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Assessing a Coalition for Outreach and Enrollment in Minnesota's Health Insurance Exchange

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Abstract

Using a case-study approach, representatives of the Insure Duluth coalition were interviewed in order to evaluate processes, strengths, challenges and outcomes associated with using a coalition approach to community outreach and enrollment in health insurance via the new state marketplace, which is part of the implementation of the Affordable Care Act. Overall, interview participants cited numerous strengths to the coalition approach as well as technical challenges with enrolling persons in health insurance. They also felt such challenges had the unintended effect of strengthening the relationships between coalition organizations. Community level outcomes were identified as being associated with the coalition's work. Participants also discussed key contextual factors supporting the coalition. The coalition approach appears to be a promising tactic to increase health insurance access. States can provide funding for and foster policies to assist coalitions expand health insurance access.

Keywords

Coalitions, Health Insurance, Health Care Access, Affordable Care Act, Interviews, Case-Study

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Assessing a Coalition for Outreach and Enrollment in Minnesota's Health Insurance Exchange

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Using a case-study approach, representatives of the Insure Duluth coalition were interviewed in order to evaluate processes, strengths, challenges and outcomes associated with using a coalition approach to community outreach and enrollment in health insurance via the new state marketplace, which is part of the implementation of the Affordable Care Act. Overall, interview participants cited numerous strengths to the coalition approach as well as technical challenges with enrolling persons in health insurance. They also felt such challenges had the unintended effect of strengthening the relationships between coalition organizations. Community level outcomes were identified as being associated with the coalition's work. Participants also discussed key contextual factors supporting the coalition. The coalition approach appears to be a promising tactic to increase health insurance access. States can provide funding for and foster policies to assist coalitions expand health insurance access. Keywords: Coalitions, Health Insurance, Health Care Access, Affordable Care Act, Interviews, Case-Study

Community coalitions have become a widespread and accepted means for addressing an array of health and social concerns. A community coalition can be defined as a group involving multiple sectors of the community coming together to solve local problems (Berkowitz & Wolff, 2000). The increasing complexity of social problems coupled with limited funding to address such issues are forcing social service agencies and community organizations to do more with less (Plastrik & Taylor, 2006). Such approaches are fitting given the multiple social, behavioral, economic, and environmental determinants of health and uninsurance.

In terms of the outcomes associated with coalitions, there have been demonstrated impacts on social norms, behaviors, programs and policies (Roussos & Fawcett, 2000) across a broad range of issues. However, systematic reviews of coalitions and other coordinated community health efforts have found limited evidence of their effect on population-level health outcomes (Kreuter, Lezin, & Young 2000; Roussos & Fawcett, 2000). Quantitative measurement of outcomes associated with coalitions has proven challenging because measures tend to be context-specific and lack information on reliability and validity (Granner & Sharpe, 2004). Furthermore, it is often challenging to attribute observed outcomes to coalition activities due to a lack of experimental research designs (Roussos & Fawcett, 2000; Zakocs & Edwards, 2006). At the same time, the complexity of issues addressed by coalitions and the complexities of the communities in which coalitions operate make systematic evaluations challenging (Wolff, 2001).

Qualitative approaches are well suited for describing coalition formation and assessing the processes that sustain coalition functioning, recognizing that coalitions cycle through stages of formation, implementation, maintenance, and institutionalization (Butterfoss et al., 2006). Context-rich discussions provide knowledge and ideas for action that are useful across settings. Further, they help advance the literature by providing real-time, real-place insight into these contextual factors that enhance coalition formation and function (Trickett et al., 2011). Qualitative approaches are relevant in the evaluation of the

Insure Duluth Coalition given the novelty of state-based health insurance exchanges and community assistance as a platform and means to increase health insurance enrollment. At this stage we do not have a handle on what works or does not work, or even what aspects of location, organizations, or service delivery might be germane to this discussion.

