# Outreach and Enrollment Strategies to Reach Rural Communities

## Connecting Kids to Coverage National Campaign

## Webinar Transcript July 31, 2018

**Jason Werden:** Welcome to today's webinar on behalf of the Centers for Medicare and Medicaid Services and the Connecting Kids to Coverage National Campaign. We invite you to join us today, and we appreciate your time as we discuss Outreach and Enrollment Strategies to Reach Rural Communities. Reaching children and families who are eligible for Medicaid and for the Children's Health Insurance Program, better known as CHIP, can be particularly challenging in rural areas across the country. Americans living in rural communities can face many obstacles, including living in communities with disproportionately higher poverty rates, more chronic conditions, and being underinsured, as well as experiencing a fragmented healthcare delivery system with an overworked and shrinking health force and lacking access to specialty services. What we'd like to do for you today is provide an opportunity to hear from a panel of speakers who are well versed in reaching rural communities. Now, we are happy to introduce the following speakers who will be joining us today. We will first hear from Dr. Cara James, Director of CMS' Office of Minority Health to give us a snapshot overview of what healthcare access and healthcare coverage looks like in rural America. We will then have John Hammarlund, who is a Deputy Consortium Administrator of the Consortium for Medicaid & Children's Health Operations and Regional Administrator, Seattle office of CMS. He will provide an overview of CMS' recently announced in May of 2018 new rural health strategy. We will then hear from Renee Bouvion, who is the Acting Regional Health Administrator with Region 10 for the Office of the Assistant Secretary of Health. Then we will have the opportunity to hear from Rachael Hamilton and Sonciray Bonnell, both with the Native American Rehabilitation Association of the Northwest (NARA). They will be able to give us a snapshot or look into ensuring access to education, physical and mental health services across rural communities. Finally, we will hear from Dr. Kay Miller Temple, who will be joining us on behalf of RHIhub. She is a Web Writer for RHIhub and is also with the University of North Dakota School of Medicine and Health Sciences. We now would like to introduce Dr. Cara James to join us today.

**Dr. Cara James:** Thank you Jason, and welcome to all of you. I appreciate the opportunity to talk to you today about some of the activities that we are doing as we are working to achieve health equity and how, in rural communities, and how our CMS strategy helps to do that. Next slide please. We are one of a number of Offices of Minority Health within HHS, and I provide that information just because I wanted to let you know that you have resources across the government that can help with that. If you could back up just one for a second please. So you can see that there is an HHS office in each as well as one in HRSA. Each of these run a number of programs that are working to address health disparities for a variety of populations, including not just ethnic and racial minorities but others as well as rural communities, children, and other populations. In our office, we have our framework and how we are approaching our work towards health equity. As you can see on the next slide, we are working to increase our understanding and awareness of disparities. We also are working to develop and disseminate solutions. And then through ourselves and our partners, implementing sustainable actions that will reduce disparities for racial and ethnic minorities, sexual and gender minorities, people with disabilities, as well as rural communities. I don't have time to go through all of the activities that we have, but I wanted to highlight a couple that may be of interest for those of you who are engaging with individuals, to help them not only sign up for coverage but to be able to understand that. On the next slide you'll see one of our initiatives called From Coverage to Care. We've actually had the pleasure of presenting some of this work on previous Connecting Kids to Coverage webinars, but these are a number of resources that we've developed to help people not only understand their coverage but to be able to use it to connect particularly to primary care and preventive services. They are available in multiple languages as well as available in hard copy for free. And if you visit our website below, you can order those and we'll send those to you. But as you can see, we have a number of resources, some focused on preventive services. There is a particular one that focuses on child health preventive services. We have added our newest tool on behavioral health as well as a resource to help individuals manage their healthcare costs. On the next slide we have another initiative that we have been doing with the Federal Office of Rural Health Policy to help manage, go back one please, chronic care conditions among individuals who have multiple chronic conditions. This has been focused specifically in rural communities as well as focusing on racial and ethnic minorities and the providers to help them become aware of the resources that we have available for this to manage those conditions. We also on the next slide do a

number of things to help individuals map data and understand what is happening at a more local level. We have a tool that's called our Mapping Medicare Disparities Tool. As you can see, it allows you to compare disparities across different conditions and to look at healthcare outcomes, cost utilization, and so forth. We continue to add data to the tool. We also are working on adding a hospital lens, and as our Medicaid data become more available we hope to be able to add that in the near future. On the next slide, I wanted to take a minute and talk about rural. And one of the things that I am going to cover today is some of the variation in how we define rural. And on the next slide, you'll see there are a key couple of definitions of rural. There are three main definitions, one developed by the Office of Management and Budget, one developed by the Census Bureau, and one developed by the Department of Agriculture. And then I added a fourth one here from the Department of Agriculture. They all have at their root our census data, and then it just varies based on that level of data that they are looking at. So as you can see, the core base statistical areas. The first one developed by the Office of Management and Budget uses county level data and has three categories of metropolitan, micropolitan, and what they call non-core-based statistical areas. The definitions of what they include in rural, basically is everything in the two and three categories. So micropolitan and the non-core-based statistical area. As you can see, that yields about 46 million individuals, or 15% of the US population based on the 2010 census data that are considered rural. In the Census Bureau itself, they have urban and rural areas. They drill down a little bit lower from county to the census block group. They have categories as kind of urbanized areas and urban clusters. So included in rural are all populations, housing and territories that are not included within those urban areas with the exception of Puerto Rico. By their method, we see about 19%, more than 59 million US residents would be classified as living in a rural community. Then within the Department of Agriculture, we have the rural urban commuting areas, or RUCAs. And that gets down to the census track level. So you can see that there are ten categories, they do a primary and secondary rating, I won't necessarily go into all the details. But the primary group between 4 and 10 are classified as rural. So that yields for them, as you can see a number in between the core based statistical areas and the urban rural areas at 51 million or 16.6%. And then the urban influence code is another area that they have captured, and that has a slightly smaller proportion. The Federal Office of Rural Health Policy, which is housed within the Health Resources and Services Administration, uses a combination of the core based statistical areas and the RUCAs that result in about 18% of the US

