# Reaching and Enrolling Families in Rural Communities

## Connecting Kids to Coverage National Campaign

## Webinar Transcript October 30, 2014

**Riley Greene:** ...and I wanted to thank you all for joining our Connecting Kids to Coverage webinar on Reaching and Enrolling Families in Rural Communities. We had almost 800 people sign up for this webinar, we know it's an in-demand topic and we're so glad you could take time out of your day to join us. We can see that people are still logging into the webinar service, so we're going to wait just a couple minutes and then get started because we have a lot of ground to cover today. But I just wanted to log on and welcome you and thank you for joining.

**Riley Greene:** Good afternoon everyone. This is Riley Greene with GMMB, and I just wanted to welcome you again and thank you for joining our webinar from CMS, the Connecting Kids to Coverage Campaign, on Reaching and Enrolling Families in Rural Communities. We're going to go ahead and get started. I just wanted to run through a couple of housekeeping items before I hand it over to Donna Cohen Ross at CMCS. We are going to keep your lines muted throughout the duration of the webinar, but we do have two different question and answer sessions lined up so you can ask our great array of speakers all of your questions on rural outreach. We will ask that you submit your questions through the chat feature of the webinar. You'll see a little control panel, a grey control panel on the right hand side of your screen. You can type your questions in there as they occur to you, send them to us and we'll queue them up and read them out during the question and answer session. All of the slides and a recording of the webinar will be available on InsureKidsNow.gov about two to three weeks after the webinar is finished so you can get a copy of those. If you want a copy of the slides any earlier than that you should all have my email address in the webinar invitation and you can feel free to reach out to me directly to get those copies. So without further ado I'm going to hand it over to Donna Cohen Ross, the Director of Enrollment Initiatives at CMCS to do a welcome and introduction. Donna?

**Donna Cohen Ross:** Great, thank you so much Riley and welcome everyone to today's webinar. We are really pleased to have such robust participation, we'll give you a count later on. But right now we've got well

over 300 people signed in, and so we're really glad to be able to offer this topic to so many interested people. As you see, we're going to have, we have quite a lineup of national and state based experts including one of our own Connecting Kids to Coverage grantees to talk about strategies and various ways of making sure that we're doing the best job that we can in reaching rural communities. I'll introduce them just before each of them speaks so that you know who they are. But first I wanted to just give us a little bit of context, because I think we always hear that there are disparities in rural communities when it comes to health, and that's true for health insurance as well. You can see in this slide that we've kind of just picked out some of this data that we think is relevant here and important in thinking about who we're trying to reach here. We know that rural communities have higher rates of uninsured, people without health insurance for both children and adults since rural families are much less likely than urban families to have access to coverage through a job, and mainly that's tied also to the lower incomes in rural areas. People who are in lower wage jobs are less likely to have employer based coverage than people in higher wage jobs. So you can see those two pieces are very much tied together. And so as a result, rural families rely much more heavily on public insurance, on Medicaid and CHIP for their children for health coverage. You can see that children in rural areas are covered by Medicaid and CHIP about 47 percent while in urban areas it's about 38 percent. So there is much more reliance on public programs and much more of a need to do outreach, and that's really the focus of our call today. I will mention as well that you just take a look if you're interested at the two papers that are cited at the bottom of this slide. The KFF, the Kaiser Family Foundation, piece in particular will give you lots more information and also some really important information about where we are as a result of the Affordable Care Act with respect to the states that have expanded Medicaid coverage for adults. Ironically many of the people who would be eligible for coverage if their state expanded are in states with very large rural populations and many of those have not yet expanded. So we have sometimes more of a coverage gap in those states with large rural populations. But still, we do have states, and you'll hear for example from Kentucky where outreach efforts can reach out to parents as well as children and that's very important in making sure that children and whole families get the coverage and the care that they need. So with that as a back drop, going forward we're going to start our conversation with our experts. And we've asked them to really focus on what some of the challenges are with respect to outreach in rural areas and what makes effective strategies particularly effective in those areas versus outreach as a

whole. So first we're going to hear from Gaby Boscan and Laura Hudson, both of the National Rural Health Association. They are going to give us a lot more background and context and tell you a little bit about their organization and the work that they do on this really important issue. So Gaby and Laura, welcome.

**Gaby Boscan:** Thank you Donna, and thank you for having us. Like Donna said, we're going to do a quick background on who NRHA is. We're non-profit, non-partisan, national membership. We have about 21,000 members, and of those members the majority are hospitals and clinics. We also serve physicians, allied health professionals, researchers, state and local agencies, and even students. So we do have great reach out throughout the nation to those working in health care in rural America. Our mission is to improve the health of the 62 million who call rural America home, and we provide leadership on rural issues through advocacy, communications, education and research. And through all of these, our main goal is to really get the point across that if you've seen one rural area you've only seen one rural area. Every area is different and has different challenges. That is also our biggest challenge, to make sure we're serving every part of the United States and meeting their needs as well.

**Laura Hudson:** We like to highlight that many times when people think of rural they think of the same picture that you see, the farmer on his land in the heartland. But rural can also be in the lush lands of the Northeast where people continue to move out from the cities, and they may not have the same access to care others do. Or rural could look like the desert of New Mexico, where to get to a specialty facility or even to reach a primary care provider you might have to drive between a mountain range, whether it's pouring down rain or snowing. So rural really is very different in every location, but rural is special, and we here at NRHA work to serve those groups.

**Gaby Boscan:** And not only that, our main goal is to also show how rural is very different from urban, and that's how we started this call. Rural is older, it's poorer, it's sicker than all of its urban counterpoints. As it was mentioned before, the percentage of those covered by Medicaid in urban is lower than in rural. So that is always our main goal in outreach, is making sure that people understand the difference and the disadvantages that the populations living in rural have versus those living in urban. It's always important to make sure that you understand that when reaching to rural communities, they can tell when people don't understand that difference.

**Laura Hudson:** Absolutely. And one of the other things that rural faces that is also an issue faced by our urban and underserved counterparts is a workforce issue. And so you can see on this slide that we've titled it Health Care Provider Shortages. There is an acronym called a HPSA, and every area is given a HPSA score, and that stands for Health Professional Shortage Areas. This is primarily used by the National Health Service Corps, a program from the Health and Human Services office. They send out physicians, mental health professionals, physician assistants, throughout the country to serve in these underserved and rural areas. But when you look at this map you see the red areas, and you can see that a lot of those correspond with rural areas whether you are looking at the Southeast or the Western United States. So when looking at rural you have to look at, how are you providing care and access to care to these individuals. As you can see bullet pointed on this same slide, when surveyed people say that access to quality healthcare is their number one health challenge when they live in rural America. While you might have 20 percent of the population living in rural, you only have nine percent of the physicians practicing there. So what can you do about that? Well, ways that NRHA and other partners are looking to do this and working with HRSA, the Federal Office of Rural Health Policy, are targeting training programs for medical residents that are going to major in family medicine and sending them to practice in a rural area so they can be exposed to the community and they also experience an expanded scope of practice, and that draws many of your students today to want to call rural home. That is not as much as the need is. So you look for things like having your family physicians work in tandem with family nurse practitioners, physician assistants and things such as that to address the workforce issues. This has to be addressed because the majority of your, or a great number of your rural family providers are actually retiring. You know, they're 70 years old and they've served the community for 40 years and they're looking for people to come and step up in those areas. So we're working with other graduates, medical education leader groups and partners to see what can be done. Some suggestions are looking to increase the number of students or a greater percentage of medical students to go into family practice and things such as that. But I wanted to highlight a couple of resources, and I apologize that they are not on our slide. But if you want some county data when you're looking to do some of these outreach and enrollment things you want to see where these scores are located. You can go to the Robert Graham Center, which is graham-center.org, and they use CMS's data from the National Provider Identifier Group, and you can actually get a break down by county. There is also a great resource called the Rural Assistance Center,

and that's a resource that has everything rural right there at your fingertips from research on family care providers to other things that have to do with rural, and that can be found at raconline.org.