The current study was undertaken to describe and assess the formation of the Insure Duluth Coalition, a community-developed coalition to increase access to health insurance in light of the Affordable Care Act's individual mandate. Coalition formation began with a lead agency bringing together key community partner organizations to focus on an issue of concern. Research indicates that coalition formation is supported by leadership from a lead agency, core members who have experience with the issue, staff who have the skills to carry out coalition tasks, and formal structures and processes for communication, decision-making, and conflict resolution (Butterfoss, Lachance, & Orians, 2006). These factors not only support coalition formation but also enhance coalition progression to the implementation stage (McLeroy et al., 1994). In addition, studies have shown improved health care utilization as a result of coalition work (Bencivenga et al., 2008; Collins, Johnson, & Becker, 2007; Fisher et al., 2004). A recent analysis of 7 community coalitions found policy and systems change as well as positive health outcomes associated with coalition work over five-years (Clark, et al., 2010). Such findings suggest that coalitions may work for increasing access to health insurance.

This study contributes to the literature by providing an in-depth view of coalition formation and the early implementation efforts of the Insure Duluth Coalition's efforts to increase access to health insurance. State-based health insurance exchanges are an innovative approach to increase access to health insurance, and ultimately health care among populations that have been uninsured. Many who have been uninsured are from vulnerable populations. This study discusses the strengths, challenges, and early outcomes of using a coalition for outreach and enrollment in health insurance via Minnesota's exchange. It is relevant for communities across the United States as they figure out ways to reach vulnerable populations and increase enrollment in health insurance.

Background on the Insure Duluth Coalition

One facet of The Affordable Care Act (ACA), a federal statute signed into law in 2010, is an individual mandate, or requirement, that certain persons purchase or otherwise obtain health insurance. This law also directs states to establish health insurance marketplaces, called exchanges, where persons who do not otherwise have health insurance (such as employer-sponsored insurance or Medicare) may purchase health insurance. In addition, through an exchange persons, meeting certain income qualifications can get subsidized assistance to pay for their insurance. Minnesota's health insurance exchange is called "MNsure." MNsure is governed by a seven-member state board appointed by the Governor and confirmed by the legislature. A legislative committee also provides operational, financial, and regulatory oversight.

MNsure was officially launched on October 1, 2013 after over two years of planning. As part of the planning process, MNsure developed training so that individuals could become "navigators" who provide one-on-one, in-person, assistance to hard-to-reach populations. These populations were most likely to use MNsure to access insurance and include people living in poverty, people of color, people with physical and/or mental disabilities, the working poor, young adults, the unemployed, and very small employers. In addition, MNsure issued a request for proposals (RFP) for organizations to improve their infrastructure for outreach and education and to further improve grassroots efforts to assist individuals and small businesses to enroll in healthcare coverage. In August 2013, MNsure awarded \$4.75

million to support 29 organizations across the state with the goal of reaching over 300,000 Minnesotans. Central to this effort are the aforementioned navigators, whose role is to help provide assistance with the complexities of insurance enrollment and obtaining government financial assistance.

In response to this RFP, Generations Health Care Initiatives (Generations), a Duluth-based foundation focused on health care access issues, formed a coalition of organizations providing health and social services to hard-to-reach populations. They received approximately \$230,000 to expand access to health insurance in these populations. Generations serves as the lead fiscal agent for Insure Duluth. This coalition represents community non-profit agencies, health care organizations, faith communities, and higher education. Prior to responding to the RFP, Generations, along with several key partner organizations, had convened community conversations around the issue of health insurance and used the data collected to inform coalition development and their response to the RFP.

The long-term goals of Insure Duluth are to increase access to health care for those in the greater Duluth area who are uninsured at 0-400% of the federal poverty limit, increase awareness of MNsure by providing coordinated outreach efforts with community organizations with a reach in to the target population, and ensure a coordinated community approach to outreach and enrollment. To meet these goals, a “hub and spokes” model serves as the conceptual model for the project. The hub and spokes model has been shown to improve access to health services for widely dispersed and isolated populations (Battye & McTaggart, 2003; Wakerman et al., 2008). The model also has been used in New York City and in the Massachusetts health insurance enrollment efforts (Families USA, 2013).