population being considered rural. So these are some of the main ways in which rural is counted. There are also a number of varieties within that, where some only use for example the non-core based statistical areas, that would leave a smaller percentage from these other. So how we define rural varies quite significantly around the government as well as in our country. But basically, somewhere between 15% and 20% of the US population is considered to live in a rural community. On the next slide, one of the things that we note is that our rural communities tend to be a little less diverse than our urban communities. So here, this is reflecting the combination of the micropolitan and metropolitan and the non-core based statistical areas in a report that the Census Bureau did, looking at some of the change between the 2000 and 2010 census data. As you can see, for those in the non-core based statistical areas, the racial and ethnic diversity is quite different but is growing, particularly among the Hispanic and Asian populations. So in the last couple of minutes that I have, I just wanted to highlight some of the health challenges that we've heard, and Jason alluded to them at the beginning as we talked about what we are seeing in rural communities. But on the next slide, and probably the one after that, you can see that in our rural communities we have across all of our communities we have excess deaths that are happening. This is work that was done last year at the CDC in their Morbidity and Mortality Weekly Report that showed excess deaths are significantly higher for the five leading causes of death in our rural communities. On the next slide, as we think about what this means for our children, we note that here you can see some of those support services that rural children are more likely to have at least one parent in fair or poor mental health, to have financial difficulties, to live in neighborhoods with limited amenities or poor conditions or little social support. Rural children are also less likely to receive preventive services as well as oral health services. They are more likely to die than their urban peers from unintentional injury. And interestingly for today's topic, they do have similar insurance rates compared to their urban peers, but tend to have a greater reliance on Medicaid for that coverage. So on the next slide, you'll see that within our rural communities we also see differences and disparities across race and ethnicity. So here you can see fair or poor health is one example where we have higher rates of fair or poor health among Black, Hispanic, and American Indians in rural areas. And on the next slide you'll see that we typically think of our rural communities as older and sicker, but in our racial and ethnic minorities within rural communities, they tend to be younger, if you'll look particularly at that center bar of the Hispanic population and the Asian Americans as well as Native Hawaiian and other Pacific Islanders,

where about two thirds of the population are between 18 and 44. Very quickly, on the next slide you'll see income differences. As we talked about earlier, for our rural children tend to have lower income and come from lower income households, but again within those rural communities you can see the disparities that we have where even greater populations have less income. And finally, where you live matters. And as you can see on the next slide, our populations are not evenly distributed across the United States. So as you're thinking about whether or not a state has maybe expanded Medicaid coverage or access to other social services very much depends where individuals are. So taking all of this into account, CMS has worked very hard to focus on what we can do to improve health outcomes in our rural communities. That led to the establishment of the CMS Rural Health Council on the next slide, of which my colleague John Hammarlund is going talk a bit more about the work we've been doing there. But as you can see, it was set up to ensure access to high quality healthcare for all Americans in rural settings to address the unique economics of providing healthcare in rural America, and finally to bring the rural healthcare focus to CMS' healthcare delivery and payment reform initiative. So I know I've gone very quickly, but on the last slide you can learn more about some of the work that we have underway as well as our efforts across the agency on rural health. And with that I will turn it over to John to talk a bit more about our rural health strategy. Thank you again for having me.

**John Hammarlund:** Thanks very much Cara. I appreciate it. This is John Hammarlund. I'm delighted to be part of this webinar today, and thanks very much for having me. As Cara mentioned, CMS has been working diligently, particularly over the past two and a half years since the CMS Rural Health Council was formed, to better address the needs of rural providers and rural patients. We've held a Solutions Summit with various rural stakeholders and several listening sessions across the country to ensure that we understand the needs of rural providers and patients and also to uncover what road blocks hamper providers from their successful participation in CMS Innovation Center projects and other transformative efforts of our agency. Next slide please. Knowing what areas we need to focus on, our rural health strategy includes five specific objectives. First, we want to apply a rural lens to the work of the agency. So we're applying rural proofing checklists to any relevant policies and procedures and initiatives that have impacts on rural plans, providers, or communities. And we'll work to identify and accelerate the diffusion of promising evidence-based practices to improve access to services and providers in rural communities.

That includes new payment and service delivery models, that the Innovation Center at CMS might be contemplating. The Innovation Center has been especially engaged in ensuring that there is a rural component to the state innovation models to make sure that changes in healthcare delivery or payment don't adversely impact rural providers, patients, or their families. Second, we want to attempt to improve access to care through provider engagement and support. So we plan to work on our rules regarding the scope of practice in an attempt to align with what states allow in terms of having clinicians practicing at the full scope of their license. And we want to better engage rural providers by implementing meaningful quality measures, which is a new approach to quality measurement that focuses on value rather than volume, therefore reducing the reporting burden. Something that is particularly important to rural providers. Third, for the past several years telehealth has been touted as a way to improve access to care. And the rural health strategy describes how we will explore options for modernizing and expanding telehealth through programs such as the Frontier Community Health Integration project demonstration and the Bundled Payments for Care Initiative models. Now, with respect to telemedicine, telehealth, we're confined by the law in several aspects of telehealth. But we are committed to being as flexible as possible whenever possible within the confines of the law. We're also exploring the expansion of virtual care, which is different from telemedicine but allows for important advances in care and in access to care such as remote patient monitoring. So an example of some of the flexibility in virtual care can be found in our recently released proposed rule called the Physician Fee Schedule, that's how CMS establishes the payments for rules for a lot of the Medicare part B services, the services that patients often receive in the doctor's office. We're planning to pay for something called a virtual check-in. This might be a phone call from a doctor to a patient recently discharged from the hospital to make sure that they are taking their medications and getting their rest. So finding a way to use technology to improve access to care is an area that we've been working on for some time, and it really has the potential to truly transform care in several key areas such as chronic care management, behavioral health, and post-acute care. Next slide please. The last two objectives of the rural health strategy, and the place where I hope that you can see yourselves in the rural health strategy. The fourth strategy is empowering patients in rural communities to make decisions about their healthcare. It's critical to empower patients to make good decisions about their health and their healthcare. And we want to collaborate with rural communication networks to develop and disseminate easy to understand

