Colorado Covering Kids and Families

The Colorado Outreach and Enrollment Work and Outcomes Strategic Plan
September 2017

The Colorado Outreach and Enrollment (O&E) Work and Outcomes Strategic Plan was created by an advisory committee of O&E experts in health insurance affordability programs over the course of approximately two and half years, and compiled by Colorado Covering Kids and Families (CKF). The O&E Learning Collaborative Advisory Committee members include staff from the 10 grantees of the Colorado Health Foundation's (the Foundation's) Community Approach to O&E funding opportunity, systems leaders such as the Colorado Department of Health Care Policy and Financing (HCPF) and Connect for Health Colorado, as well as others. **The recommendations made within the plan are those of the advisory committee members themselves to accomplish the identified goal and objectives.** This document was created as a CKF deliverable to the Foundation as part of the grant for the O&E Learning Collaborative. The committee and CKF hope that this Strategic Plan may help inform future O&E funding opportunities from the Foundation.

During the creation of the Strategic Plan, separate sub-committees worked on developing the various tactics by objective. In spite of different committees focusing on different areas of the Strategic Plan, there were key needs that came up throughout. It was identified that a neutral entity would be needed to carry out various information gathering, resource provision, and training evaluation tasks. An online resource library was repeatedly identified as important. Also, there was a strong desire to gather additional information through surveys and focus groups.

Note: Different organizations and agencies with different strengths, leverage points, and connections may help implement this strategic plan. As a result, those implementing the plan are encouraged to adjust the recommendations based on their role in the overall outreach and enrollment system (e.g., as an advocate, policy maker, state agency) to achieve the intended results. Additional implementation suggestions were provided by committee members' community partners in Appendix H for consideration by whoever will implement this plan.

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General Considerations

As the implementing organization(s) works toward these goals, objectives, and tactics, the committee believes these general considerations are important to keep in mind for the Strategic Plan to be successful:

1. Use data to drive tactics. It is essential to have data elements that are comparable across the entire state so that data can be compared between different assistance sites and help sites determine if improvements need to be made between sites. It is also important to attain local data that may be richer than state data in certain localities.
2. Consider how existing structures (e.g., the state's Integrated Project Teams) and resources can be leveraged and/or improved.
3. The aims described in this document reflect values that the committee believes should be incorporated into the current health coverage program system, as well as any other health coverage programs that may be implemented in the future. This is especially true of the values to streamline and simplify the eligibility process where possible.
4. This work may be applicable to O&E efforts for other assistance programs beyond health coverage programs.
5. Though the primary focus is on consumer independence, this committee realizes that some level of assistance will always be necessary. Priority should be placed on supporting sustainable O&E services within organizations that serve vulnerable populations

and developing strong referral networks to ensure that consumers are referred to the appropriate services.

6. There should be adequate and timely funding from applicable sources (tax base/Foundation/etc.) for the assister community to engage, enroll, and educate (including provision of health insurance literacy information) consumers. Funding should be committed in adequate time for the assisters to plan and staff appropriately, especially as it relates to annual recurring events, like open enrollment.
7. There should be both a state and community-level commitment to enrollment. This means that not only entities like HCPF and Connect for Health Colorado should be committed to this process, but also correctional institutions and public school systems, as well as other community-based entities.

Vision

All Coloradans have access to health coverage[1] that promotes their well-being.

Mission

To provide leadership and set the strategic direction for efficient and effective outreach and enrollment (O&E) activities across Colorado.

Goal

To establish a statewide and community-level consumer engagement process and to improve the assister[2] and consumer experience by simplifying and streamlining the eligibility and enrollment process for health coverage programs, with the intent of continuing to reduce the uninsured rate and increasing retention and utilization of health coverage.

Objectives and Tactics

1. Objective 1: Identify a statewide approach for qualifying[3] and reporting barriers to outreach, enrollment, and retention in health coverage. (Note: See Appendix A for a document summarizing the current state of reporting barriers in Colorado.)
    a) Tactic 1: Determine a process for what types of barriers should be qualified, reported, and prioritized.

[1] "Health coverage" as defined by the O&E Learning Collaborative Advisory Committee includes public programs (e.g., Health First Colorado (Colorado's Medicaid Program), Child Health Plan *Plus* (CHP+), and Medicare); private health insurance, including Qualified Health Plans offered through the Connect for Health Colorado state-based marketplace with financial assistance (including Advanced Premium Tax Credits (APTCs) and/or Cost Sharing Reductions (CSRs)) and without financial assistance; and charitable programs such as the Kaiser Permanente Colorado Bridge Program. While not health insurance, the Colorado Indigent Care Program and other sliding fee scale programs offered by Federally Qualified Health Centers and other safety net providers cover some of the costs of care and are programs assisters help consumers enroll into when other options are not available.

[2] An "assister" as defined by the O&E Learning Collaborative Advisory Committee means anyone who provides outreach and/or education on health coverage programs, and/or helps with the process of applying for and enrolling in health coverage. This includes, but is not limited to, Connect for Health Colorado Health Coverage Guides, Certified Application Counselors, and service center representatives; health coverage brokers/agents; staff at Colorado Department of Health Care Policy and Financing Medical Assistance sites, Certified Application Assistance Sites, Presumptive Eligibility sites, hospital out-stationing sites, and customer service centers; and staff at county departments of human/social services.

[3] "Qualifying" as defined by the O&E Learning Collaborative Advisory Committee means to determine if a barrier is a true barrier to enrollment and retention versus a barrier caused by a user or training error.

i. The types of barriers which should be qualified, reported, and prioritized may be separated into systems and non-systems barriers.
    1. Examples of systems[4] barriers include issues related to the eligibility and enrollment technology system used for determination of eligibility through paper, phone, or online systems, and enrollment into health coverage.
    2. Examples of non-systems barriers identified by the advisory committee include client correspondence, access to providers, cost of health coverage, and limited plan coverage. Outreach barriers may also fall under non-systems barriers such as client communications regarding eligibility and benefits that are difficult to understand; the inability of assisters to help clients in the language in which the clients are most proficient; special populations or complex circumstances; and a lack of a statewide, consistent, unifying outreach mission among all social service and assister organizations in Colorado. Barriers to retention may also fall into non-systems barriers including consumers[5] not responding to their renewal packets because they do not understand what they need to do to stay enrolled, and the need to actively select a plan and pay premiums for Connect for Health Colorado health coverage plans. Note: In regard to renewal packets, this committee acknowledges that the language has greatly improved in them since the March 2017 release of enhanced renewal packets. However, this committee did not conduct any evaluation specific to these packets and believes continued monitoring is needed to fully understand the improvement to the consumer experience.

b) Tactic 2: Determine a process for reaching out to the O&E community and consumers to identify barriers.
    i. Explore ways to create and fund a neutral entity[6] to identify systems and non-systems barriers experienced across the state, potentially with funding responsibility shared by key stakeholders and/or systems leaders.[7] Options may include regional surveys or focus groups (see Appendix B for additional information on surveys/focus groups).[8]
    ii. Explore ways to create, or leverage an existing, statewide-accessible phone number for reporting of systems and non-systems issues for assisters and consumers who are not directly affiliated with systems leaders. In order to best

[4] "Systems" are defined here as the Colorado Benefits Management System (CBMS), the Program Eligibility and Application Kit (PEAK), and Connect for Health Colorado's (the Marketplace's) system that is used for enrollment into private health insurance through their marketplace. Additionally, "systems" includes the various interfaces to other systems (e.g., Social Security Administration, Colorado Department of Labor, etc.) that provide verification associated with these three primary systems.

[5] Consumers are those who assisters serve, including all populations within the state that may need compassionate help from assisters and this may include a unique combination of cultural variables—including ability, age, beliefs, ethnicity, experience, gender, gender identity, linguistic background, national origin, race, religion, sexual orientation, and socioeconomic status—that the consumers bring to interactions.

[6] The "neutral entity" referred to throughout this document could one or more organizations performing roles under the Strategic Plan.

[7] Systems leaders include the Governor's Office of Information Technology, Colorado Department of Health Care Policy and Financing, Connect for Health Colorado, and the PEAK Outreach Initiative.