A key facet of the model is a centralized “hub,” that coordinates community-wide activities (such as referral and larger events) and provides administrative support (e.g. training, communications, data tracking, planning) and leadership of the coalition. The “spokes” in Insure Duluth’s model included four enrollment sites staffed with navigators plus a mobile navigator. Navigators, in addition to providing enrollment assistance, conducted outreach activities. Other community organizations, health care entities, and the faith community formed the “wheel base.” These organizations supported the work of the navigators by conducting outreach within their target populations and providing referrals. Figure 1 presents a pictorial representation of the “hub and spokes” model of the project and Table 1 presents the coalition’s logic model. This model is also very similar to network administrative organizations in public administration (Provan & Kenis, 2007).

Figure 1. Insure Duluth Conceptual Model

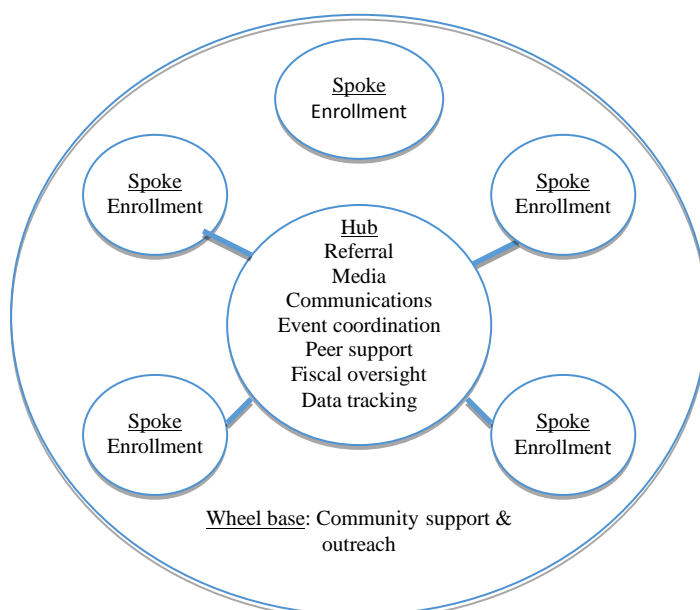


Table 1. Insure Duluth Logic Model

Goals	Objectives	Activities	Evaluation/ Measurement
1) Increase access to health care coverage for those in the greater Duluth area who are uninsured at 0-400% of FPL.	<ul style="list-style-type: none"> New enrollment sites that will enroll 1,160 individuals in MA, MNcare, or a QHP by October 1st 2014 	<ul style="list-style-type: none"> Onsight enrollment at Chum, Community Action Duluth, Salvation Army Targeted mobile enrollment at sites without an assister Enrollment oversight and assistance by Health Care Access Office staff 3 Enrollment Fairs in targeted neighborhoods tied to neighborhood canvasses 	<ul style="list-style-type: none"> Track enrollment information through data collection method currently used by Generations and Health Care Access Office Data provided by MNsure on successful enrollment through website Attendance at enrollment events
2) Increase awareness of MNsure by providing coordinated outreach efforts with community organizations with a reach into targeted populations.	<ul style="list-style-type: none"> Coordinate resources with community partners to reach target populations 10 outreach and enrollment events targeting specific populations Reach 40,000 individuals through community partner mailings, door to door canvass, enrollment events, program participants 	<ul style="list-style-type: none"> Hire Outreach Coordinator to: develop local message for target audiences, support community partners in outreach needs, presentations, oversee enrollment fairs and canvass events Coordinate 3 door to door canvasses in targeted neighborhoods to drive attendance at enrollment events 	<ul style="list-style-type: none"> Number of presentations and resources (such as newsletter articles, bulletin inserts, advertisements in community papers, etc.) Number of doors canvassed Number of printed materials distributed Number of media stories in the area Data provided by MNsure on successful enrollment through website
3) Ensure a coordinated community approach to outreach and enrollment	<ul style="list-style-type: none"> Creative problem solving, dialogue between organizations, shared resources, exchange of best practices so that organizations can do their work more effectively Expand impact of resources beyond Duluth Create opportunities to work with brokers for information exchange and referrals; appoint broker liaison 	<ul style="list-style-type: none"> Project Director facilitates monthly meeting of stakeholders and regular email updates (as needed) Duluth Collaborative and AEOA have quarterly meetings for the Northeast Area of MN Project Director and AEOA will facilitate regular communications and referrals between organizations in the region Broker to meet with Community Assisters to share updates, Community Assisters available to meet with brokers, referrals between brokers and Community Assisters when necessary 	<ul style="list-style-type: none"> Attendance at stakeholder meetings and number of email updates Process evaluation of coordinated model used by the Collaborative