materials to help rural consumers navigate the healthcare system. As healthcare continues to evolve and transform, it will be critical that we foster the engagement of all consumers in their healthcare. Patients usually don't know what things like community health integration or chronic care management services are, but we should all know how to talk to consumers about the impacts of those kinds of services in a way that's meaningful and understandable and digestible to them. So we need to address questions like, how do services affect their co-payments or deductibles? What is a patient's responsibility when agreeing to receive certain services like integrated care services? And then finally, our rural health strategy talks about partnerships. Next slide please. We've been and will continue to work with partners to understand and evaluate the impacts of CMS programs on rural communities and supporting states in their work to transform care in rural areas. One way we do this is through our Patients Over Paperwork initiative, where we hold listening sessions with specific stakeholder groups like doctors, nursing homes, hospitals, and patients to understand where roadblocks exist to providing timely efficient care and to get the ideas from the people we're talking to about what we could do better. Also, our CMS regional offices, such as my Seattle office, go out on road trips through rural areas of our state, meeting with healthcare providers to hear about their challenges with Medicare, Medicaid, and the health plans under our programs. Also, every six weeks or so, CMS sponsors a rural health open door forum call where we talk about particularly Medicare's latest innovations and payment rules and projects with partner organizations who sign up for our listserv. I would encourage you to sign up for the listserv, I'll have a resource for you shortly. We also share information with our rural partners through publications like our MLM Matters weekly electronic newsletters, as well as webinars that we host on specific programs and requests for information. Many of these engagements are specific to healthcare providers, and those of you who work for a healthcare provider may find some of them of value. Finally, we try to connect stakeholders where appropriate to help them learn from each other as well. So we're actively encouraging and facilitating the sharing of promising practices throughout and across the healthcare spectrum. Final slide please. So we invite you to learn more about the CMS Rural Health Strategy by going to our Rural Health website, which you see on the slide. We also have a fact sheet about the Rural Health Strategy so you can learn more. And you can learn more about the open door forum calls I mentioned earlier and sign up to be on our listserv to get the agenda and information about those calls. I

encourage you to do that. Well, thank you again for having me on this webinar. I will now hand it back to our facilitators. Thank you.

**Jason Werden:** Thank you very much John, and thank you Dr. James as well. We very much appreciate your collective input. We'd like to pause for a brief moment and share two poll questions with you, the audience. First, we'd like to share: Is your organization currently engaged in rural health outreach and enrollment activities? You are invited to select a response and we will capture your responses here. If you are currently conducting activities that's great. We are certainly interested in learning more from you, and we will share later in this webinar exactly how you can do so. And if you're not and you're here to learn a bit more about how you can get involved, thank you for joining. This will be a great opportunity for you to learn how you can take today's learnings and put them into practice at your local organization. Let's show those results. Great. So a number of you are currently conducting outreach and enrollment activities. That's phenomenal. We appreciate the feedback. We now will share a second poll question. That question is, which group does your organization hope to partner with for rural health outreach in the future? Whether it be schools, health providers, faith organizations, government agencies, or engaging with local media. If you're working with any of those, or if you are currently working towards how you would like to do that with your organization, please share your feedback today. Let's see those results as well. Very much across the board, a lot of individuals who are working with schools and health providers. And a little bit even with local media, government agencies, and faith organizations. That is great feedback to see. As mentioned, we will share additional poll questions throughout this webinar, and as both John and Dr. James shared, if you are interested in learning more we invite you to go to cms.gov/ruralhealth, cms.gov/omh, and to visit the rural health open door forum as well, they are a great resource for all here involved. Next we'd like to introduce Renee Bouvion, the Acting Regional Health Administrator, Region 10, in the Office of the Assistant Secretary for Health. Renee?

**Renee Bouvion:** Thanks Jason. I'm happy to be here today to share some information about our office's experiences in working with rural communities. I'm going to start by sharing some information about our office and our regions, and then I'll talk about our efforts to work with partners in rural areas. Next slide. The Office of the Assistant Secretary for Health, for those of you who aren't familiar with it, works to optimize the nation's investment in health and science to advance health equity and improve the health of all people. Our work is carried out by twelve core

public health offices, ten regional offices, and a number of presidential and secretarial advisory committees. The work of our office focuses on public health issues that cut across the Department of Health and Human Services. Currently, those include opioid use disorder and health equity. Next slide. There are ten regional offices around the country, and on this slide you can see how those regions are divided up as well as the locations of the regional offices. I do need to point out that the Region 3 office is actually in Philadelphia and not D.C. Each office is led by a Regional Health Administrator, and their photos are included here. Regional teams use their expertise and networks to catalyze public health action and impact leading health indicators. We do this through coordination and collaboration around HHS priorities and by establishing partnerships to leverage assets and advance public health. Next slide. Our regional offices work as conveners, connectors, and communicators. We are actively involved in convening meetings with state and local public health officials and other stakeholders to better understand their priorities and challenges and find ways to support their work. We're also connectors, we have strong networks and we're able to connect people or organizations with similar interests or goals to work together, share resources and lessons learned. As communicators, we disseminate information about HHS and other initiatives severally to our key partners and regional distribution lists. We want to ensure that organizations in our region are able to take advantage of the tools and resources that are available to address important public health issues, including campaigns such as Connecting Kids to Coverage. Next slide. Given the way that HHS divides the country into regions, every region has rural areas. So what I'm going to be talking about isn't specific or unique to region 10, and any one of my regional colleagues could be giving this presentation. I do want to just provide a quick snapshot of what rural looks like in Region 10. The Region 10 states of Alaska, Oregon, Idaho, and Washington make up almost one quarter of the land area of the United States, but only has 4% of the population. Next slide. And here you can see how the individual states of the region compare to the U.S. as a whole, with Alaska and Idaho having the highest percentages of rural populations in our region. Next slide. When we look at percentages of uninsured children under the age of 18, we can clearly understand why working in rural areas is important for a campaign such as Connecting Kids to Coverage. Nationally and in every state of Region 10, more children in non-metro counties lack health insurance compared to those in metro counties. So now that I've given you a little bit of background about our office and our region, I'm going to talk about how we approach working with rural communities. Next slide. And this is our challenge.

