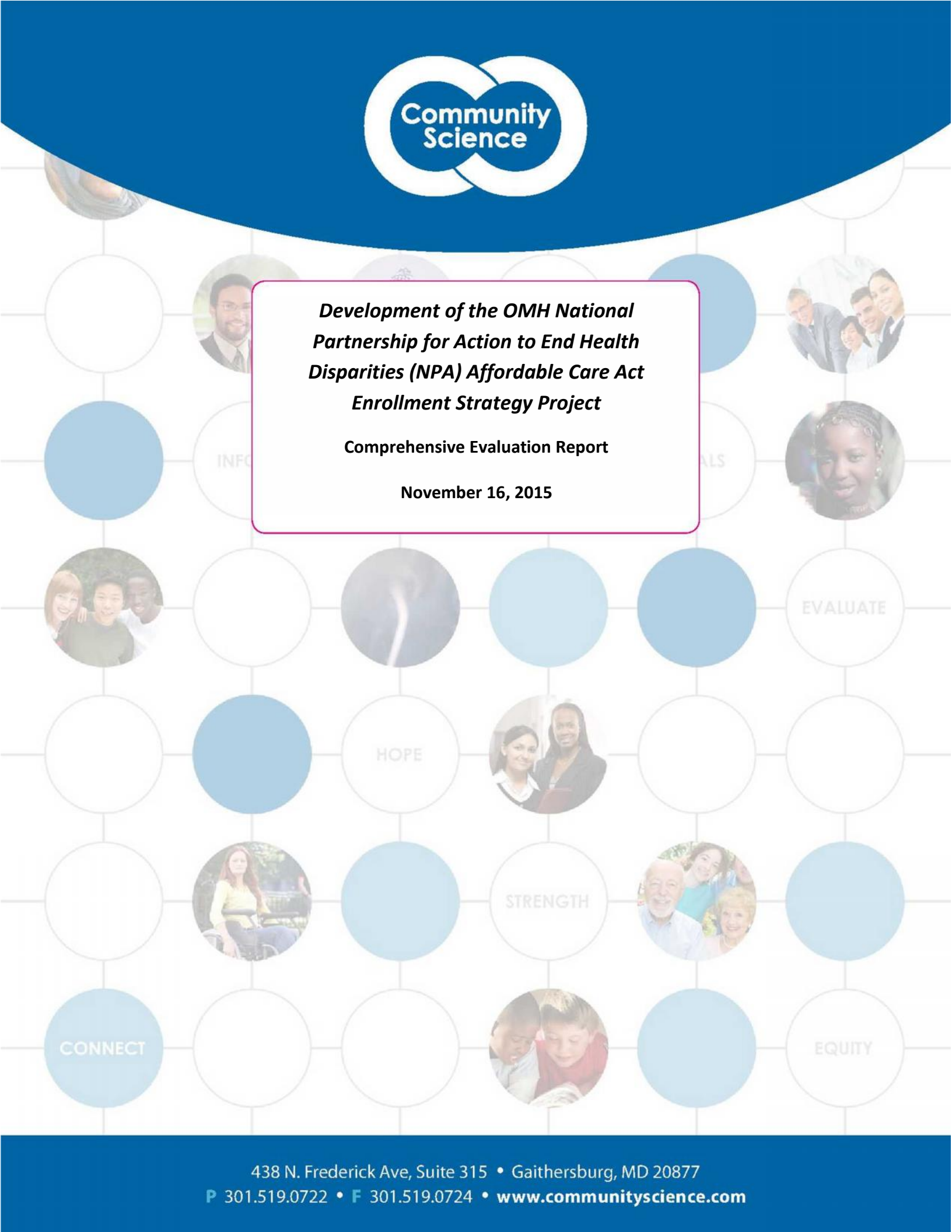

Development of the OMH National Partnership for Action to End Health Disparities (NPA) Affordable Care Act Enrollment Strategy Project

Comprehensive Evaluation Report

November 16, 2015

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Executive Summary

Introduction

The National Partnership for Action to End Health Disparities (NPA) is an initiative to increase the effectiveness of health equity efforts, led by U.S. Department of Health and Human Services Office of Minority Health (OMH). One of the top priorities of the NPA is to educate the uninsured and underinsured about how to enroll in health insurance and how to access preventive care available through the provisions of the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA). To advance the NPA's ACA agenda in 2014-15, Community Science developed and evaluated outreach and education strategies targeted at 5,000 to 10,000 uninsured and newly enrolled individuals from hard-to-reach racial and ethnic minority populations in the United States.

Evaluation Aims

Although community outreach is a core component of many interventions, evaluation efforts often fail to assess their effectiveness (Richard, Bell, Elwood, & Dayton-Shotts, 1996; Needle et al., 2005; Joly, Williamson, Bernard, Mittal, & Pratt, 2012; Whitney, Dutcher, & Keselman, 2013). Outreach is a key part of increasing awareness among potential service recipients, addressing barriers to access and ensuring uptake of service, particularly among marginalized populations (Richard et al., 1996; Needle et al., 2005; Whitney et al., 2013). Thus, assessing ACA outreach and education strategies for racial and ethnic minority and other underserved populations is critical in order to document and share lessons learned and inform future efforts to reduce health disparities. The overarching objective of the evaluation was to *document the effectiveness of ACA outreach and education strategies and identify those strategies that are effective in reaching specific vulnerable populations.*

Methodology

Procedures

To recruit partners to implement ACA outreach and education and data collection activities, the Evaluation Team conducted a search to identify national, regional, and local organizations in the identified target areas that serve vulnerable populations in need of ACA outreach and education. The Evaluation Team issued a *Solicitation for Partners,* which was distributed to the NPA's Regional Health Equity Councils (RHECs) and other organizations that, in turn, were asked to distribute the solicitation throughout their networks. The Evaluation Team received a total of 37 Letters of Interest from organizations, all of which were invited to submit a full application. Thereafter, 26 completed applications were received.

The Evaluation Team provided training and tailored technical assistance to all selected ACA Outreach Project partners (hereafter referred to as project partners) to ensure that high-quality data were collected from a large percentage of event participants. Past outreach evaluation studies had found that these organizations were in key locations to identify local public information needs, conduct outreach, and assess the outreach's effectiveness (Richard et al., 1996; Balcázar, Alvarado, Hollen, Yanira, & Pedregón, 2005**;** Balcázar et al., 2006). To effectively assess outreach, community partners also must be trained in data collection to collect quality data on outreach activities (Richard et al., 1996).

Measures

The Evaluation Team developed a set of measures and related data collection instruments to ensure that partner organizations collected quality participant- and event-level data during ACA pre-enrollment

and healthcare utilization outreach events. Data collection instruments included the Enrollment and Utilization Assessment Forms (see Appendix A), the Event Log, and the Enrollment and Utilization Interview Protocols (see Appendix B). Evaluation Team members translated both the enrollment and utilization outreach assessment instruments into Spanish. In addition, several partners translated the forms into other languages, including Hindi, Arabic, Korean, Khmer, and French Creole, and the Evaluation Team made them available to all partners. The following is a description of each of the core data collection tools and resources produced by the Evaluation Team:

- **Enrollment and Utilization Assessment Forms** were completed by event participants to assess knowledge gain using a retrospective pre-test approach (Nimon, Zigarmi, & Allen, 2011) relevant to the insurance enrollment provisions and requirements of the ACA and key topics in the From Coverage to Care[1] (health insurance utilization) framework. This instrument also assessed uptake (that is, intent to take action) to enroll or to utilize health care coverage. The instrument also included items on key demographics and sample characteristics including primary language(s) spoken, race/ethnicity, age, and technology literacy.
- **Event Logs** were used by partner(s) to track outreach event details, including outreach activity type (group presentation or individualized contacts); number of participants per outreach activity; number of assessment forms completed per outreach activity; number of interpreter contacts; and languages in which assistance was provided.
- **Enrollment and Utilization Interview Protocols** were administered by Evaluation Team members to select partners to document the challenges that participants experienced in accessing preventive healthcare or enrolling in health insurance as well as challenges and successes experienced by event organizers to implementing outreach efforts.

Analysis

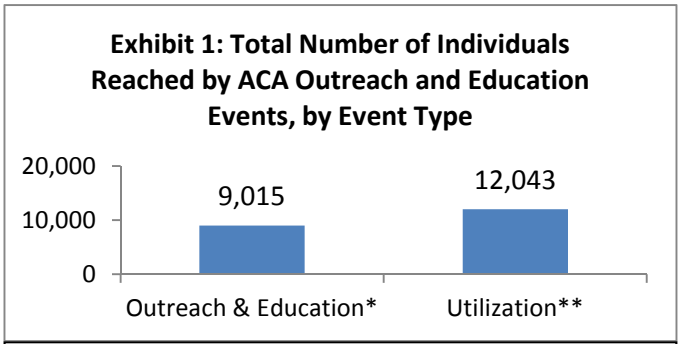
Partner organizations collected and entered participant-level data into a database designed using Qualtrics software. Partners recorded event-level data in an Event Log using formatted Excel spreadsheets. Updates to event-level data were completed regularly by partners. Participant-level data included unique survey identifiers to allow the Evaluation Team to link participant-level data with event-level data. The data were cleaned and merged to include the event-level data and the participant-level data in one database that was designed and managed using Stata 14, a data analysis software program.

In addition to the analysis of participant level data, the Evaluation Team completed a total of 11 semi-structured interviews (six using the *Enrollment Interview Instrument*, and five using the *Utilization Interview Instrument*) with key informants from the partner organizations. Key informants included community-based organization executive directors, university faculty, statewide navigators, faith-based leaders, and other staff from a variety of partner organizations. The objective of these interviews was to learn about the successes and challenges they experienced organizing and conducting ACA outreach and education events. Results from the interviews contribute to the overall findings and recommendations presented in the reports.

[1] Centers for Medicare and Medicaid Services, see resources at https://marketplace.cms.gov/technical-assistance-resources/c2c.html

Findings

Assessment of Reach and Engagement



Partner organizations reached a total of 21,058 individuals, more than double the target set at the onset of the project. Exhibit 1 shows that partner organizations reported that 9,015 individuals participated in enrollment-focused outreach events and 12,043 attendees participated in healthcare utilization-focused events. The combined total is more than double the target set by OMH to reach 5,000-10,000 individuals. The larger number was due, in part, to effective promotion of events within the communities of need, effective partnerships among community-based organizations, and higher-than-expected demand for healthcare utilization events.

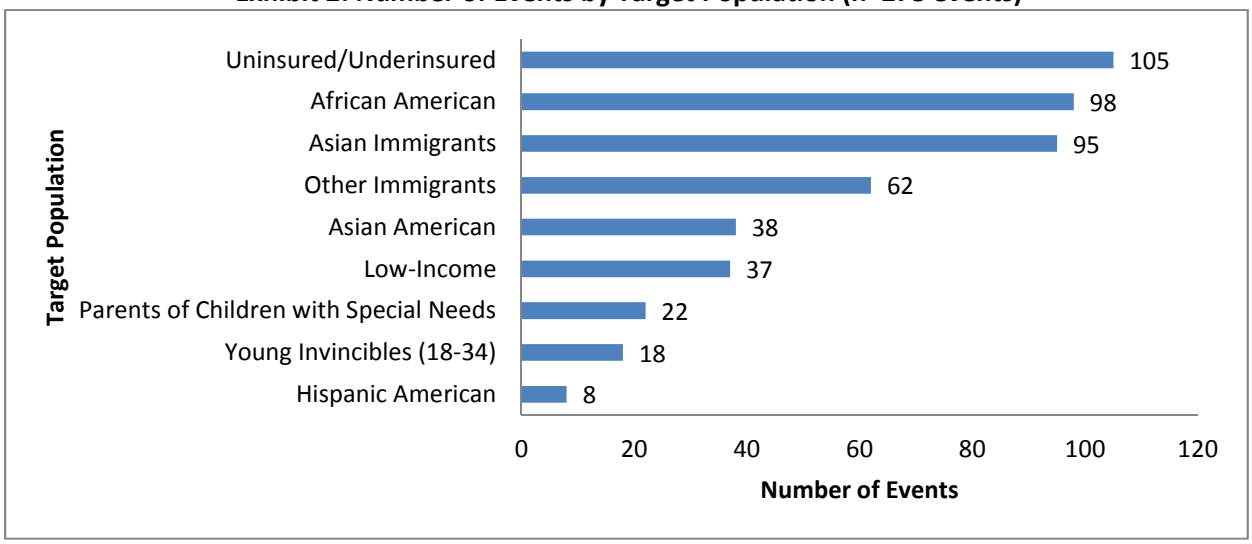
Partner organizations conducted ACA outreach and education events in 13 states – about a quarter of the country – and the District of Columbia. The total of 362 ACA outreach and education events took place in the following states: Alabama, California, Colorado, Georgia, Louisiana, Michigan, Missouri, New York, New Jersey, Maryland, Tennessee, Texas, Virginia, and Washington, DC. Of these 14 locations, a total of 10 were identified by the Evaluation Team as target areas of high priority for ACA outreach and education given their high number of uninsured populations, as well as the number of newly insured individuals.

The majority of individuals who participated in ACA events self-identified as belonging to a racial or ethnic minority group. The majority (86.3%, *n* = 6,271) of ACA event participants who completed an event assessment form self-identified as a member of a racial or ethnic minority group. In addition, respondents reported a wide diversity of primary languages spoken at home in addition to English. These included Spanish (15%, *n* = 993), Korean (5%, *n* = 330), Vietnamese (4.8%, *n* = 322), and Khmer (4.8%, *n* = 319). This demonstrates that the events reached the minority populations the event organizers targeted and that the organizers' event promotion efforts were successful. Efforts included running advertisements in ethnic newspapers, posting flyers in the target populations' language in places of worship, social service settings (e.g., community health centers), and recent-immigrant housing facilities.

About 1 in 4 event participants reported not having access to the Internet and just over 1 in 3 participants reported not being comfortable using technology. Overall, the majority of participants (74.2%, *n* = 5,509) had access to a computer and felt comfortable using it (65.1%, *n* = 4,826). Nevertheless, approximately one-quarter of participants reported not having access to the Internet (25.8%, *n* = 1,911), and one-third (34.9%, *n* = 2,585) reported not being computer literate or comfortable completing an online application. Further, older respondents tended to be less likely to report that they had access to the internet and were less likely to report that they were comfortable using computers and the internet when compared to younger respondents. This suggests that the ACA online enrollment process continues to be a serious barrier to many underserved populations. Designing enrollment events that have navigators and certified application counselors (CACs) should be a key strategy to enroll populations who remain uninsured.

Partner organizations succeeded in their plan to reach racial and ethnic minority populations that were uninsured or underinsured. Partners reported that 105 of their outreach and education events generally targeted uninsured or underinsured individuals (see Exhibit 2). Ninety-eight events targeted African Americans. Ninety-five events targeted Asian immigrants, and 62 events targeted other immigrant groups.

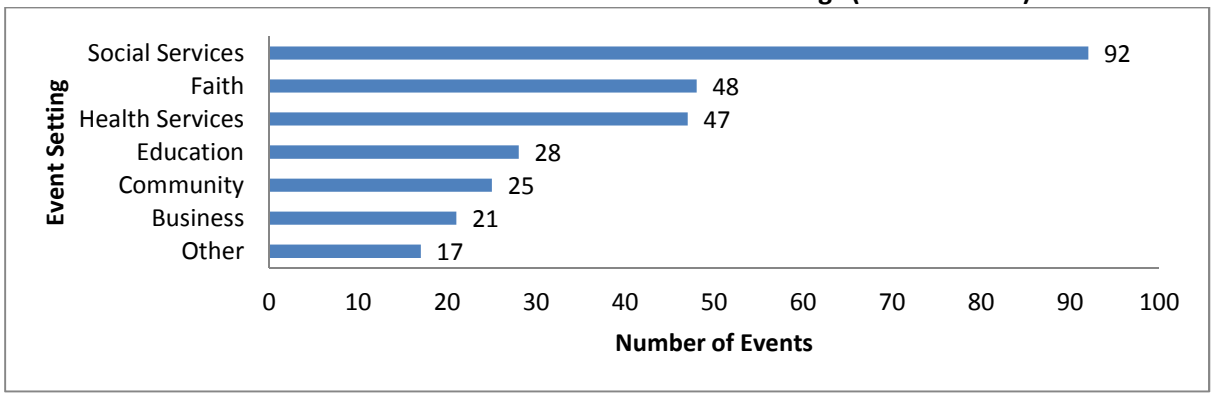
Exhibit 2: Number of Events by Target Population (n=278 events)



Notes: In addition to the events shown, five events targeted Whites; one event targeted the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community; and two events targeted refugees. Partners could select up to two target populations for a single event and therefore, the total number of events add up to more than 278.