**Gaby Boscan:** And following up on what Laura was saying, in addition to physician shortages, rural areas may lack public transportation, access to healthy food. Some of these rural areas can be considered food deserts. And there are just extreme distances and challenges within just the geography of rural areas that really hinder the access to care. So it's important to reach out and make sure that these people living in rural America have that access to care and the coverage they need to get it. All of these disparities are compounded within our senior and minority populations who are living in rural. That is always a main focus of the National Rural Health Association, working with our minority populations living throughout rural America. So to expand a little more within the rural health disparities, they are likely to report fair to poor health compared to their urban counterparts. They report more obesity. Studies show that 35 percent of children living in rural America are considered overweight or obese. Compare that to 30 percent of children living in urban. There are also statistics on 35 percent of children in rural live with a smoker compared with 24 percent living in urban areas. There is more chronic disease in rural. The diabetes rate nationwide is 9.3 percent of the population and in rural areas in West Virginia can go as high as 14 percent. So there is definitely the need for healthcare and coverage in rural areas and for rural kids.

**Laura Hudson:** So we've painted a picture of that rural is different and that there are great reasons to go out and do outreach and enrollment in rural areas. But we also wanted to share that we do identify partners for you, you don't have to go it alone. The NRHA has 42 state rural health association affiliates, we can see that on the map here. And these state associations are really the state champions and advocates for rural health in those areas. So as you are looking to go and do this outreach to reach these children and their parents that we've outlined, they are a good place to start. Whether it's in giving you a contact person at a hospital there or a trusted community advisor to show you who to go and talk to about maybe doing an outreach event at a community fair or maybe even a religious organization or something like that. These state rural health associations can help you identify those partners. Or even better, they can help be a connector between you and the other stakeholders in the area. Because again, rural is very innovative in the way that they do things because they have fewer people to do them. It does increase the need to be inventive. We want you

to be able to partner with them and come away, you know what to do. I can also provide the links that offer the contact information for these individuals. But these state associations are as you can see here, they do offer education whether it be training to people who work at these facilities or to community advisers. They really do try to be connectors and also those that hold data on rural in their area. So if you're looking for some data or some information for a report that you're filing to be able to go out to these areas and do some outreach, they also might have that information. But again you can always contact the National Rural Health Association and we can be of assistance as well. And then we wanted to show you a map of the NRHA membership because we feel like it's important to say that even though we represent 21,000 people, these just aren't people, these are leaders in the field of rural health. Whether they be administrators or they be practitioners or they be the people that are utilizing the rural health access in their areas. The NRHA really is proud of itself for being to say that our membership, even though they are in the field in rural America they are still making an impact on the national level because they are informing us of what the needs are in their area so that we can take that on and see if it's a national trend, a regional trend, or anything like that, try to work and identify these things.

**Gaby Boscan:** And so with that, we want to make sure you stay involved. We have a great website with a lot of resources, especially when it comes to advocacy and legislation, anything that is happening in Congress is up on our website and you can find more information there. Members have access to our blog and our updates, and we also have educational opportunities open to the public throughout the year where people can come and learn more and network. And if you ever have any questions we are a resource and we're here to help any way we can. So with that, that's rural. And if you have any questions, here's our contact information.

**Donna Cohen Ross:** Thank you so much Laura and Gaby. That was really helpful with some of the background information and we especially thank you for letting everyone on the phone know how to get in contact with the organization in their state. I saw from your map some of them are more in full swing than others, but it sounded like you are pretty well dispersed across the country, so that is really terrific. So we'll come back to you in a few minutes with some questions if folks have them. But now I'd like to introduce Rachelle Rubinow from Community Catalyst. She is the Program and Policy Associate working on Outreach and Enrollment. Community

Catalyst is based in Boston, but Rachelle, what do you have to tell us about outreach in rural areas?

**Rachelle Rubinow:** Hi everyone, and thanks Donna. So I'd like to start my presentation today by telling you a little bit about who Community Catalyst is and how we've been involved in rural outreach. Community Catalyst is a national non-profit health advocacy organization that was founded in 1998. As Donna just mentioned, our main office is in Boston, but we also have staff around the country including Pennsylvania, Washington D.C., Georgia and Missouri. While we are an organization with a national scope, one big focus of our work is supporting state based and local consumer health advocates now in over 40 states who have been involved in outreach work to uninsured populations. So we work with advocates who work both directly with rural populations or who partner with rural organizations on outreach work. During last year's open enrollment period, we spoke with advocates regularly and provided what we call learning community calls or opportunities to share information, advice, and assess best practices. And so a lot of the information that I'm going to share with you today comes from the conversations we've had with our advocates about their outreach strategies over the past year. So my co-presenters touched on this, so I'll just go over this quickly. Some of the unique features of rural communities that our advocates keep in mind when performing their outreach and enrollment work is the differences in geography such as lower population density and higher rates of seasonal or cyclical employment can lead to rural areas having higher uninsured rates as well as fewer health care providers and resources overall. And so that can really compound the difficulties in reaching populations. So what do these differences mean for rural children and how do they affect outreach to rural populations? So as Donna touched on earlier, children in rural areas are more likely to be uninsured than their urban and suburban counterparts. In addition, since children are more likely to be covered when their parents are covered the higher rates of seasonal and cyclical employment can mean higher rates of uninsured and underinsured parents, which in turn can mean higher rates of uninsured children. Children in rural areas are also more likely to live in deep poverty, poverty in low income households, which means they rely more heavily on public health insurance programs. And so overall, conducting outreach for the programs Medicaid and CHIP is really important in rural areas because the higher rates of uninsured parents leads to higher rates of uninsured children and children in these areas are already more likely to be uninsured than in urban or suburban areas. So now I'd like to go into some of the