Working to foster coordination and collaboration on public health issues in the vast states of Region 10 with a team based in our regional office here in Seattle. Our solution? Partnerships. We have a small staff and an equally small travel budget, so we can really only accomplish what we do through partnerships and collaborations with local organizations. Our partners include state and local health departments, health systems, community based organizations, and many others. Next slide. Partnerships take time and effort to develop. It's often tempting to think that it's easier to go alone, that you'll be able to accomplish things more quickly and with fewer potential complications. But when you're working alone, you're more likely to make missteps or not understand the community, especially if it's a new area or you are doing it, like we are, from a geographical distance. So here is why it has benefited us to take the time and effort to develop relationships and partnerships with local organizations in rural areas. Partnerships act as a force multiplier. Working with partners dramatically increases the effectiveness of our office and extends our reach. The organizations we work with are the experts on their communities. Working with them allows us to better understand the context in which we're operating. Partners from the community know what the issues are, how to best reach and engage key stakeholders, and all of this helps tailor our approach so the work is useful and meaningful. Finally, we see partnerships as a two way street and want our partners to benefit from a relationship as much as we do. In rural areas, it's not unusual for us to work with small grassroots community based organizations, and this gives us opportunities to provide technical assistance and build capacity where needed to benefit the organization and the community after the project is complete. Next slide. Here are some of the lessons that we've learned in cultivating and establishing partnerships, especially in rural communities. Cultivating partnerships can be a lot of work, especially when you are doing it from a distance. We've found that having partnership development as a priority for our office has been helpful. We identify areas where we need new or additional partners and track our progress regularly. Your current partners or existing networks are a great place to start. Once we've identified areas where we need new or additional partners, we ask around in our current networks who we should consider approaching. It's also helpful when a current partner can make an introduction to other organizations. Those introductions really help pave the way for initial conversations. Successful partnerships are a benefit to all the organizations at the table. One of the first things we do in talking with potential partners is learn about their organization's priorities and focus areas to identify places where our work would be stronger together and

everyone would be fulfilling some part of their mission. Communication is another key element to cultivating successful partnerships. We take the time to listen to what our partners are saying in terms of what their interests are as well as how we can work best together. It's important that we clearly communicate any possible limitations of the partnership and be realistic about what we want to accomplish. Next slide. Now I'm going to share a real life example of how partnerships have allowed our office to reach rural communities. In 2011, we became interested in doing some work to address health disparities among the largest racial and ethnic minority group in our region, Latinos. We knew that some of our existing partners would also be interested and brought them together to discuss the right approach. In talking with our partners, we decided to focus on women as they play such a critical role in the health of their families and community. We wanted to provide information and resources to public health and social service providers who work with Latinas and their families. These providers, including community health workers and case managers, are important sources of health information in the communities where they work. The first event was held in Seattle, and about forty people participated. That's not a huge event, but it was quite successful, and it created a lot of interest from some additional partners. The following year in 2012, with several new partners on board, we were able to replicate the event in Granger, which is in rural eastern Washington and has a large Latino population. Expanding our event wouldn't have been possible without the partners that we had here in Seattle who also have staff in eastern Washington and were able to help by providing input on the agenda and helping us to organize something that would meet the needs of that specific community. Next slide. After five years of practice with this model and working with partners to reach rural communities in Washington state, we wondered if it would be possible to expand to another state in our region. We had some key contacts in Idaho and worked with them to identify some potential partners. In 2015, we brought them together by phone to discuss our Latina Health Symposium model and gauge their interest in working with us. Luckily for us, they were enthusiastic and planning began for an event that was held in 2016. A second event was held in 2017, and we're now working with them to plan another event that will take place in 2019. A similar thing happened in Oregon, and our staff has been able to bring together a planning group. They are planning an event that will take place this coming September. They are already talking about the possibility of holding events on the eastern side of Oregon state in 2019. After the events are held in September 2018, more than a thousand providers who work with Latinas will have been

reached since 2011. Next slide. So why has all this worked? Without our partners, our office would not have had the success that we've had in expanding our efforts to address health issues within rural communities. Over years of holding the Latina Health Symposium Event, we've worked with amazing partners, both here in Seattle and in the rural communities where the events were held. Our partners have provided crucial input on the health issues in their communities that allowed us to tailor each event to address the specific needs of each location as well as highlight local organizations and resources. They also help us promote the event, and that has led to an increasing number of participants each year. Their feedback has really helped us to improve the events along the way so that more providers can participate. In Granger in eastern Washington, we got the message loud and clear that we needed to have some interpreters so that non-English speaking providers, especially community health workers in the area, could attend the event. Leveraging an internal partnership here with CMS and Seattle Regional Office, we were able to provide interpreters for the last two years. It's really our partners who have allowed these events to continue over the course of seven years. And a part of this process has been building the capacity of some of the smaller organizations that we've been working with. They've been able to take on increasingly larger roles in leading the planning process and developing the agendas to the extent that we really act more as advisors now. So I hope this example of our Latina Health Symposium events has demonstrated how working with partners can be a key component in any strategy to reach rural communities. Next slide. I just highlighted here some tools that might support you engaging with rural communities, and my contact information is there as well. And I'll turn it back to Jason.

**Jason Werden:** Thank you so much Renee, that was great. We very much appreciate your time today. We would like to share our third poll question if we may. That question is, what types of outreach has your organization found successful when conducting rural health outreach? We have a few options here for you to look into, whether it be school information nights, mobile health clinics, sharing information with state organizations, or adding information to school registration forms, taking the opportunity to reach similar audiences, as we mentioned, through these additional avenues. If you have not conducted rural health outreach to this point, again, we invite you to continue to learn more while you're here and to take this opportunity to hear from these speakers today. Let's take a look at those results that are coming in. We see that a number of you are using school information nights

on campuses and in classrooms to share information. We'll remind you that the Connecting Kids to Coverage Campaign does offer tailored school based outreach tools, and a number of customizable materials on the school outreach library at insurekidsnow.gov, resources that we will share and discuss further in today's webinar. Next we'd like to introduce our friends from the Native American Rehabilitation Association of the Northwest, otherwise known as NARA, Sonciray Bonnell and Rachael Hamilton. Sonciray is the Oregon Health Plan Manger. Rachael is the lead of the Connecting Kids Outreach Program. Sonciray and Rachael, welcome.