Partner organizations hosted outreach and education events in a variety of settings, including human and social services organizations, places of worship, businesses, and various locations within communities. Exhibit 3 shows that about one third of events (92) were conducted in offices where social services are delivered, including family resource centers, immigrant services programs, and libraries; 13 partner organizations convened at least one event in such settings. Another common event setting was in faith-based locations (48) such as churches, temples, and faith-based conferences; 10 partner organizations convened events in these settings. Forty-seven events were hosted in health service settings such as health fairs, clinics, hospitals, and pharmacies; 9 partner organizations held events in those settings.

Exhibit 3: ACA Outreach and Education Event Settings (n=278 events)

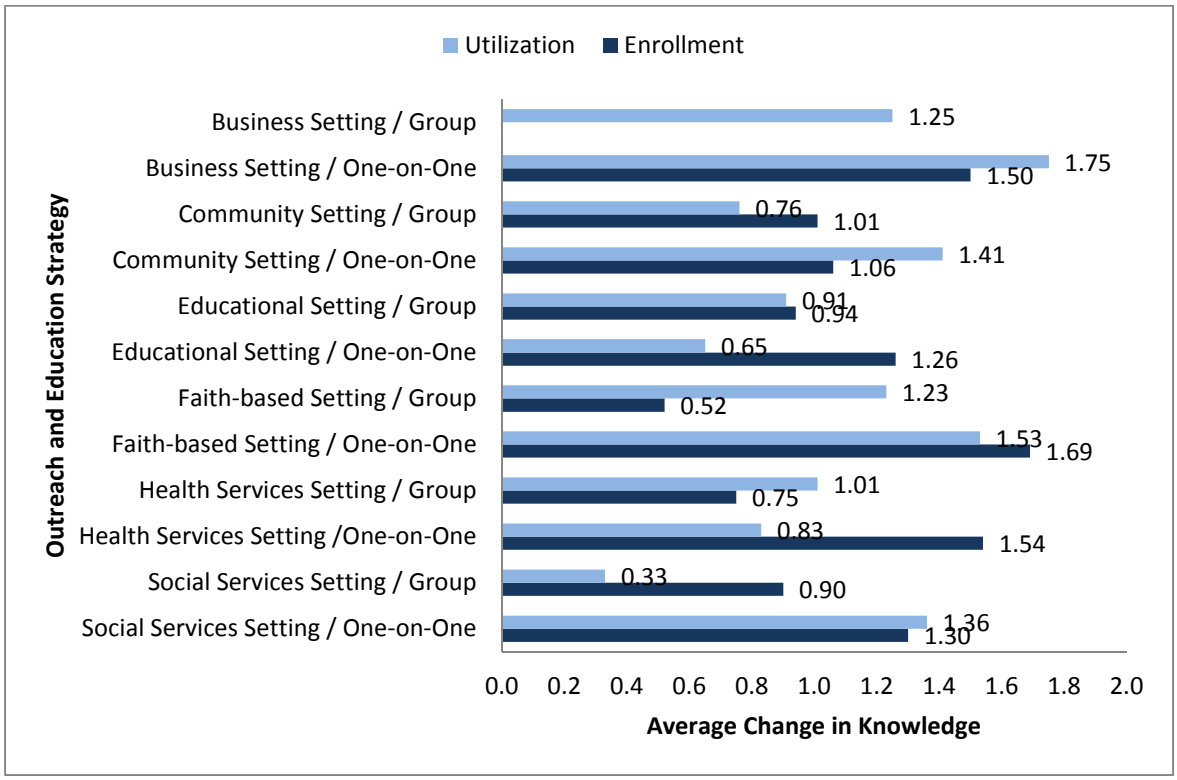


Note: A total of 84 events were excluded from the analysis due to data quality issues.

Assessment of the Effectiveness of Outreach and Education Strategies

This section discusses the overall effect that partner outreach and education strategies had on event participants' overall knowledge and their motivation to act. Outreach and education strategies were considered effective if they resulted in knowledge gains by those participating and if the information shared motivated them to act (for example, to enroll in or use their health insurance). An outreach and education strategy has two components: a *setting* and a *mode of delivery* of the information (one-on-one or one-to-many).[2] The Evaluation Team grouped events by setting and mode to construct and compare strategies. Exhibit 4 shows the knowledge-change scores for all 12 strategies. For enrollment strategies, the scores represent average percentage changes in knowledge about the ACA and its provisions, and for utilization strategies the scores represent change in knowledge of health insurance.

Exhibit 4: Average Change in Knowledge Before and After Event, by Outreach and Education Strategy



Note: Respondents were asked to indicate their perceived knowledge in eight areas related to health coverage enrollment before and after participating in enrollment focused outreach and education events using a scale ranging from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. Respondents were asked to indicate their perceived knowledge in nine areas related to health coverage utilization before and after participating in utilization focused outreach and education events using a scale ranging from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. The average change reflects a change in the mean scores, subtracting the average across all knowledge indicators before the event from the average across all knowledge indicators after the event.

[2] One-on-one information sharing included conducting intercepts in various locations, distributing information to individuals by setting up a booth or table in strategic locations such as outside of supermarkets, business offices, health centers, and community events. One-to-many sharing included delivering presentations to groups of individuals.

Individuals who participated in outreach and education events in faith-based and business settings and those who received information one-on-one both experienced larger gains in knowledge of the ACA and health insurance than those who attended events in other settings. Conducting outreach and education one-on-one in faith-based settings such as churches, mosques, and faith conferences was the strategy that resulted in the highest change in knowledge of the ACA (1.69)[3] and health insurance (1.54), as shown in Exhibit 4. Outreach and education delivered through individual contact with participants in local business settings such as grocery stores and barbershops was a strategy that resulted in the next highest amount of change in knowledge of the ACA (1.50) and health insurance (1.75).

Participants who received information in a group setting experienced smaller gains in knowledge of the ACA and health insurance compared to those that received information one-on-one. The results indicate that increases in knowledge for those who participated in group presentations was considerably lower than for those who received information one-on-one. Specifically, those who received information in a setting where social services were delivered experienced the smallest knowledge gains (0.33). Event organizers noted using the social services setting as a strategy to access a large number of their target population. However, upon further reflection, event organizers noted that these participants were too distracted and not primed to receive or retain information, since their primary reason for being present at the location was to access needed social services.

Participants who received group presentations in social service settings reported the highest likelihood of researching or considering health coverage options after participating in events that focused on enrollment in health coverage. Participants who received outreach and education through group presentations in social service settings such as family resource centers and immigration services agencies were most likely to report a moderate or high likelihood that they intended to gather more information about their health insurance policies or do more thinking about the coverage options that were appropriate for themselves or their families (100%, *n* = 26), rather than enrolling in health insurance (see Exhibit 5). This finding adds to the previous observation that individuals who are accessing social services are not primed to receive, retain, or act on information because they are preoccupied with receiving needed services. As such, events that take place in social service settings should consider employing a participant referral process that provides participants with contact information of local navigator organizations, or copies of frequently asked questions regarding enrollment.

[3] Number represents average change in knowledge before and after participating in the event.

Exhibit 5: Respondents' Intent to Take Action to Enroll in Health Insurance Post-Event, by Strategy

Outreach and Education Strategy	Plan to Enroll/change insurance		Gather more info/ Do more thinking	
	%	n	%	n
Faith-based Setting / One-on-One	96.7	29	93.8	30
Health Services Setting / Group	95.0	211	97.9	232
Educational Setting / Group	94.4	68	97.2	70
Health Services Setting /One-on-One	93.5	100	98.1	105
Educational Setting / One-on-One	91.2	177	87.9	197
Community Setting / Group	91.2	177	96.9	190
Social Services Setting / Group	88.0	22	100	26
Business Setting / One-on-One	87.7	50	98.4	60
Faith-based Setting / Group	85.1	561	91.5	761
Social Services Setting / One-on-One	84.6	478	97.1	503
Community Setting / One-on-One	83.0	576	96.4	587

Note: Business setting/group is omitted due to small sample sizes.

Participants in faith-based settings reported the highest likelihood of making an appointment with a navigator or health insurance representative or obtaining health insurance online or over the phone. Ninety-seven percent of participants (*n* = 29) that received outreach and education one-on-one in faith-based settings such as churches, mosques, and faith conferences were most likely to report a moderate or high likelihood that they intended to contact a navigator or other health insurance representative or enroll in health coverage online or over the phone (see Exhibit 5).

Participants who received group presentations that focused on the use of health coverage in faith-based settings were the most motivated to take action to use their health coverage. Exhibit 6 shows that participants who received outreach and education through group presentations in faith-based settings such as churches, mosques, and faith conferences were most likely to report a moderate or high likelihood that they intended to find out more about their coverage and costs of health insurance (100%, *n* = 91), find and choose a doctor or nurse who takes their insurance (98.9%, *n* = 86), or make an appointment with their regular doctor or nurse for medical care (98.8%, *n* = 82).

Exhibit 6: Respondents' Intent to Take Action to Utilize Insurance Post-Event, by Strategy

Outreach and Education Strategy	Find more info about coverage/costs		Find/choose doctor/nurse		Make an appointment with doctor/nurse		Plan to Enroll/change insurance	
	%	n	%	n	%	n	%	n
Faith-based Setting / Group	100	91	98.9	86	98.8	82	80.2	73
Social Services Setting / One-on-One	96.6	311	97.2	312	96.6	309	94.1	302
Health Services Setting / Group	96.5	879	94.5	848	95.8	862	77.2	692
Community Setting / One-on-One	95.5	491	94.0	482	94.5	485	86.4	443
Community Setting / Group	95.5	610	95.0	605	95.1	606	84.5	539
Social Services Setting / Group	95.3	224	94.5	222	98.7	235	84.6	198
Business Setting / One-on-One	94.1	80	94.0	79	90.6	77	84.5	71
Faith-based Setting / One-on-One	84.6	148	81.7	143	83.4	146	68.4	119
Educational Setting / Group	87.0	60	58.0	40	69.6	48	65.2	45
Health Services Setting / One-on-One	83.5	263	77.8	235	79.3	237	66.2	198
Educational Setting / One-on-One	60.7	148	55.6	135	63.4	154	42.8	104

Note: Business Setting / group is omitted due to small sample sizes.

Conclusions and Recommendations

The passage of the ACA in March 2010 marked an important change in the course of health care regulation and reform in the U.S. The primary objective of the law is to cut the uninsured rate in the nation and expand public and private insurance coverage options for all citizens. For the ACA to be successful and deliver on its promises of increased coverage, quality health care, and cost containment, there must be widespread adoption. This requires reaching out to the uninsured; including those who are young and healthy, as well as vulnerable populations that have limited or no access to healthcare.

As the nation moves on to the third open enrollment season and beyond, the pool of uninsured individuals will continue to decrease. This will make it increasingly difficult to identify and reach the remaining pockets of uninsured individuals around the country. Given the findings from the present evaluation, the outreach and education strategies that are likely to work are targeted, grassroots-based approaches that involve organizations that know their communities, their social support structures, and the needs of their members.

The process of identifying selected organizations—those from states with a high percentage of uninsured and newly insured individuals and that have a deep understanding of the needs of their target populations—and providing them with seed funding to kick-start or supplement their ACA outreach and education activities has proven successful in many respects. This grassroots approach to raising awareness about the ACA and training underserved populations in how to use their newly acquired health insurance policy produced significant increases in participants' knowledge of the ACA, motivated them to enroll or seek out more information in order to enroll, and increased participants' overall understanding of how to use their newly acquired insurance policy. In addition, organizations were able to reach a larger number of individuals than anticipated due to increases in demand for the information.

Below are key lessons learned and recommendations based on the data collected and analyzed by the Evaluation Team.

Awareness of the ACA and training in health insurance utilization continue to be needed in underserved communities. Although the percentage of people with health coverage has increased considerably over the last two years since the implementation of the ACA (Cohen & Martinez, 2015), event organizers noted that there remains a big need for increasing awareness of the ACA and delivering training and information on health insurance utilization to underserved communities—especially recent immigrants, Hispanics, and those who do not have experience navigating the U.S. healthcare system. Support for this claim can be seen in the data collected from healthcare utilization events, which showed that while 79% of participants reported visiting a nurse or doctor during their first year of being insured, only 66% reported accessing preventive care services, and only 62% accessed dental care services. Appendix E includes findings from healthcare and health insurance utilization events conducted by partner organizations.

Limited English proficiency (LEP), lack of trust, and limited health insurance literacy are the three most prominent barriers to enrollment in the ACA and utilization of health insurance. According to outreach and education event organizers, the three most prominent barriers to enrollment in the ACA and utilization of health insurance are LEP, lack of trust, and limited health insurance literacy (see Appendix C for a summary of findings from qualitative interviews with event staff). Effective outreach and education strategies need to be comprehensive and address all three barriers in order to be effective. The findings presented in this report offer strategies for organizing outreach and education events.

- ***Recruit and train multi-lingual navigators to attend enrollment events.*** Having multi-lingual navigators can address LEP, health literacy, and technology literacy barriers. However, to be effective, navigators must speak the target population's language. Events that only include English-speaking navigators and have interpreters available to assist participants with enrollment can result in extending an already long application process and potentially deter participants from completing the enrollment application.

- ***Structure comprehensive outreach and education events using multiple modes of delivery, including one-on-ones, group presentations, and distribution of hard-copy materials.*** One-on-one interaction is the mode of delivering ACA and health insurance literacy education that resulted in the highest increases in knowledge. Although group presentations are a cost-effective method for reaching many individuals, the one-on-one approach seems to be more effective. To minimize costs, event organizers need to leverage their funds by partnering with organizations within the community that are trusted by the target population.

- ***Identify trusted, faith-based gatekeepers to participate in outreach and education events.*** Evaluation findings suggest that the settings that led to the greatest increases in the intent to act (for example, to enroll or use health insurance) were faith-based locations. Event organizers noted that the greatest barrier to enrollment in underserved communities is lack of trust. As such, the lesson noted was, "If I trust, I will do." In essence, people are more open to receiving information and are more likely to act on the information being shared when they participate in events that are (1) hosted in trusted locations and (2) endorsed by trusted individuals, such as faith leaders. As such, gatekeepers (e.g., ministers and other religious leaders) should not only be asked for permission to have access to a target group or community (e.g., a congregation), but to actively participate in the event by leading a discussion or delivering a key message.

- ***Encourage outreach and education events in faith-based settings that include a one-on-one exchange of information.*** The findings suggest that outreach and education delivered through *individual contact* with participants in faith-based settings such as churches, mosques, and faith conferences, was among the strategies that resulted in the highest levels of knowledge gain on the ACA. Similarly, participants who received information through individual contact in faith-based settings reported the highest likelihood of making an appointment with a navigator or health insurance representative or obtaining health insurance online or over the phone. As such, events conducted in faith-based settings should not only focus on delivering a presentation but also build in time to exchange information on a personal level. This strategy includes recruiting faith leaders or respected members of the faith community to serve as gatekeepers and have them assist with one-on-one interaction with event participants.

- ***Consider using immigration lawyers as gatekeepers in communities with high concentrations of recent immigrants.*** Having a good understanding of underserved populations and the communities in which they reside is a key strategy for organizing and conducting effective ACA outreach and education. Event organizers observed that in underserved communities there exists trust between professionals who provide legal services to recent immigrants, specifically immigration lawyers. Using professionals who provide legal services within communities proved to be a successful outreach strategy. This strategy addressed events that were targeted for Hispanic/Latino participants as well as recent Asian immigrants. A strategy for recruiting professionals is to offer co-sponsorship of the events, which could help promote their services within the community.

- ***Design outreach and education events tailored specifically for males and couples.*** Female participants in outreach and education events outnumbered males by half. Only 36.6 percent of participants were male. Future outreach strategies should focus their efforts on reaching males. Event organizers noted that women who started the application process were at times challenged by questions that pertained to information that their male spouse or partner might have. Therefore, event organizers felt that it was important to consider strategies to encourage couples to participate in events together and to increase the participation of men.

1. Introduction

The National Partnership for Action to End Health Disparities is an initiative to increase the effectiveness of health equity efforts, led by U.S. Department of Health and Human Services Office of Minority Health (OMH). One of the top priorities of the NPA is to educate the uninsured and underinsured about how to enroll in health insurance and how to access preventive care available through the provisions of the Affordable Care Act (ACA).

To advance the NPA's ACA agenda in 2014-15, Community Science developed and evaluated outreach and education strategies targeted at 5,000 to 10,000 uninsured and newly enrolled individuals from hard-to-reach racial and ethnic minority populations in the United States. The purpose of the project was twofold: (1) to document the reach and impact of ACA outreach and education strategies for racial and ethnic minority and other underserved populations that are uninsured and newly insured; and (2) to evaluate effective ACA outreach and education strategies. This deliverable, entitled *Comprehensive Evaluation Report,* represents Deliverable 10 in the project work plan.