outreach strategies that our state based advocates reported were effective in engaging rural populations. Due to some of the unique features of rural areas that I mentioned earlier such as lower population density, some of our advocates reported that the communities within these areas were often harder to reach which made it more difficult for those organizations to break into those communities and build relationships with them. For those reasons I wanted to share strategies with you that our advocates felt were successful ways for organizations to really engage with rural communities and begin to build those relationships. The four strategies that I'm going to discuss are building relationships with local media, training the trainer or educating rural organizations, meeting rural residents where they are, and then engaging and supporting rural organizations in outreach education and enrollment coalitions. So one effective way to reach rural populations is through the use of local media outlets such as newspaper and radio. Many rural communities have a newspaper that covers local events such as sports games and community fairs, and many residents are often loyal readers. So placing ads in these papers can be a low cost way to reach many rural residents. However, because many rural residents are seasonal or cyclical employees, their daily schedules aren't always conducive to spending long periods of time reading articles. And also due to the geography of rural areas, a lot of residents spend long periods of time in the car which can make radio an especially effective strategy. Printing ads or radio spots can be costly however, and so I also wanted to mention some traditionally less expensive media outlets such as farm bureau newsletters, community or church bulletins, and ethnic media sources. And lastly, earned media is also a much more cost effective way to raise awareness and generate publicity. So another cost effective way to use radio is by offering to have an organization member or enrollment assister sit in on the radio program to provide information or answer questions. A good example of this is an advocate partner of ours in Alabama had one of the members sit in as a regular guest on a local radio program to just talk about health insurance and answer people's questions. Another advocacy group of ours in Maryland has created ads and has actually now partnered with the Maryland Rural Health Association to strategize about how to best reach rural areas of the state with these ads. So overall, using media in rural areas our advocates found is really about having more of a local community oriented focus when trying to generate media opportunities, and really trying to build those relationships within the community and work collaboratively on a media project. While it may take more time than traditional media outlets, it can also be more of a bang for your buck type of strategy, because in the long run it will help form

a more long term relationship and can lead to multiple opportunities to collaborate in the future. So the second strategy that I'd like to discuss is finding an organization that already has ties to rural communities and educating them on the information you or your organization would like to provide, which is what we call training the trainer. A lot of our advocates found that seeking out organizations who have pre-established ties to rural communities can really help to spread information in a way that is likely to resonate with and reach those communities. Training the trainer is a great strategy because it really allows organizations to leverage each other's capacities to achieve a shared goal. While your organization can provide the knowledge and expertise on Medicaid and CHIP, rural organizations can then provide the ability to organize and engage their rural constituent base. For example, an advocacy group of ours in Oregon hosted a conference for more than 200 community health workers, and they trained those health workers in how to assist Latino families with enrollment into Affordable Care Act programs. In addition, an advocate contact of our in Pennsylvania actually created a trainer curriculum to teach local members of the community in how to do outreach and how to connect individuals to enrollment, and they actually created courses and exams to take to make sure everyone who went through the program was sufficiently knowledgeable. An additional strategy is meeting rural residents where they are or in areas that they are highly likely to frequent. What a lot of our advocates found during the first open enrollment period is that instead of placing advertisements in the communities and asking residents to come to you, it was much more effective to instead actually go into those areas where the target populations were most likely to frequent. But this approach can actually take one of two forms. Some of our advocates worked in regions with migrant farm workers, and they used a model of training community health workers or promotoras to go out into migrant farm worker neighborhoods to provide information or education on the spot. This model I would say works well both for outreach or just getting information out about Medicaid or CHIP, as well as for enrollment because promotoras are often able to provide enrollment assistance in native languages, access interpreter or translator services, and provide information in a culturally competent manner. In contrast, other organizations have found that they were able to reach more rural residents in a smaller period of time by going to more urban areas that rural residents were still likely to frequent such as retail stores and grocery stores that rural residents were likely to go to during a routine trip to those areas. For example, rural residents may make a weekly or bi-weekly trip to the grocery store, and so conducting outreach at that type of location may lead to more

frequent encounters with rural residents. This strategy can be really effective in outreach because of the ability to reach many people at one time, but it's not always as effective a strategy for enrollment because based on the type of venue you may be in it may not be as amenable for consumers to share or discuss their private health information. A really great example of meeting consumers where they are is, we had an enrollment assister who we worked with in a really rural and conservative area of Pennsylvania, and he was initially having a really difficult time reaching people at his office. But he found that actually going to the local library to hold office hours was a really effective strategy because it was a highly frequented location and because it was it was a very familiar and comfortable place for people to meet and talk. And so he ended up having a much easier time having discussions and ultimately doing successful enrollments of individuals at that location. So the final strategy that I'd like to share with you relates to the strategy of forming effective partnerships with rural organizations but is really one particular aspect of that strategy, which is supporting rural organizations in their participation within outreach, education and enrollment coalitions. So inviting a rural organization, by which I mean any organization that is based in a rural area, can really contribute to the diversity and robustness of your outreach, education and enrollment coalition if you participate in one. However, once you have successfully brought the organization on board it is important to keep in mind some of the unique challenges these groups can face. For example, rural organizations can be under resourced, which may make it more difficult for them to conduct frequent or extensive travel to outreach events or coalition meetings. Additionally, a lack of resources may mean that rural organizations may rely more heavily on coalition partners to produce resources such as communications resources. Rural organizations might benefit from having a template resource provided that they can easily alter and tailor to meet their needs. And lastly, rural organizations may not have as easy or consistent access to internet services. So what I'd last like to share with you are the types of potential partners that our advocates worked with to strengthen their outreach coalitions and maximize their enrollment efforts. Groups such as schools, Head Start programs, and childcare centers can be really effective ways of reaching parents and families. Groups such as county extension offices or faith-based groups can be effective at building ties with local communities. And lastly, provider groups can be important partners in connecting rural communities with both coverage and care. So with that I will conclude my presentation, so thank you so much for having me.

**Donna Cohen Ross:** Thanks so much Rachelle. I think we are at our question and answer period, which is great because I'm sure that from the presentations that you just heard already the wheels are beginning to turn and we have some questions for folks. Riley, do you want to start us off?

**Riley Greene:** Absolutely. I'll jump in here, and we do have a few questions through the chat so thanks for submitting those. To everyone else, remember you can type your question in in that control panel. So I first wanted to ask Laura or Gaby just to repeat those couple of websites that you mentioned as resources for folks. We have a lot of positive response with people wanting the links, so we've sent those out through the chat, a lot of people wanted to follow through with those.

**Laura Hudson:** Absolutely, thank you very much. One of the resources is the Robert Graham Center, which is the policy arm of the American Academy of Family Physicians. The Graham Center's website is graham-center.org. There you can find the primary care physician mapper program. Another link is for the Rural Assistance Center which can provide research data and connection points for all things rural. And that can be found at raconline.org. Finally, we referenced the Rural Training Track Program, and that can be found at traindocsrural.org. Please also see our NRHA website which was on the slide, ruralhealthweb.org. That is where you can find the link to our state rural health associations, it can be found from our main website going to the Networking and Programs, and then you'll see a menu pop out where you'll see the State Rural Health Association linkages. Thanks for the question.

**Riley Greene:** Great, thanks so much Laura and Gaby. I have a question for Rachelle now. Sarah Dinger is asking, you mentioned that there is an organization in Pennsylvania that offers Train the Trainer sessions. She is curious if you could share the name of that organization and where they could find some information on the organization to connect? So I don't know if that is putting you on the spot. Do you have that information on hand or could we follow up with Sarah?