**Sonciray Bonnell:** Thank you so much. Next slide. So we have a few slides that, we're really not going to talk a lot about NARA, but I wanted to have that in front of you so that at a future date you can go back and look. NARA has been around since 1970. We have ten different sites around the Portland metro area, and I've listed them here. Next slide. We did want to put a little about who we are as a culture. We do focus on the American Indian/Alaska Native population in the Portland metro area, but we help everyone that comes to our clinic. Next slide. I've listed nine federally recognized tribes in our state, and I want to talk a little bit about how and why we were asked to present. NARA received a CMS grant, Connecting Kids, which focuses on enrolling American Indian and Alaska Native kids and their parents into health coverage, specifically Medicaid. And that's why we were asked to do this, because the grant was written statewide. So the three person team travels across the state. We've met with all of the nine tribes, that was our initial introduction, to see if we could help them with getting their community members signed up for health coverage. Next slide. I've provided a map. I wanted to give folks an idea of how far away some of these places are. Our closest reservation, tribe, to Portland is Grande Ronde, and you'll see it to the left there towards the coast. The farthest away is Burns Paiute, and we have Flo and Liz heading out there on Thursday night, it's a 5.5 hour drive. I'm convinced that Burns is actually frontier rather than just rural. It's way out there. Next slide. I've provided a glossary, so you see what NARA stands for. Oregon's Medicaid program is called the Oregon Health Plan, we often just call it OHP. So we'll be using that throughout the webinar. And then Oregon Health Authority is where OHP lives within that department. Our community partners, I know across the United States they are called different things, but these are certified application assisters. So folks who are trained and are able to help consumers sign up for not only health coverage on the federal marketplace but in the Medicaid program. So in Oregon, we use both community partners and certified application

assisters. Next slide. So I'm going to hand this over to Rachael, and she's going to talk a little bit about the rural sketch. And I did want to say that we are going to go into details on some of these bullets on the next few slides.

**Rachael Hamilton:** Thank you so much for having me. So these are just a few challenges that we have encountered when working with rural communities. Like Sonciray said, we actually go into more detail with a few of them. With these, when we work with rural communities, we run into geographic isolation. They're way off the grid. And that can create problems for us to be able to get to them with the long distance, they're far from resources, we encounter weather problems here in Oregon. A lot of the passes when it's snowy get very dangerous, so it's harder to get out to those communities when we need to meet with them. This also brings fewer application assisters, fewer resources to work with clients that are in need of gaining access to health coverage. There's also a lack of cultural compatibility along the way, and this can create a problem with communication and understanding exactly what OHP can offer. So when we speak with folks, we just try to give as much information as we can. There is also a problem with the facilities being neglected for lack of funding and not being able to provide such resources.

**Sonciray Bonnell:** I know, this is Sonciray again. I want to just be very clear. We are talking about rural communities and we are talking about American Indian/Alaska Native communities. Very similar issues, but as you'll see in future slides we kind of divvy them out and say in general rural here are the challenges, and then when we get specific to tribal communities it is even more detailed.

**Rachael Hamilton:** Yeah, definitely. And also, as we all know, there is a higher rate of uninsured, and this creates problems along the way for folks that are needing access to health coverage. We'll go to the next slide. So these are a few challenges that we have come across when we work with our communities and like Sonciray said, a lot of our focus is with American Indian and Alaska Native families and communities. So they are very close knit communities. They don't like to talk to outside members, they don't like to talk to strangers, just in general across the board. And when we're trying to talk to them about health insurance, it can be scary for them. So some of the solutions that we've come up with is just making sure that we are very clear in what we are trying to talk to them about, what we're trying to offer them. We continue to use established relationships with then that NARA already has. We've been working with tribal communities for an incredibly

long time, and so we use this as an advantage to continue to make sure that we can provide them the best service that we can.

**Sonciray Bonnell:** And I would add to that. NARA does have a really great reputation. We have our inpatient residential treatment program has helped so many people from across the United States. So when we show up they are like, Oh NARA, and they want to come and tell about their father or daughter who went through our treatment center and is alive and well and healthy. So we do have that to rely on. And I want to point out that, you know, we're in Oregon, the Portland metro area, and so why are we rural? Well, because we wrote the grant that way, but also we want to work with our nine federally recognized tribes. And we do have experience. I have probably 25-30 years working with tribal organizations in Oregon, and that includes working directly with the nine tribes. I'm an enrolled tribal member at Pueblo Sandia. And Flo Bergland is Navajo. She lived and worked on the Navajo reservation. So between us, we do have not only work but living experience with rural communities.

**Rachael Hamilton:** Absolutely. Another thing that we do as well is we make sure that we do research before we go out to these events. We find out who we're working with, and just working with the tribes we become aware of how things work there before we go. A lot of the tribes do have application assisters. They might have one or two or a handful. So we always make sure that we engage with them as well, because we're not, we don't just show up to take over. We want to offer our services to help and make sure that we can connect these members with an application assister that is going to be close to them. We also just listen, and we ask how we can help. We offer our services in any way that we can, and we make sure that we are available always. Next slide. Another challenge that we do have is distance. A lot of the tribes, as you could see in the previous map, it does show that they are far away from the Portland metro area. So it can be quite a drive to make sure that we get to those locations. Weather of course plays a factor. And we are statewide for the services that we provide. We try, some of the solutions. We make sure that we have multiple things lined up when we go meet with these tribes. We try to set up, if we're going to an event and we'll meet with an education department, and just use our time, make sure we can get to all the places we can get on time. We are grant funded, so we are specifically to do outreach with just health, so we definitely can make sure that we get across the state. Then I'm going to jump down to remote help. This is one of the biggest things we can do across the state. We can help remotely. We can have folks sign the consent form, and we can help them

actually over the phone as long as we get it signed. I'm actually going to introduce Florinda Bergland, and she's going to share a story about how we were able to help remotely. And here she is.

**Flo Bergland:** Hello everyone. So I'd like to tell a story, and this story happened a few months ago, in June. Liz and I, our colleague, she was with me when we went on our travel trip to Klamath Falls. We stopped at Head Start in Roseburg, Oregon, and we introduced ourselves and told them that we are Oregon Health Plan assisters reaching out to see if there are any family members that need any assistance. They were pretty surprised and shocked and overwhelmed and pretty happy that we were there in person. On our way to Klamath Falls, they gave us a call and said hey, we would like for your team to come back, we would love your assistance, we have a health fair coming up. So after our meeting with Klamath Falls, we drove back down to Roseburg, Oregon. We set up our table. We had our contact forms. We communicated with the community population. And we actually were very resourceful. We did the consent forms, the parents came in. We had one family enrolled in Oregon Health Plan. We renewed three families. And it is really good knowing the fact that when we come together, we are strategizing and conquering a few of our challenges as a team.