[8] Whenever possible, surveys or focus groups referenced throughout this document should be combined to reduce undue burden on assisters. A footnote has been included after each reference to "surveys/focus groups" recommending which ones could be grouped together. Each grouping is designated by a letter. The recommendation for this reference is survey/focus group A. Survey/focus group A is focused on reaching out to assisters to gather information related to barriers, assister proficiency, training, and promising practices. (See Appendix B for a full list of survey/focus groups.)

meet the needs of the community, the phone number should be answered by a live technician instead of an interactive voice response system and have access to resources that support consumers and assisters. Consider also including an optional email address. There should be individuals at this number who can identify to which entity a barrier should be reported.

c) Tactic 3: Determine a process for qualifying barriers to outreach, enrollment, and retention in health coverage.
    i. Processes for qualifying systems issues are currently in place, and should continue to be used and/or improved. One improvement may include additional funding for systems fixes to allow more systems issues to be prioritized and resolved.
    ii. Non-systems barriers are diverse, and a coalition should be leveraged or created that uses a coordinated process to qualify the barriers. The coalition should elicit help from stakeholders such as HCPF, Connect for Health Colorado, the PEAK Outreach Initiative, the Colorado Division of Insurance, and/or other relevant entities.
d) Tactic 4: Determine a process for how systems and non-systems barriers are reported and to whom.
    i. Ensure that current or emerging ways to report systems and non-systems barriers are well-known, effective, and clearly will not invite negative repercussion for consumers and assisters who report them. Additionally, the ways to report barriers should be accessible, simple, and trending issues should be easily tracked. Encourage assisters and consumers to use them as a primary method to report barriers.
    ii. Whenever possible, support the ability of existing organizations to effectively respond to and improve systems and non-systems barriers that are communicated through existing channels.
    iii. Prioritize and implement a unified process to capture and address non-systems issues, while leveraging existing entities and structures. This work should be done in concert with the activities described in (1)(c)(ii) to qualify the barriers, and could be done by a lead organization[9] and coalition that address overarching non-systems issues that cannot be attributed to one agency. Any coalition should include wide representation from involved stakeholders including state agencies, assisters, consumer advocates, consumers, and others.
    iv. Determine and implement an effective process for entities and groups that are already addressing identified non-systems issues to incorporate feedback from assisters and consumers, and to communicate the progress on their work back to the coalition discussed in (1)(d)(iii) above.
    v. Determine and implement an effective process for entities to easily send systems or non-systems barriers that are reported to the incorrect entity to the correct entity. This process should include a way to keep the person who reported the barrier initially apprised of the barrier and solution's progress.
    vi. As mentioned in (1)(b), a statewide accessible phone number may be used and incorporated into a process for consumers and assisters to report systems and non-systems barriers.
e) Tactic 5: Determine a process for assisters to problem-solve non-systems challenges and share promising[10] practices for resolving non-systems challenges with each other.

[9] This is different than the neutral entity referenced in other places in this document.
[10] Promising practices, for the purposes of this document, are timely practices based on the particular time/region/etc. identified by assisters and/or trainers that are showing as promising for successful work with target populations.

i. Create or leverage an existing online resource library[11] where assisters can problem-solve non-systems challenges, share promising practices, and access a curated library of resource materials. Also, ensure the online resource is supported through sufficient funding.

2. Objective 2: Identify a statewide approach for recommending solutions and communicating solutions or updates to barriers back to assisters and/or consumers (as applicable) to create a more standardized, seamless, and assister/consumer-friendly eligibility and enrollment process.
    a) Tactic 1: Develop a process for identifying solutions for both systems and non-systems barriers, including needed policy, outreach, retention, and enrollment barrier solutions.
        i. Leverage existing systems and partnerships whenever possible.
        ii. Systems leaders identify all entities that may be impacted by a systems change (e.g., other programs, consumers, assisters, counties, etc.) and have them represented when drafting solutions.
        iii. Ensure that whatever group is tasked with creating solutions has the appropriate amount of funding and state support to be able to make improvements.
        iv. Establish a way to involve consumers in the development and testing process of solutions within tight development timelines.
        v. Prioritize solutions that address the genesis of the barrier versus solutions that only address the barrier at a superficial level.
        vi. Whenever possible, proactively address systems and non-systems issues that may become barriers.
        vii. Be mindful of systems and non-systems solutions' upstream and downstream impacts including but are not limited to:
            1. Creating new barriers for consumers to accessing health coverage.
            2. The creation of solutions, recommendations, or mandates for assisters that may be difficult to implement without sufficient resources/funding.
            3. Evaluate the solution's effectiveness before implementing.
        viii. If generated solutions have too great a fiscal impact to be implemented, consider alternative solutions by requesting feedback from additional channels, including assisters, to generate more fiscally acceptable solutions.
    b) Tactic 2: Develop a process for prioritizing solutions for barriers.
        i. Use the same process as detailed in (1)(c) for qualifying barriers.
    c) Tactic 3: Determine a process to communicate resolved and unresolved barriers and general successes out to those who provided the barrier information, as well as to the assister community holistically.
        i. Those responsible entities to whom a systems or non-systems barrier is reported should report out barrier resolutions, report out information on when a barrier cannot be resolved (or resolved immediately), and report out general successes directly to those who reported the barrier, as well as to the assister community holistically.
        ii. Those who are communicating about systems and non-systems barriers should use existing, useful channels as

[11] The "online resource library" referred to throughout the document is the same resource.

possible, and those channels should be more broadly publicized. Those responsible for reporting out on systems and non-systems barriers should do so in a timely manner to ensure that assisters are able to integrate the resolution or temporary fix into practice as soon as possible.

3. Objective 3: Identify a statewide approach to cultural competency[12] and creating and utilizing culturally appropriate[13] resources and tools to engage, enroll, and retain consumers.
    a) Tactic 1: Develop guidelines for cultural competency of Colorado assisters and systems.
        i. Research and create a definition for "culturally competent."
        ii. Research already-adopted guidelines from other organizations and experts for cultural competency, and use them to inform the development of cultural competency guidelines for Colorado assisters and health coverage systems.
    b) Tactic 2: Develop guidelines for culturally appropriate materials.
        i. Research and create a definition for "culturally appropriate."
        ii. Research already adopted guidelines from other organizations and experts for culturally appropriate materials, and use them to develop guidelines for assisters about culturally appropriate materials
    c) Tactic 3: Develop a training for assisters about cultural competency and cultural appropriateness.
        i. An organization with expertise in cultural competency, cultural appropriateness, social determinants of health, and health literacy should be recruited and funded to develop the training. The organization should:
            1. Host bi-annual webinars for assisters on cultural competency and on what makes materials culturally appropriate.
            2. Host deep-dive webinar training on specific topics for assisters on relevant topics related to cultural appropriateness and/or cultural competency.
            3. Ensure trainings address all population pools[14] in Colorado, to equip assisters to tailor their assistance to meet the needs of local populations.
    d) Tactic 4: Identify the entities that currently create culturally appropriate resources and tools. Identify these resources and tools and how they are shared with assisters and consumers by those entities.
        i. Research and identify a master list of agencies that create materials.
        ii. Identify resources and tools that the agencies already created, including those on health insurance literacy.
        iii. Research established guidelines for how to use the agencies' materials.

[12] This is a guideline versus a definition: cultural competency is about how assisters conduct themselves with consumers with regard to and knowledge about a consumer's cultural identity and expectations.
[13] This is a guideline versus a definition: culturally appropriate is about the content of information presented to consumers with regard to and knowledge of the consumer's preferred language, etc.
[14] Definition of population pools includes all populations within the state that may need help from assisters and this may include a unique combination of cultural variables—including ability, age, beliefs, ethnicity, experience, gender, gender identity, linguistic background, national origin, race, religion, sexual orientation, and socioeconomic status—that the consumers bring to interactions. The basis for this definition is from the American Speech-Language-Hearing Association: http://www.asha.org/Practice-Portal/Professional-Issues/Cultural-Competence/.

iv. Verify if there are gaps in the resources for identified population pools.
v. Share resources and tools with assisters and consumers through an online resource library.
    1. If possible, leverage an existing online resource library.
    2. Consider one online resource library for consumers and one for assisters, or a consumer-facing side to the assister website.
    3. A consumer-facing website should use plain language and be available in the language(s) of the intended audience(s).
    4. Be sure to address regional considerations in any consumer-facing website.
    5. Ensure that organizations that provide technical assistance to assisters have access to this online resource library (libraries) as to provide the best possible support.

e) Tactic 5: Research and identify population pools in Colorado.
    i. Use data, including the number served and the amount of need for different population pools, to determine where to prioritize community-based assistance because of limited county or regional resources.
    ii. Identify sources of information for identifying population pools.
        1. Sources to consider:
            a. State refugee office
            b. County websites containing demographic information
            c. School districts
            d. Colorado Health Access Survey
            e. Local public health agencies
            f. U.S. Census Bureau resources including the American Community Survey, Community Population Survey, and American Fact Finder

f) Tactic 6: Create promising practice guidelines for working with and using culturally appropriate resources with each specifically identified population as relevant by region.