2. Evaluation Aims

Although community outreach is a core component of many interventions, evaluation efforts often fail to assess their effectiveness (Richard, Bell, Elwood, & Dayton-Shotts, 1996; Needle et al., 2005; Joly, Williamson, Bernard, Mittal, & Pratt, 2012; Whitney, Dutcher, & Keselman, 2013). Outreach is a key part of increasing awareness among potential service recipients, addressing barriers to access and ensuring uptake of service, particularly among marginalized populations (Richard et al., 1996; Needle et al., 2005; Whitney et al., 2013). Thus, assessing ACA outreach and education strategies for racial and ethnic minority and other underserved populations is critical in order to document and share lessons learned and inform future efforts to reduce health disparities. The overarching objective of the evaluation was to *document the effectiveness of ACA outreach and education strategies and identify those strategies that are effective in reaching specific vulnerable populations.*

To accomplish this objective, community partner organizations collected data from individuals who participated in pre-enrollment and healthcare-utilization events designed to reach specific target populations. Analyses of individual-level data were used both to determine whether the outreach and education events reached the target population(s) and to identify how effective they were. For example, the analyses sought to identify whether the events resulted in participants' increased knowledge about the ACA and being more likely to take action and enroll in or access health services. Our Evaluation Team operationally defined outreach and education strategies as "effective" by measuring four key constructs: (1) event or intervention reach; (2) engagement of hard-to-reach communities; (3) increase in knowledge; and (4) uptake of information (that is, intent to enroll in or access health services).

The Evaluation Team chose to measure these constructs based on the Kirkpatrick "Four Levels of Evaluation" approach, which can be used to guide assessment of many forms of learning and training (Kirkpatrick, 1994). This approach focuses on (1) participants' reactions to the learning process, materials, instructor, and venue; (2) increases in knowledge and skills; (3) applications of learning that translate into behavior change; and (4) impacts of learning on broader goals or objectives. The evaluation predominately focused on the learning and behavior components of the Kirkpatrick approach. Specifically, for pre-enrollment events, the evaluation captured knowledge gains among

participants on topics such as health benefits/services available under the ACA, types of policies available on the marketplace, and tax credits and other programs that make insurance more affordable. For events focusing on preventive healthcare utilization, the evaluation assessed participants' knowledge gains in coverage-to-care topics such as selecting a primary care provider, making an appointment, and preparing for a visit with a healthcare provider.

Although the evaluation did not capture behavior change among participants directly, data relevant to behavior change were collected through questions inquiring about participants' intent to take specific next steps to address their healthcare needs. For pre-enrollment events, key steps in the enrollment process included gathering more information about health insurance policies and making an appointment with a navigator or health insurance agent. For preventive healthcare utilization events, key next steps were learning more about coverage and the costs of health insurance, identifying an "in-network" provider, and making an appointment for preventive care.

The evaluation addresses four primary and 12 secondary questions related to pre-enrollment and preventive healthcare utilization outreach strategies with a focus on four domains related to **reach**, **engagement** (through culturally and linguistically appropriate services), **knowledge gains**, and **intent to take action**. Exhibit 1 includes the primary and secondary evaluation questions addressed and the instruments used to answer the questions.

Exhibit 1: Summary of Evaluation Questions and Data Sources

Primary/Secondary Evaluation Questions	Data Sources: Participant Form	Event Log	Interview
1. To what extent did outreach events ***reach*** the targeted communities?			
a. What were the number and characteristics of *participants* reached?	X	X	
i. How many participants were reached through ACA outreach strategies overall, and within each type of outreach (pre-enrollment and preventive healthcare utilization)?		X	
ii. What were the demographic characteristics of event participants, in terms of age, gender, race and ethnicity, primary language(s) spoken, and insurance status?	X		
b. What were the number and characteristics of *outreach events* held?		X	
i. How many events were held overall, by targeted racial and ethnic group, and within each type of outreach (pre-enrollment and preventive healthcare utilization)?		X	
ii. What were the most prevalent *contexts and modes of outreach publicity and delivery,* overall, by targeted racial and ethnic group, and within each type of outreach (pre-enrollment and preventive healthcare utilization)?		X	
iii. What were the primary challenges that outreach organizers faced in reaching vulnerable populations, within each type of outreach (pre-enrollment and preventive healthcare utilization)?			X
2. To what extent did outreach events ***engage*** hard-to-reach populations through culturally and linguistically appropriate services (CLAS)?			
a. What language assistance services were provided (interpretation, translation, other)?	X	X	X
i. In what languages were language assistance services provided?		X	X
ii. Did participants report being aware of the availability of language assistance services?	X		
iii. Did participants report utilizing language assistance services?	X		
b. How were outreach strategies (including event publicity) culturally adapted to meet the needs of target populations?		X	X
3. Which outreach events were associated with participant ***knowledge gains***?			
a. Which pre-enrollment outreach event characteristics were associated with higher knowledge gain scores among participants?	X	X	
b. Which preventive healthcare utilization outreach event characteristics were associated with higher knowledge gain scores among participants?	X	X	
4. Which outreach events were associated with higher participant report of ***intent to take action***?			
a. Which pre-enrollment outreach events were associated with higher participant report of intent to take action *to enroll in healthcare coverage*?	X	X	
i. What were the primary challenges to enrollment experienced by participants, as reported by outreach staff?			X
b. Which preventive healthcare utilization events were associated with higher participant report of intent to take action *to access preventive healthcare*?	X	X	
i. What were the primary challenges to accessing preventive healthcare experienced by participants, as reported by outreach staff?			X

3. Methodology

Procedure

To identify target areas of high priority for ACA outreach and education activities, the Evaluation Team analyzed current state levels based on five indicators of need for ACA pre-enrollment and healthcare utilization outreach: (1) marketplace type, (2) number of newly enrolled, (3) number of potential enrollees, (4) Medicaid expansion status, and (5) minority uninsured rate. Sources of data used to characterize states by each of the five indicators included the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Kaiser Commission on Medicaid and the Uninsured, and The Henry J. Kaiser Family Foundation (KFF). As a result, the following 19 states were prioritized as target areas: Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Michigan, Missouri, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Tennessee, Texas, Virginia, and Washington.

To recruit partners to implement ACA outreach and education and data collection activities, the Evaluation Team conducted a search to identify national, regional, and local organizations in the identified target areas that serve vulnerable populations in need of ACA outreach and education. The Evaluation Team issued a *Solicitation for Partners,* which was distributed to the NPA's Regional Health Equity Councils and other organizations that, in turn, were asked to distribute the solicitation throughout their networks. The Evaluation Team received a total of 37 Letters of Interest from organizations, all of which were invited to submit a full application. Thereafter, 26 completed applications were received.

The applications were scored based on the extent to which they: (1) described and documented the need for outreach and education for the target population, (2) documented how the applicant organization and its partners would reached the target population(s), (3) illustrated the applicant's experience conducting ACA outreach and education, (4) showed organizational capacity to collect data from the target population, (5) described a feasible plan to provide language access to limited English-proficient individuals, and (6) offered a reasonable budget based on the number of participants to be reached and leveraging of funds from other sources. Embedded in the analysis of applications across many of these criteria was an emphasis on the applicant organization's deep knowledge of, connection to, and credibility with the targeted population for the outreach. The Evaluation Team assessed applicant strategies looking for approaches that emphasized "meeting [target population(s)] where they are," for example by locating outreach in places frequented by the target population, including bodegas, Asian supermarkets, local libraries, Hindu temples, AME churches, and barbershops. By tapping into these assets within the social organization of hard-to-reach communities of priority to OMH, the goal was to promote greater equity in access to and awareness of the provisions of the ACA and information relevant to utilization. The search process resulted in the selection of 15 partner organizations, each of which signed a Memorandum of Agreement to implement outreach, education, and data collection activities for this project.

The Evaluation Team provided training and tailored technical assistance to all selected ACA Outreach Project partners (hereafter referred to as project partners) to ensure that high-quality data were collected from a large percentage of event participants. Past outreach evaluation studies had found that these organizations were in key locations to identify local public information needs, conduct outreach, and assess the outreach's effectiveness (Richard et al., 1996; Balcázar, Alvarado, Hollen, Yanira, & Pedregón, 2005**;** Balcázar et al., 2006). To effectively assess outreach, community partners also must be trained in data collection to collect quality data on outreach activities (Richard et al., 1996). The tools

and training resources that the Evaluation Team developed to provide training and technical assistance to project partners included the following:

- **Data Collection and Entry Training Presentation:** Detailed information on the protocol and resources; how to handle specific frequently asked questions (FAQs) from participants during data collection; and steps for ensuring accurate data entry;
- **Survey Administration Protocol**: Steps to follow before, during, and after each outreach event for administering surveys, including evaluation tools and materials to bring to each outreach activity and how to handle data to ensure security, anonymity, and confidentiality;
- **Event Log Protocol:** Description of the log and standard procedures to ensure that log information is collected consistently and accurately across events;
- **Recruitment Script:** Script for requesting participants' response to the assessment, explaining the purpose of the assessment, and steps for completing the form; and
- **Participant Database:** A database shell, which includes a quality assurance protocol, used by organizations to enter individual-level data.

Measures

The Evaluation Team developed measures to ensure quality participant- and event-level data collection following ACA pre-enrollment and healthcare utilization outreach events. Data collection instruments included the Enrollment and Utilization Assessment Forms (see Appendix A), the Event Log, and the Enrollment and Utilization Interview Protocols (see Appendix B). Evaluation Team members translated both the enrollment and utilization outreach assessment instruments into Spanish. In addition, several partners translated the forms into other languages, including Hindi, Arabic, Korean and Khmer, and French Creole, and the Evaluation Team made them available to all partners.

The following is a description of each of the core data collection tools and resources:

- **Enrollment and Utilization Assessment Forms** were completed by event participants to assess knowledge gain using a retrospective pre-test approach (Nimon, Zigarmi, & Allen, 2011) relevant to the insurance enrollment provisions and requirements of the ACA and key topics in the From Coverage to Care[4] (health insurance utilization) framework. This instrument also assessed uptake (that is, intent to take action) to enroll or to utilize health care coverage. The instrument also included items on key demographics and sample characteristics including primary language(s) spoken, race/ethnicity, age, and technology literacy.
- **Event Logs** were completed by partner(s) following each event to document outreach event focus (pre-enrollment or healthcare utilization); outreach activity type (group presentation or individualized contacts); number of participants per outreach activity; number of assessment forms completed per outreach activity; number of interpreter contacts; languages in which assistance was provided; number of on-site ACA enrollments; number of on-site navigators; number of client contacts by navigators; number of appointments scheduled with navigators at the event; targeted racial and ethnic communities; language assistance services provided; mode of outreach event publicity; cultural adaptations to content; and challenges faced in reaching targeted community.

[4] Centers for Medicare and Medicaid Services, see resources at https://marketplace.cms.gov/technical-assistance-resources/c2c.html

- **Enrollment and Utilization Interview Protocols** were administered by Evaluation Team members to select partners in order to document the challenges that participants experienced in accessing preventive healthcare or enrolling in health insurance as well as challenges experienced by event organizers to implementing outreach and key contributors to their successful efforts (see Appendix B).

Analysis

Project partners entered participant-level data into a database which was designed using Qualtrics software. Event-level data were entered by partners directly in the Event Log, a formatted Excel spreadsheet with locked dropdown menu options and formulas. Updates to event-level data were completed regularly by partners. Participant-level data included unique survey identifiers to allow the Evaluation Team to link participant-level data with event-level data. Following receipt of data collected from outreach participants by project partners, the data were cleaned and merged to include the event-level data and the participant-level data in one database, managed within Stata 14 software. In their Event Logs, project partner organizations reported collecting 8,943 event assessment forms out of a total of 19,677 attendees, a response rate of 45.4%. These figures exclude data from one partner due to data quality concerns.

Reach and Engagement

The Evaluation Team generated descriptive statistics (frequencies, measures of central tendency, and standard deviation) to determine the distribution of values and address questions related to reach at the event and participant levels.

Knowledge Gain and Intent to Enroll

At the participant-level, the Evaluation Team conducted non-parametric statistical analysis (Wilcoxon signed-rank test) on retrospective pre- and post-event knowledge scores to determine whether differences were significant overall, by outreach objective, and within targeted racial and ethnic groups. The Evaluation Team conducted descriptive statistics to examine participants' likelihood of taking specific actions after the event to enroll in or use health coverage. To examine which outreach strategies were associated with participant knowledge gains and intent to take action, the Evaluation Team stratified partners' events by the event setting (for example, whether it was a faith-based location such as a church versus a social service agency), the mode of outreach (one-on-one outreach or group presentation with question and answer), and the objective of the outreach (enrollment or utilization). The Evaluation Team then used descriptive statistics (frequencies, means, and standard deviations) to examine which strategies were associated with (1) the greatest increases in knowledge regarding healthcare utilization and enrollment and (2) the highest levels of participant likelihood of taking specific actions after the event to enroll in or use health coverage.

Key Informant Interviews

In order to add context and richness to the participant-level data, the Evaluation Team completed 11 in-depth, semi-structured interviews (six using the *Enrollment Interview Instrument*, and five using the *Utilization Interview Instrument*) with outreach event hosts, event planners, champions of coverage, and navigators to query them about barriers and challenges to conducting successful outreach events and enrolling eligible, uninsured participants, and about events focused on utilization of health insurance. Appendix C includes a summary of the findings from the interviews. Results from the interviews were incorporated into the overall findings and recommendations presented in the report.

Limitations

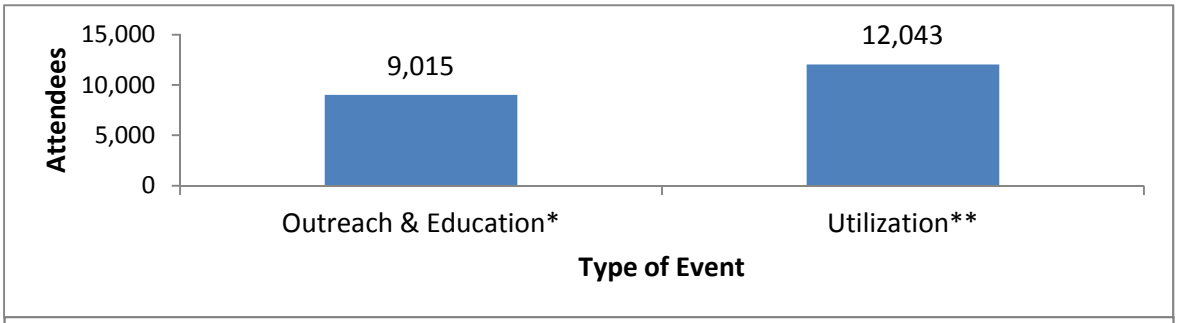
The design of this evaluation was based on a convenience sampling approach and did not include randomization of the outreach exposure or other survey design features that could support generalizability beyond the participants in the reported outreach activities. Further, the study asked respondents to rate their perceived knowledge on topics related to health coverage enrollment and utilization but did not assess their actual knowledge of these topics. Immediately after participating in outreach and education events, respondents were asked to rate the likelihood of their taking action to enroll in or use health coverage. In the absence of a post-event follow-up, however, we could not confirm whether respondents actually took action to enroll in or use health coverage.

4. Findings

Partner organizations' outreach events were designed to deliver accurate information about the ACA to a specific difficult-to-reach population or community, raise awareness about health insurance benefits under the ACA to eligible persons, and create a network of community champions to serve as resource persons for the ACA. The ultimate aim of these events was to promote enrollment among uninsured and eligible racial and ethnic minority communities during the enrollment period as well as the use of health coverage. The following subsections present the results of the outreach and education efforts. Specifically, this section answers evaluation questions 1 and 2: "To what extent did outreach events reach the targeted communities?" and "To what extent did the events reach the targeted population groups?"

Partner organizations reached a total of 21,058 individuals, more than double the target set at the onset of the project. Exhibit 2 shows that partner organizations reported that 9,015 individuals participated in enrollment-focused outreach events and 12,043 attendees participated in healthcare utilization-focused events. This combined total is more than double the target set by OMH to reach 5,000-10,000 individuals. This was due, in part, to effective promotion of events within the communities of need, effective partnerships between community-based organizations, and higher-than-expected demand for healthcare utilization events. Specifically, demand far surpassed the participation partner organizations expectations. For instance, in California, an organization that serves recent immigrants from Cambodia doubled the number of its enrollment events based on the increased demand generated by initial advertising of the events. Also, in Georgia, the partner organization that serves mostly African Americans tripled the number of events it had originally planned given the increased demand for utilization events.

