an opportunity for grantees to discuss enrollment barriers and build relationships with staff at MassHealth and other agencies. Attendees typically shared the information and materials received at forums with other staff at their organizations. One grantee also shared the information and materials from the forums with other agencies in its community via a quarterly scheduled luncheon. Grantees also developed collaborative relationships with staff at the MassHealth Central Processing Unit and regional MECs. One grantee attended meetings and trainings sponsored by the Department of Public Health and Department of Transitional Assistance to better understand the system for enrolling refugees and to work with staff at these agencies on ways to improve the enrollment process for this population. In all cases, establishing relationships with staff at key state agencies enabled grantees to better advocate on behalf of consumers and to more effectively and efficiently resolve specific barriers to coverage.

Professional Associations, Advocacy Groups, and Research Entities

Grantees reported long-standing relationships with a range of professional associations and advocacy groups, including Action for Boston Community Development (ABCD), Health Care For All (HCFA), Outreach Worker Training Institute, and Community Catalyst's New England Alliance for Children's Health Care. Participation in meetings sponsored by these organizations provided opportunities for grantees to highlight consumer barriers to insurance, engage

> "Participating in such meetings and through networks provides (our agency) an opportunity to communicate needs of the homeless community and engage with stakeholders on problem solving and larger advocacy efforts to bring about change."

with stakeholders in problem solving, foster relationships with agency staff, and create new points of contact.

These relationships also generated other opportunities to advance consumer-friendly policies and procedures. For example, one grantee worked directly with HCFA and MassHealth to obtain better coverage for two pregnant women. Another received a small grant from HCFA to help explain and promote the Affordable Care Act to consumers. Another grantee collected data on reasons for MassHealth claims denials and shared this information with partner agencies (MassHealth, Massachusetts League of Community Health Centers, and HCFA) to facilitate a discussion on how to resolve future denials of claims. And, as one last example, the Massachusetts Medicaid Policy Institute (MMPI) and the UMass Center for Health Law and Economics drew upon the experiences of all the 2011–2013 Connecting Consumers with Care grantees to better understand recent efforts by MassHealth to address enrollment volatility and to provide recommendations to mitigate remaining challenges. The findings were particularly timely in light of preparations for ACA implementation and were disseminated widely to MMPI's and the Foundation's stakeholders.

Local Organizations

In addition to statewide associations and advocacy groups, grantees engaged local organizations in their efforts to address system-level barriers. For example, one grantee participated in the Southeast Region Roundtable, which successfully advocated for allowing eligibility review forms to be faxed (instead of mailed) to the region's Central Processing Unit. This, in turn, contributed to shorter wait times for consumers to receive their eligibility determination. Another grantee attended its city's Health Care Task Force Leadership Summit and collaborated with task force members on a regular basis. Specific policy priorities identified by the group included efforts to restore MassHealth dental benefit for adults and premium reductions for Commonwealth Care health plans. Another grantee, through its membership in the local Community Health Network and role as coordinator of a local health care alliance group, engaged in efforts to improve health planning and collaboration for consumers. An outgrowth of this work was the development of Mobilizing Action for Planning and Partnerships (MAPP), a community-driven strategic planning process that allows consumers to advocate on health programs and practices in their community.

BARRIERS

Grantees reported fewer challenges around their work collaborating with external partners and advocating for change than they did in the other two Connecting Consumers with Care program component areas. Of the barriers and challenges noted, two themes dominated what grantees reported. One barrier related to staff turnover at external partner agencies and organizations, which sometimes made it difficult to develop and maintain professional relationships and to sustain efforts around a particular issue. A second barrier concerned the time and resources it took to develop and sustain external collaborations and partnerships, time that took away from a grantee's ability to provide direct outreach, enrollment, and education services to consumers. No grantee questioned the absolute necessity of collaborating with outside entities. Given limited resources, however, it can be hard to juggle competing demands.
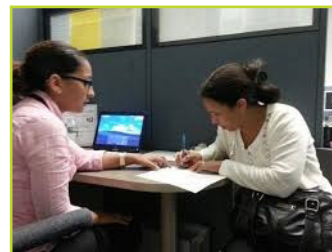
SECTION 6: DISCUSSION AND PREVIEW OF THE OCTOBER 2013–SEPTEMBER 2015 FUNDING CYCLE

The purpose of this final section is to revisit the evaluation aims, describe the progress grantees made over the two-year cycle, and pinpoint factors that seemed to facilitate accomplishments across the three program areas (outreach and enrollment, consumer self-sufficiency, and collaborative problem solving), as well as the barriers that persisted. The section concludes with a preview of the October 2013–September 2015 Connecting Consumers with Care funding cycle.