**Rachelle Rubinow:** I'm happy to follow up with Sarah.

**Riley Greene:** Great, thanks Rachelle. Sarah, we will follow up with you with that information in Pennsylvania. Lots of questions coming in now. Just to answer the most common one, if you email me at riley.greene@gmmb.com, that is girl-mary-mary-boy dot com, I can send you a copy of the slides. They will also be available online at InsureKidsNow.gov along with a recording of the webinar in about two to

three weeks it takes to put up there. But I'm happy to share those with you in advance. I also have a question here for, I think this is a good one for Laura and Gaby. It comes from Vicki Bogazutski, sorry if I've messed up your last name. But Vicki is wondering if there are special programs or funding supports available for outreach within communities based on that HPSA data you mentioned in addition to efforts to draw providers into the area. So do you know about any funding support available?

**Gaby Boscan**: Not off the top of our head. I mean, it always helps to have that information when applying for grants. It definitely sets you apart because you have a foolproof way of showing that you are underserved or that there is a need. So it is always helpful to put that information in any sort of grant application because it does help to showcase the need. We can look into it and see if there are any specific grants out there for that and send that information to Riley, either way. But I don't have any specifics off the top of my head but it is definitely recommended to use that data whenever you are applying for a grant if you do fall under a HPSA area.

**Laura Hudson:** And I'd just like to add that many of our state rural health associations have found success with reaching out to community or state private foundations, and they do use that information to say how they could use what is more of a seed grant to do some of that outreach and enrollment. And on a greater scheme, from the Navigator grants that have been put out through numerous federal agencies, in talking with the secretary's office they say many of the applications that they have received, if there was a collaboration arm, I know that the last panelist mentioned Maryland in that way and working with the state rural health association there, it was good that the state rural health association came on to partner with the larger organization and again providing that data about the need for it to be more specified in rural. But as Gaby said, we can follow up and look and see about some special grant opportunities as well.

**Riley Greene:** Great.

**Donna Cohen Ross:** Riley?

**Riley Greene:** Donna, go ahead.

**Donna Cohen Ross:** Hi Riley, thank you. So I have a question which is for either one of our panelists, but I was prompted to think about this question based on something Rachelle mentioned. And that was, I think Rachelle you mentioned the promotora strategy that we know is working really well in local communities, not only rural communities but certainly very helpful

there. And you mentioned working with migrant farm workers. But I was wondering if either you or Laura and Gaby wanted to say something about the rise of Latino and Spanish speaking populations in general in rural areas and in states where people might not ordinarily think that there are large Spanish speaking populations, I'm thinking particularly of North Carolina and other southern states. I was wondering if either of you wanted to comment on that and how that should help us think about our outreach work.

**Gaby Boscan:** Hi Donna, this is Gaby. We have done some work along the border, the US/Mexico border, and obviously there are high populations of Spanish speakers. The first thing we found was that everything needed to be in Spanish. So we had to translate all of our information and make sure that the person doing the outreach was someone local and someone that was trusted in those communities. And that will vary by state and by area. Also kind of understanding what the background of that group may be. If you are working in Texas you may have the majority of your population be Mexican. If you are working in the Northeast you may have more of a background of Puerto Rican. So it's really important to understand where they are coming from because every country is different and they each have a different cultural background, they have different ways of saying things. Even though they all speak Spanish they do have their specific dialect I guess you would say. So it was always very important, it was the first thing we found out, is to really translate everything and then work with people in the community that spoke the language that understood who everyone was and really got us in the door to bring the information that we were trying to give them. So that would be the number one thing is to work with someone in the community.

**Donna Cohen Ross:** I think that's generally good advice, and certainly in the work that we do to try to translate our materials into whatever language I think the advice you give is what we always follow and that is to make sure that folks in that community can understand and feel comfortable with the interpretation that we put on paper or on the air. So thank you for that. Rachelle, I don't know if you had anything you wanted to say, but then I think, Riley I think we probably want to keep going. But Rachelle, did you have anything you wanted to say about this topic or anything else?

**Rachelle Rubinow:** Yes, just to echo and reinforce what Gaby and Laura said about translating materials and really making sure they are culturally competent. I know something one of our advocates found is that really having a native Spanish speaker doing the translation or the drafting of the

resources rather than taking something written in English and using Google to translate and translating it that way, was the way to make sure the materials would resonate with native Spanish speakers. I think another thing that our advocates found is that when working in a rural community that is also a native Spanish speaking community, it can make it harder to reach in that the conversations or the views about insurance are also a little bit different. Our advocates found that health care is really viewed as very transactional, as let's just pay for it as we go. And so they found when going out into those areas they kind of had to do both their traditional outreach and enrollment but also really pivot to having a conversation about what the value of insurance is.

**Donna Cohen Ross:** Thank you. Riley, you want to move us along?

**Riley Greene:** Absolutely. Thank you all for your great questions and keep in mind we have another question and answer session coming up at the end. But we will keep on keeping on because we have two more folks to hear from who also have some excellent strategies to share for reaching rural communities.

**Donna Cohen Ross:** Great, thank you so much Riley and thanks everybody for your great questions. And I will just say that we got just about to 500 participants on this call which is really quite phenomenal for us. But next I'd like to welcome Kayla Combs. She is the Rural Project Manager for the Kentucky Office of Rural Health. Kentucky is a state that has been really going very strong with respect to outreach and enrollment, and I think she has some strategies and advice to offer all of us as we move forward. So welcome Kayla.

**Kayla Combs:** Thanks Donna for that introduction and thank you all for having me here today. I'll start off by just talking a little bit about what the Kentucky Office of Rural Health is just for you guys that don't know what your Office of Rural Health does. Keep in mind there is an Office of Rural Health in each of the 50 states, and I'll give you some contacts, a link at the end if you are interested in looking up who that is in your state. So we are funded by the Office of Rural Health Policy, and our office here in Kentucky is one of two located in a rural area. So we are at the University of Kentucky Center of Excellence in Rural Health, and that's in Hazard. So for those of you who don't know where Hazard is, that's southeastern Kentucky, a town of about 5,000. We have four major programs that run through the Kentucky Office of Rural Health. We have the actual, and we call it the KORH, the KORH program. The staff that we have, we have five staff here,