g) Tactic 7: Develop a recommendation for how to streamline the creation, maintenance, outreach with, and management of new and existing consumer resources and tools.
    i. Use one central online resource library for assisters to access resources and tools.
    ii. Identify an entity[15] to maintain the resource hub and advocate for culturally appropriate materials including:
        1. Generating a monthly correspondence to assisters who participate in the online resource library to highlight available resources and various outreach tactics for identified population pools.
        2. Encouraging systems leaders and other entities that create outreach materials to ensure the materials are culturally appropriate and address all identified state population pools.
        3. Encouraging creation of materials that are easy to rebrand and to use in print and online formats, including social media.
        4. Vetting all materials stored in the online resource library using the following tactics:

[15] Recommend this be considered the same third-party entity identified elsewhere in this document.

a. Review materials in the context of definitions and guidelines created by the organization(s) implementing the Strategic Plan.
b. Evaluate the sources of culturally appropriate materials.
c. Consumer testing of culturally appropriate materials through the use of consumer surveys or focus groups[16] involving those for whom the materials are intended.
d. Assister testing of culturally appropriate materials through the use of assister surveys or focus groups[17] involving the assisters who help those for whom the materials are intended.

iii. Create a recommendation list for translation of culturally appropriate materials.
1. Research translation services options.
a. Use existing national or state entity to find list of recommended translators.
2. Create a guide for assisters to contact translation services, including a recommended list of experienced, validated translators. One example in Colorado is the Colorado Alliance for Health Equity and Practice where free translation services are available.
3. Encourage use of consistent, quality translation services across the state for uniformity of translated materials.
4. Create guidelines for assisters for how resources should be translated to consider both language and culture.

iv. Create a recommendation for use of interpreters.
1. Research interpreter service options, both in-person and telephonic.
2. Create an assister guide for contacting and utilizing reliable interpreter resources.

v. Create promising practices guides for working with various populations.
1. Systems leaders identify existing list of dos and don'ts for social media and provide to assisters through existing channels.
2. Ensure that identified population pools are all addressed during guide creation.
3. Identify targeted outreach approaches for the gaps identified in part (3)(d)(iv) above.
4. The organization(s) that implements the Strategic Plan should work with systems leaders to identify outreach promising practices for culturally appropriate materials. They should contact assisters to share the identified promising practices with them, as well as provide recommendations on how outreach with these materials should be performed with consumers.

vi. Setup a feedback loop from the assister community regarding success of outreach practices using online resource library discussion feature and established channels quarterly. A report out of successful practices will be housed on the online resource library.

h) Tactic 8: Consult with O&E agencies across Colorado to promote and use culturally appropriate materials, as well as to use the online resource library for those materials.
i. Identify and contact assisters that could use materials.

[16] Recommend survey/focus group B. This group is focused on reaching out to consumers regarding culturally appropriate materials.
[17] Recommend survey/focus group C. This group is focused on reaching out to assisters regarding culturally appropriate materials.

ii. Consult with entities and assisters to encourage them to promote and use the materials.

4. Objective 4: Identify an approach to assister training that is standardized, high-quality, and comprehensive and results in proficient assisters.
    a) Tactic 1: Define what a proficient assister is and how to measure proficiency related to O&E, including retention.
        i. The advisory committee recommends the following definition: A proficient assister is a fully trained individual who is confident and competent to offer application assistance in their area of expertise that results in measurable outcomes in acceptance, denial, and/or maintenance of public or private health coverage for the consumer.
            1. Maintenance includes renewals, processing changes, and knowing who to refer a consumer to if your organization does not provide the services they need.
        ii. Proficiency may be measured in the following ways:
            1. Currently assister proficiency may be measured against the requirements of their role as laid out in accurate Standard Operating Procedures and information available in trainings as created by assister organizations or systems leaders, as well as any available federal guidance. The requirements of the assister role can be gathered through a focus group or survey.[18]
            2. Assuming that a proficient assister is an assister who is effective in their position, measures of proficiency may be determined by identifying current effective assistors across the state and surveying or holding focus groups[19] with them to establish what promising practices can be identified and how they achieve their effectiveness.
    b) Tactic 2: Define standardized, high-quality, and comprehensive assister training.
        i. Standard, high quality and comprehensive training means parameters are set in an assister's role and responsibilities by certifying entities.
        ii. Standard, high quality and comprehensive training means the training is consistent across entities, as applicable, and is formed from promising practices.
    c) Tactic 3: Identify and regularly update the list of entities that provide training to assisters.
        i. Current entities as of summer 2017:
            1. The Staff Development Center (SDC) trains counties and Medical Assistance (MA) sites primarily on the Colorado Benefits Management System (CBMS). The SDC is staffed by HCPF and the Colorado Department of Human Services (CDHS) staff. They are housed separately from either organization. The SDC also trains the trainers at counties and MA sites so they can deliver the training directly.
            2. HCPF trains Presumptive Eligibility site staff initially and provides periodic ongoing training. HCPF also trains Certified Application Assistance Site staff and provides them with retraining upon request. These trainings are typically via webinar. Also, HCPF offers periodic trainings for counties and community

[18] Recommend survey/focus group A.
[19] Recommend survey/focus group A.

partners on policy, programmatic, and operational updates. This training is primarily provided through webinars, frequently asked questions documents, and desk aides.

3. Connect for Health Colorado trains members of the Assistance Network and certified brokers. Most of their training is through online modules.
4. Program Eligibility and Application Kit (PEAK) Outreach Initiative trains community partners and front-facing county staff (those engaging with consumers directly) on the PEAK online application. They also provide various training resources on their website.

ii. Additional focus groups or surveys[20] should be performed with assisters to identify other trainers. Additionally, a meeting should be held with identified training entities to gather this information.

d) Tactic 4: Develop a recommendation for how training entities should work together to standardize and deliver training for assisters.

i. The advisory committee recommends that there should be one, expert neutral entity that evaluates training in Colorado that is not affiliated with any current training entity in Colorado. This entity would evaluate all planned new and on-going trainings for assisters in Colorado (both in-person and virtual), and maintain all training materials in a central online resource library. Training should be available on an ongoing basis, in addition to large annual trainings such as the 2015, 2016, and 2017 Building Better Health conferences (an annual training conference for Colorado assisters on topics related to health insurance affordability programs). The training process should include ongoing access to the online resource library where training is stored for all assisters.

1. The neutral entity should administer surveys or conduct focus groups[21] of assisters who are going through training so the neutral entity can bring this information back to the main certifying entities. These surveys or focus groups should identify gaps in training and where more training is needed. Recommendations should be made by the neutral entity on how to bridge the gaps. Information on learning modalities as well as content should be included. There should be a formal process for the neutral entity to collect the information and to provide the information to the certifying entities.
2. The neutral entity should ensure that the Connect for Health Colorado Assistance Network receives adequate training on public health coverage programs and policies (including Modified Adjusted Gross Income (MAGI) and non-MAGI Health First Colorado (Colorado's Medicaid Program) programs and CHP+), and that state certified assisters receive adequate training on Connect for Health Colorado health coverage options and policies. Adequate training should be defined during a collaborative meeting between a neutral entity, Connect for Health Colorado, and HCPF. The neutral entity should be tasked with evaluating if what is defined as adequate training is achieved, and report back to Connect for Health Colorado and HCPF on the results of that evaluation.
3. The neutral entity should be able to direct all assisters to the training resources they need based on certification and job description.

[20] Recommend survey/focus group A.
[21] Recommend survey/focus group D. This group is focused on reaching out to assisters who have recently gone through training.

4. When designating the neutral entity, ensure they have appropriate funding and resources to perform the requested tasks, and buy-in from systems experts and training entities with whom they will need to work so that the strategic plan can be carried out.
5. Work with current training entities to ensure training is developed whenever it is needed, specifically including training around common barriers experienced by assisters.

ii. The amount of the comprehensive training provided should be based on the tasks required of the assister.
iii. Provide regular feedback to assisters on their performance such as enrollment numbers, success of enrollments, and accuracy of data entry.
iv. Use a survey or focus group[22] to gather feedback on how training entities could work together to standardize and deliver training.
v. Identify a neutral entity that can train beginning assisters who are not county workers or members of the Assistance Network who need more policy training than what is currently available to Certified Application Assistance Sites.