**Sonciray Bonnell:** I wanted to add too, it is so essential to have somebody that you know at the tribe to introduce you to the rest of the department. That is essential, and so far at all of the nine tribes we have managed to find somebody, usually in the health department. But that is key, because if we were to go there on our own not knowing anybody, for those of you who work in rural communities you know that that's a difficult egg to crack. Next slide. And so this one is more specific. Remember I talked about rural versus rural native populations. That's what this challenge is. The general distrust that we already talked about with outsiders, but the U.S. government, we're talking broken treaties or treaties where healthcare was promised. U.S. history. So that's a real issue, not only out at the tribes but within the four walls of NARA sites. And so our solution is then to meet where they are most comfortable. So go out to the tribes, or get local buy in from somebody that you might know that lives and works out there. And we do have a lot of experience working with tribes, so we do have that on our side. We also want to make sure that when we are out at the tribes, or even for our NARA clients, if this is outside of our OHP/Medicaid scope, we are still going to help them. If they need some, if elders need some help or somebody needs food stamps, our team will just step in there and assist. Also, just understanding generational trauma. What American Indians and Alaska Natives have

experienced. And I don't have experience, but my mom or grandparents or my great grandparents experienced it, and it affects me today. So that goes a long way when working with tribes. Next slide please. Also, so the Indian Health Service, it's not true insurance. So we get a lot of native folks who do not want to sign up for the Oregon Health Plan or purchase health insurance because they feel like they have kind of prepaid that with the land that was ceded. So that is always a conversation, both within NARA and definitely out at the tribes, definitely out at the tribes we get a lot more pushback of, why should we buy insurance or sign up for OHP when we're native and have IHS. We are constantly having those conversations. We do try to explain the difference between private health insurance and clinics, IHS clinics. One of the ways we do that is to say, if you were to get cancer or in a major car accident, we can't help you within the four walls of a clinic. And neither can any of the tribes, because they are not hospitals. So we tell the folks that in that case you would need to go to the hospital, and you would be billed directly for all those services provided. And sometimes that works and sometimes it doesn't. So we just keep having that conversation with them. And the other solution is just explaining what the Oregon Health Plan is and how many benefits they get and how to use it. Next slide. So I think that is everything.

**Flo Bergland:** I have one thing. This is Flo again. And I just wanted to stress that when we communicate with the nine tribes, we like to communicate with the health directors, we like to communicate with all the assisters on the tribal reservations and say, we are working with you and we want to ensure and focus on our clients' enrollment in Oregon Health Plan.

**Sonciray Bonnell:** Good. We want to thank the rest of the panelists, that was very interesting, and I want to thank NARA staff that is on the webinar, we had a few of them that were pretty excited that we were doing this. So thank you all, I hope you have a great rest of the day.

**Jason Werden:** Thank you all very much. That was a very detailed overview from our friends at NARA and the NARA northwest team. Thank you for your time today. Again, if you are interested in learning more about NARA northwest, visit www.naranorthwest.org. We will now share our fourth poll question of today's webinar. What kind of health provider partnership has been most successful in your rural health outreach? Are you coordinating with doctors and nurses on the local health level? Are you working with dentists, pharmacists, or with local community health centers? Or it may be an instance where you have not yet partnered with any health

providers but are looking to learn about those opportunities by joining today's webinar. We'll take a minute and allow you to supply your feedback. Let's take a look at those results. Trying to look back across the board mostly here are allying with local community health centers, about 52% of the responses. Thank you for your feedback. As we usually do in these instances, we will share feedback on all of these poll questions and on the results following today's webinar, and all of this will be accessible in the coming weeks. We'd like now to move on to our last panelist of the day. Dr. Kay Miller Temple is a web writer with the Rural Health Information Hub, RHIhub, and is based in North Dakota at the University of North Dakota's Health and Sciences. She will be sharing today information on increasing rural health and well being through community engagement and targeted and timely resources. She has a number of real life experiences and examples to share with us today as well. Dr. Miller Temple, hello.

**Dr. Kay Miller Temple:** Hi, good afternoon. Again, my name is Kay Miller Temple, and I'm a content writer at the Rural Health Information Hub. Thanks for inviting Rural Health Information Hub to participate today. Next slide. The Rural Health Information Hub is a national clearinghouse for rural health information. We are funded by the Federal Office of Rural Health Policy and located at the North Dakota Center for Rural Health. We partner with the Walsh Center for Rural Health Analysis and the Rural Policy Research Institute. As a federally funded organization, all our resources are free. Next slide. RHIhub's annual site visits have grown to one million, and we aim to be your first stop for rural health information. Next slide. I'd like to mention some of our many resources. Our online library contains thousands of publications, maps, news articles, and funding opportunities. But in our data visualization section, you'll find even more topic focused maps and charts with national, state, and county level data. Along with in depth information in our topic guides and our state guides, we have an online magazine, the Rural Monitor, that features in depth stories examining key rural health issues. Another resource, the MI Rural tool, is found in our Tools for Success section. This tool will provide answers for those exploring whether a location meets a given definition of rural, those definitions that were mentioned by Dr. James. Next slide. In a 2006 U.S. Census blog post, Life Off of the Highway: Snapshot of Rural America, the author is reminded that the rural population is not the same everywhere except in its distinction of not being urban. Frequently categorized as older, sicker, poorer, less likely, less able to have engaged in higher education opportunities, rural America can also be described by one word: diverse. Because rural health

education and rural healthcare delivery efforts must accommodate that diversity, state efforts might look different from one another. Even within the same state, the health landscape may look different from region to region. At RHIhub, we have a bird's eye view of the diversity of our rural communities' health care activities and feature them in another important free resource, the Models and Innovation section. Here, successful programs and innovations for rural health issues are searchable by evidence level, state, topic, and funding source. Many of these models are backed by rural research studies. Others are stand alone, anecdotal accounts. Overall, model strategy is a unique way to translate rural success among geography and democracy, with one model strategy possibly being adapted by a rural community thousands of miles away. These models have elements of flexibility, innovation, creativity, the ingredients for meeting rural health needs. And a number of these models are especially helpful for efforts focused on insurance education eligibility and enrollment. We would like to share some of those programs and their specific strategies today. Next slide. First, let's talk about programs and strategies that depend on key individuals, for example, community healthcare workers, or CHWs. The American Public Health Association defines a community health worker as a frontline public health worker who is a trusted member of or has an unusually close understanding of the community served. Many rural communities depend on these respected professionals to answer multiple types of outreach needs, including health care coverage and enrollment. I share an Indiana model in innovation here, the ASPIN network. It currently offers robust CHW training for several needs, including enrollment navigators. Like many CHWs, those in this program are dually culturally competent, a phrase that describes the many CHWs who not only understand their local rural culture, but often have membership in or unique insight into health attitudes and practices of specific groups such as Latinos, American Indians, or Asian Americans. Another Indiana model is the Noble County Outreach Project, which uses another specially trained individual, the outreach enrollment specialist. The OES works in community location such as the WIC clinic, the schools, the local hospitals to offer enrollment services for Indiana Medicaid Health Indiana plan and the private health insurance marketplace. Wisconsin is the location of a unique program that uses CACs, or certified application counselors, to provide outreach to isolated seniors, old order Amish, Medicaid dental patients, and Latino groups. A notable accomplishment of this program is that from April 2016 to April 2017 outreach and enrollment services reached nearly 2,500 people, and the program's single CAC directly helped nearly 650 individuals complete