just the ins and outs, day to day activities. And then we have the Medicare Rural Hospital Flexibility Grant which we call Flex, and the Small Hospital Improvement Program Grant which we refer to as SHIP. I'm the project manager over both of those grants, and I primarily work with small rural and critical access hospitals. So that's kind of what I do here in the Kentucky Office of Rural Health. And then we also have the State Loan Repayment Program. So keeping in line with talking about the HPSA areas, that is kind of where we use HPSA areas to provide and place providers in those shortage areas here in Kentucky with that program. So just looking at Kentucky, as we went through the ACA last year and our governor decided to expand Medicaid here in the state and also did a state-based health insurance marketplace. Here in Kentucky that is the Kentucky Healthy Benefit Exchange and also referred to as Kynect, that's what the website is, and for shorter reasons we call them Kynect. So just to look at what role that the Kentucky Office of Rural Health had in outreach and enrollment, and I'll preface this by saying that the benefit exchange and Kynect, they really had the biggest role here in enrollment in Kentucky, but we were a rural health office, we knew what kind of partnerships we had across the state with rural providers and rural health partnerships. We knew we had a role to play in this outreach as well, and we decided to play to our strengths with our strong ties with the rural communities all across the state, we are a state wide organization so we are familiar with rural communities from east to west, north to south. So what we did, we partnered with Kynect to reach the providers in rural areas. And we wanted to help them enroll the patients, the people in their communities, because these providers they're the ones that know their communities best. So instead of us reaching out directly to those community members we actually kind of went with the approach to reach out to providers and assist them in assisting their community. So to do that we partnered with other rural entities across the state, area health education centers, different rural health networks, universities, hospitals, all sorts of folks across the state do this work in Kentucky. And then I'll skip ahead to the next one, and then go back to this slide. Okay. So what did it look like, what we did? So what we did, is we did a road show model. I mentioned we were taking this information to the providers in these communities. So we did a road show model. We did four different sessions across the state, our audience primarily being rural providers, coalitions, agencies, the Kynectors, the actual people who were signing folks up on the insurance, clinic management staff, hospital management staff, a variety of folks. We had one community forum, so this was new for us. We decided to test the waters. We had some people come to us, and they said, we want to

reach out to the providers but we also want to reach out to our community, it is a pretty rural community in northeastern Kentucky. So during the day we had our provider focused session, and then in the evening we had a community forum. So we had a lot of outreach to that community inviting folks to come, learn about what Kynect was, learn about the insurance marketplace. And we actually had probably five or six Kynectors volunteer their time in the evening to come be onsite at that forum and sign people up on the insurance as they came out. So we got about two dozen people signed up there on the spot which was great. So we consider that a success. So what did it look like? The Kynect representatives, lots of times it was the executive director or if he wasn't able to make it they would send another knowledgeable employee there at Kynect. They would present about an hour and then they would do a question and answer session for folks there. In every session, I think the lowest number we had was about 80 but usually we had right around 100 people attending. So we had the Kynectors on site like I mentioned. Our goal was to have people leave with a greater knowledge of how Kynect works and how they can use it to help their patients in their communities. So now I'll go back. So our responsibility as the state office was to find these partnering agencies. We knew them better than anyone else, and actually after we did one or two of these sessions they started coming to us and saying that they wanted to do this in their part of the state. So that was great, and we knew we were doing something right then. So we would contact the speakers at Kynect, get them on board, tell them when we needed them to be there, where we needed them to be. Then we would work on getting the word out. So we had pretty extensive listservs here, we used the Primary Care Association newsletter, the Rural Health Association newsletter. All kinds of folks across the state helped us get this word out, hey we're having a session in Hazard, we're having a session in Morehead, come out here, hear what we're going to say, it's free, provide lunch, all that good stuff. Then we also did registration and we facilitated the session and recorded the question and answer session, and we were able to send that out afterword with a follow up evaluation. And then Kynect threw in all the speakers' travel, they presented at no charge, and like I mentioned the presentations were two hours, the first hour being a review of Kynect and the second for question and answer. Okay. So just to show you guys some of our outreach effort, this is what our map looked like after our four sessions. We colored in a county for each participant that we had. So if we had a participant in Perry we colored it in. So we felt like we covered a pretty good part of the state, and most of that that you see in the most rural parts of the state. And then the next map that I have to show you

guys, it is a map of Kentucky's uninsured. So this was a little over a year ago before people started signing up on the exchange. The map doesn't look great, there is a lot of red there. We have some very high percentages of uninsured across Kentucky. But then the next map I'll show you, this is after the ACA. So there was a 42 percent drop in uninsured across the state, and our colors look much better. And 80 percent of those that signed up through Kynect were eligible for Medicaid. So very heavy Medicaid population here in Kentucky, and thanks to that a lot of these providers that were seeing a lot of completely uninsured patients, underinsured patients, charity care, that is all dropping and now these providers, hospitals, clinics, they are getting paid for these visits that before they weren't. So I went through it pretty quick, but I did just want to mention before I end, work with those partners across the state, and if you don't have any good rural partners or you are looking for some good rural partners, please reach out to your state office. That's what we're here for, putting you in touch with those folks. That second link that I have there, and feel free to email me with any questions you have, but the second link there is for NOSORH, the National Organization of State Offices of Rural Health. You can find state by state who your SORH is and how you can get in contact with them, because using your SORH for finding your rural partners... We are not able to pay for food, it's hard for us to pay even to have a room to have these sessions in. So through our partnerships we were able to provide lunch for everyone that was a big draw for people to come. Definitely we could not have done it without these great partners to give us some space, and we just had some wonderful places to have these sessions and really great turnouts. And I just put the link for the Kentucky Rural Health Association, I was talking about that earlier, NRHA is a great resource as well, your state health association, use them that's what they're there for. And then if you want to check out the Kynect website that link is there on the bottom. So that's all I have to say, thank you all.

**Donna Cohen Ross:** Kayla, thank you so much. I know we're going to come back to you with some questions. So stick with us. Before we do though, we have our final speaker, and I'm really pleased to introduce Stacey Wright. She is the Program Manager at the Telluride Foundation, the Tri-County Health Network, and one of our Connecting Kids to Coverage grantees in target markets for our Connecting Kids to Coverage Campaign. So Stacey, thank you for being with us, and I turn the floor to you.

**Stacey Wright:** Thank you Donna, and thanks everybody else who is still on the phone from across the country. It is pretty exciting. My name is Stacey Wright, and I am the Programs Manager for Tri-County Health Network. The

Telluride Foundation is our parent organization. We are a not for profit entity committed to improving the quality and coordination of health and health care services in rural southwest Colorado by increasing access to health care and integrative health services at lower cost, and we try to accomplish this through collaboration and innovation. We consist of seven network members that include a rural health clinic and two federally qualified health centers. One serves a more than 50 percent Hispanic population including migrant farm workers and the second includes a dental clinic. We have a primary care clinic with a 24 hour emergency center, a not for profit community hospital, a regional community health center, and our parent organization the Telluride Foundation is a 501c3 community foundation. We offer five primary community programs that include insurance assistance. To date our insurance enrollment navigators have enrolled 955 individuals into Medicaid, and we've educated and enrolled more than 1,000 people through Colorado's insurance marketplace. We have a school based mobile dental clinic that serves more than 900 kids twice per year for preventive dental care with no out of pocket cost to the parent. As of this year we serve sixteen schools in four rural counties. Consent forms on this program also highlight, they identify uninsured children. Additionally, we collaborate with school districts to receive their free and reduced lunch rosters because we are certified application assistance sites, and as many of you know a child that qualifies for FRL will also qualify for Medicaid or CHP+. And through this program, our navigators contact all these families to enlist them in our enrollment services. We have a non-emergency medical shuttle which offers rides assisting rural residents. We average about 144 people per year to and from their appointments, and some of these rides are more than 100 miles each way. Finally, we have a chronic disease care management program that includes community health workers. They are non-clinical and they work in the field. These workers have screened more than 1,000 individuals for heart disease and diabetes, and they offer referrals and peer support for lifestyle change. Akin to that, we have patient health navigators that work within the network clinics, and they care manage 2,443 clinic registry patients that have been diagnosed with diabetes or cardiovascular disease. Like the CHWs they offer referrals and peer support. So as you can see through our programs, identifying the uninsured makes our inter-program referrals very easy. And looking at the population details of rural Colorado, we outreach through the counties of San Miguel, Ouray, Delta and the west end of Montrose County. This overall area is identified as a Health Professional Shortage Area and a Medically Underserved Area and Population for primary dental and mental health care. These designations signify as at risk