Outreach was done through existing local and regional social service programs (e.g. utility bill payment assistance, food shelf, parish nurses). In addition, the coalition hosted outreach events and conducted door-to-door canvassing in zip codes with the highest rates of uninsurance. Navigator actively enrolled persons into health insurance plans available through MNsure. Generations convened monthly meetings for all coalition members and held

ad-hoc meetings for outreach and navigators. Through April, 2014, Insure Duluth participated in 135 outreach events and reached over 56,000 people through these outreach efforts. In addition, they made approximately 300,000 media contacts through print and broadcast media (newspapers, editorials, TV news and ads in various local publications).

Background on the Community

Coalition efforts were centered within the community of Duluth, Minnesota, which is located at the Western tip of Lake Superior. The total population of the three county metropolitan area is just under 300,000; however, the population of the coalition's service area was estimated at 135,000 and includes just the southern portion of St. Louis County. The geography of the three county surrounding area is vast and largely rural, leaving the coalition's target area somewhat bounded. Rates of uninsurance for St. Louis County are slightly higher than the state's rate of 9% uninsured, with approximately 11% of adults ages 18-64 being uninsured (U.S. Census Bureau, 2014a). In addition, the area has a lower median household income, \$41,300 compared to the state median of \$59,100 (U.S. Census Bureau, 2014b).

Estimates of Increases in the Numbers of Persons Insured

Early reports document the success of efforts to enroll persons in health insurance. Statewide, it is estimated that approximately 180,500 Minnesotans gained insurance coverage between October 1, 2013 and May 1, 2014. This translates into a 40.6% reduction in the size of the uninsured population (State Health Access Data Assistance Center, 2014). Locally, the navigators associated with Insure Duluth enrolled 2,043 individuals in health insurance between October 1, 2013 and September 30, 2014. The majority of these enrolled in Medicaid (64.3%). In addition, navigators assisted many people who started an application but got stuck or frustrated, or completed the application on their own. They also helped persons who had insurance but were looking for better coverage and/or a better price. Thus, the coalition's enrollment numbers do not reflect all those enrolled from the service area. Assuming the reduction in uninsurance for the coalition's service area mirrors that at the state level, the coalition enrolled approximately one-third of the persons who gained insurance in the service area.

Role of the Evaluator

Kim Nichols Dauner, M.P.H., Ph.D., is an Assistant Professor in the Health Care Management Program at the University of Minnesota Duluth. Dr. Dauner has experience evaluating community health collaborations and in qualitative methodologies. Dr. Dauner was asked by the coalition to conduct a formative evaluation after receipt of funding from MNsure. While Dr. Dauner has attended some coalition meetings, her primary role was to present findings to coalition members and to get feedback that her analysis and interpretation was founded in the data (Lincoln & Guba, 1985). Her role was separate from others affiliated with the coalition who conduct outreach to young adult populations enrolled in higher education.

Methods

The goal of this evaluation is to use a case-study approach to provide lessons learned on the utility of using a coalition approach for outreach and enrollment in health insurance marketplaces. Specific research questions were:

- 1) What factors helped Insure Duluth develop and carry out outreach and enrollment in health insurance exchanges?
- 2) What was challenging when it came to the development of the coalition and implementation of coalition activities?
- 3) What changed (either at the organizational or societal level) as a result of the coalition?
- 4) How can this information inform the coalition's work?

A case study approach was necessary as using a coalition to conduct outreach and enrollment in the state's health insurance exchange was unique. Many grantees were focused on a single underserved population, versus an entire community. Moreover, many grantees were located in more populous, more urban areas. Because exchanges operate at the state level there did not appear to be viable comparisons outside Minnesota. Also because exchanges are new, there are no established best practices for outreach and enrollment. The research was exploratory in nature – to explaining what exists and how those processes operate in situ. As such, an additional aim is to document the contextual factors most relevant to implementing such approaches in our community. While much work has gone into documenting the formation of the on-line marketplace exchanges and statewide marketing efforts, regional or local level outreach has not been studied in-depth. Nevertheless, it has been suggested that localized, extensive outreach is most needed to reach those most in need of access to health care (Kaiser Family Foundation, 2013).