Assess progress made across grantee sites on select outreach and enrollment measures

The 13 grantees reported serving a median of 439 consumers each month, accounting for over 335,000 encounters related to health insurance assistance over the two-year period. Grantees assisted a median of 69 consumers each month with submitted applications via the Virtual Gateway, Real Benefits, and the Medical Benefits Request (MBR) form (used by MassHealth, Commonwealth Care, the Health Safety Net, and the Children's Medical Security Plan). Grantees also assisted a median of 87 consumers each month with their annual eligibility review.

There was wide variation among grantees in the number of consumers assisted and the number of encounters. The evaluation team cautions against using this variance as a measure of relative success, as several factors may affect the number of consumers any given grantee reported. In particular, grantee sites varied in the amount of *additional* resources they had (over and above funding from the Foundation) for outreach and enrollment activities. They also adopted different approaches to reporting consumers assisted under the program. In the future, the Foundation will need to add more clarity to its reporting questions to achieve greater consistency in data collection across grantees. Finally, variation is also expected across geography and consumer characteristics. Regardless, the quantitative performance measures suggest that grantees play important roles in the communities they serve and are effectively reaching out to consumers and enrolling them in insurance coverage.

Describe the practices grantees adopted to reach out to consumers and enroll them in insurance, increase consumer self-sufficiency, and collaborate with other stakeholders to minimize barriers to care

Grantees adopted a range of practices to achieve the performance levels noted above, as well as to advance consumer self-sufficiency and collaborate with stakeholders to address system-level barriers. While the evaluation was unable to assess the relative utility of different practices, because of limited outcomes data and limited ability to adjust for key site-level organizational factors, it can identify common themes across grantees that may be indicative of more promising practices. In this regard, evaluation findings suggest that three key factors facilitated grantees' efforts under the Connecting Consumers with Care program. As detailed below, these include culturally competent outreach and enrollment staff, strong intra- and inter-organizational relationships, and tools that advanced consumer independence.

A critically important ingredient associated with grantee efforts under all three program areas was having knowledgeable and caring staff, as well as staff that reflected the linguistic and cultural backgrounds of the consumers being served. This was central to grantees gaining access to communities, effectively communicating with consumers, and providing education and educational tools in ways that met the needs of consumers. To achieve this, many grantees hired and trained staff who resided in the communities they served. They also solicited feedback from consumers about what they needed to more effectively connect with health insurance and health care. This, in turn, enabled grantees to build trust with consumers and to help consumers overcome concerns about engaging with and applying for health benefits. Having close and credible connections to the communities they served also enhanced grantees' abilities to effectively collaborate with other organizations to address system-level barriers.

Grantees' success in connecting consumers with care was also facilitated by their developing and sustaining a broad range of linkages with external organizations and agencies, as well as links with other divisions within their own organizations (when applicable). These relationships were central to grantees' success in reaching consumers in need of assistance, largely by cultivating a system of mutual referrals. Grantees also fostered relationships and worked closely with staff at MassHealth and the MECs to resolve questions about specific applications, renewals, or denials. Finally, grantees developed and maintained connections with other state agencies, policy groups, and advocacy organizations so that they might better advocate for system-level improvements.

A final common feature across grantees was the strategies they implemented to enhance consumer self-sufficiency. Grantees developed a variety of materials, toolkits, and guides intended to educate consumers and help them navigate systems of health coverage and care. Most grantees also offered workshops or trainings to make the online Virtual Gateway more accessible, including instruction on topics ranging from basic computer literacy to utilizing the My Account Page. While the degree of success associated with these efforts is unknown, grantees have moved beyond outreach and enrollment to adopting practices that aim to empower consumers to manage these processes with increasing independence.