enrollment. The next model, the Santa Cruz County Adolescent Wellness Network, is unique in that it engages rural youth, a group often overlooked and underestimated. With proper training, they are a proven, valuable resource for themselves, their peers, their families, helping the senior members of not only their own families but often for those of their friends. Due to their age, they may not be able to perform actual enrollment activities, but they can prove a valuable member of any outreach team. We encourage you to review this model's Youth Involvement Toolkit. Next slide. A number of organizations assist with rural outreach education and enrollment efforts. We'll start with perhaps the most obvious, rural hospitals and clinics. It can be difficult for some rural hospitals and clinics to invest resources in these activities, and organizations in Louisiana have success using certified application counselors. This program has roots in the Affordable Care Act outreach efforts and is still able to use that enrollment infrastructure for their state's Medicaid expansion. Rural community schools can help with outreach, and once again diversity applies. Specifically, in frontier and remote communities, school nurses are often the go-to medical professionals for disseminating health information, especially when the nearest healthcare facility might be over one hundred miles away. So their main focus is routine nursing interventions. In Virginia, the Nelson County School Nurse Program, school nurses also take time to educate parents about the state's health insurance program available for their children. In many rural areas, schools are functioning as a strategic healthcare delivery site, especially for preventive care. Taking rural healthcare access to another level for children and youth is the school based health centers. According to the Health Resources and Services Administration, school based health centers are often operated as a partnership between the school and a community health organization. Louisiana has a school based health center staffed mainly by specially trained nurse practitioners providing oral health prevention. These providers must also engage in outreach when they identify oral health treatment needs. Building on the program's success and dissatisfied by no show rates for these treatment appointments they worked hard to get, they have current grant funding for dental case management, another opportunity for healthcare coverage enrollment activities. You will often hear talk of rural communities depending on their healthcare organizations, their schools, and their faith based organizations, or FBOs. FBOs are often specifically vested in the health profiles of their congregants. In North Carolina, the Partners in Health and Wholeness is a network of 475 congregations with a mission of building partnerships between congregations and existing state health programs, even serving as health promotion

centers. Obvious then is the possibility for reaching women and children through a network like this. Next slide. Though not specifically tied to enrollment efforts, the models I review next are certain to provide seeds for innovation, proving that often the greatest value of our models and innovations lies in their potential for sparking creativity to meet other needs. For example, connecting with trusted community members may offer valuable insight for efforts to meet a rural population where they are. A food bank's summer meal program in eastern Tennessee was grateful to school bus drivers who not only knew where and when children in rural areas would likely be gathered, but understood the challenging road conditions that would be encountered to get food there in the first place. Alabama's Kid One Transport. Exploding from one individual's idea, this organization now has twenty-one vehicles parked in driveways across the state in order for their local drivers to take rural expectant mothers and children to medical appointments in urban locations. They work with 700 healthcare organizations, county health departments, community service agencies, physicians, government agencies, and nonprofits throughout Alabama. Perhaps not uniquely rural, but still valuable, is the Guest Speaker Appearance at special rural events such as health fairs, county fairs, and local service organization meetings. The Texas C-STEP Program's community health workers are speakers at community events or senior centers, providing outreach and education on the importance of cancer screening. Those workers even help the audience make mammogram, pap smear, or colon cancer screening appointments. Next slide. When it comes to health education outreach and enrollment efforts, local rural media and social media can't be overlooked as partners. In the second of our two-part Rural Monitor story on rural health literacy issues, Who Is Delivering Health Information, rural newspaper experts shared that over 85% of rural Americans get a weekly newspaper, allowing newspapers to function as a health information disseminator. Librarians told of how they meet their rural patrons' health information needs. And in another Rural Monitor story on social media, rural healthcare providers share how they leverage social media to attract patients to a healthcare message. Next slide. We need to specifically point out to today's listeners that RHIhub has sixteen evidence based toolkits that are step by step guides for using evidence based programs for addressing rural health challenges. Yes, evidence based. Next slide. First, our Rural Community Health Toolkit is a general toolkit with information, resources, and materials to help develop any community health program, including one focused on outreach and enrollment. Note, this toolkit's modules focus on creating programs with an evidence based

implementation plan that also includes a framework to evaluate a program's effectiveness. There are also plans for sustainability, dissemination of results to project partners, funders, and the broader rural health community. Next slide. We'd also like to highlight the Rural Community Health Workers Toolkit and the Rural Oral Health Toolkit both provide information for specific outreach and enrollment efforts. Last slide. In conclusion, whether you are trying to reach rural residents in remote areas or frontier areas in the northwest or in the southeast, we hope that these highlights featuring the diversity and successes of some of our nation's rural programs provide a framework for replication or serve as a spark for new ideas that translate across geography, program focus, targeted age group, and especially provide ideas for outreach and enrollment efforts. If you have any questions or would like further information on any of our resources shared today, you can reach me at kay@ruralhealthinfo.org, or feel free to call us at 1-800-270-1898 and our information specialist will pick up the phone and provide you with free customized assistance. And of course, follow us on Facebook and Twitter. Thanks again for allowing us to participate, and back to the facilitators.