communities with too few primary care providers, medium-high poverty pockets, and extreme poverty and elderly populations. One such community has close to a quarter of their population over 65 years old and growing. Our counties are comprised of high mesa mountains, rugged 14,000 foot peaks, and red rock canyons located in the southern most region of the western slope. Cities and towns are separated by rural county roads and limited state highway systems that cross mountain passes and provide challenging driving conditions, especially during the harsh winters. The network's four service county area is over 5,000 square miles, and we average about four people per square mile excluding the largest cities of Montrose and Delta, as compared to the Colorado state average which is about 41 persons per square mile. The clinics serving these regions are truly frontier clinics and some of the most rural medical clinics in the state. But to truly understand the unique needs of our region, I want to underscore the varying cultural differences between each community. And the best example of this is a community that is tourism-driven with a high have versus have not population. This community placed a sugary drink tax initiative on its ballot just last year. And in stark comparison to that community we have a small mining and farming community that passed an ordinance making gun ownership mandatory. These communities are less than 60 miles apart, and both of them require drastically different approaches to rural outreach. So what makes rural outreach difficult? Isolated communities are typically very tight knit and are extremely hyper sensitive to what we call "stranger danger." These families stay in their communities for generations and when you are new to town the entire community knows it. Rural and frontier communities tend to be strongly Republican and are in general opposed to government involvement. They historically have little input into state or federal policy. Rural communities do not receive the services or resources that are available in urban areas, and typically there is one small community clinic or residents must travel outside of their community for care. Now often our navigators will hear a rural resident say, I never go to the doctor, or if I have to see somebody I will go to the emergency room. And we find that this attitude is sometimes due to the fact that providers in these areas are transient and residents feel like they have no real connection to a doctor. Or maybe something occurred outside of the clinic walls that initiates a person's barrier to seeing a local provider, maybe an occurrence in an alternate forum such as small government or a school or community event can lead to an overall barrier to care. For obvious reasons, lack of internet connectivity and limited cell use in rural areas can make outreach and follow up difficult as limited minutes will prompt unreturned phone calls. An overall lack of health

literacy leads to difficulties in outreach, from the complexity of the application process to confusing approval and renewal letters and all the letters in between lead to frustration. We often find that this frustration leads to people not even opening their mail. Speaking to this point, it is very important that all outreach materials are really easy to understand and are also available in both English and Spanish. Rural residents take great pride in taking care of their own, and often responses will include, my family doesn't take government handouts. Geographic isolation is an obvious barrier to rural outreach, and we'll talk more about navigator availability during an upcoming slide. Typically, rural residents are hardworking people, which can lead to procrastination because as we've noted the enrollment and follow up materials can be difficult to understand which will sometimes lead a person to say, I just can't think about this right now, this process is way too overwhelming. So what do you want to try to avoid in rural outreach? First of all, it's really important to understand scare tactics or high pressure tactics simply do not work. Saying to somebody, it's the law, or you have to, while this is true it really won't get you anywhere. You need to keep government out of the conversation whenever possible. You can remind a person that you are available to answer questions but you are not there to argue or to try to change their political stance. Also, don't avoid the difficulties associated with the application process. Don't expound on them, but don't pretend it's always easy. Try to keep the conversation limited to what insurance can do for the individual or their families, and importantly if you don't know an answer admit it and follow up with the correct answer. Because follow up will always build trust in a rural community. Don't forget you can gauge someone's understanding of the application process or Medicaid and CHP+ benefits during your conversation. Offer your education when it's needed, but don't assume ignorance. And remember, rural residents are typically law-abiding citizens. While they might not agree with their government, they will typically follow the law. So keep in touch with them and make yourself available for when they are ready to move forward. In looking at enrollment assistance and elements to success, our greatest through all of our programs is hiring local navigators. Local navigators are the key to success in rural communities. Locals are seen out in their communities, grocery stores, post offices, local clinics, school functions and community events. They become known as a local resource, as a local help to enroll and troubleshoot. Navigators live in the communities where they provide outreach activities and will be hired in part for their relationship and respect within the community. When hiring in a rural area, remember you can teach someone eligibility rules, the enrollment process, and how to use

the computer, but you can never create trust and community relationships. A rural navigator must be boots on the ground, meaning they must be out and available in the community. Don't ever expect rural residents to come to you, you are going to have to go where they're comfortable. And to that extent, you must remain regionally located. Rural people will generally not travel out of their community for service. We've found that meeting clients at libraries and home visitations always work the best. While you need to have a presence at local events, you might not be approached in public but people will notice your attendance and they will note your connection to the services you provide. They will follow up with you later. Typically these clients will work 8-5, 7-6, or two or more jobs, and our navigators always answer and return phone calls when their clients are available. They meet after hours, before hours, and over the weekends. Calls are returned within 24 business hours, and this is also stated on their voice mail. This keeps their clients from wondering or worrying when they'll be called back. Remember that once a client has made the move to actually contact you, they have admitted to themselves that they do need help. So don't make them wait for that phone call. An enrollment conversation might occur three or more times before the individual feels comfortable enough to enroll with you. So the best way to leave any conversation is, here's my card, please feel free to contact me with any questions. And typically these people will call you back. And while rural people are private, they share good and bad experiences with friends and family. So once a navigator has had a few successes in a rural community, the community members will begin to identify the navigator as a trusted hand. Word will get around and the phone will start ringing, so soon you will be enrolling the client's extended family and their friends. So what works in rural outreach? Connecting locally. And you guys have heard about this through all the different slides, but I'm going to touch on it again because it is so important. Community based navigators work hands on with potential enrollees. They make follow up calls, they help troubleshoot, they offer health literacy, and they are accessible at convenient locations within their communities to help individuals. Connecting Kids to Relationship building. Remember the key here is follow up, availability and dependability. You simply must return phone calls in a timely manner. Positioning outreach as a resource. Explain to clients that you are there to offer education regarding the new insurance laws but not to change their minds or argue politics. You are in the business of enrolling and educating. And to this extent, developing a relationship with your local health and human services department is incredibly important. Go in to these ladies and gentlemen, talk to them, explain your availability outside of

their office hours or your availability to help in the field. Being seen as a resource by HHS staff will develop what we all know will be a mutually beneficial relationship. Moving on, don't spin or use lingo that will be viewed as dishonest or avoidant. Nobody likes to feel tricked. Remember that this is a private population. They don't want their neighbors seeing them going to an assistance office, and libraries as we have all been saying are a great resource as well as going into a client's house. And finally, navigators must as we say beat the streets. They have to get out in their communities to meet customers on the street, hand shaking, handing out business cards, word of mouth is key. I know most of us hand out more business cards while we're walking in the alley to the grocery store or going into the library or post office than almost any outreach event. So that will wrap me up. Thank you.