5. Objective 5: Identify a process for determining and sharing O&E statewide, regional, and local promising practices with the O&E community in Colorado.
    a) Tactic 1: Develop a recommendation on how to determine what a promising practice is based on measurement and evaluation of O&E activities.
        i. Gather national, statewide, regional, and local promising O&E practices through the use of an online forum website[23] to determine what promising practices are.
        ii. Use surveys or focus groups[24] to determine what constitutes an O&E promising practice.
        iii. Gather promising practices through Colorado assister coalition meetings and existing Colorado-focused documents, toolkits, and other materials.
        iv. Utilize a nonpartisan health policy research group to assist with measurement and evaluation of what an O&E promising practice is.
        v. After developing an understanding of what are considered promising practices in O&E, work backward from these to determine what defines a promising practice in O&E. If cultivating community partnerships is determined to be an O&E promising practice, determine the most beneficial community partnerships by using a partner evaluation tool, such as Connect for Health Colorado and Enroll America's partnership evaluation tool (see Appendix C).
    b) Tactic 2: Develop a recommendation on how promising practices, ineffective practices, or practices that are no longer effective are collected from the O&E assister community.
        i. Collect O&E promising practices, ineffective practices, or practices that are no longer effective through an online

[22] Recommend survey/focus group A.
[23] The online forum website referenced throughout this document may either be separate from or a part of the online resource library website. This forum should be well curated to increase organization and effectiveness.
[24] Recommend survey/focus group A.

forum website, assister coalition meetings, regional debriefs, and surveys or focus groups.[25]

c) Tactic 3: Develop a recommendation on how O&E promising practices, ineffective practices, or practices that are no longer effective are shared with assisters.
    i. Share O&E practices with Colorado assisters through the neutral entity.
    ii. This neutral entity should maintain an online resource library of these O&E practices and share them out in a variety of different ways including written, in-person trainings, and conference calls. Assisters should have ongoing access to the O&E practice online resource library. Practices should be shared in a timely manner. Assisters should be able to rate the shared promising practices.
    iii. These practices should also be included in on-going assister training.
    iv. The neutral entity should also share out O&E practices through existing channels to reach the largest number of assisters, including through avenues such as assister newsletters and the Building Better Health conference. O&E practices should be available on an ongoing basis.
d) Tactic 4: Develop a recommendation on how to follow-up with assisters regarding recommended O&E promising practices to see if they are working.
    i. Have an organization that specializes in nonpartisan health policy research use surveys or focus groups[26] to talk to assisters on their use of O&E promising practices to see if those practices were effective; survey/focus group questions should include how the particular promising practices were implemented. That organization would analyze the survey/focus group results and create a report from these results.
        1. Assisters across the state should be encouraged to try similar tactics to develop an understanding of what works well in certain areas versus all areas of the state.
    ii. Promising practices to be tried and evaluated by assisters should come from the neutral entity's O&E promising practice online resource library.
    iii. HCPF and Connect for Health Colorado are encouraged to request information from their channels on what is working best in each region through their existing data collection processes and in-person debriefs following the open enrollment period. They should be encouraged to share this information through an online resource library that all assisters can access.
        1. These entities should collect data in such a way that O&E practices can be shared based on what practices are effective based on population and region.
        2. Promising practices should be gathered in a timely manner.
        3. Application and enrollment tips and tricks should be available to consumers to encourage their self-reliance.

6. Objective 6: Identify statewide, regional, and local approaches to outreach for enrollment and for retention of consumers enrolled in health coverage.

[25] Recommend survey/focus group A.
[26] Recommend survey/focus group A.

a) Tactic 1: Identify current data sources for consumers enrolled in health coverage, consumers who churn between coverage, and the eligible but not enrolled (EBNE) population.
    i. Consumers who are enrolled in health coverage.
        1. Use this broad definition of health coverage: Health coverage includes public programs (e.g., Health First Colorado, Child Health Plan *Plus* (CHP+), and Medicare); private health insurance including Qualified Health Plans offered through the Connect for Health Colorado state-based marketplace with financial assistance (including Advanced Premium Tax Credits (APTCs) and/or Cost Sharing Reductions (CSRs)) and without financial assistance; and charitable programs such as the Kaiser Permanente Colorado Bridge Program. While not health insurance, the Colorado Indigent Care Program and other sliding fee scale programs offered by Federally Qualified Health Centers and other safety net providers cover some of the costs of care and are programs assisters help consumers enroll into when other options are not available.
        2. Recommended data sources to consider include the following (see additional information on some of these sources in Appendix D):
           (Note: Consider using data sources where data could be compared by different entities across the state. Understand the need to help assisters become aware of primary data sources so this is possible.)
            a. Connect for Health Colorado effectuated enrollments for marketplace enrollments.
            b. Connect for Health Colorado Book of Business for marketplace enrollments (available monthly).
            c. Connect for Health Colorado's metrics website, including annual reports, monthly dashboards, and open enrollment reports.
            d. HCPF's monthly caseload reports for Health First Colorado and CHP+ (this is county level data, the preference would be by enrollee for each assistance site).
            e. HCPF's county factsheets for Health First Colorado and CHP+.
            f. Individual carrier enrollment data.
            g. Colorado Health Institute data.
            h. The Assistant Secretary for Planning and Evaluation Office of Health Policy data.
    ii. Consumers who churn[27] between coverage.
        1. Types of data that could be used to help identify churn between coverage sources include the following:
            a. CBMS reports of those denied for being over income, redetermination dates for coverage, and information from regional care organizations on who is losing coverage.
            b. Data from counties/regional care organizations through the use of business associate agreements or memorandums of understanding.

[27] The agreed upon definition of "churn" by the committee is the act of moving between health coverage sources (between or within public programs, between public and private programs, and between types of insurance/carriers on the Connect for Health Colorado marketplace) or off of health coverage entirely.

c. Data from insurance carriers related to life change events, including termination of employment and divorce or legal separation.
d. Data on those who have lost employer-sponsored coverage and may now be eligible for Health First Colorado. This data may be available from county workforce centers, newspaper announcements, by preemptively sending outreach information to companies (for example, companies that are volatile, large, and/or those that employ seasonal workers), and by working with rapid response teams from the Colorado Department of Labor and Employment (CDLE).
e. Other triggering events for churn (birth of a child, marriage) and where to get the data: birthing centers, courthouse records, and area religious leaders.
f. Identify churn data that is specific to seasonal workers.

iii. The EBNE population.

1. EBNE data needs to be accessed regularly to get the most current and accurate information possible. Agreement should be reached on the resources, process, and timing to access the data; however, since reports may change each year, an annual review of resources, process, and timing is recommended. Sources of EBNE data as of summer 2017 include:
    a. The "Colorado Outreach & Enrollment Health Data Map" created by the North Colorado Health Alliance (see Appendix E).
    b. Information gathered for the O&E Learning Collaborative Advisory Committee to detail out these tactics (see Appendix F).
    c. CBMS reports on consumers denied coverage for being a lawful permanent resident for less than five years.
    d. Free and reduced school lunch data.
    e. The Colorado Health Institute's EBNE data.
2. Determine uniform demographics on the EBNE population.
    a. Determine who/what entities to collect demographics from.
    b. Identify a common reporting tool to capture the data.
    c. Develop a reporting tool to share EBNE data with the O&E community.
3. Determine a process for how EBNE data from Colorado should be used to determine who the EBNE are.
    a. Once primary data sources for EBNE are agreed upon, mock up standard report(s) and visuals.

b) Tactic 2: Use the available data to identify and define each population that is enrolled in coverage, churns between coverage, or is EBNE.

c) Tactic 3: Common data measures should be used by assisters across the entire state, when possible, so data can be compared between organizations and used to improve O&E.

i. Common data measures should be developed through collaboration of both the data reporting and data gathering organizations.

ii. So that assisters can identify which assister organizations may be beneficial to compare themselves to and brainstorm with, common organizational demographics should also be collected.

d) Tactic 4: Develop recommendations on how to best outreach to those currently enrolled, those who churn, and the EBNE both at a statewide, regional, and local level in Colorado (see Appendix G for additional recommendations on messaging and tactics to deliver the messaging):
   i. Those who are currently enrolled in coverage to help them retain coverage.
   ii. Those who churn to retain coverage.
   iii. The EBNE population to get them enrolled in coverage.
      1. Target outreach messaging by specific populations: those eligible for APTC but not enrolled, CHP+ children, young invincibles, Spanish-speakers/Hispanic population, lawful permanent residents, those who are wary of government/prize self-sufficiency, early retirees, over 65 and not eligible for Medicare, and Medicare eligible with savings programs. Note: Ideally, populations would be identified based on data. The populations listed are meant to serve as directional guidance from experienced assisters for the populations they feel should be pursued; however, additional or different populations may also be relevant in the future based on data or assister experience.