Exhibit 2: Total Number of Individuals Reached by ACA Outreach and Education Events, by Event Type

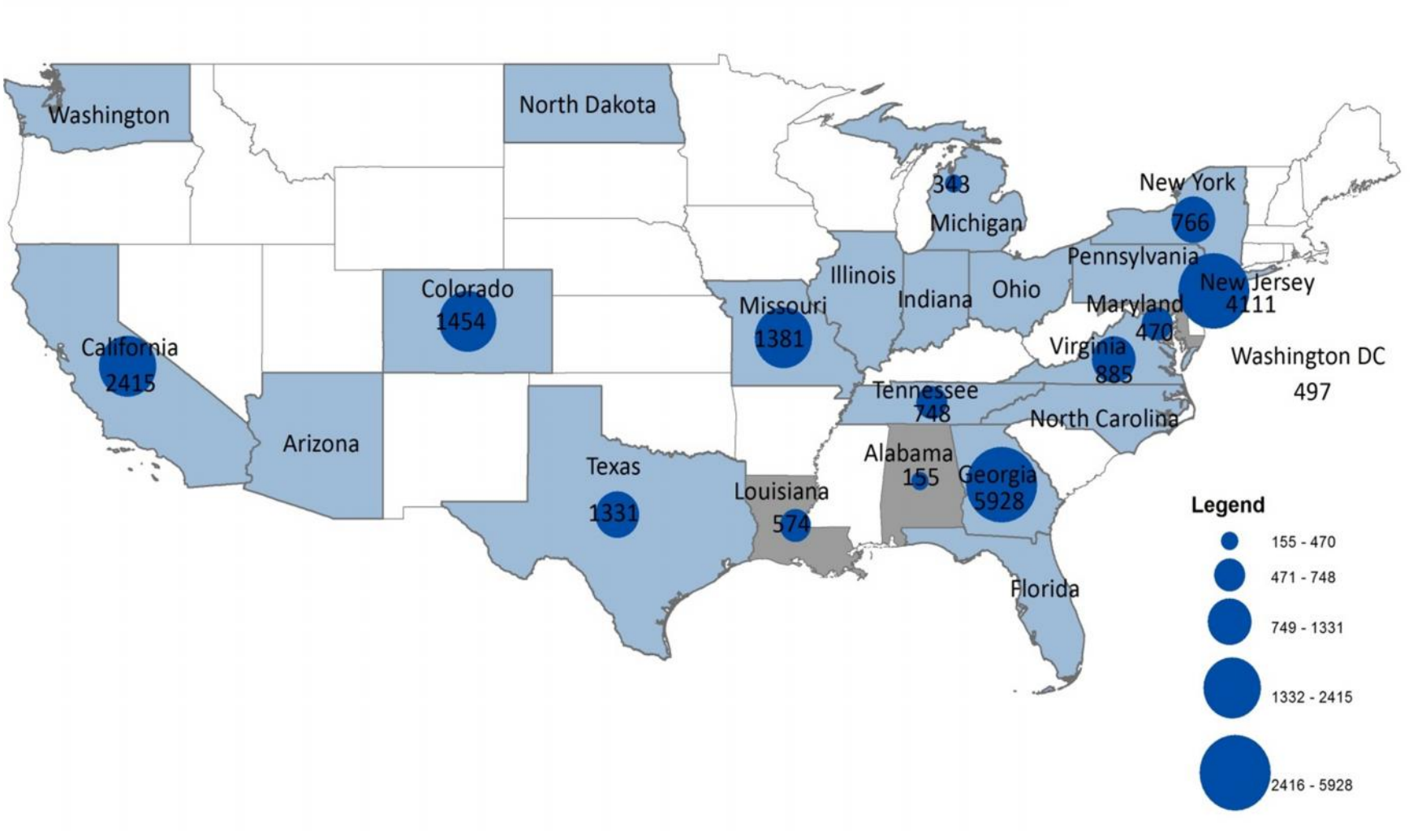


*Events focused on enrollment
**Events focused on healthcare utilization

Partner organizations conducted ACA outreach and education events in 13 states – about a quarter of the country – and the District of Columbia. Exhibit 3 shows the location of the 362 ACA outreach and education events that took place in the following states: Alabama, California, Colorado, Georgia, Louisiana, Michigan, Missouri, New York, New Jersey, Maryland, Tennessee, Texas, Virginia, and Washington, DC. Of these 14 locations, a total of 10 were identified by the Evaluation Team as target areas of high priority for ACA outreach and education activities (high-need states are shaded in blue in Exhibit 3).[5] Events were also conducted in three states and Washington, DC (shaded in gray) that were not included in the original list of target areas. These locations were selected based on partner organizations' documentation showing high need within specific communities. A total of nine states identified as high-need did not host events and should be considered for future funding, specifically Arizona, Florida, Illinois, Indiana, North Carolina, North Dakota, Ohio, Pennsylvania, and Washington.

[5] High-need states were selected based on five factors: (1) marketplace type, (2) percentage of newly enrolled, (3) potential enrollees, (4) Medicaid expansion status, and (5) minority uninsured rate.

Exhibit 3: Location of ACA Outreach and Education Events and Number of Attendees (n=21,058)



The majority of individuals who participated in ACA events self-identified as belonging to a racial or ethnic minority group. Exhibit 4 shows that the majority (86.3%, *n* = 6,271) of ACA event participants who completed an event assessment form self-identified as a member of a racial or ethnic minority group. In addition, respondents reported a wide diversity of primary languages spoken at home in addition to English. These included Spanish (15%, *n* = 993), Korean (5%, *n* = 330), Vietnamese (4.8%, *n* = 322), and Khmer (4.8%, *n* = 319). This suggests that the events reached the minority populations the event organizers targeted and that the organizers' event promotion efforts were successful. Efforts included running advertisements in ethnic newspapers, posting flyers in the target populations' language in places of worship, social service settings (e.g., community health centers), and recent-immigrant housing facilities.

About 1 in 4 event participants reported not having access to the Internet and just over 1 in 3 participants reported not being comfortable using technology. Overall, the majority of participants (74.2%, *n* = 5,509) had access to a computer and felt comfortable using it (65.1%, *n* = 4,826). Nevertheless, approximately one-quarter of participants reported not having access to the Internet (25.8%, *n* = 1,911), and one-third (34.9%, *n* = 2,585) reported not being computer literate or comfortable completing an online application. Further, older respondents tended to be less likely to report that they had access to the internet and were less likely to report that they were comfortable using computers and the internet when compared to younger respondents (Exhibit 5). The data indicate a trend in age that the older a person is, the less likely they are to comfortably access the internet. This shows that the ACA online enrollment process continues to be a serious barrier to many underserved populations. Designing enrollment events that have navigators and certified application counselors (CACs) should be a key strategy to enroll populations who remain uninsured.

Exhibit 4: Characteristics of ACA Outreach Event Participants (N=8,943)*

Characteristics	Number	Percent
Age group		
18-34	2,431	33.3
35-44	1,840	25.2
45-54	1,517	20.8
55-64	1,125	15.4
65+	379	5.2
Total	7,292	100.0
Gender		
Female	4,385	63.4
Male	2,534	36.6
Total	6,919	100.0
Race/ethnicity		
Black/African American	2,674	36.8
Asian	1,914	26.3
Hispanic/Latino	1,626	22.4
White/Caucasian	842	11.6
Other**	151	2.1
American Indian/Alaska Native	41	0.6
Native Hawaiian/Pacific Islander	16	0.2
Total	7,264	100.0
Language		
English Only	3,658	55.1
Spanish	993	15.0
Korean	330	5.0
Vietnamese	322	4.8
Khmer	319	4.8
Other***	1019	15.3
Total	6,641	100.0
Technology		
Has access to the Internet	5,509	74.2
Comfortable computers/Internet	4,826	65.1

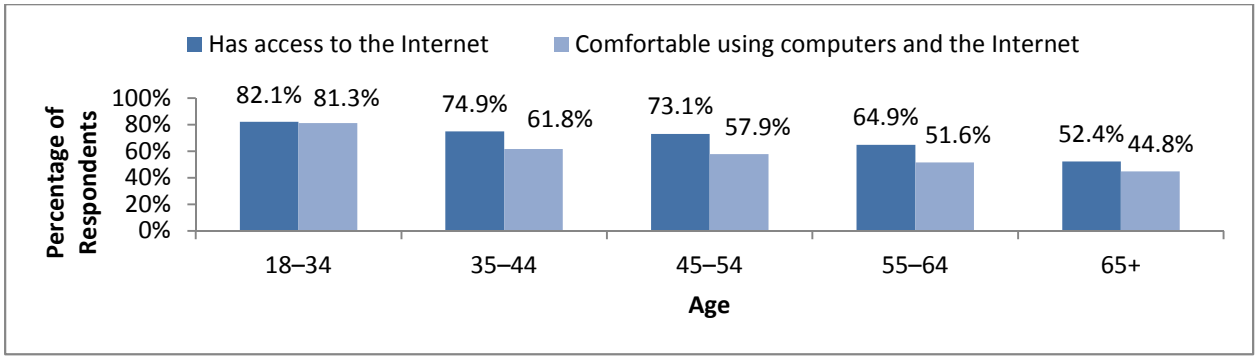
*Overall response rate is 45.4%

**151 participants self-identified as "other" race and ethnicity.

***1,019 participants reported speaking 37 other languages at home, English and another language, or multiple non-English languages.

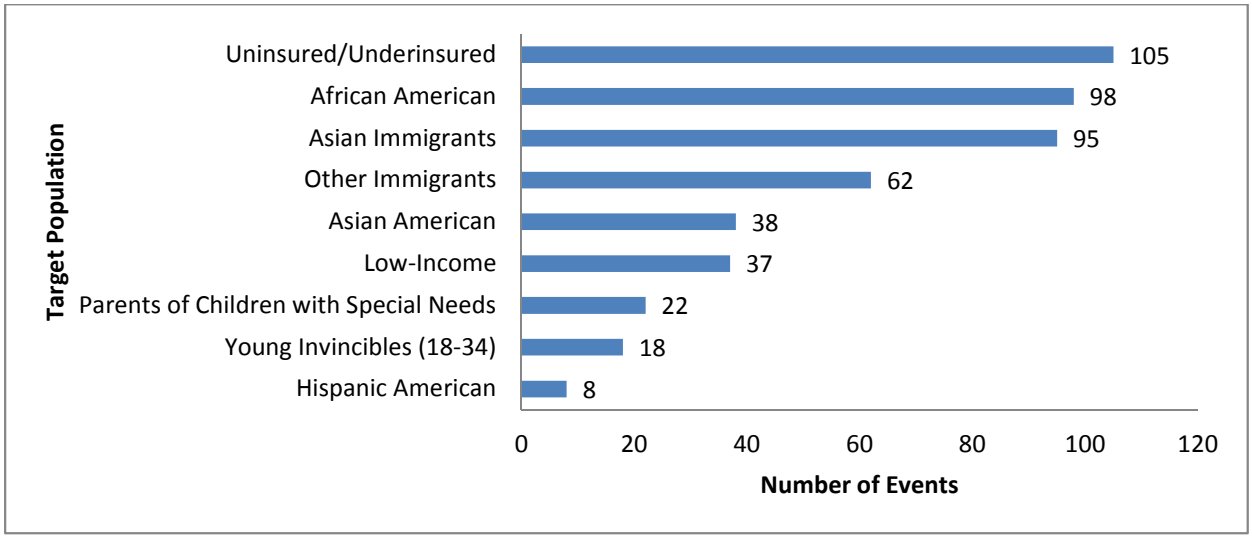
Notes: Data from three organizations are not included in the final counts due to data quality concerns.

Exhibit 5: Access to the Internet and Comfort Using Computers and the Internet, by Age



Partner organizations succeeded in their plan to reach racial and ethnic minority populations that were uninsured or underinsured. Partners reported that 105 of their outreach and education events generally targeted uninsured or underinsured individuals (see Exhibit 6). Ninety-eight events targeted African Americans. Ninety-five events targeted Asian immigrants, and 62 events targeted other immigrant groups.

Exhibit 6: Total Number of Events, by Target Population (n=278 events)

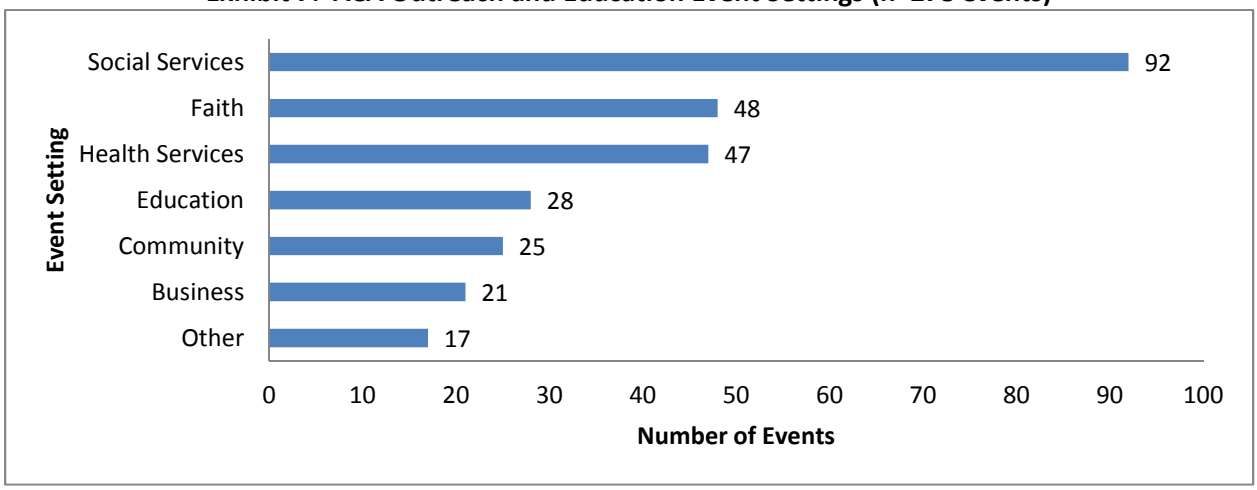


Notes: In addition to the events shown in this graph, five events targeted Whites, one event targeted the LGBTQ community, and two events targeted refugees. Partners could select up to two target populations for a single event and therefore the total number of events will sum to more than 278. A total of 84 events were excluded from the analysis due to data quality issues.

Partner organizations hosted outreach and education events in a variety of settings, including human and social services organizations, places of worship, businesses, and various locations within communities. Exhibit 7 shows that about one-third of events (92) were conducted in social service settings, including family resource centers, immigrant services programs, and libraries; 13 partners

convened at least one event in such settings. Another common event setting was in faith-based locations (48) such as churches, temples, and faith-based gatherings; 10 partner organizations convened events in these settings. Forty-seven events were hosted in health service settings such as health fairs, clinics, hospitals, and pharmacies; 9 partner organizations held events in such settings.

Exhibit 7: ACA Outreach and Education Event Settings (n=278 events)



Note: A total of 84 events were excluded from the analysis due to data quality issues.

Assessment of the Effectiveness of Outreach and Education Strategies

This section discusses the overall effect that partner outreach and education strategies had on event participants' overall knowledge and their motivation to act. The findings answer evaluation questions 3 and 4: "Which outreach strategies were associated with participant knowledge gain?" and "Which strategies led to higher proportions of individuals indicating their intent to either enroll in health insurance or access or use their new health insurance policy?"

Outreach and education strategies were considered "effective" if they resulted in knowledge gains by those participating and if the information shared motivated these people to act (for example, to enroll in or use their health insurance). An outreach and education strategy has two components: a *setting* and a *mode of delivery* of the information (one-on-one or one-to-many).[6] The Evaluation Team grouped events by setting and mode to construct and compare strategies. Exhibit 7 shows the knowledge-change scores for all 12 strategies. For enrollment strategies, the scores represent average percentage changes in knowledge about the ACA and its provisions, and for utilization strategies the scores represent change in knowledge of health insurance. Appendix D outlines the procedure followed by the Evaluation Team to compute change scores and provides a summary of aggregated knowledge-change scores for all strategies, by type of event.