**Jason Werden:** Thank you very much Kay. We appreciate your time today. I'd like to quickly go through our last poll question for the day. As we discussed the many types of ways to engage with your means of reaching out to the rural community, we're interested to hear back from you. What type of local media engagement would best serve your outreach and enrollment efforts in reaching your rural community? Whether it be through radio, TV, an op-ed letter to the editor, blog post or online coverage, or even through the community newsletter or through a school PTA newsletter. Let's take a look at those responses. Thank you very much for your feedback today. Certainly again, noting that school and community newsletters are a highlight of your feedback, and that school based tools are of high interest. Do know that the Connecting Kids to Coverage Campaign does offer a number of school based outreach tools, and those can be found at insurekidsnow.gov. And speaking of those resources, we can go through the many resources that are available to you and each of your organizations. Next slide please. First I want to take a look at the Rural Health Outreach Tip Sheet. We've developed a tip sheet with five ways to conduct outreach in rural communities. This, as you'll see on the screen here, is an opportunity to identify eligible means for families to use these tips to incorporate into their outreach. There are a number of strategies in play. These are five tips to help you make outreach work. This is available for download of course at

insurekidsnow.gov. Next slide. We recently worked with the Mountain Comprehensive Health Corporation to develop this new video. It's an opportunity to show you in the field what organizations like yourselves are doing to work with rural communities locally. Reaching children and families that are eligible for Medicaid and CHIP, as we mentioned, can be particularly challenging in rural areas across the country. In Whitesburg, Kentucky, MCHC, Mountain Comprehensive Health Corporation, is working within rural communities to help families enroll in and gain access to proper health care. Now, MCHC is one of the largest rural health centers in the country, but there are many organizations who are joining us here today who we do feel will find a lot of value in this video. Following today's webinar and in follow up to all of you who have attended, we will be sharing through the eNewsletter, an opportunity to view this video as it is posted to our Outreach Tool Library. A link to that will also be included on insurekidsnow.gov. Next slide. We also want to provide an opportunity in this outreach tool library to see where we have additional campaign materials and resources available to all of you. From customizable posters to palm cards and videos, we mentioned tip sheets. Informational webinars such as this one, we have a webinar archive that has all of our previous webinars for your review. We of course have the Campaign Notes eNewsletter, which we encourage you to subscribe to if you have not already, to keep up to date with all of the news across the campaign. Many ready-made articles and radio scripts and digital media tools and radio and television PSAs, all accessible and many of which are customizable for your use on a regular basis and in your outreach efforts moving forward. Next slide. Those digital media tools can be used on social media. We have graphics, guides, web buttons and banners. A number of sample posts even that you are able to use. All of these are available as a guide for developing your outreach strategy in the rural community. These are as always available at insurekidsnow.gov. Next slide. A few examples of materials that we have outside of just strictly rural health. We have many topic areas and initiatives that reach other audiences that we have also covered on previous webinars and that we have examples of on insurekidsnow.gov. Whether the topic be back to school, oral health, your vision, engaging teens, using sports and athletics in schools as a method of engaging those teens, and year round enrollment at any time of the year. Next slide. We mentioned those customizable materials from posters, flyers, palm cards. All are at your disposal to customize to fit your organization and your audience. These are available at insurekidsnow.gov, and they provide an opportunity for you to add your logo, your organization, and your contact information so that you can properly reach your audiences. Next slide. For

more on these best practices for outreach and enrollment, we do invite you to visit the Outreach Video Library and Outreach Tool Library at insurekidsnow.gov as well as this webinar archive that I did mention. They have all of our webinars dating back to the beginning of this campaign. Two that we reference here, because they are of particular interest. The last one we did in June on connecting students to coverage this back to school season, is still viable and of topical note. And also, one of our previous webinars on reaching rural communities and how we reach and enroll families across that rural audience nationwide. Those are all available at, you guessed it, insurekidsnow.gov. Next slide. Many of our speakers today have mentioned similarly, we want you to keep in touch with all of us at the campaign as well as across our network of partner organizations. You can follow us on Twitter @IKNGov. You can engage with the campaign all across social media by sending us a tweet, re-tweeting any of our information, or send us a message with the hashtags #Enroll365, #KidsEnroll, or #Medicaid or #CHIP. As I mentioned, do sign up for our eNewsletters, there is a hyperlink on the screen but in our follow up we will also share a direct link to sign up and subscribe. If you have any questions at all or wish to contact the campaign or have questions that you want to take beyond today's webinar, email us at any time. connectingkids@cms.hhs.gov. Next slide. We want to hear from you as well. We mention all of this as a means of providing an opportunity to hear back from all of you across the network. If you have outreach and enrollment stories, best practices, challenges that you face that you want to share with the campaign or are looking at additional input on, do contact us, and we would love to hear your stories. That then takes us as well to our Q&A portion today. We've left the Q&A platform open throughout the webinar for you to provide your questions. We've gotten a few back here that we are excited to pose and share with you today. Our first question is for Dr. Cara James at OMH. Dr. James, the question we received is, Are the Coverage to Care materials available at a lower reading level, such as the fifth or sixth grade level of reading?

**Dr. Cara James:** Thank you for that question Jason. We have worked very hard to get the materials to as low a level as possible. Unfortunately, we are not at a fifth or sixth grade level, but that's part of the reason we have a variety of tools that are available. So for those with maybe lower health literacy, the Five Ways to Make the Most of Your Coverage is something that might be easier for that population to focus on. But the other, the roadmap and the other materials are testing at about an eighth grade level. We do

continue to try and see if we can lower the level and still include the important information that people need.

**Jason Werden:** Thank you for that feedback Dr. James. Our second question goes out to our friends at NARA. Is there any telemedicine being used in the communities that you referenced, and are you able to share any details on that if so? We might have lost our friends at NARA for this afternoon, but do know that all the questions posed today will be sent out to all of our speakers following today's webinar. If we have you, Kay, still on the line, we have one more question that is being posed your way. Are the toolkits that you mentioned from RHIhub, are they culturally specific to different populations across your communities?

**Dr. Kay Miller Temple:** I don't believe, most of them are not.

**Jason Werden:** Okay. Well, we will reference again that a number of materials available through the campaign are customizable and also address multiple audiences, and we have an opportunity to share that information with you through insurekidsnow.gov at any point that you might be interested. I will say once more, if we did not get to any question that you had today, or if you happen to think of it after the fact, do share it with us. We will include it in our after action with all of our speakers today and get back to you with a response via email in the coming days. We will also note that everything that you saw here today on this presentation as well as the recording of the presentation itself will be available within two weeks of today's date, when we will post it to the insurekidsnow.gov page as well as the webinar archive previously mentioned. You can reference these resources and all of the campaign's resources at any time. Thank you all for joining today's webinar, and remember that all of these resources are available for download, reference, and use at insurekidsnow.gov.