Appendix A

Existing Processes for Consumers, Assistance Sites/Brokers, CBOs, and Counties to Report Barriers
Objectives 1(c) and 1(d)
May 2017

Note: While the chart in Appendix A includes several common avenues for reporting barriers, it is not intended to be a comprehensive list of all channels for reporting barriers.

Objective 1 (c) and (d). Process for Reporting Systems Barriers to Enrollment and Retention				
Process for Reporting	**Consumers**	**Assistance Sites and Brokers**	**Community-based Organizations (CBOs)**	**Counties and Medical Assistance (MA) Sites**
PEAK Outreach Initiative			*Tips and Tricks monthly calls *PEAK View	
Colorado Department of Health Care Policy and Financing (HCPF)	*Health First Colorado (Colorado's Medicaid Program) Member Contact Center *Monthly Disability Community Meeting *Member Experience Advisory Councils for Health First Colorado and for Child Health Plan *Plus* (CHP+) *HCPF website survey		*Colorado Covering Kids and Families (CKF) Coalition meeting attendance (HCPF also attends meetings, and/or CKF communicates with HCPF on behalf of CBOs) *HCPF survey on client correspondence *Ad hoc requests related to policy and systems changes *HCPF contract manager for Presumptive Eligibility sites and Certified Application Assistance Sites	*HCPF contract manager *HCPF county liaisons *County meetings
Governor's Office of Information	*PEAK Technical Support Call Center *CBMS.Help@state.us.gov	*PEAK Technical Support Call Center *CBMS.Help@state.us.gov	*PEAK Technical Support Call Center *CBMS.Help@state.us.gov	*CBMS.Help@state.us.gov *OIT hosts County/MA Site Knowledge Transfer calls

Technology (OIT)		*OIT hosts Colorado Benefits Management System (CBMS) Post Build Support Calls for CBOs on the Thursday following major builds	*OIT hosts CBMS Post Build Support Calls for CBOs on the Thursday following major builds *CBO support calls	following CBMS builds *CBMS Help Desk Tickets
Connect for Health Colorado	Connect for Health Colorado Customer Service Center	*Weekly/bi-weekly Assistance Network calls (for Assistance Network) *Broker Focus Group (for brokers) *Community-based Assistance Programs Focus Group (for Assistance Network) *Connect for Health Colorado Customer Service Center call line dedicated to Assisters and Brokers	*Connect for Health Colorado Customer Service Center *Community-based Assistance Programs Focus Group	*Connect for Health Colorado Customer Service Center
Customer and Community Partner Integrated Project Team (CCP IPT) and User Experience Integrated Project Team (User IPT)		There are two Integrated Project Teams: (1) The CCP IPT is to effectively oversee all external facing aspects of the state's eligibility and enrollment ecosystems. CCP IPT members include representatives from the Colorado Department of Human Services (CDHS), community partners, Connect for Health Colorado, counties, HCPF, the Staff Development Center, OIT/Deloitte, and the Colorado Department of Public Health and Environment (Office of Early Childhood). (2) The objective of the User IPT is through a unified vision for end users for the state of Colorado, effectively and efficiently manage the state systems to meet the needs of internal users who process in CBMS. User IPT members include representatives from CDHS, counties, HCPF, the Staff Development Center, OIT, Deloitte, Connect for Health Colorado, PEAK Outreach Initiative, Deloitte, and Denver Health - CMAP.		

Objective 1 (c) and (d). Process for Reporting Non-Systems Barriers to Enrollment and Retention (communication, cost of health insurance, limited plan carriers and plans, provider access, development of state-wide mission)				
Process for Reporting	Consumers	Assistance Sites and Brokers	CBOs	Counties and MA Sites
Colorado Consumer Health Initiative and Center for Health Progress			*Health Systems Transformation Coalition	
HCPF	*Member Experience Advisory Councils for Health First Colorado and for CHP+ *Monthly Disability Community Meeting *HCPF website survey	*HCPF survey on client correspondence *Project/program-specific stakeholder meetings convened by HCPF	*CKF Coalition meeting attendance *Monthly Disability Community Meeting (not the purpose of this meeting, but feedback is collected there) *HCPF survey on client correspondence *Ad hoc requests related to policy changes *Public Rule Review process for rule changes before and when presented to the Medical Services Board *Project/program-specific stakeholder meetings convened by HCPF	*HCPF county liaisons *County meetings *Project/program-specific stakeholder meetings convened by HCPF
Connect for Health Colorado	*Outreach and Communications Advisory Group (may be discontinued soon – Aug. 2017)	*Board Advisory Group *Brokers Focus Group (for brokers) *Weekly/bi-weekly Assistance Network calls (for Assistance Network)	*Board Advisory Group (limited membership) *Community-based Assistance Programs Focus Group *Outreach and	*Community-based Assistance Programs Focus Group *Outreach and Communications Advisory Group (may be

		*Community-based Assistance Programs Focus Group (for Assistance Network) *Outreach and Communications Advisory Group (may be discontinued soon – Aug. 2017)	Communications Advisory Group (may be discontinued soon – Aug. 2017) *CBOs can share thoughts during public comment at board and committee meetings	discontinued soon – Aug. 2017)
CCP IPT		The mission of the CCP IPT is to effectively oversee all external facing aspects of the state's eligibility and enrollment ecosystems. CCP IPT members include representatives from CDHS, community partners, Connect for Health Colorado, counties, HCPF, the Staff Development Center, OIT/Deloitte, and the Colorado Department of Public Health and Environment (Office of Early Childhood).		

Objective 1 (c) and (d). Process for Qualifying Systems Barriers to Enrollment and Retention	
HCPF	If a reported systems barrier is functioning as designed, HCPF reviews the submitted information to determine what, if any, combination of a system fix, policy change, and/or communication is needed.
OIT	When issues are reported to the CBMS Help Desk, OIT and Deloitte work together to identify the nature of the problem and the process for resolution.
Connect for Health Colorado	Non-PEAK/CBMS systems issues are addressed internally within Connect for Health Colorado staff and the appropriate board subcommittees.
CCP IPT and User IPT	There two Integrated Project Teams, the CCP IPT and the User IPT. They were established to bring forth barriers and qualify and identify solutions to streamline the customer and CBMS user experience with the eligibility and enrollment ecosystems. The project teams provide recommendations to the Work Plan Subcommittee (WPSC) which provides recommendations to the Executive Steering Committee (ESC). WPSC members include program directors from HCPF and CDHS, OIT's Director of Health Information Systems and CBMS, and representatives from Connect for Health Colorado and counties via the Colorado Human Services Directors Association (CHSDA). Members of the ESC include the Executive Directors of HCPF, CDHS, OIT, and Connect for Health Colorado; a county commissioner from Colorado Counties, Inc.; a representative from the Governor's Office and CHSDA.
Objective 1 (c) and (d). Process for Qualifying Non-Systems Barriers to Enrollment and Retention (communication, cost of health insurance, limited plan carriers and plans, provider access, development of state-wide mission))	
HCPF	HCPF works with internal and external stakeholders, and its county, state, and federal partners to address non-systems barriers.
OIT	
Colorado Division of Insurance	
Connect for Health Colorado	Non-PEAK/CBMS issues are addressed internally within Connect for Health Colorado staff and the appropriate board subcommittees.
CCP IPT	The CCP IPT was established to address both systems and non-systems eligibility and enrollment barriers as they pertain to the access, use, and functionality of PEAK/CBMS. However, it may not be the appropriate place to address non-PEAK/CBMS barriers.

Appendix B

List of Surveys/Focus Groups

Whenever possible, surveys or focus groups referenced throughout this document should be combined to reduce undue burden on assisters. A footnote has been included after each reference to “surveys/focus groups” recommending which ones could be grouped together. Each grouping is designated by a letter.

- Survey/focus group A is focused on reaching out to assisters to gather information related to barriers, assister proficiency, training, and promising practices.
- Survey/focus group B is focused on reaching out to consumers regarding culturally appropriate materials.
- Survey/focus group C is focused on reaching out to assisters regarding culturally appropriate materials.
- Survey/focus group D is focused on reaching out to assisters who have recently gone through training.