Individuals who participated in outreach and education events in faith-based and business settings and those who received information one-on-one both experienced larger gains in knowledge of the ACA and health insurance than those who attended events in other settings. Doing outreach and

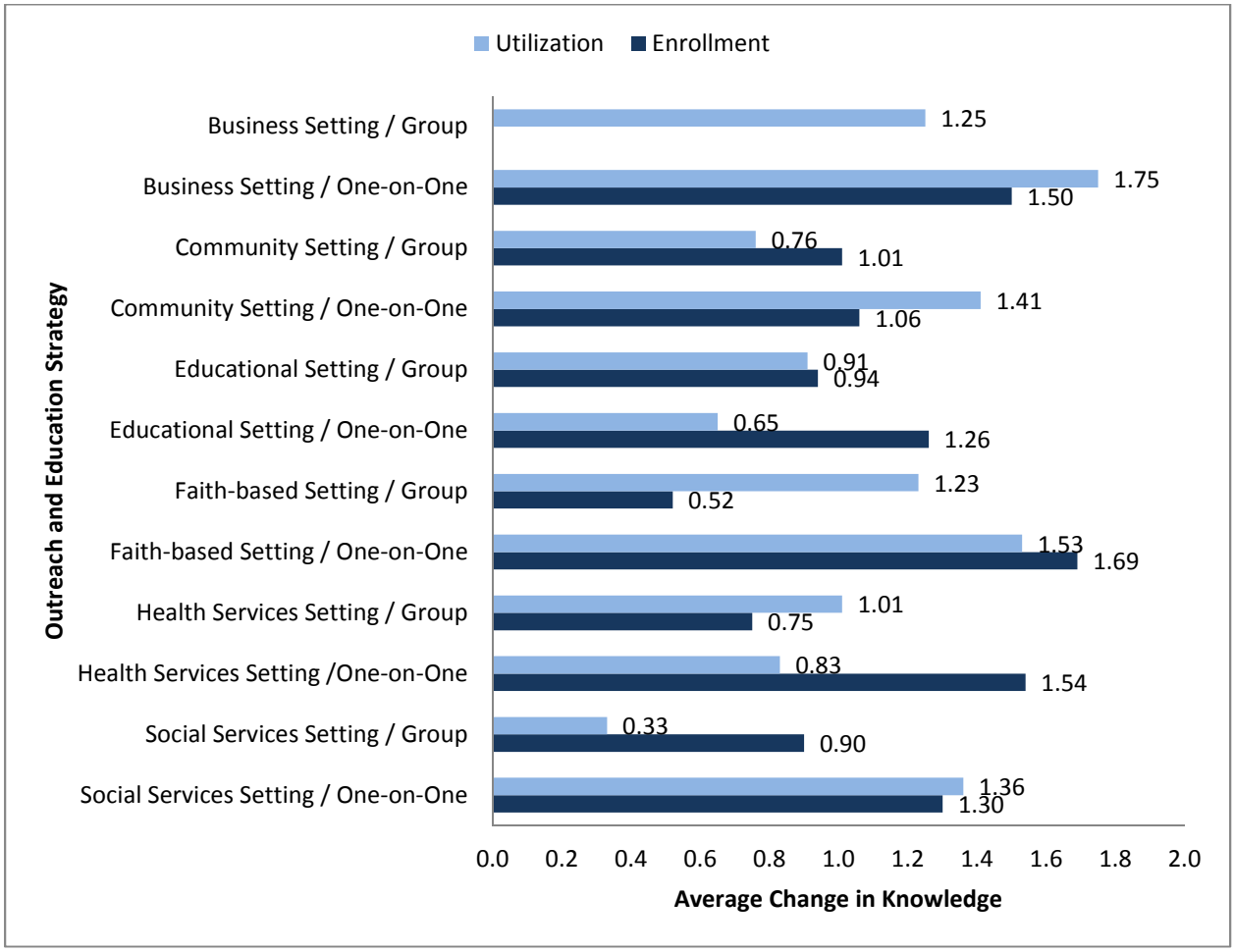
[6] One-on-one information sharing included conducting intercepts in various locations, distributing information to individuals by setting up a booth or table in strategic locations such as outside of supermarkets, business offices, health centers, and community events. One-to-many sharing included delivering presentations to groups of individuals.

education one-on-one in faith-based settings such as churches, mosques, and faith conferences was the strategy that resulted in the highest change in knowledge of the ACA (1.69)[7] and health insurance (1.54), as shown in Exhibit 8. Outreach and education delivered through individual contact with participants in local business settings such as grocery stores and barbershops was a strategy that resulted in the next highest amount of change in knowledge of the ACA (1.50) and health insurance (1.75).

Participants who received information in a group setting experienced smaller gains in knowledge of the ACA and health insurance compared to those that received information one-on-one. The results show that increases in knowledge for those who participated in group presentations was considerably lower than for those who received information one-on-one. Specifically, those who received information in a setting where social services were delivered experienced the smallest knowledge gains (0.33). Event organizers noted that the reasoning behind using the social services setting as a strategy was that these were good locations to access a large number of their target population. However, upon further reflection, event organizers noted that these participants were too distracted and not primed to receive or retain information, since their primary reason for being present at the location was to access needed social services.

[7] Number represents average change in knowledge before and after participating in the event.

Exhibit 8: Average Change in Knowledge Before and After the Event, by Outreach and Education Strategy



Note: Respondents were asked to indicate their perceived knowledge in 8 areas related to health coverage enrollment before and after participating in enrollment focused outreach and education events using a scale ranging from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. Respondents were asked to indicate their perceived knowledge in 9 areas related to health coverage utilization before and after participating in utilization focused outreach and education events using a scale ranging from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. The average change reflects a change in the mean scores, subtracting the average across all knowledge indicators before the event from the average across all knowledge indicators after the event.

Participants who received group presentations in social service settings reported the highest likelihood of researching or considering health coverage options after participating in events that focused on enrollment in health coverage. Participants who received outreach and education through group presentations in social service settings such as family resource centers and immigration services agencies were most likely to report a moderate or high likelihood that they intended to gather more information about their health insurance policies or do more thinking about the coverage options that were appropriate for themselves or their families (100%, *n* = 26), rather than enrolling in health insurance (see Exhibit 9). This finding adds to the previous observation that individuals who are accessing social services are not primed to receive, retain, or act on information because they are

preoccupied with receiving needed services. As such, events that take place in social service settings should consider employing a participant referral process that provides participants with contact information of local navigator organizations, or copies of frequently asked questions regarding the enrollment. Participants can also be asked to complete a referral card that can be shared with navigators, so they can conduct follow-up with participants.

Participants in faith-based settings reported the highest likelihood of making an appointment with a navigator or health insurance representative or obtaining health insurance online or over the phone. Ninety-seven percent of participants (*n* = 29) that received outreach and education one-on-one in faith-based settings such as churches, mosques, and faith conferences were most likely to report a moderate or high likelihood that they intended to contact a navigator or other health insurance representative or enroll in health coverage online or over the phone (see Exhibit 9).

Exhibit 9: Respondents' Intent to Take Action to Enroll in Health Insurance Post-Event, by Strategy

Outreach and Education Strategy	Plan to Enroll/change insurance		Gather more info/ Do more thinking	
	%	n	%	n
Faith-based Setting / One-on-One	96.7	29	93.8	30
Health Services Setting / Group	95.0	211	97.9	232
Educational Setting / Group	94.4	68	97.2	70
Health Services Setting /One-on-One	93.5	100	98.1	105
Educational Setting / One-on-One	91.2	177	87.9	197
Community Setting / Group	91.2	177	96.9	190
Social Services Setting / Group	88.0	22	100	26
Business Setting / One-on-One	87.7	50	98.4	60
Faith-based Setting / Group	85.1	561	91.5	761
Social Services Setting / One-on-One	84.6	478	97.1	503
Community Setting / One-on-One	83.0	576	96.4	587

Note: Business setting/group is omitted due to small cell sizes.

Participants who received group presentations that focused on the use of health coverage in faith-based settings were the most motivated to take action to use their health coverage. Exhibit 10 shows that participants who received outreach and education through group presentations in faith-based settings such as churches, mosques, and faith conferences were most likely to report a moderate or high likelihood that they intended to find out more about their coverage and costs of health insurance (100%, *n* = 91), find and choose a doctor or nurse who takes their insurance (98.9%, *n* = 86), or make an appointment with their regular doctor or nurse for medical care (98.8%, *n* = 82).

Exhibit 10: Respondents' Intent to Take Action to Utilize Insurance Post-Event, by Strategy

Outreach and Education Strategy	Find more info about coverage/costs		Find/choose doctor/nurse		Make an appointment with doctor/nurse		Plan to Enroll/change insurance	
	%	n	%	n	%	n	%	n
Faith-based Setting / Group	100	91	98.9	86	98.8	82	80.2	73
Social Services Setting / One-on-One	96.6	311	97.2	312	96.6	309	94.1	302
Health Services Setting / Group	96.5	879	94.5	848	95.8	862	77.2	692
Community Setting / One-on-One	95.5	491	94.0	482	94.5	485	86.4	443
Community Setting / Group	95.5	610	95.0	605	95.1	606	84.5	539
Social Services Setting / Group	95.3	224	94.5	222	98.7	235	84.6	198
Business Setting / One-on-One	94.1	80	94.0	79	90.6	77	84.5	71
Faith-based Setting / One-on-One	84.6	148	81.7	143	83.4	146	68.4	119
Educational Setting / Group	87.0	60	58.0	40	69.6	48	65.2	45
Health Services Setting / One-on-One	83.5	263	77.8	235	79.3	237	66.2	198
Educational Setting / One-on-One	60.7	148	55.6	135	63.4	154	42.8	104

Note: Business Setting / group is omitted due to small cell sizes.

5. Conclusions and Recommendations

The passage of the ACA in March 2010 marked an important change in the course of health care regulation and reform in the U.S. The primary objective of the law is to cut the uninsured rate in the nation and expand public and private insurance coverage options for all citizens. For the ACA to be successful and deliver on its promises of increased coverage, quality health care, and cost containment, there must be widespread adoption. This requires reaching out to the uninsured; including those who are young and healthy, as well as vulnerable populations that have limited or no access to healthcare.

As the nation moves on to the third open enrollment season and beyond, the pool of uninsured individuals will continue to decrease. This will make it increasingly difficult to identify and reach the remaining pockets of uninsured individuals around the country. Given the findings from the present evaluation, the outreach and education strategies that are likely to work are targeted, grassroots-based approaches that involve organizations that know their communities, their social support structures, and the needs of their members. A broad reach approach such as door-to-door canvassing or traditional and social media campaigns are not likely to be as effective.

The process of identifying selected organizations—those from states with a high percentage of uninsured and newly insured individuals and that have a deep understanding of the needs of their target populations—and providing them with seed funding to kick-start or supplement their ACA outreach and education activities has proven successful in many respects. This grassroots approach to raising awareness about the ACA and training underserved populations in how to use their newly acquired health insurance policy produced significant increases in participants' knowledge of the ACA, motivated them to enroll or seek out more information in order to enroll, and increased participants' overall understanding of how to use their newly acquired insurance policy. In addition, organizations were able to reach a larger number of individuals than anticipated due to increases in demand for the information.

Below are key lessons learned and recommendations based on the data collected and analyzed by the Evaluation Team.

Awareness of the ACA and training in health insurance utilization continue to be needed in underserved communities. Although the percentage of people with health coverage has increased considerably over the last two years since the implementation of the ACA (Cohen & Martinez, 2015), event organizers noted that there remains a big need for increasing awareness of the ACA and delivering training and information on health insurance utilization to underserved communities—especially recent immigrants, Hispanics, and those who do not have experience navigating the U.S. healthcare system. Support for this claim can be seen in the data collected from healthcare utilization events, which showed that while 79% of participants reported visiting a nurse or doctor during their first year of being insured, only 66% reported accessing preventive care services, and only 62% accessed dental care services. Appendix E includes findings from healthcare and health insurance utilization events conducted by partner organizations.

Limited English proficiency (LEP), lack of trust, and limited health insurance literacy are the three most prominent barriers to enrollment in the ACA and utilization of health insurance. According to outreach and education event organizers, the three most prominent barriers to enrollment in the ACA and utilization of health insurance are LEP, lack of trust, and limited health insurance literacy (see Appendix C for a summary of findings from qualitative interviews with event staff). Effective outreach and education strategies need to be comprehensive and address all three barriers in order to be effective. The findings presented in this report offer strategies for organizing outreach and education events.

- ***Recruit and train multi-lingual navigators to attend enrollment events.*** Having multi-lingual navigators can address LEP, health literacy, and technology literacy barriers. However, to be effective, navigators must speak the target population's language. Events that only include English-speaking navigators and have interpreters available to assist participants with enrollment can result in extending an already long application process and potentially deter participants from completing the enrollment application.

- ***Structure comprehensive outreach and education events using multiple modes of delivery, including one-on-ones, group presentations, and distribution of hard-copy materials.*** One-on-one interaction is the mode of delivering ACA and health insurance literacy education that resulted in the highest increases in knowledge. Although group presentations are a cost-effective method for reaching many individuals, the more high-touch one-on-one approach seems to be more effective. To minimize costs, event organizers need to leverage their funds by partnering with organizations within the community that are trusted by the target population.

- ***Identify trusted, faith-based gatekeepers to participate in outreach and education events.*** The evaluation found that the settings that led to the greatest increases in the intent to act (for example, to enroll or use health insurance) were faith-based locations. Event organizers noted that the greatest barrier to enrollment in underserved communities is lack of trust. As such, the lesson noted was, "If I trust, I will do." In essence, people are more open to receiving information and are more likely to act on the information being shared when they participate in events that are (1) hosted in trusted locations and (2) endorsed by trusted individuals, such as faith leaders. As such, gatekeepers should not only be asked for permission to have access to a

target group or community (e.g., a congregation), but to actively participate in the event by leading a discussion or delivering a key message.

- ***Encourage outreach and education events in faith-based settings that include a one-on-one exchange of information.*** The findings suggest that outreach and education delivered through *individual contact* with participants in faith-based settings such as churches, mosques, and faith conferences, was among the strategies that resulted in the highest levels of knowledge gain on the ACA. Similarly, participants who received information through individual contact in faith-based settings reported the highest likelihood of making an appointment with a navigator or health insurance representative or obtaining health insurance online or over the phone. As such, events conducted in faith-based settings should not only focus on delivering a presentation but also build in time to exchange information on a personal level. This strategy includes recruiting faith leaders or respected members of the faith community to serve as gatekeepers and have them assist with one-on-one interaction with event participants.

- ***Consider using immigration lawyers as gatekeepers in communities with high concentrations of recent immigrants.*** Having a good understanding of underserved populations and the communities in which they reside is a key strategy for organizing and conducting effective ACA outreach and education. Event organizers observed that in underserved communities there exists trust between professionals who provide legal services to recent immigrants, specifically immigration lawyers. Using professionals who provide legal services within communities proved to be a successful outreach strategy. This strategy addressed events that were targeted for Hispanic/Latino participants as well as recent Asian immigrants. A strategy for recruiting professionals is to offer co-sponsorship of the events, which can offer them visibility within the community.

- ***Design outreach and education events tailored specifically for males and couples.*** Female participants in outreach and education events outnumbered males by half. Only 36.6 percent of participants were male. Future outreach strategies should focus their efforts on reaching males. Event organizers noted that women who started the application process were at times challenged by questions that pertained to information that their male spouse or partner might have. Therefore, event organizers felt that it was important to consider strategies to encourage couples to participate in events together and to increase the participation of men.

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Appendix A: Enrollment and Utilization Assessment Forms

PRIOR TO MAKING COPIES, EVENT LEAD ORGANIZATION MUST FILL IN EVENT LEAD ORGANIZATION AND EVENT START DATE IN BOX BELOW
2015 Version
Event Lead Organization:_____ | Event Type: Utilization | Event Start Date: _____ | Survey ID # _____

ACA Event Assessment Form

Please place a checkmark (✓) in ONE box to answer the questions below.