My approach to this aspect of the evaluation uses a realist framework. Such an approach recognizes that observable behaviors and socially constructed realities are inseparable (Maxwell, 2012). Put in a more concrete way, those interviewed both generated the products of the coalition and assigned meaning and interpreted such events. Such strategies have been applied in health services research as a way to generate themes related to the description and explanation of complex, real-world phenomena (Bradley, Curry, & Devers, 2007). In addition, empowerment evaluation principles informed this research. Such approaches aim to increase the capacity of programs to discover and use evaluation findings for continuous improvement (Fetterman, 1996). These principles were used in practice by the timing data collection as well as frequently presenting back evaluation findings to the coalition.

Semi-structured interviews were conducted with 25 persons representing the 14 partner organizations comprising the Insure Duluth coalition. At least one person from each organization participating in the coalition was interviewed, and for all but one organization everyone working on coalition activities participated in an interview. Coalition organizations included the lead agency, local non-profit social service agencies, two health care entities, and a state advocacy organization. The roles of persons interviewed included lead agency staff (the hub), navigators (spokes), and project staff from partner organizations conducting outreach (wheel base organizations). All staff and navigators participated in an interview. Interviews primarily took place at individuals' worksites. When more than one person from an organization worked on the coalition, all persons were interviewed together. The largest interview group was four persons, most interviews were with one or two persons. Interview questions solicited information on respondents' perspectives as to the processes, benefits, challenges and outcomes associated with the coalition's development and current work. See Appendix A for the interview guide.

The interviews began in January 2014, which was approximately at the mid-point of the designated open enrollment period and were completed in March 2014. The timing was selected so that interview participants would have had time to implement outreach and

enrollment activities but before the end of the enrollment period so that any issues identified could inform current practice. Interviews were audiotaped with the consent of those being interviewed. Each interview lasted approximately 45 minutes. Dr. Dauner interviewed all 25 persons and was accompanied by a student intern who took notes on the interview. The study protocol has been approved by the University of Minnesota Institutional Review Board and was considered exempt from full review.

Interview notes were typed up and then audiotapes were reviewed in order to augment the notes. Thematic analysis was performed with the goal of generating themes related to using and understanding a coalition-based approach to outreach and health insurance enrollment for exchanges. Preliminary themes were identified and presented back to the coalition as way to member-check initial findings (Lincoln & Guba, 1985). Coalition meeting minutes were used to clarify interview data (for example descriptions of the content of op-ed pieces and the dates and types of outreach events helped put participants' comments on the outcomes associated with those events into perspective).

The research questions were used as an initial framework for creating themes (e.g., strengths, challenges, outcomes). Initial themes were then further grouped into relevant subcategories that arose from the data. The themes were then further analyzed using a process of clustering, ordering, and categorizing with the goal of identifying patterns among themes that characterize the specific experiences of individuals into insights relevant across the whole coalition (Bradley, Curry & Devers, 2007; Patton, 2001). For example, strengths were further grouped based on whether they were related to coalition development or implementation. Themes were also analyzed to reveal the underlying meanings participants associated them with. One example of this can be seen with the challenges posed by MNsure. While participants discussed concrete technical and communication challenges coming from MNsure, they also began to discuss their analysis of these challenges and how they helped unite the coalition.

Results

The interviews revealed a number of factors relevant to developing and implementing coordinated coalition approaches to outreach and enrollment in health insurance exchanges. Interview participants discussed coalition strengths and challenges, cited organizational and community outcomes, and discussed the effect of community context on the coalition's work. Table 2 presents an overview of all themes.