Appendix C

Connect for Health Colorado and Enroll America's Partnership Evaluation Tool

Partnership Evaluation Tool – the purpose of this tool to help you evaluate and measure how much you collaborate with key community partners for outreach and enrollment. Consider what strategies you might use to strengthen new or existing partnerships.			
Level 1 - Strong	**Level 2 - Moderate**	**Level 3 - Low**	**Level 4 - None**
Meets regularly to collaborate	Intermittently collaborates	Rarely collaborates	Does not collaborate
Strong co-location (provided a designated office space)	Shared space (allows to use a public space regularly)	General use space (allows to use a public space occasionally)	Space is not shared
Makes a warm-hand off or helps the consumer schedule an appointment for enrollment assistance	Collects commit cards or provides information about my organization	Displays/hands-out collateral materials	Does not share collateral materials
The enrollment assistance work is aligned, integrated, and a priority for the organization	The enrollment assistance work is a priority for the organization (one of many)	The enrollment assistance work is a low priority for the organization	The enrollment assistance work is not a priority for the organization
Marketing is integrated with organization's communication channels (Connector widget on site, social media, etc.)	Marketing information is sometimes shared	Marketing information is rarely shared	Marketing is not shared
Organization regularly directs electronic communications to customer/client base	Organization sometimes directs electronic communications to customer/client base	Organization rarely directs electronic communications to customer/client	Communications are not shared electronically
Will meet regularly to troubleshoot and improve referral process	Will meet occasionally to improve referral process	Difficult to change/improve referral process	Will not refer

Will confirm client is connected	Will assist in making introduction	Provides contact information	Does not inform consumer
Two-way referral relationship	One-way referral relationship	One time referral	No referral
Regularly initiates inquiry with consumer regarding health coverage status	Sometimes initiates inquiry with consumer regarding health coverage status	Rarely initiates inquiry with consumer regarding health coverage status	Does not initiate an inquiry with consumer regarding health coverage status
Access to health coverage falls within the core priorities of the organization	Access to health coverage may be one of many priorities of the organization	Access to health coverage may be a low priority for the organization	Access to health coverage may not be priority for the organization

Organization	**Ranking**	**Notes**

Appendix D

Where to Locate Data on the Currently Enrolled: March 2017 prepared by Colorado Covering Kids and Families and Enroll America

- The Colorado Department of Health Care Policy and Financing (HCPF)
  - HCPF's monthly Health First Colorado (Colorado's Medicaid Program) and Child Health Plan *Plus* (CHP+) caseload reports.
    - Health First Colorado totals by month for the whole state by subprogram.
    - Regional care organization numbers by county.
    - CHP+ totals by month for the whole state by various federal poverty levels and by subprogram.
  - HCPF's County Factsheets from state fiscal year 2015 to 2016. Health First Colorado is referred to as Medicaid in these factsheets.
    - Medicaid expenditures.
    - Top claim types.
    - Number of Medicaid adults (expansion and non-expansion) and number of Medicaid children.
    - Number of CHP+ members.
  - Other data from the Colorado Benefits Management System.

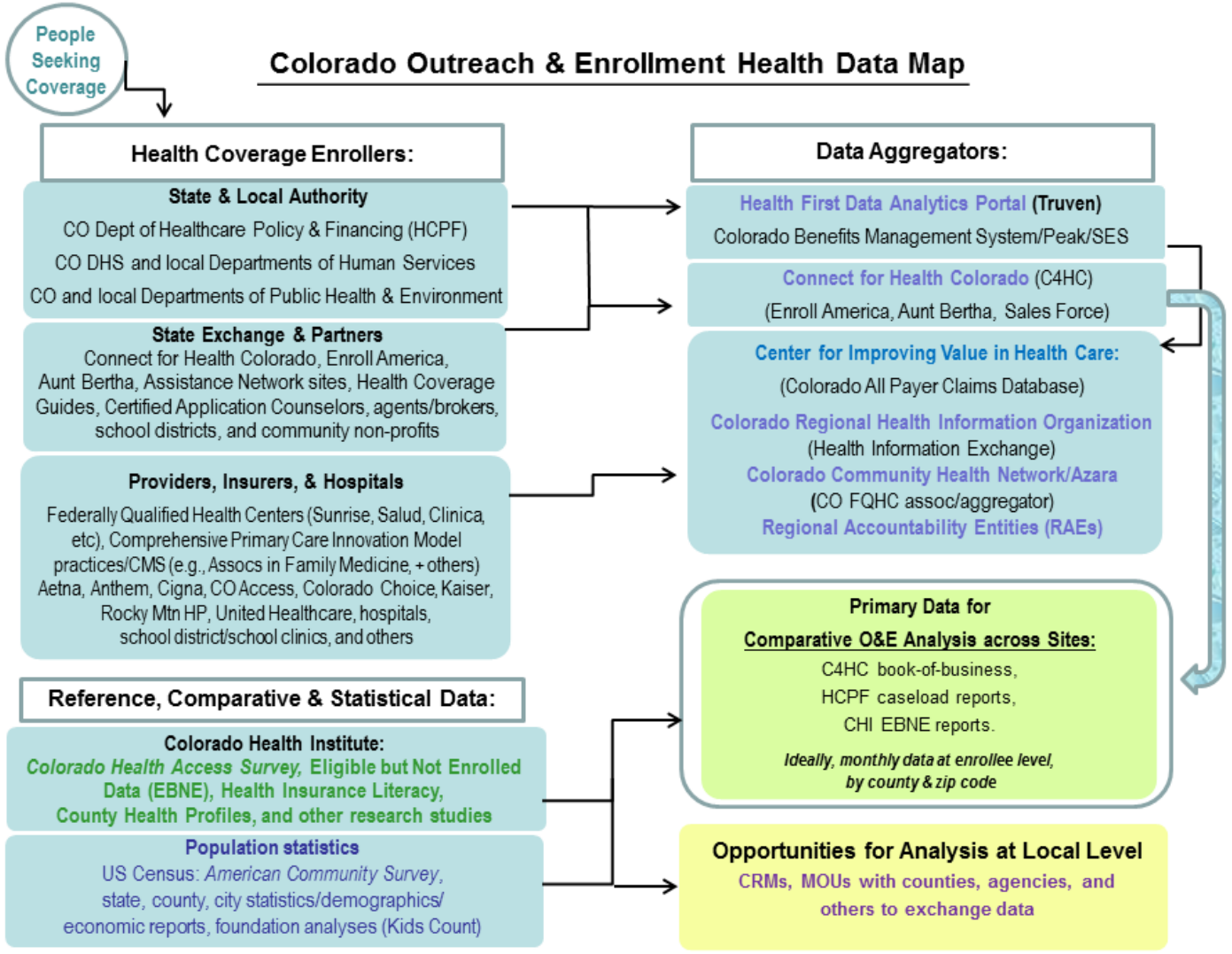
- Connect for Health Colorado
  - General metrics page.
  - Connect for Health Colorado 2016 Annual Report.
    - Page 6 contains the number enrolled for the whole state, percentage by age, percentage who received financial assistance.
  - Marketplace dashboard for January 2017.
    - More details about marketplace enrollments across the state.
  - 2015-2016 Open Enrollment Report by the Numbers (2016-2017 not available yet).
    - Page 10 starts the appendix with more detailed numbers, includes enrollments by percentage by age, by gender, by region, and by household size.
    - Page 12 is enrollment numbers by county.
    - Page 13 is average monthly premium tax credit by county.
  - Data in the Books of Business provided to individual Assistance Sites.

- Colorado Health Institute
  - A one-time report titled "Higher Rate of Eligible Coloradans Are Getting Coverage" provides Medicaid, adult and child, enrolled and eligible but not enrolled by county, 2015 data.

- The Assistant Secretary for Planning and Evaluation Office of Health Policy
    - Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report. This report was for the following period: November 1, 2015 through February 1, 2016. Search by keyword “Colorado” for Colorado data.
- Places to consider getting additional data:
    - Through direct contact with regional care organizations around the state. One regional care organization has been reported to provide Health First Colorado enrollments and information on those about to lose coverage for those members who are attributed to the local Community Health Center as their primary care provider.

Appendix E

Colorado Outreach & Enrollment Health Data Map prepared by North Colorado Health Alliance



Appendix F

Where to Locate Data on the Uninsured: March 2017 prepared by Colorado Covering Kids and Families and Enroll America

- Eligible but Not Enrolled (EBNE) Numbers
  - Enroll America/Colorado Health Institute (CHI) maps (provided at January advisory committee meeting)
  - Connect for Health Colorado Market by ZIP code
  - CHI's Colorado Health Access Survey analysis and data
- EBNE Demographics
  - Demographic data is available at the county level, but not the zip code level. The suggestion from the O&E Learning Collaborative Advisory Committee was for grantees to consider reaching out to their counties directly for this information.
- Uninsured Rates
  - Enroll America's 2016 Uninsured Estimates Map
  - Enroll America's Colorado State Snapshot of uninsured, including some state-level (and a few county-level) demographics
  - Enroll America's all counties in Colorado uninsured rates by major demographic groups
- General Demographic Data
  - American Fact Finder (from the United States Census Bureau): Demographics by county
  - Information through public health departments:
    - Ex. Mesa County

Appendix G

Additional Objective 6 Details

Appendix G contains detailed thoughts of the O&E Learning Collaborative Advisory Committee Objective 6 Subcommittee, including recommendations for implementing the tactics.