1. AFTER participating in today's event, HOW WELL DO YOU UNDERSTAND _____?	Not At All	A Little	Some What	Very Well	Topic Not Covered
a. The importance of healthy eating and active living	❒	❒	❒	❒	❒
b. What health services are paid for by your insurance	❒	❒	❒	❒	❒
c. Costs in your health insurance plan (premiums, co-pays, and deductibles)	❒	❒	❒	❒	❒
d. The difference between "in-network" and "out-of-network" care	❒	❒	❒	❒	❒
e. How to find a doctor or nurse who takes your insurance	❒	❒	❒	❒	❒
f. When to go to your doctor versus when to go to the emergency room	❒	❒	❒	❒	❒
g. What to do BEFORE you go to your doctor or nurse	❒	❒	❒	❒	❒
h. How to request language help (translation/interpretation) from your doctor	❒	❒	❒	❒	❒
i. What to do AFTER you go to your doctor or nurse	❒	❒	❒	❒	❒

2. AFTER participating in today's event, HOW LIKELY ARE YOU TO _____?	Not At All	A Little	Some What	Very Likely
a. Find out more about your coverage and costs of health insurance	❒	❒	❒	❒
b. Find and choose a doctor or nurse who takes your insurance	❒	❒	❒	❒
c. Make an appointment with your regular doctor or nurse for medical care	❒	❒	❒	❒
d. Enroll in or change your health insurance plan	❒	❒	❒	❒

3. Thinking about YOURSELF ONLY, do you _____?	YES	NO
a. Have health insurance coverage	❒	❒
b. Have access to a computer with Internet service	❒	❒
c. Feel comfortable using computers and accessing the internet	❒	❒

4. Thinking about TODAY'S EVENT, did you _____?	YES	NO
a. Know language help (translation/interpretation) was available	❒	❒
b. Request language help (translation/interpretation)	❒	❒

5. Thinking about THIS PAST YEAR, did you _____?	YES	NO	
a. Have health insurance coverage the whole year	❒	❒	
b. Use insurance coverage to get health care	❒	❒	
c. REGULARLY go to see a MEDICAL DOCTOR OR NURSE	❒	❒	
d. Go to a MEDICAL DOCTOR OR NURSE	❒	❒	
e. Go to a DENTIST	❒	❒	
f. Go to a MENTAL HEALTH CARE specialist	❒	❒	
g. Go to URGENT CARE or the EMERGENCY ROOM	❒	❒	**If Yes, how many times?** ___

6. BEFORE today's event, HOW WELL DID YOU UNDERSTAND _____?	Not At All	A Little	Some What	Very Well
a. The importance of healthy eating and active living	❒	❒	❒	❒
b. What health services are paid for by your insurance	❒	❒	❒	❒
c. Costs in your health insurance plan (premiums, co-pays, and deductibles)	❒	❒	❒	❒
d. The difference between "in-network" and "out-of-network" care	❒	❒	❒	❒
e. How to find a doctor or nurse who takes your insurance	❒	❒	❒	❒
f. When to go to your doctor versus when to go to the emergency room	❒	❒	❒	❒
g. What to do BEFORE you go to your doctor or nurse	❒	❒	❒	❒
h. How to request language help (translation/interpretation) from your doctor	❒	❒	❒	❒
i. What to do AFTER you go to your doctor or nurse	❒	❒	❒	❒

7. Please tell us about yourself.

a. **What is your GENDER?** ❒ Male ❒ Female

b. **What is your AGE?** ❒ 18-34 ❒ 35-44 ❒ 45-54 ❒ 55-64 ❒ 65+

c. **What RACE/ETHNICITY best identifies you?**

❒ White/ Caucasian | ❒ Black/ African American | ❒ Latino/ Hispanic | ❒ American Indian/ Alaska Native | ❒ Asian | ❒ Native Hawaiian/ Pacific Islander | ❒ Other

If OTHER RACE/ETHNICITY, please indicate which in this space:

d. **What PRIMARY LANGUAGE do you SPEAK AT HOME?**

NATIONAL PARTNERSHIP FOR ACTION
to End Health Disparities

PRIOR TO MAKING COPIES, EVENT LEAD ORGANIZATION MUST FILL IN EVENT LEAD ORGANIZATION AND EVENT START DATE IN BOX BELOW
2015 Version
Event Lead Organization:_____ | Event Type: Enrollment | Event Start Date: _____ | Survey ID #_____

ACA Event Assessment Form

Please place a checkmark (✓) in ONE box to answer the questions below.

1. AFTER participating in today's event, HOW WELL DO YOU UNDERSTAND _____?	Not At All	A Little	Some What	Very Well	Topic Not Covered
a. What the Affordable Care Act law means for you and your family	❒	❒	❒	❒	❒
b. The benefits of the Affordable Care Act	❒	❒	❒	❒	❒
c. The insurance enrollment deadlines for this year	❒	❒	❒	❒	❒
d. The requirements and penalties in the Affordable Care Act law	❒	❒	❒	❒	❒
e. Types of insurance policies available on the Marketplace	❒	❒	❒	❒	❒
f. How health insurance really works	❒	❒	❒	❒	❒
g. Ways to buy insurance on the Marketplace	❒	❒	❒	❒	❒
h. Tax credits and other options to make insurance more affordable	❒	❒	❒	❒	❒

2. AFTER participating in today's event, HOW LIKELY ARE YOU TO _____?	Not At All	A Little	Some What	Very Likely	
a. Gather more information about health insurance policies before you enroll	❒	❒	❒	❒	
b. Do more thinking about what options are best for you and your family	❒	❒	❒	❒	
c. Make an appointment with a navigator or health insurance agent to enroll	❒	❒	❒	❒	
d. Enroll in or change your insurance through the ACA website or 800 number	❒	❒	❒	❒	

3. Thinking about YOURSELF ONLY, do you _____?	YES	NO			
a. Have health insurance coverage	❒	❒			
b. Have access to a computer with Internet service	❒	❒			
c. Feel comfortable using computers and accessing the internet	❒	❒			

4. Thinking about TODAY'S EVENT, did you _____?	YES	NO			
a. Know language help (translated materials, interpreter) was available	❒	❒			
b. Request language help (translated materials, interpreter)	❒	❒			

5. Thinking about THIS PAST YEAR, did you _____?	YES	NO			
a. Have health insurance coverage the whole year	❒	❒			
b. Use insurance coverage to get health care	❒	❒			
c. REGULARLY go to see a MEDICAL DOCTOR OR NURSE	❒	❒			
d. Go to a MEDICAL DOCTOR OR NURSE	❒	❒			
e. Go to a DENTIST	❒	❒			
f. Go to a MENTAL HEALTH CARE specialist	❒	❒			
g. Go to URGENT CARE or the EMERGENCY ROOM	❒	❒	If yes, how many times? __		

6. BEFORE today's event, HOW WELL DID YOU UNDERSTAND _____?	Not At All	A Little	Some What	Very Well	
a. What the Affordable Care Act law means for you and your family	❒	❒	❒	❒	
b. The benefits of the Affordable Care Act	❒	❒	❒	❒	
c. The insurance enrollment deadlines for this year	❒	❒	❒	❒	
d. The requirements and penalties in the Affordable Care Act law	❒	❒	❒	❒	
e. Types of insurance policies available on the Marketplace	❒	❒	❒	❒	
f. How health insurance really works	❒	❒	❒	❒	
g. Ways to buy insurance on the Marketplace	❒	❒	❒	❒	
h. Tax credits and other options to make insurance more affordable	❒	❒	❒	❒	

7. Please tell us about yourself.

a. **What is your GENDER?**		b. **What is your AGE?**				
❒ Male	❒ Female	❒ 18-34	❒ 35-44	❒ 45-54	❒ 55-64	❒ 65+

c. **What RACE/ETHNICITY best identifies you?**

❒ White/ Caucasian	❒ Black/ African American	❒ Latino/ Hispanic	❒ American Indian/ Alaska Native	❒ Asian	❒ Native Hawaiian/ Pacific Islander	❒ Other

If OTHER RACE/ETHNICITY, please indicate which in this space:

d. **What PRIMARY LANGUAGE do you SPEAK AT HOME?**

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Appendix B: Enrollment and Utilization Interview Protocols

The Affordable Care Act Outreach Strategy Project
Interviews to Inform Deliverable 6: Report on Best Practices, Challenges, and Opportunities

Interview Protocol for ACA Outreach - Enrollment
DRAFT
May 4, 2015

At Community Science, we have been so pleased to partner with [name of organization] to support your efforts educate hard-to-reach individuals about the Affordable Care Act and encourage next steps towards utilization of newly acquired health insurance coverage. The purpose of this interview is to learn more from you about your strategy. Namely, we are interested in understanding your target population, the innovative approach you took in implementing an outreach strategy to this population, and the rationale for the need for outreach to this population. We are also curious to learn what worked and what didn't work in order to inform and prepare for the next enrollment period. Last, we hope to gain insights into challenges and opportunities you foresee related to the implementation of the ACA.

Note that all the responses we get, including yours, will be aggregated and summarized in a report that we will submit to the Office of Minority Health in the Dept. of Health and Human Services. Your responses will not be linked to you. Your name or your organization's name also will not be used.

Your participation is voluntary. You may stop the interview at any time or not answer a certain question. Do you have any questions before we begin?

[*If the respondent has questions that you cannot answer, let the respondent know that you will find out the answer. Ask the respondent if he/she is comfortable continuing the interview even if you cannot answer the questions at this time. If the respondent says no, then inform the respondent that you will follow up with the answer within one to two days. At the time when you contact the respondent with the answer, ask if you can schedule a new time for the interview*.]

1. Please describe the effort to reach out to and educate individuals about the Affordable Care Act and to promote health insurance enrollment.

    a. What was the population or populations that the effort was focused on, and why?

    b. What was your overall goal and purpose in conducting the outreach?

    c. What was the overall strategy? How did you develop this strategy?

    d. How did you publicize your outreach strategy?

        i. PROMPT: How did you ensure that you were publicizing in the channels that would reach and engage your target population best?
        ii. PROMPT: Which publicity strategies seemed to work well or poorly with your target population, and why?

e. How was your strategy innovative or culturally responsive to your target population?
    i. PROMPT: Did you culturally adapt presentation slides, brochures, or other materials? If so, how?

    ii. PROMPT: Did you translate materials and presentations into a language spoken by your target population?

2. In your opinion, was the effort successful or not? What indicated success to you?

    a. [If it was successful] what facilitated its success?
        i. Your organization's knowledge, skills, relationships, etc?
        ii. Other partners' knowledge, skills, relationships, etc.?
        iii. The navigators? [if applicable]
        iv. The people who came to the event or were reached by the event?
        v. Other?
    b. [if it was not successful] Why? What would you differently next time to ensure success?

3. [If it was successful] what contributed to its success? [if it was not successful] Why? What would you do differently next time to ensure success?

4. What were the challenges you faced as you implemented your outreach activities?

5. How easy or difficult was it for you to coordinate navigator or other in-person assistance services on-site at your outreach activities?
    a. PROMPT: If you had in-person assistance on-site, did they have prior experience working with your target population? Did you feel they had sufficient cultural competency in working with your population? Were they bilingual (if needed)?
    b. PROMPT: If it was difficult to obtain navigator services on-site, what were some of the barriers? If it was fairly easy, to what do you attribute this?

6. What were the challenges your target population faced in enrolling or trying to change their health insurance plan?

7. If you were to advise another organization or community about what they should do to successfully motivate *your* target population to enroll in health insurance through the provisions of the Affordable Care Act, what would you tell them?

8. Are there any other lessons learned that you would like to share that we have not discussed?

9. Do you have any additional comments?

Thank you for your time. Your feedback is valuable and will inform our report to the Office of Minority Health on Best Practices, Challenges, and Opportunities related to the ACA. We appreciate your support and partnership in this effort to promote the equitable implementation of the Affordable Care Act to benefit all communities.

The Affordable Care Act Outreach Strategy Project
Interview Questions for ACA outreach - Health Care Utilization

1. Please describe the effort to reach out to and educate individuals about the Affordable Care Act and to promote health insurance utilization.

    a. What was the population or populations that the effort was focused on, and why?

    b. What was your overall goal and purpose in conducting the outreach?

    c. What were the reported barriers your target population faced specific to health care and health insurance utilization?

    d. How knowledgeable was your target population with health insurance terms like in-network care, deductibles, co-pays, out-of-pocket maximums, coinsurance, etc.? Were there any patterns or common gaps in their health insurance and health care literacy? If so, how did you address this?

    e. What was your overall strategy to promote health insurance utilization? How did you develop this strategy?

    f. How did you publicize your outreach strategy?

    g. How was your strategy innovative or culturally responsive to your target population?

2. In your opinion, was the effort successful or not? What indicated success to you?

3. [If it was successful] what contributed to its success? [if it was not successful] Why? What would you do differently next time to ensure success?

4. What were the challenges you faced as you implemented your outreach activities?

5. What were the challenges your target population faced in utilizing and maintaining health care coverage?

6. If you were to advise another organization or community about what they should do to successfully motivate *your* target population to utilize and maintain their health insurance through the provisions of the Affordable Care Act, what would you tell them?

Appendix C: Summary of Findings from Qualitative Interviews with Event Staff

The following findings represent data collected from 11 in-depth, semi-structured interviews with local outreach event hosts, event planners, champions of coverage, and navigators in response to questions regarding barriers and challenges to conducting successful outreach events and enrolling eligible, uninsured participants, as well as events focused on utilization of health insurance. Exhibit 1 summarizes the challenges identified by key respondents in 2014 and 2015. The exhibit also provides the number of key informant organizations that identify the challenge as impacting their work for 2015.

Exhibit 1: Key Barriers and Challenges Experienced by Key Informant Organizations by Year

Challenge	2014 (n=14)	2015 (n=11)
Low health insurance/health care literacy	■	7
Low English language literacy	■	7
Low reading literacy	■	6
Misperceptions about health insurance and the ACA and trust	■	5
Lack of male participation in events		3
Lack of financial resources and adequate training for navigators, CACs, and other on-site staff	■	3
Seasonal effects	■	2
Insufficient publicity for events	■	2
Complexity and confusion driven by inconsistency between state and federal policies	■	2
Conflicts and tension with other organizations		2
Increasing knowledge and understanding of ACA enrollment among the public		2
Insufficient research and planning	■	0
Low technology literacy	■	0
Enrollment process confidentiality	■	0
Enrollment process complexity due to eligibility questions	■	0

Notes: The table includes major themes identified by two or more key informant organizations.
Source: 2014 and 2015 Key Informant Interviews

Barriers and Challenges Related to Target Populations

Target population members' low health insurance and health care literacy created a barrier to their enrollment in and utilization of health insurance. As in 2014, key informants commonly cited low health insurance and health care system literacy as a challenge for target population members. Seven organizations noted their target population had limited knowledge of or struggled to understand key healthcare topics such as the actual cost of healthcare vs. its perceived high cost, co-pays, in-network vs. out-of-network care, primary care, HMOs, billing, and similar topics. Four of these organizations further described the lack of knowledge of the American healthcare system and the use of health insurance among immigrants and refugees. One organization remarked, "Some of our immigrant population could not wrap their heads around the idea of using insurance for preventive services. This is because they are used to the idea of 'how can the insurance benefit me now' and not 'how can I use it for preventative measures.' This is because some the clients come from countries where you only pay for insurance when you need it."

Target population members' low English language literacy creates a barrier to their enrollment in and utilization of health insurance. Seven key informants described their target populations' low English-language literacy as a challenge. These organizations said their target populations often were most comfortable speaking a range of languages other than English such as Spanish, Hindi, French, Creole, Korean, Taiwanese, Cantonese, Mandarin, and others. They reported a high need for translation services at outreach events and for publicity and outreach materials that were translated into other languages.

Target population members' low reading literacy creates a barrier to their enrollment in and utilization of health insurance. Six key informants noted even native English speakers often had difficulty reading the handouts and materials provided to educate on ACA enrollment and the use of health insurance. These organizations described the need to make sure materials and presentations are simple and easy to comprehend. One organization that primarily served African Americans noted, "There also are language barriers even among African Americans who speak English….we condensed information, brought it to their reading level, and got to the point right away—knowing their attention span for this kind of information was low."

Target population members' misperceptions about health insurance and the ACA and trust issues created a barrier to their enrollment in and utilization of health insurance. Overall, five key informants remarked that attitudes and misperceptions of the ACA and health insurance posed challenges among their target populations. Two of the five organizations described fears among mixed-immigration-status families and undocumented individuals. One of the five organizations said it is difficult to insure an entire mixed-immigration-status family because they fear health insurance is expensive. Both organizations noted that mixed-immigrant-status families and undocumented individuals fear enrolling because of fears of deportation. Three organizations described the lack of knowledge among new immigrants that they have to get covered within 90 days. Three organizations believe their populations made a general assumption that insurance would be unaffordable and one further noted a lack of knowledge about limitations on coverage because of pre-existing conditions. One organization said they met with entrenched political attitudes of opposition to "Obamacare" in some parts of their state. Two organizations said women tended to be more concerned about enrolling in and using health care than men.

Barriers and Challenges Related to Planning and Implementation

A lack of financial resources and adequate training for navigators, CACs, and other on-site staff reduced the effectiveness of outreach efforts. Navigators and certified application counselors (CACs) often facilitated enrollment at outreach events without compensation, using their personal laptops, and paying for materials, transportation, and other expenses out-of-pocket. With a lack of dedicated funding, organizations may experience difficulty securing navigators for outreach events. One organization noted they had difficultly securing navigators for all their events because they did not have enough funding. Another organization said they would have preferred to have navigators at their events but could not because of limited funding. They addressed their issue, however, by staffing all events with CACs. A third organization reported they did not have enough manpower to serve the needs of their target

population at events; at times service recipients came in for enrollment and others desired information about how to utilize health insurance and it was difficult to balance the needs with the available staff. Organizations also noted that navigators that do not have the language skills of the target population made the enrollment process very long given the language differences. When interpreters were made available, it still made the process longer than instances where there was parity in the language skills of the navigator and event participant.