Theme 1: How History, Community and Leadership Help A Coalition Get and Stay Together

The question related to what has worked well elicited the biggest responses from participants. Participants discussed those processes and actions internal to the group that have contributed to the feeling that the coalition is successfully meeting its goals. Participants distinguished between those factors that occurred early on in coalition development as well as on-going ones. Factors that helped get the coalition off the ground included a shared history of working together, buy-in from members and the community on the need to increase health insurance access, and the inclusion of a variety of stakeholders. In addition the services provided by the lead agency and the use of data-driven approach were strengths.

The history between some of the organizations, and involving all possible stakeholders from the outset helped to unite the coalition around the issue of health insurance access. This shared value was important to the inclusion of health care organizations within

the coalition, since this was the first time many of the social service agencies had partnered with larger health care organizations in a significant way and trust needed to be established. As one person put it “hospitals and [a faith-based agency for the homeless] now have a shared vision of increasing access to health care”.

As the coalition moved from development to activity implementation, participants expressed high levels of community and organizational buy-in to the need for increased access to health insurance. Many saw that need as an integral part of larger social issues (e.g. poverty) since they represent social service organizations serving populations that tend to be uninsured. Participating health care organizations, while acknowledging an untapped revenue source, also talked about the need to keep patients healthy, especially given the need to decrease the high cost of care and the introduction of new payment models that promote prevention.

Table 2. Themes Related to a Coalition Approach to Health Insurance Exchange Outreach and Enrollment

Theme	Definition
<u>Strengths</u>	
Shared history	Descriptions of how a history of working together in the past enabled the current coalition partnerships
Shared mission/buy-in	Descriptions of how all organizations shared a common mission or valued the issue of increasing access to health insurance
Lead agency coordination	Descriptions of the value of the services provided by the lead agency (i.e. communication, coordination, leadership within the coalition and with external constituencies)
Representativeness	Descriptions of how all stakeholders were a part of the coalition
Data-driven approaches	Discussion on the idea that activities were driven by community level data on the problem of uninsurance
Funding/shared resources	Description of the benefits of MNsure funding and/or other funding that was used to achieve coalition goals
Task specialization/inter-agency collaboration	Descriptions of the roles various organizations took on to complete coalition activities and the collaboration that occurred in order to get the work done.
<u>Challenges</u>	
MNsure	Descriptions of the technical, administrative, and resource challenges presented by the on-line health insurance marketplace developed by MNsure
<u>Outcomes</u>	
Outreach events	Descriptions on the number and diversity of outreach materials and events that were produced
Integration into regular work	Description of how either conducting outreach or navigation was integrated into the agency’s on-going work and/or how an agency’s scope was expanded
Community changes	Description of perceived community changes as a result of the coalitions work.
Upstream responses	Description of feelings on MNsure’s responsiveness to coalition feedback since their voice represented many versus a few
<u>Sustainability</u>	
Continuing the work	Discussion of what it will take to continue the work of the coalition, recognition of who is still uninsured

<u>Community context</u> Long-term interorganizational relationships Geography	Descriptions of how coalition many coalition partners had a long-term history of addressing community needs of poverty and substance abuse way before health insurance access was an issue/policy Description of the location and size of the community may affect coalition work
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Strong leadership from the lead agency was also crucial for providing oversight and coordinating across various stakeholder groups. In addition participants used words like “trusted” to describe the reputation of the lead agency. Leadership and trust were especially important for bringing in groups that had not worked together historically. As well, a data-driven approach was used early on to define community need. Community conversations were held early on to gather community input on the need for health insurance. The data that came out of these conversations helped secure the buy-in of stakeholders. The use of theory-driven approaches to collaboration and project activities (e.g., the hub-and-spokes models) helped make the process about what was good for the community and not about the agenda of any single organization. Strong central leadership also allowed partner agencies to spend more time focused on outreach and enrollment and not the day-to-day planning and management of operations. In response to what has worked well, one person describes this sentiment, “Having [Generations staff members] taking the lead and getting everything in place with the coalition and working with MNsure.”