Note: Ideally, populations, messaging, and tactics would be identified based on data. These populations, messages, and tactics are meant to serve as directional guidance from experienced assisters as to the populations who they feel should be pursued, and the messages and tactics that worked well for them in a cost effective way; however, additional or different populations, messages, and tactics may also be relevant in the future based on data or assister experience.

e) Tactic 4: Develop recommendations on how to best outreach to:
    iv. Those who are currently enrolled in coverage to help them retain coverage.
        1. Messaging
            a. Public coverage
                i. Importance of coverage.
                ii. Health benefits covered by a particular program.
                iii. Importance of reporting changes timely.
                iv. Importance of renewing benefits timely.
                v. Education on how to use benefits.
                vi. Enrollment system changes and fixes.
                vii. Policy changes.
            b. Private insurance with tax credits
                i. Importance of coverage.
                ii. Health benefits covered with insurance.
                iii. Importance of reporting changes timely.
                iv. Health insurance literacy.
                v. Enrollment system changes and fixes.
                vi. Policy changes.
            c. Private insurance without tax credits
                i. Education about the availability of APTC and CSR.
                ii. Education about CHP+.
                iii. Importance of maintaining health coverage.
            d. Other care options – alternatives to insurance coverage
                i. Charity Care

1. Education about open enrollment periods.
2. Health benefits covered.
3. Importance of renewing benefits timely.

ii. Concierge Care[28] – Primary Care Subscription

1. "Tax deduction available."
2. Education about the need for high deductible health insurance.

2. Ways for assisters to deliver these messages
   a. Text.
   b. E-mail.
   c. Robocalling, if permitted by assister's certifying entity.
   d. Provider education and outreach – work with regional care organizations.
   e. Include information in insurance carrier mailings (e.g., statement of benefit, invoices, etc.).
   f. Community professionals (e.g., area hospitals, clinics, etc.).

v. Those who churn to retain coverage.

1. Messaging
   a. "Don't go uncovered."
   b. "Health insurance is personal; it's important to work with an assister to see what is right for an individual and their family."
   c. Assisters are here to help, who they are (Health Coverage Guides, Certified Application Counselors, brokers), and where to go to access that help.
   d. Stress the value of coverage.
   e. Education about enrollment windows: time sensitivity of getting covered or covered again. Timeframes for re-engaging.
   f. Importance of reporting changes in a timely manner.
2. Ways for assisters to deliver these messages (consider based on program audience):
   Note: Materials should include organization contact information. Materials include one-pagers, flyer, brochure, PowerPoint, business card, and tear-off pads. Include information on churn: how many days the consumer has to seek new coverage, and who the consumer should contact (e.g., website assister information).
   a. Reach out to businesses and provide materials regarding other options to Consolidated Omnibus Budget Reconciliation, or COBRA, coverage and Colorado Continuation/Conversion[29]; workforce development centers; packets for human resource departments with sample materials for consumers (including a poster for the break room – could also work for those

[28] Concierge care is when a consumer pays a membership fee for access to a primary care doctor or group of doctors.
[29] Per Connect for Health Colorado, Colorado Continuation/Conversion coverage was created by the Colorado legislature to fill gaps left by COBRA. Click here for more information.

churning off coverage); and packets to business leaders contacted through service clubs, the chamber of commerce, a small business incubator, or economic development group. Reach out to human resources staff through national, state-level, and regional associations.

b. Work with CDLE rapid response teams.
c. Provide written materials to other professionals who provide assistance with other social determinates of health support where health coverage may also be a factor (e.g., housing, employment, food, education, etc.).
d. Presentations to agencies that work with consumers/potential consumers and then leave paper materials behind.
e. Consider if it is possible to get information out via carriers.
f. Through providers: if consumers come in to access services and are both uninsured and also qualify for a special enrollment period due to a life change event.
g. Working with local charity organizations to educate about coverage options.
h. Social media.
i. Radio.
j. Posters in libraries, workforce centers, and other locations where people may be looking for work.

vi. The eligible but not enrolled (EBNE) population to get them enrolled in coverage.
    1. Target outreach **messaging** by specific populations: those eligible for APTC but not enrolled, CHP+ children, young invincibles, Spanish-speakers/Hispanic population, lawful permanent residents, those who are wary of government/prize self-sufficiency, early retirees, over 65 and not eligible for Medicare, and Medicare eligible with savings programs.
        a. When addressing EBNE populations that contain both Health First Colorado (Colorado's Medicaid Program)/CHP+ and marketplace populations, include messaging for both populations on your materials.
        b. General
            i. "Did you know that health coverage is available and affordable – possibly free?"
            ii. "Benefits: Preventative health benefits, etc. are available."
            iii. "Anyone can get hurt; having health coverage is about peace of mind."
            iv. "It's about breaking the law, and you pay one way or another, so doesn't it make sense to have insurance and not go bankrupt?"
            v. "Don't risk financial ruin."
            vi. "You pay one way or the other – why not have coverage?"
            vii. Importance of health coverage.
        c. Those who are eligible for APTC but are not enrolled
            i. "There is financial assistance available."

ii. “Premium help is available.”
iii. “Not using your tax credits is like leaving money on the table.”
iv. “Did you know that health coverage is available and affordable – possibly free?”
v. “You pay one way or the other – why not have coverage?”
vi. “Using your tax credit means you have more money left for other essentials.”
vii. “If you don’t qualify for government programs, there is still assistance available.”
viii. “Save on health coverage and use that money to improve your quality of life.”
ix. “Everyone wants to save money on premiums; no one wants to pay full price!”
x. Messaging including national and/or state data on how many who shop in the marketplace do not pay full price for their premiums.
xi. Avoid references to government in the messaging.
xii. Consumer test messaging to this population.

d. CHP+ children
   i. “You may qualify for affordable health coverage with just a small annual premium and little or no co-pays.”
   ii. “Preventative care is covered.”
   iii. “Provide protection and stability for your children.”
   iv. “Dental and vision coverage (it’s a PLUS!).”
e. Young invincibles
   i. Method: Use humor generally.
   ii. “Accidents can happen – it’s better to be covered than not.”
   iii. “The financial risk is too great not to have health coverage.”
   iv. “Get health coverage for long-term financial well-being.”
   v. “It’s affordable and may be free.”
   vi. “It’s the law; don’t get hit with a fine.”
f. Spanish-speaking/Hispanic
   i. “Your family depends on you.”
   ii. “Health coverage is important to developing financial stability.”
   iii. “Accidents happen; it’s best to be protected.”
   iv. “It’s the law; there is a penalty if you don’t have health coverage.”
g. Lawfully permanent residents
   i. “If you don’t qualify for government programs, there is still assistance available.”
   ii. “Your family depends on you.”
   iii. “Health coverage is important to developing financial stability.”
   iv. “Accidents happen; it’s best to be protected.”
   v. “It’s the law; there is a penalty if you don’t have health coverage.”

vi. "We're not Immigration and Customs Enforcement (ICE)."

h. Those who are wary of government/prize self-sufficiency
    i. "There is affordable health coverage available."
    ii. "There is free assistance available to get health coverage."
    iii. "Health coverage is about protection."
    iv. "You have contributed to this – you are eligible."
    v. "If you don't have health coverage, then we may all have to pay your way; you being covered protects society."
    vi. Explain the benefits, especially preventative care.
i. Early retirees
    i. "Make sure to think through your financial future; don't leave yourself open to big expenses due to not having health coverage."
    ii. "Secure/protect your financial future."
    iii. "Eligibility is based on taxable income, not savings."
    iv. "Health coverage = peace of mind."
j. Over 65 and not eligible for Medicare
    i. "Security and protection."
    ii. "Protect your spouse's future."
k. Medicare but eligible for Medicare Savings Programs (MSP)
    i. "Additional protection and security."
    ii. "Save on health coverage and use that money to improve your quality of life."
    iii. Education about MSP.