Organizing and partner organizations' insufficient publicity for events reduced their potential impact. Two key informants reported challenges adequately publicizing their events. One key informant noted their organization's limited staff meant they did not have the capacity to advertise as much as they would have liked. Another organization that primarily conducted outreach in local churches noted the important role that faith leaders can play in promoting events, "Most of the time we got good turnout but at one of the churches the pastor did not market it as he should have and we had low turnout with only three or four people attending."

The public's increased knowledge and understanding of health insurance enrollment, while positive, reduced the effectiveness of ongoing enrollment efforts. Two organizations that focused in part on enrollment noted the public's increasing awareness of opportunities to enroll in health insurance, partly attributable to the great success of the efforts of 2014, created reduced interest in enrollment-focused activities and, in some cases, produced a desire for more information on how to actually use health coverage. One organization noted,

"One of the biggest challenges we encountered was that people were more interested in health utilization than enrollment. That is because people were more interested in understanding how they could use insurance. This could be because most people by now are aware of health insurance enrollment. At first we were worried that we were not enrolling as many people as we would like to, but after looking into it we discovered that we were not the only organization that was having this problem. Enrollment in [our state] has decreased and we speculate that the reason could be that some people now understand the enrollment process and have become self-sufficient. Therefore most of the need is on how to use the insurance."

The need to manage conflicts, duplication of services, and relationships between other community-based and partner organizations reduced the potential impact of outreach and education events. Two key informants described challenges arising from conflicts with other community organizations. Both noted they would participate in community events and be surprised to find that other groups were doing the same work. One organization noted sometimes partner organizations have different approaches to working with a given target population that can create conflict. They also said sometimes a partner organization has more expertise working with a given population, but members of that population come to the key informant's organization for services which creates a conflict between wanting to serve those people without "stepping on the partner organizations' toes."

Inclement weather caused event cancellations. Two organizations noted severe weather was an obstacle to successfully implementing outreach events as planned. One of these organizations said inclement weather caused them to cancel events that would have allowed

them to reach a disadvantaged, rural population. The other organization reported bad weather was a general barrier that resulted in cancelling events.

Lack of male participation in events leads to ineffective outreach and education and enrollment. Three key informants noted that events consistently have more females than males. The lack of participation often lead to females not having the necessary information to complete the application process. For instance, event participants noted that female participants did not have access to tax returns and were not able to calculate annual income. In addition, they were not able to decide on a plan without consulting with their spouse.

The differing state and federal policies created confusion about health insurance enrollment and utilization among target population members. Two key informants noted a lack of information or inconsistent information from and between state and federal authorities contributed to the complexity of enrollment and being able to utilize health insurance. They said the different eligibility requirements at the federal and state levels created confusion for people who visited the state-based or federal health insurance websites. One organization also reported other organizations in the community, not as well versed in the enrollment or health insurance utilization, contributed to this confusion by providing incorrect information to clients about the differences between federal and state eligibility.

Emerging Best Practices

The findings below represent data collected during 11 in-depth, semi-structured interviews with local outreach event hosts, event planners, champions of coverage, and navigators in response to questions regarding advice they would give to other organizations for outreach activities conducted in future enrollment periods.

Culturally and linguistically adapting outreach materials and information to be responsive to the target population. All 11 key informants commented on the importance of ensuring the materials, presentations, and information were culturally and linguistically appropriate for their target populations. Several informants noted the need to make sure materials are available in various languages and to ensure the reading level, regardless of language, is accessible to those of all education levels. Other key informants described adapting materials to meet the informational needs of their target population. For example, an organization working with South Asian business owners ensured their materials were relevant for someone who is self-employed. Another group working with African Americans noted a concern about how the ACA and health insurance can benefit people at different stages of their lives and produced pamphlets that provided this information.

Hosting group events and providing one-on-one outreach in locations frequented by and comfortable to the target population. Ten key informants highlighted the necessity of disseminating information in locations and at events commonly visited by the target population. Key informants describe the importance of forming partnerships with other organizations such as churches, temples, community centers, and other community-based organizations to leverage their location and relationships to access the target population. One

key informant that primarily served African Americans noted, “I partnered with [organizations]. I also had tables at a church retreat and went to Historically Black Colleges and Universities (HBCUs). So I went to hard-to-hard to reach populations instead of them finding me. I also visited barbershops were I tried to get people to enroll.” Another key informant that served the South Asian community reported, “We developed partnerships with places in the community where our community members congregate.” A third key informant said the importance of utilizing existing events, “We leveraged existing events going on in that community. For example, tomorrow there is a health fair that a church is doing and we are building on that to do health care utilization event. Using those kinds of opportunities to reach your target population [is important].”

Utilizing different outreach and education strategies depending on the target population. Seven key informants described the importance of being flexible and adapting their outreach strategies to meet the needs of specific populations. Key informants stressed that for some communities, one-on-one outreach and education may be most effective, and in others a group presentation might be most effective. A key informant argued, “Utilize different types of strategies depending on the target population. For example, [use] one-on-one sessions for one group and tabling for another.” Another key informant noted, “Other organizations should be flexible to switch strategies—go to the barbershop! Traditional strategies do not always work so organizations have to use other strategies.”

***Publicizing events in high traffic venues and forums specific to the targeted population*.** Five key informants noted it was important to identify ethnic-specific radio stations, newspapers, places of business, and social media platforms as outlets for publicizing outreach, education, and enrollment events. Key informants also said word-of-mouth publicity from a trusted source often is very effective in getting people to attend outreach and education events.

***Understanding how the targeted community vets newcomers to establish credibility*.** Four key informants noted the importance of understanding how different populations judge credibility and to use strategies responsible to these practices to ensure the audience will be open to receiving the information being shared. One key informant noted, “Knowing the community is key to establishing that we are trustworthy to give this information. Know your target population! For example, for Hispanics, there are certain ways to speak and approach them. Come with a nice demeanor and be talkative, and then they are more open to you. With Cambodians explain everything and then they open up. You want to get the trust of the community, if they don’t trust you they aren’t going to want to talk to you.” Another key informant said, “The workers that went to these communities also looked like and spoke the same language as the target population. That was one reason our outreach was so strong. We looked like them, we knew them, we came from where they come from. We were ‘from the streets.’ Knowing the community is the way toward establishing we are trustworthy to give this information.

Appendix D: Summary of ACA Outreach and Education Events Completed by Partner Organizations, by Target Population, Location, Mode, and Event Type

Summary of ACA Events Completed by Partner Organizations, by Target Population, Location, Mode, and Event Type

Partner Organization (State)	Target Population	Outreach & Education Setting	1:1	Group	Enrollment	Utilization	Total Events
Bessie Mae Women and Family Health Center (NJ)	Low-Income (18); Uninsured/Underinsured (18)	Social-Library (4); Social-Family Resource Center (1); Business-Tax Clinic (2); Ed-Community College (2); Faith-Christian Church(1)	18	0	6	12	18
Center for Pan Asian Community Services (GA)	Immigrant-East Asian Origin (14); Central American Origin (1); General (1); Mexican Origin (1); Young Invincibles (18-34) (1)	Business-Supermarket (2); Community-Cultural Festival/Event (2); Health-Health Fair (2); Social-Immigrant Services Program (2)	6	10	2	14	16
Coalition for Asian American Children & Families (NY)	Immigrant-East Asian Origin (23); General (12); Southeast Asian Origin (6); South Asian Origin (4); Mexican Origin (2); Caribbean Origin (2); West African Origin (1); US Born-Asian American (10); Uninsured/Underinsured (7); Refugee-Any Origin (2); LGBTQ (1); Low-Income (1); Young Invincibles (18-34) (1)	Social-Family Resource Center (31); General or Other (1); Faith - Faith-Based Conference (4); Mosque (1); Health-Health Fair (2); Community Clinic (1); Business-Supermarket (1); Ed-General 4-Year University (1)	29	13	0	42	42
Colorado Alliance for Health Equity & Practice (CO)	Uninsured/Underinsured (30); Immigrant-General (2)	Business-Supermarket (9); Faith - Christian Church (6); Mosque (6); Buddhist Temple (1); Health-Community Clinic (5); Ed-Public K-12 School (1); Social-General or Other (1); Social-Prisoner Re-Entry Program (1)	23	7	4	26	30
Critical Learning Systems, Inc. (TN)	US Born-African American (13); Immigrant-Mexican Origin (1); Low-Income (2)	Faith-Christian Church (3); Faith-Based Conference (1); Health-Community Clinic (2); Health Fair (1); Business-Barbershop (2); Ed-Historically Black College/University (HBCU) (2); Community-YMCA / Recreation Center (1); Social-Family Resource Center (1)	5	8	6	7	13
Hindu American Seva Communities (NJ, MD)	Immigrant-South Asian Origin (20); US Born-Asian American (18); Hispanic American (1); Uninsured/Underinsured (3)	Faith-Hindu Temple (8); Faith-Based Conference (2); Mosque (1); Social-Family Resource Center (4); Library (2); General or Other (1); Business-Ethnic Grocery (1); Community-YMCA/Recreation Center (2); Ed-Community College (1)	14	9	13	10	23

Partner Organization (State)	Target Population	Outreach & Education Setting	1:1	Group	Enrollment	Utilization	Total Events
Let's Make a Difference Coalition (VA)	US Born - African American (5); Low-Income (4); Uninsured/Underinsured (3); Young Invincibles (18-34) (1)	Faith - Christian Church (5); Social-General or Other (4); Social-Family Resource Center (1); Community-Cultural Festival/Event (2); Ed - Community College (1)	1	12	6	7	13
MQVN Community Development Corporation (LA)	Immigrant-Southeast Asian Origin (6); Mexican Origin (1); US Born - Asian American (4); Uninsured/Underinsured (3)	Community-Cultural Festival/Event (4); Social - General or Other (2); Health-Health Fair (1)	4	3	3	4	7
Michigan Minority Health Coalition (MI)	US Born-Asian American (4); Hispanic American (1); Immigrant-South Asian Origin (3); Southeast Asian Origin (1); Low-Income (1)	Faith-Mosque (2); Health-Health Fair (1); Social-General or Other (1); Social-Immigrant Services Program (1)	0	5	4	1	5
New Jersey Parents Caucus, Inc. (NJ)	US Born-African American (54); Immigrant-General (32); Parents of Children with Special Needs (22)	Health-Hospital (29); Social-General or Other (24); Ed-Community College (1)	53	1	54	0	54
Omega Health Group (TX)	Young Invincibles (18-34) (15)	Ed-General 4-Year University (15)	0	15	15	0	15
Puerto Rican Unity for Progress, Inc. (NJ)	Immigrant-Caribbean Origin (7); Low-Income (5); US Born-African American (7); Hispanic American (3); White American (2)	Social-Family Resource Center (3); Immigrant Services Program (3); Ed-General 4-Year University (2); Public K-12 School (1); Business-Hotel (1); Community-Cultural Festival/Event (1); Health-Pharmacy (1)	7	5	4	8	12
United Cambodian Community (CA)	Immigrant-Southeast Asian Origin (12); South Asian Origin (1); Uninsured/Underinsured (9); Low-Income (6)	Community-Cultural Festival/Event (8); Social-General or Other (2); Business-Ethnic Grocery (1); Community-Park (1); Ed-Public K-12 School (1); Faith-Christian Church (1)	13	1	14	0	14
VSNS, Inc. (GA)	US Born-African American (16); Hispanic American (2); White American (3); Uninsured/Underinsured (5); Immigrant-East Asian Origin (1); South Asian Origin (1)	Faith-Christian Church (6); Business-Supermarket (2); Community-Cultural Festival/Event (2); Park (2); Health-Community Clinic (1); Health Fair (1); Social-General or Other (1); Social-Immigrant Services Program (1)	11	5	5	11	16

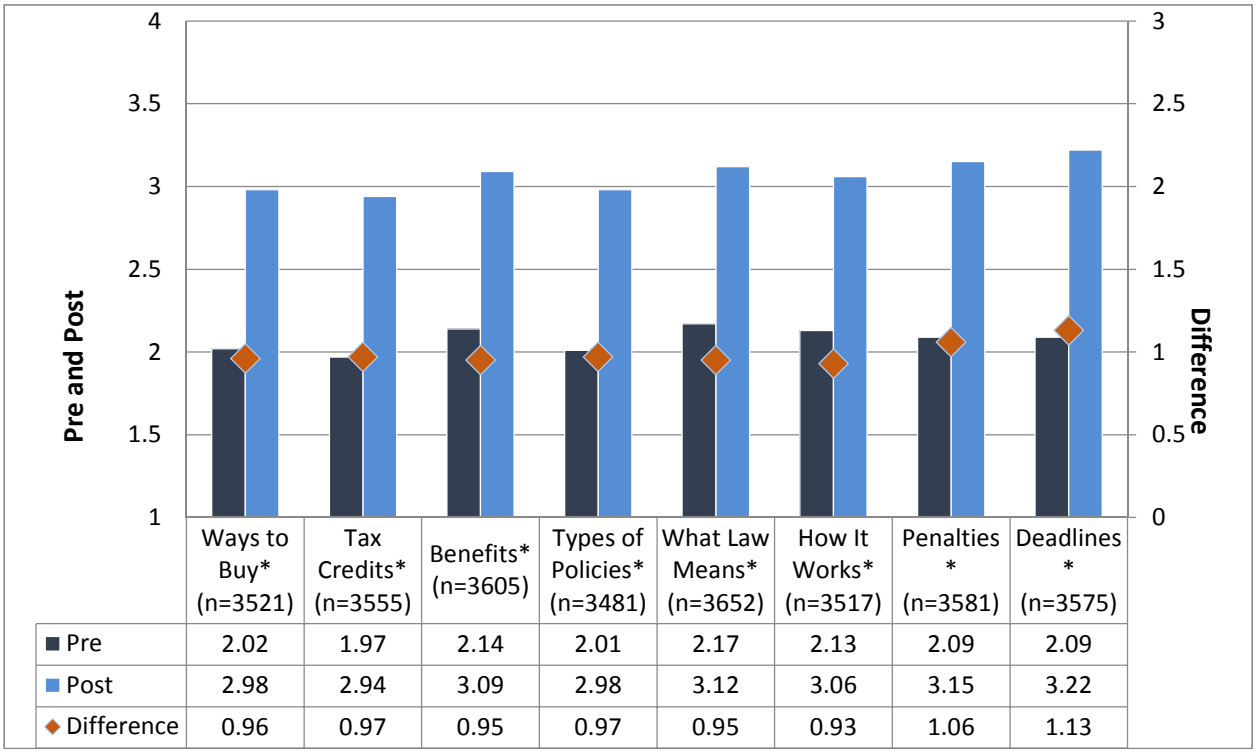
Note: Data for Harris Stowe State University are not included because of data quality concerns.

Appendix E: Summary of Event Participant Change in Knowledge and Intent to Act

Perceived Knowledge Gain

Using a retrospective pretest approach, respondents were asked to rate their perceived knowledge before and after the outreach event in eight ACA health insurance enrollment knowledge areas. Wilcoxon signed-rank tests comparing respondents' post-event perceptions of their knowledge before and after the event revealed statistically significant mean differences in all the content areas. Exhibit 1 shows that, on average, participants had the greatest gains in knowledge in the following two areas: the insurance enrollment deadlines for this year (MD = 1.13, $p < .001$) and the requirements and penalties in the ACA (MD = 1.06, $p < .001$). The smallest gain was observed in how health insurance really works (MD = 0.93, $p < .001$).