**Donna Cohen Ross:** Great. Stacey, thank you so much for that really important set of strategies and do's and don'ts, and I would just venture to say that so much of what you said is true no matter what kind of community our outreach partners are working in. I think they are all predicated on respect for people and wanting to help and meet people where they are which so many of you said. So thank you so much for that. I think we are - okay, it's my turn for just a moment before we get to some questions. I wanted to mention one strategy that is actually a new enrollment strategy under the Affordable Care Act, and I want to mention it because it has to do with working with hospitals. It's the Hospital Presumptive Eligibility Provision which I'll explain in a moment. The reason I wanted to raise it here is that so many of you are keenly aware, I know we've been reading in a lot of the newspapers but also hearing about just the difficulties that rural hospitals are facing. One of the important steps that I wanted to offer is that working with hospitals in your community to boost enrollment, to do outreach and boost enrollment in Medicaid and CHIP is very important for patients and members of the community but can also help the hospitals themselves. It can help them in terms of creating more of a revenue source, lowering uncompensated care because more people have insurance, and is a really important setting for outreach and enrollment. It also is helpful because we know from our general experience with outreach that when we do outreach when people are seeking health care that is an important time to talk about insurance. So I just want to mention some of the key highlights of what the Hospital Presumptive Eligibility strategy is. We probably should think about another webinar where we go into this in a little bit more detail. But for some of you, hopefully many of you who are familiar with presumptive

eligibility as an enrollment strategy, you may know that for many years states have been able to use presumptive eligibility with pregnant women and with children in particular, and this is a strategy where qualified entities, mainly providers but not only providers, it could be schools, it could be Head Start programs when we're talking about kids, are able to get some very basic information from families and if a child or an individual appears eligible for Medicaid or CHIP enroll that person on the spot for a temporary period and while that person has presumptive eligibility they need to take steps to complete the full application process to get ongoing coverage, but in the meantime they can get medicine if they need it, they can see a doctor or other provider for any kind of exam or treatment that they might need. And of course, the provider gets Connecting Kids to paid and again the person gets the care that they need. This is true even if after the full application process is completed it turns out that for some reason the person was in fact not eligible. During that presumptive period, which lasts usually four to six weeks depending on the timing of the presumptive determination, that person can get care. It's a critically important way to facilitate enrollment and it's especially important to follow up and close the loop on that application so that the person gets ongoing care. Now, what's different about Hospital Presumptive Eligibility? Well, for the first time, hospitals can raise their hands and say that they are interested in conducting presumptive eligibility determinations whether or not their state has picked up the option to do presumptive eligibility for some of the populations that I mentioned a moment ago, pregnant women or children. Hospitals can do presumptive eligibility determinations if they decide that they would like to conduct this strategy. States will train them on the protocol that they need to use and will help in monitoring them so that they can pinpoint areas where they might need some extra training or extra help in completing the process correctly. Presumptive eligibility can be done through hospitals not just for hospital patients but for others in the community who come to the hospital or clinics associated with the hospital for care. And it isn't again just for pregnant women or children, which is usually the populations we think of as presumptive eligibility or populations that we can extend presumptive eligibility, but it can also be for adults who may be eligible for Medicaid. So it's a critically important opportunity, and if you are working with a hospital that is interested the first step is to contact your state Medicaid agency, have them contact the state Medicaid agency, and let them know that they're interested and then there should be training in place and help for that hospital in coming on board as a qualified entity for presumptive eligibility. And again, if there is interest we can set up a webinar later in our

series to talk about this in some more detail. Mostly, the people in hospitals who would conduct the presumptive eligibility determinations might be hospital social workers, it might be the people in the billing department, it could be a host of different kinds of staff. But I wanted to just take an opportunity before we go back to questions and answers to pick up what a couple of our speakers talked about. I think early on Laura may have talked about it and I think Stacey may have just mentioned it. And that is the push to bring providers, whether they are doctors or other health care providers, into underserved communities particularly in rural areas though not exclusively. And I just wanted to highlight that we have a number of our outreach grantees that have worked with doctors, have worked residents, have worked with medical students to make sure that they understand the basics about Medicaid and CHIP and how to enroll even though they're not likely to be the people that would help somebody walk through the application itself although sometimes they are. Sometimes medical students have taken on that responsibility. But we know that people do trust their health care providers, and so it is really important to include them in your outreach. They are incredibly important spokespeople and trusted advisors for many of the families that we're serving. So I wanted to just highlight that as a group that we definitely want to include in our outreach. So Riley, I think we're ready for Q&A, we're still doing pretty well.

**Riley Greene:** Yeah, absolutely. And actually, before we get to the final Q&A I'm going to run through some additional national resources as well as Connecting Kids to Coverage Campaign resources that folks can use in their outreach in rural communities. So just quickly on this slide we wanted to compile for you all some additional resources beyond what our webinar speakers shared with you today that you could consider working with to further your reach, your in reach into these rural communities. And these resources include of course 4-H. 4-H has state chapters often run through a university cooperative extension, and we've included the link to that resource there. Land grant colleges of course have an outreach mandate, so they are a good partner to work with in your state. There are some bi-weekly question and answer webinars available to you that we have put the web address contact information, and again we will share a copy of the slides with everyone afterwards you can have these links handy. A Rural Health Research Gateway where you can learn about ongoing and past studies on rural health. And finally, the National Advisory Committee on Rural Health and Human Services Policy Brief includes a lot of great information about rural health disparities as well as effective strategies to

consider when reaching folks in these communities and enrolling them in new health insurance options. So those are just some more national resources. We also wanted to touch on some Connecting Kids to Coverage Campaign resources. If you go to InsureKidsNow.gov, we have a suite of materials available. But today I'm going to focus on ones that are relevant to the rural outreach strategies that our presenters touched on earlier. So first and foremost, to Rachelle's at Community Catalyst point about earned media being an effective way to reach folks in rural communities through the radio stations that they are listening to during their long drives or otherwise. We do have public service announcements available on Insure Kids Now. We have both TV and radio in English and Spanish and in 30- and 60-second iterations. Coupled with those PSAs we have a little tip sheet for how to use PSAs that will help you understand where they can be placed, who you can work with to place them, and even some pitch letters you can use to send to your local media contacts to encourage them to place these public service announcements. On the topic of radio, we also have live read radio scripts. These are 15-, 30-, and 60-second scripts, so literally just the things that you can read out on the radio that are great to share with any local on-air personalities that you might have relationships with or during events that if they have any gap time in their content you can squeeze your message about low cost quality insurance available to folks in rural communities with these live read radio scripts. We also have template print articles that can be used for both your local newspapers and media outlets but also for community newsletters, school bulletins, and other community communications that you can customize with your local information but that are pre-written so it is easy for you to drop that information in and share with any kind of standing community communication that might have need for content. Some other campaign resources we have. If you are signed up for our Connecting Kids to Coverage listserv you will get an eNewsletter shortly on some more ideas for rural outreach as well as faith-based outreach which is another good tactic to combine in your rural outreach. All of our webinars from the past and moving forward will be available online, both the slides and the recording. We've got the link for that there, again this is all at InsureKidsNow.gov. We also have some excellent outreach videos that have some different ideas from states across the country doing outreach in different communities that you can take a look at. And coming up in November we're going to do a webinar on Reaching Latino Families. So I'd ask that you keep your eye out for that webinar invitation as we'd love to have you all back online then. Finally, I'll just talk about the Connecting Kids to Coverage materials. We have some really great materials developed that