2. Ways for assisters to deliver these messages
    a. Use EBNE data to identify zip codes with the highest number of EBNE and reach out to them. If possible, also cross-reference by particular subsets of the EBNE population you would like to reach.
    b. If an organization has access to databases where data on individuals receiving other public assistance is stored, use those databases to determine other consumers who may be eligible for medical assistance and outreach to them.
    c. Setup memorandums of understanding with health care providers to access their consumer information in order to outreach to those consumers who sought care without having health coverage. If possible, confirm these consumers do not already have access to public or private health coverage before performing outreach.
    d. General population
        i. Identify zip codes and do direct mail.
        ii. Advertise through the newspaper, local movie theaters, and public transit.

iii. Rural advertisement placement: bathroom stalls and over urinals in bars, restaurants, bowling alleys, and community meeting places.
iv. Computer monitor screenshots at libraries, recreation centers, community colleges, and county human/social services lobbies.
v. Radio: public service announcements, interviews, and advertising.
vi. Social media and online forums.

e. Target outreach **tactics** by specific populations: those eligible for APTC but not enrolled, CHP+ children, young invincibles, Spanish-speakers/Hispanic population, lawful permanent residents, those who are wary of government/prize self-sufficiency, early retirees, over 65 and not eligible for Medicare, and Medicare eligible with savings programs.
    i. General population:
        1. Be frequently present in the communities in which you would like to perform outreach.
        2. Develop materials specific to the communities you want to reach.
    ii. Those eligible for APTC but not enrolled
        1. Identify assisters who work with a larger volume of these EBNE to encourage their clients to enroll with APTCs and track data related to these clients.
        2. Encourage brokers and assisters to partner to reach this population within the Connect for Health guidelines.
    iii. CHP+ children
        1. Work with school districts to access free and reduced school lunch program participants.
        2. Work with school human resources departments.
        3. Back-to-School nights.
        4. Send materials home via weekly folders.
        5. Articles in school newsletters.
        6. Materials in teacher resource kits for struggling families.
    iv. Young invincibles
        1. College and community college resource tables.
        2. At colleges that require undergraduate students to buy their health coverage if they do not have their own, target international students and their families and graduate students and their families. Work with the dean of international students to reach international students.
        3. Advertise on public transit.
        4. Advertise in movie theaters using a 15 second video that can also be leveraged through social media channels.

5. Advertise through social media: Instagram, Facebook, Snapchat, and Twitter.
6. Visit bars and Meet Up groups.
7. Advertise in newspapers, community concert venue guides, and food magazines.
8. Use English and Spanish posters with eye-catching images, and hang them in coffee shops, pot shops, pubs, and other gathering places.
9. Create a flyer for local pizza delivery services to staple to the top of their pizza boxes.
10. Place flyers at trailheads and local campgrounds.
11. Put flyers on cars at campus sporting events, during festivals, and during concerts.
12. Advertise in school newspapers, especially special editions.

v. Spanish-speaking/Hispanic
    1. Work within the community by having culturally-competent staff, native Spanish-speaking staff, and all of those staff working with trusted community partners within the Spanish-speaking/Hispanic community.
    2. Work with Spanish-speaking faith leaders and churches.
    3. Do radio ads and radio interviews.
    4. Advertise on local Spanish-speaking television channels.
    5. Advertise through Spanish-speaking newspapers or provide general newspaper inserts in both Spanish and English.
    6. Advertise on public transit, in movie theaters, and through social media.
    7. Reach out to restaurant associations to speak with restaurant managers.
    8. Attend Cinco de Mayo and Día de los Muertos celebrations.
    9. Visit bars and social clubs.
    10. Partner with school districts.
vi. Lawful permanent residents
    1. Do radio ads.
    2. Reach out to immigration lawyers and legal services.
    3. Work with community advocacy groups.
    4. Reach out via trusted community partners.
vii. Those who are wary of government/prize self-sufficiency
    1. Outreach using social media, local neighborhood listservs, websites like “Nextdoor,” or online neighborhood bulletins.
    2. Advertise in neighborhood newsletters.
    3. Flyer libraries and other community centers or gathering spots.
    4. Co-locate at a trusted community partner or medical provider.

5. Be present in rural communities on a regular basis.
6. Partner with trusted local community partners or leaders.

viii. Early retirees
1. Reach early retirees through financial planners as a referral source.
2. Outreach at classes for those considering retirement in the community.
3. Work with human resources at large companies.
4. Flyer libraries, golf courses, Silver Sneaker recreational centers, and other gathering spots.
5. Partner with the American Association of Retired Persons (AARP).

ix. Population over 65 but not eligible for Medicare
1. Partner with the AARP.
2. Reach out to senior advocacy groups, the local Area Agencies on Aging (AAA), and Medicare ombudsman.
3. Reach out to State Health Insurance Assistance Program (SHIP) staff.
4. Outreach to social clubs (knitting groups), veteran's organizations, and service organizations (e.g., Elks Lodge, the Moose Lodge, etc.), senior centers, and Silver Sneaker recreation centers.
5. Outreach to senior lobbying organizations.
6. Outreach to low-income senior housing organizations.
7. Reach out to county government and school districts that may have senior-associated programs.
8. Partner with faith-based organizations.

x. Medicare but eligible for additional programs (MSP)
1. Partner with the AARP.
2. Reach out to senior advocacy groups, the local AAA, and Medicare ombudsman.
3. Reach out to SHIP staff.
4. Outreach to social clubs (knitting groups), veteran's organizations, and service organizations (e.g., Elks Lodge, the Moose Lodge, etc.), senior centers, and Silver Sneaker recreation centers.
5. Outreach to senior lobbying organizations.
6. Outreach to low-income senior housing organizations.
7. Reach out to county government and school districts that may have senior-associated programs.
8. Partner with faith-based organizations.

Appendix H

Implementation Suggestions

In the spring of 2017, the O&E Learning Collaborative Advisory Committee created four subcommittees to work on incorporating greater detail into the Strategic Plan objectives in the form of tactics. Once the work from those subcommittees was integrated into the Strategic Plan, it was time for the Strategic Plan to be shared with the larger assister community to see if the committee was creating a plan that other assisters in the state agreed with. Numerous committee members sent a draft of the plan out to a select group of community partners for review. Many of the comments those partners returned were incorporated into the Strategic Plan itself. Some comments were too specific to be included in the overarching Strategic Plan; however, they were still worth capturing here for consideration by whoever may work to implement the Strategic Plan.

- General Strategic Plan notes
    - Consider increased "view only" access to the Colorado Benefits Management System (CBMS) for assisters.
    - Create a visual communications plan for assisters that explains in detail who assisters should call if they experience a particular issue and how to escalate issues if the first person they contact does not resolve the issue.
    - Create a resource manual for assisters for easy access to rules, processes, and common forms similar to the Colorado Indigent Care Program manual.
- Objective 1
    - General Objective 1 notes
        - Ensure that the O&E community that is reached out to includes the county, especially in relationship to retention.
        - Consider how assisters could have a primary contact person, based on program, to reach out to when there is a particular issue.
    - Tactic 4: Considerations for when the federal government is not supportive of the assisters' work, including messaging.
- Objective 2
    - Tactic 1: Consider creating an email list of interested assisters across the state that could be emailed whenever there is an important policy change or system update.
- Objective 3
    - General Objective 3 notes
        - Consider what languages would be available on websites that are meant to serve consumers. If consumers need in-person assistance, how would they be referred to an assister in their area that speaks their native language?
    - Tactic 3: Consider reaching out to community-based organizations across the state that already have a proven track record in cultural competency when developing state trainings.

    - Tactic 3: Provide examples to assisters on what has and has not worked regarding O&E for each specific culture/ethnicity in Colorado.
    - Tactic 5: Consider the population of children within the school districts who are ineligible for health insurance affordability programs.
- Objective 4
    - General Objective 4 notes
        - If training is created related to addressing known barriers, focus on ensuring that system leaders' call centers receive this information.
        - Consider the importance of training based on regional considerations.
    - Tactic 1: Consider measuring proficiency by appointments per capita.
    - Tactic 4: Consider how assisters could receive monthly reports on their enrollment numbers, outcomes of enrollments, and accuracy of data entry for them to work on self-improvement. Consider how mentorship could be encouraged or supported within O&E organizations to support assisters in improving.
    - Tactic 4: A preference was expressed for the Staff Development Center and Connect for Health Colorado to work more closely together to develop joint training.
    - Tactic 4: Consider the neutral entity reaching out to assisters when evaluating the training that is being provided to receive additional feedback.
- Objective 5
    - General Objective 5 notes
        - Use health insurance literacy to promote consumer independence.
- Objective 6
    - General Objective 6 notes
        - Create a planning timeline for assisters six months in advance of the open enrollment period.
        - Consider if patient financial services in hospitals and other provider offices might be able to provide data to assisters on those who still have remaining high balances, possibly through a memorandum of understanding. Alternatively, perhaps these offices would be willing to provide outreach mailings out to individuals with high balances on behalf of assisters.