Exhibit 1: Difference in Perceived Knowledge on ACA Enrollment across Eight Indicators



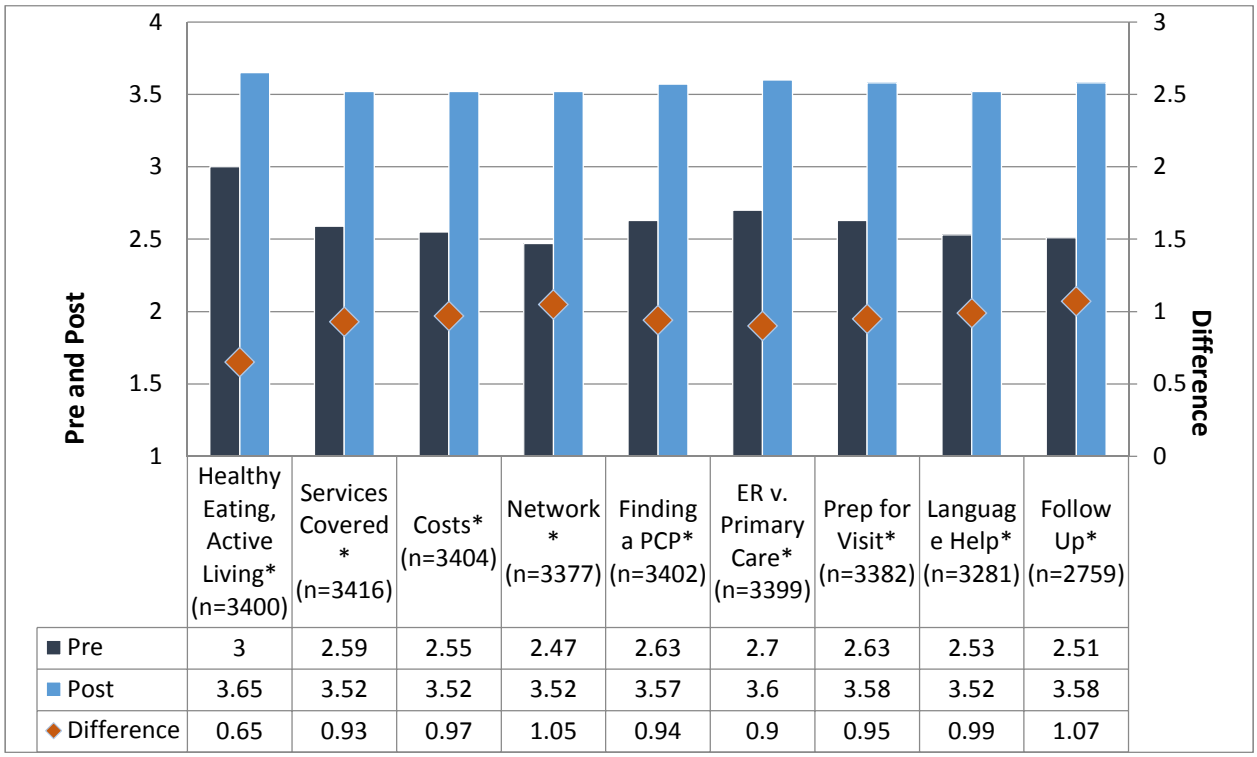
	Ways to Buy* (n=3521)	Tax Credits* (n=3555)	Benefits* (n=3605)	Types of Policies* (n=3481)	What Law Means* (n=3652)	How It Works* (n=3517)	Penalties * (n=3581)	Deadlines * (n=3575)
Pre	2.02	1.97	2.14	2.01	2.17	2.13	2.09	2.09
Post	2.98	2.94	3.09	2.98	3.12	3.06	3.15	3.22
Difference	0.96	0.97	0.95	0.97	0.95	0.93	1.06	1.13

Note. Difference is indicated by the red diamond, which refers to the axis on the right. Difference reflects a change in the mean scores, subtracting the perceived knowledge mean scores for each item from the retrospective pretest from mean scores for each respective item at post. Scales ranged from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. Asterisk indicates statistical significance at $p < .001$ level.

Using a retrospective pretest approach, respondents were asked to rate their perceived knowledge before and after the outreach event in nine health care utilization knowledge areas, based on the From Coverage to Care technical assistance series produced by the Centers for Medicare and Medicaid Services (2014). Wilcoxon signed-rank tests comparing respondents' post-event perceptions of their knowledge before and after the event revealed statistically significant mean differences in all the content areas. Exhibit 2 shows that, on average, participants had the greatest gains in knowledge in the following three topic areas: follow-up activities after visiting a provider (MD = 1.07, $p < .001$), "in-network" and "out-of-network" care (MD = 1.05, $p < .001$), and how to request language assistance

(translation/interpretation) from the doctor (MD = 0.99, $p < .001$). The smallest gain was observed in healthy eating and active living (MD = 0.65, $p < .001$).

Exhibit 2: Difference in Perceived Knowledge on Health Insurance Utilization Across Nine Indicators



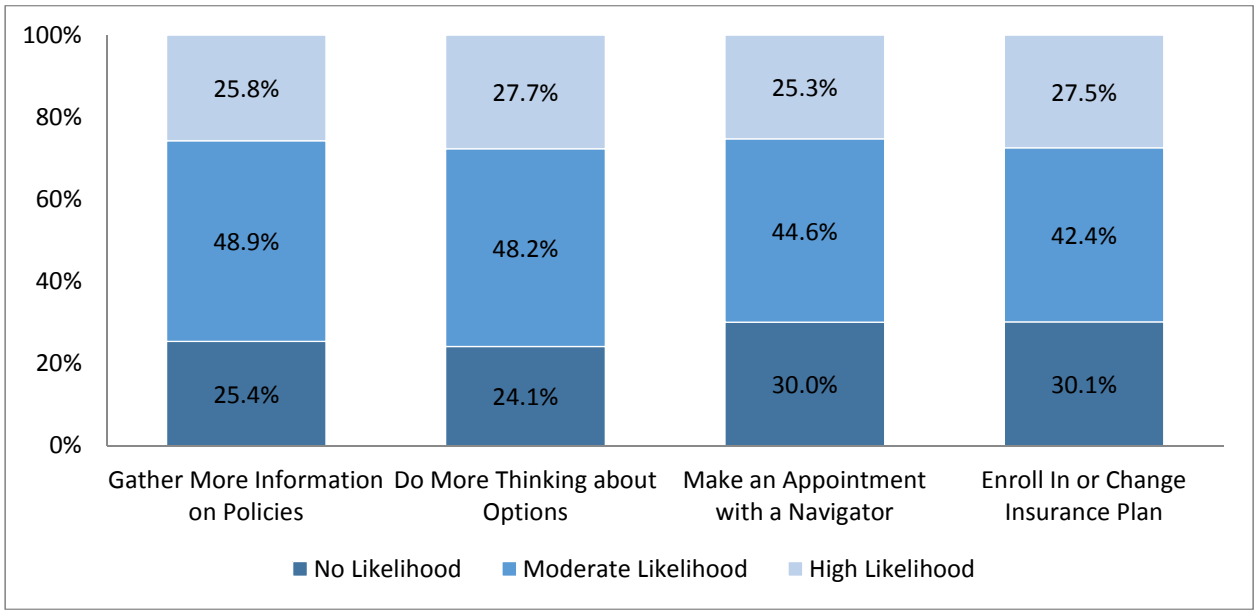
	Healthy Eating, Active Living* (n=3400)	Services Covered* (n=3416)	Costs* (n=3404)	Network* (n=3377)	Finding a PCP* (n=3402)	ER v. Primary Care* (n=3399)	Prep for Visit* (n=3382)	Language Help* (n=3281)	Follow Up* (n=2759)
Pre	3	2.59	2.55	2.47	2.63	2.7	2.63	2.53	2.51
Post	3.65	3.52	3.52	3.52	3.57	3.6	3.58	3.52	3.58
Difference	0.65	0.93	0.97	1.05	0.94	0.9	0.95	0.99	1.07

Note. Difference is indicated by the red diamond, which refers to the axis on the right. Difference reflects a change in the mean scores, subtracting the perceived knowledge mean scores for each item from the retrospective pretest from mean scores for each respective item at post. Scales ranged from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. Asterisk indicates statistical significance at $p < .001$ level.

Participants' Likelihood of Taking Action after the Event

Respondents were asked to rate their intention to engage in four actions related to health insurance following the enrollment event (see Exhibit 3). Respondents reported the greatest moderate or high level of intent to do more thinking about their options (75.9%) and gather more information about policies (74.6%).

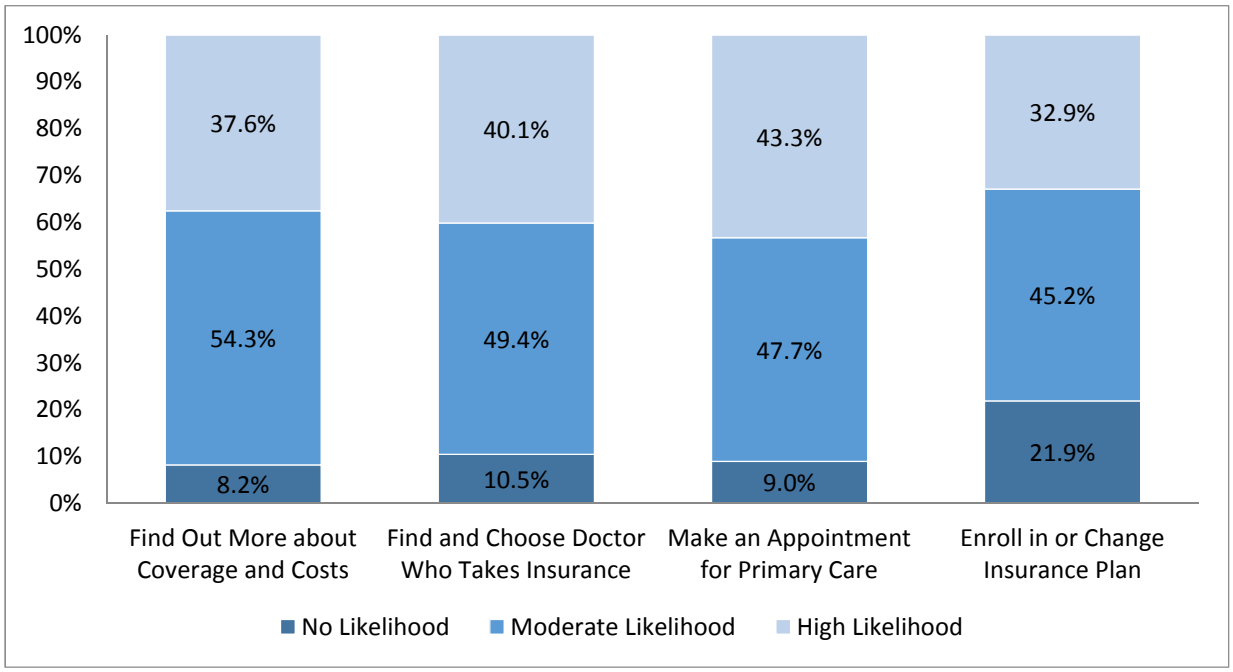
Exhibit 3: Respondents' Intent to Take Action to Enroll in Health Insurance Post-Event



Note. Scales ranged from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. The High Likelihood category included "A Lot" responses; the Moderate Likelihood category combined "A Little" and "Somewhat" responses, and the No Likelihood category included "Not at All" responses. Data labels are removed for percentages less than 5% for visual clarity.

Respondents were asked to rate their intention to engage in four actions related to health insurance following the utilization event (see Exhibit 4). On average across all events most respondents indicated intent to take action to utilize insurance post-event. Ninety-two percent of respondents reported moderate or high likelihood of gathering more information about insurance coverage and costs. Similarly, respondents' intent to make an appointment with their regular doctor or nurse for medical care was high, with 91% of the respondents reporting moderate or high likelihood of taking this action.

Exhibit 4: Respondents' Intent to Take Action to Utilize Insurance Post-Event



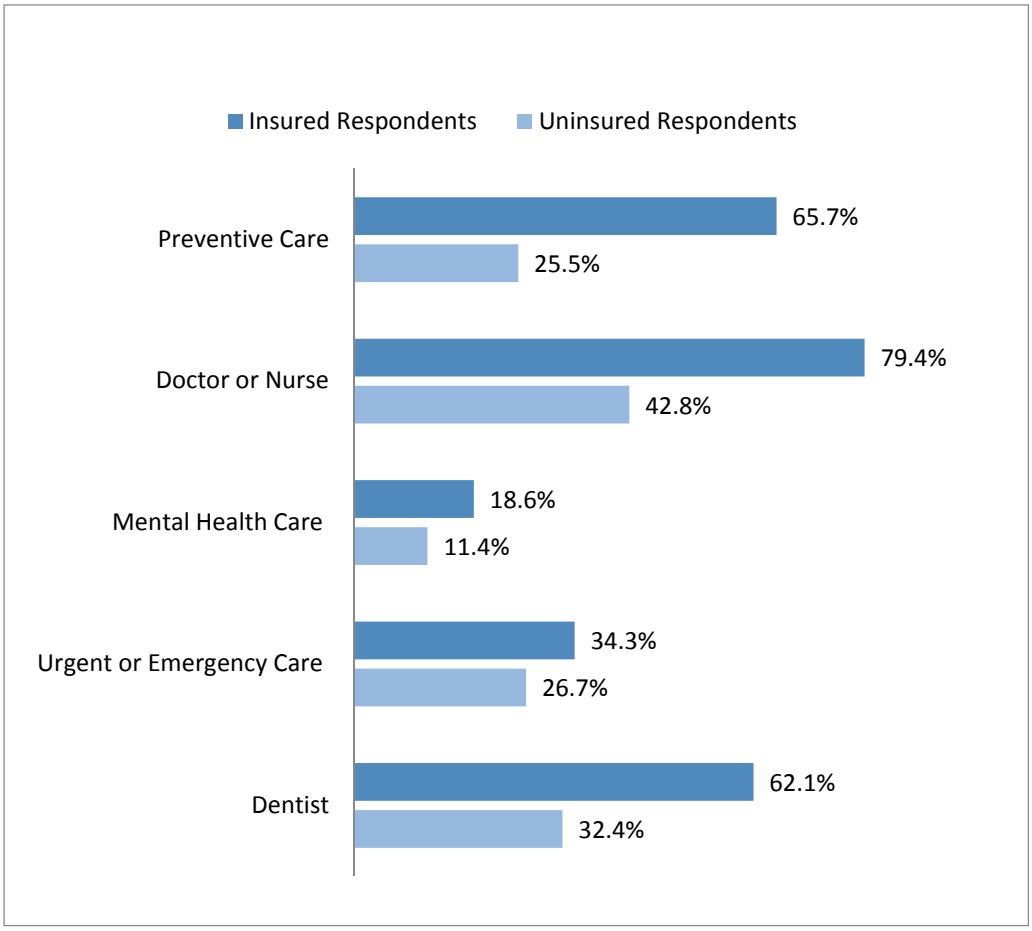
Note. Scales ranged from 1 to 4, with 1 = Not at All, 2 = A Little, 3 = Somewhat, and 4 = A Lot. The High Likelihood category included "A Lot" responses; the Moderate Likelihood category combined "A Little" and "Somewhat" responses, and the No Likelihood category included "Not at All" responses. Data labels are removed for percentages less than 5% for visual clarity.

Appendix F: Summary of Findings of Healthcare and Health Insurance Utilization by the Newly Enrolled

Healthcare and Health Insurance Utilization among Respondents

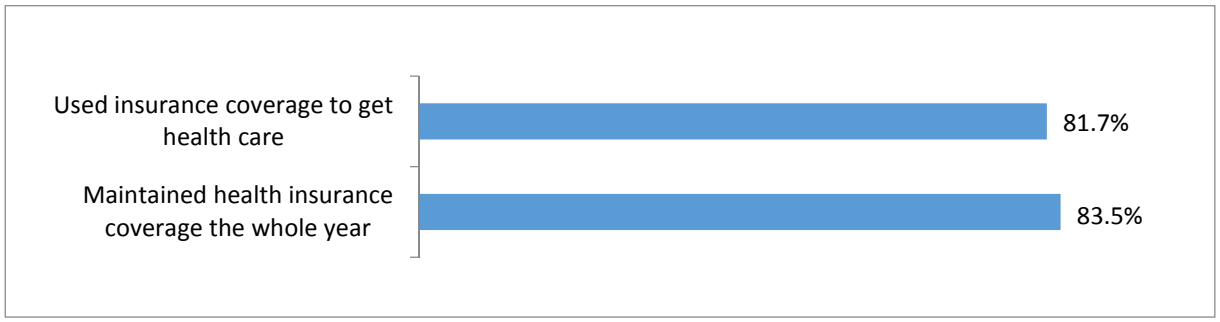
The majority of participants with health insurance reported visiting a nurse or doctor (79%), using preventive care (66%), and using dental care services (62%) (see Exhibit 1). As might be expected, utilization rates among uninsured respondents in these three types of health care services were much lower (26% for preventive care, 43% for visiting a nurse or doctor, and 33% for using dental care services). Slightly more insured respondents (34%) reported accessing mental health care during the past year than uninsured respondents (27%). More insured respondents (19%) reported accessing urgent or emergency care during the past year than uninsured respondents (11%).

Exhibit 1: Healthcare Utilization by Health Insurance Coverage Status



In addition, respondents indicated whether they used insurance coverage to access healthcare in the past year and whether they maintained health insurance for the entire year (see Exhibit 2).

Exhibit 2: Health Insurance Utilization



Among those who indicated they had health insurance coverage, 84% reported maintaining health insurance for the whole year, and 82% reported utilizing insurance.