are customizable. We have a bunch of different ones, some aimed at teens as you can see on the right here, "Health coverage for teens who just want to have fun." We have what we call our mustachioed boy here in the middle, "I'm young but I wasn't born yesterday." And then a Back-to-School one on the left. All of these are customizable with your program name, your state income eligibility for a family of four, your website and phone number, and up to two logos that you would like to add. So you can reach out to the design services at CMS to order these customized materials, and they will provide you a PDF within two weeks of placing your order online. And we have all those materials available in English and Spanish, and many are available in a range of different languages that you can see here. So to Donna's point, we are now back in question and answer, I know you all have submitted a lot of great questions. Donna, did you want to lead us off here with some that we had from our original speakers?

**Donna Cohen Ross:** Yes, one or two. So thanks Riley and thanks for going through so many of our great materials, and I hope folks are finding these useful. So I just wanted to clarify, I think we had one question about the Presumptive Eligibility piece and it's a really good question. The person who raised the question wanted clarification about whether the Hospital Presumptive Eligibility is only possible in Medicaid expansion states. That's a really good question, and I want to clarify that any state, actually every state must allow hospitals to conduct presumptive eligibility determinations if the hospital chooses to do it. So it's not related to whether or not the state expands Medicaid or not. Really good question, so thank you for asking that. Before we go to new questions, I want to bring us back. I think Rachelle and I think Stacey both mentioned conducting outreach through local libraries. And we know that libraries have been tremendously helpful, they've been great partners just all across the country. We did have a question early on but I pose it to both of you to say a few more words about what services are being offered at libraries to help people with enrollment. If you wanted to expand on that, I think we had some interest.

**Stacey Wright:** Okay, this is Stacey speaking right now. What we have found is in all of the communities we serve, we have really made a big hit at the libraries. We have the librarians in all these communities give our navigators two days a week, sometimes more or less depending what time of the year that we're in. They let us rent or sign up for their rooms months down the road, and so our navigators go in there and hold regular office hours. So while typically they stay booked out for these times in the office at the libraries, they also receive walk-ins. And if you're there maybe every

Wednesday during a certain time the community starts knowing when you're around. As well, the libraries tend to stay open a little bit later which makes it available for people to come in after work.

**Donna Cohen Ross:** Thanks so much Stacey. Rachelle, did you have anything you wanted to add?

**Rachelle Rubinow:** Our advocates had a very similar experience in both that they would rent space within libraries to hold office hours for scheduled appointments but then would take walk-in appointments as well. And I think they found, it was funny. I think some advocates reported that they had more luck talking about health insurance in more of a health care setting, but the experience for advocates who worked in libraries, they had a really successful and effective time as well. I think because libraries were just such a familiar, comfortable place for people to go, so they really found it was easy to have a good dialogue with people in those locations.

**Donna Cohen Ross:** Thank you. Riley, do we have some new questions that have come through? I still have my list of previous questions, but if there are some new ones why don't you take a stab at that.

**Riley Greene:** We actually have a lot of questions coming in about where people can find the Connecting Kids to Coverage resources that I just went through. So I sent a link out to all of you through the chat, but that's InsureKidsNow.gov is where you can find all of those campaign resources that I just buzzed through. Otherwise Donna I think the question list you've got in front of you is our most recent one.

**Donna Cohen Ross:** Well I'll ask one more because I think it also ties into a topic that is coming up in our eNewsletter. Earlier in the webinar we got a question for, and I'm going to just open it up to any of our speakers, to talk a little bit about effective strategies or particular successes that you've had working with faith-based organizations in your rural outreach activities. If anyone has anything to share on that, we had a question.

**Rachelle Rubinow:** So I can start.

**Donna Cohen Ross:** Go for it.

**Rachelle Rubinow:** This is Rachelle speaking. A lot of our advocates had success working with faith-based groups. I think the most successful strategy was finding one member of the group or community and asking if they could either join a sermon to be there at the end to offer enrollment assistance or if they could actually be part of that service and have the

pastor or leader introduce them to talk about the Affordable Care Act, Medicaid or CHIP. A lot of our advocates had luck being at the faith-based group's setting and just offering their services as part of the services that were already going on.

**Donna Cohen Ross:** Thanks. Does anyone else have anything additional to share? I think we're always interested in what specific strategies are working with any particular group.

**Stacey Wright:** This is Stacey. Yes, we actually had a little bit better luck. Some of the churches that hand out the pamphlets at the beginning that give everybody, you know, the list of what will be covered at the service, we had a couple of churches willing at the end of that to actually put a note saying, do you need health insurance for you or your family? There is a free service provided, call this person. That was kind of our best segue into faith-based.

**Donna Cohen Ross:** Great, thank you. And I think that actually raises a point that I know I've heard quite a lot, and that I think it might go back to your point earlier about people really valuing their privacy. They might not want to sign up after the service or at some other activity, but having the information given to them from a trusted source where they can then call on their own and follow through is a really effective strategy. So it sounds like that's what you've experienced. Are there any additional questions Riley coming through the chat or should we give people back five minutes of their day and end just a little early?

**Riley Greene:** I will answer one more question that I saw, which was on the customizable materials through Connecting Kids to Coverage and if they were free or not. And I will just share that they are free to have them customized. You just send an email with your order in. You are just responsible for the printing, so you will get a print ready PDF sent back to you at no charge but whatever your printing cost and quantity are you would incur for yourself. And just to repeat where folks can find all of these great resources, it is InsureKidsNow.gov, that is I-N-S-U-R-E KIDS NOW DOT GOV. We will certainly follow up with the slides from this presentation as there are a lot of links and contact information that you all are interested in. But otherwise that pretty much wraps up our questions. So Donna, over to you to close us out.

**Donna Cohen Ross:** Thank you so much. Well I just want to extend another note of great thanks to all of our presenters, Gaby, Laura, Kayla,

Rachelle and Stacey. And of course Riley to you and to the team at GMMB, really thank you so much for pulling this really great webinar together and I especially want to thank the hundreds of participants who dialed in and logged into the webinar today. I think we will find that this was maybe one of our most well attended webinars of all. So we really do thank you and we're interested in hearing from you about what other topics you might be interested in as we go forward, either for webinars or newsletters. We're interested in hearing what you're doing in your community. So thank you all so much, and just keep your eye on your email. We'll be letting you know about future webinars and other activities. So thank you so much. Enjoy the rest of your day.

**Riley Greene:** Great, thanks. Goodbye everyone.