Characterize barriers experienced by grantees as they work to meet the goals and expectations of the program

Results from the evaluation, while very successful overall, also indicate a relatively common set of factors across grantees that hindered efforts to connect consumers with care. Specifically, three main categories of barriers were identified: system-level barriers; barriers related to the organizational capacities of the grantee organizations themselves; and consumer-level barriers.

At the system level, grantees consistently described long wait times for applications to be processed, long wait times for phone calls to be answered at local MECs, and generally complicated insurance enrollment and renewal processes. As a consequence, grantee staff reported delays in their efforts to enroll consumers. A related system-level barrier is that English and Spanish are the dominant languages for communication from MassHealth and related public insurance programs, thereby posing challenges for consumers who speak a language other than English or Spanish or have limited literacy skills.

Grantees also experienced challenges related to their own organizational capacities to serve the volume and diversity of consumers needing assistance. The high demand at some sites resulted in long wait times for an appointment with an enrollment worker, with some consumers needing to make more than one visit before they could be seen. In addition to high demand, grantees experienced challenges related to effectively serving populations that represented enormous linguistic and cultural diversity. Grantees stressed the critical importance of having outreach and enrollment workers that linguistically and culturally reflected the populations they serve. Yet this was not always possible, especially for uncommon languages and cultures. This, in turn, created barriers to outreach and enrollment efforts, as well as barriers to providing effective education and empowerment tools for these populations.

A final barrier associated with efforts to connect consumers with care related to complexities in the lives of the consumers served by the program. In addition to language barriers, some consumers experienced barriers related to transportation, documentation needed for insurance applications, homelessness, and computer skills and access. Some consumers were also challenged to prioritize health care access and insurance over more immediate and pressing needs (such as for housing and food). Some consumers worked multiple jobs and thus did not have time to attend meetings, workshops, or trainings. Grantees adopted practices to minimize at least some of these barriers. Regardless, in at least some instances, these barriers limited the degree to which grantees could effectively outreach, enroll, and promote self-sufficiency.

OCTOBER 2013–SEPTEMBER 2015 FUNDING CYCLE

The Foundation continued its Connecting Consumers with Care grant program for another two-year cycle, which began on October 1, 2013, and ends on September 30, 2015. This new funding cycle increased the number of grantees from 13 to 16. Twelve of the 13 grantees in the 2011–2013 cohort continue their work in this new cycle, and four new organizations joined the program. The primary objectives of the grant program again focus on outreach and enrollment, and supporting consumers in becoming more self-sufficient in navigating the health care system and acquiring and maintaining insurance. There is additionally an enhanced focus on organizational capacity and skill building to support grantees in their approaches to consumer self-sufficiency.

The lessons learned from the 2011–2013 Connecting Consumers with Care program come at a critical time. While this funding cycle preceded the first ACA open enrollment period, the experiences of the grantee organizations remain informative to the evolving health insurance and health care landscape. A central finding is the critical role that community-based organizations and community health centers can play in facilitating access to coverage for some of the most vulnerable and hard-to-reach populations. And just as important is the post-enrollment support (e.g., education on how to use health insurance, connecting consumers with primary care, assistance with eligibility renewal, etc.) that organizations provide, as an insurance card does not guarantee access to care.

The findings from this evaluation can serve as a guide for the specific practices associated with these efforts for incoming grantees, grantees that have been in the program for several years, other organizations doing or considering doing similar work, state and federal policymakers, and funders looking to support this type of work. Further, as the new cohort of grantees continues to respond to changes in the health insurance marketplace, future evaluation work will be charged with capturing the new lessons learned and factors critical to success.

APPENDIX: LIST OF OCTOBER 2011–SEPTEMBER 2013 GRANTEES WITH GEOGRAPHIES

Boston Public Health Commission/Mayor's Health Line
Boston

Brockton Neighborhood Health Center
Brockton

Caring Health Center
Springfield

Community Action Committee of Cape Cod & Islands, Inc.
Hyannis

Community Health Center of Franklin County
Turners Falls

Community Health Connections
Fitchburg

Ecu-Health Care, Inc.
North Adams

Family Health Center of Worcester
Worcester

Hilltown Community Health Centers
Worthington

Joint Committee for Children's Health Care in Everett
Everett

Lynn Community Health Center
Lynn

Vineyard Health Care Access Program
West Tisbury

Whittier Street Health Center
Roxbury