After the beginning of open enrollment, having people with the right skills and passion to serve as leads for the navigation and outreach teams was seen as a key factor. Likewise, sites found that proactive and consistent communication from the lead agency and between stakeholders was helpful. Interviewees felt that these on-going factors tended to help the group stay motivated to do the work and made the work easier to do. One person described “not feeling alone” in the work. Over time, these communications led to shared resources and specialization occurring. For example interviewees discussed the coordinating role United Way 2-1-1 played in the referral process as well as the mobility of navigators to respond to community demand. United Way 2-1-1 would field calls from people requesting assistance and then refer them based on the location and availability of navigators. Interviewees also viewed the leveraging of other grant funding as being a critical factor to their success, as well as an outcome of their work. This included money to hire community health workers for door knocking. They also mentioned the in-kind contributions of the group’s members.

These factors also helped stakeholders to feel like there was unity among the coalition members and they used words such as “synergy” and “division of labor” to discuss the beneficial relationships across coalition members. Participants discussed how truly collaborative the group was. As such, many described feeling that they were not alone in doing the work, having positive experience working with partner organizations, the alignment of results with goals, and the feeling like they had helped people. These tended to increase feelings of motivation and energy and helpfulness and helped sustain the on-going work. The following quote demonstrates these sentiments.

benefit of doing outreach events was everyone having their hand in creating events, you can just say “well, we need some navigators here” and “ok, I’ll do that one” and we could jump back and forth and always more people who can help.

Theme 2: External Challenges (and How They Helped and Hindered Coalition Work)

At the same time, participants felt there were some barriers to their work. Unlike the strengths, these were external to the coalition and arose from working with MNsure. MNsure's challenges have been highly publicized (see Optum, 2014 for a summary report of their challenges) and the participants discussed their experiences with those challenges. These included technical glitches in the MNsure software and operating system, call center staffing shortages, a lack of proactive and timely communication about identified problems, a lack of timely outreach materials, enrollment verification issues for both public and private insurance consumers, and the inadequacy of the navigator training that was provided. Furthermore, participants felt that the challenges, coupled with a limited window of time in which to enroll people into health insurance, was stressful. Related to this, participants feared community repercussions. One person described that MNsure "decreased our power to advocate" for clients. As well, respondents were concerned that these challenges would affect their future work.

The whole process of people getting insurance [through MNsure] is really ambiguous right now. So there's a lot of processes that MNsure hasn't worked out. So you'll help someone enroll and it says "You're going to get Medicaid." Great, but then what?

While these challenges diminished capacity to enroll people, it was felt that most of these barriers have lessened and that internal coalition resources were deployed to diminish their effects. As one participant put it, "difficult conditions would have collapsed a lesser coalition."

Theme 3: Outcomes of Coalition Work

Interview participants cited a number of outcomes associated with their work. They spoke of the number and diversity of outreach events that were put together and the development of localized outreach materials such as a rack card advertising the availability of enrollment assistance. They also discussed how outreach and navigation work were integrated into their current workflow. This was particularly true of agencies that provided direct service to the populations most needing insurance such as a homeless outreach organization and a program for utility assistance. Agencies that provided community level outreach discussed how their involvement with Insure Duluth helped "widen our scope" by expanding their organization's mission in a positive way.

Community changes were also mentioned as outcomes of Insure Duluth's work. Interviewees felt that as a group they were able to steer the public conversation surrounding the ACA. Specifically, they felt they were able to depoliticize the ACA locally and gain positive media coverage by highlighting enrollment success stories and publishing op-eds. Another outcome was an improved relationship between local health care entities and the social service agencies that deal with social and economic determinants of health. They also felt they were able to begin to make in-roads with the greater business community. One interview participant discussed how the positive media saved time and energy to focus on coalition work:

All the positive messages about the ACA [in contrast to the negatives about websites not working more nationally] in general we did not have to battle a

lot of hostilities or negative comments and spend time countering negative stuff.

Another aspect of this theme was how the coalition was able to influence MNsure processes and policies. Part of this stemmed from the fact that members of the coalition were asked to serve as “Strategic Allies” for MNsure. Strategic Allies met regularly with MNsure staff to provide feedback from around the state. This made people feel as if their concerns were more likely to “be heard.” Participants attributed this feeling to the coalition having strength in numbers and that this resulted in upstream changes that benefited not just Duluth but all of Minnesota. Interviewees felt that they had helped prioritize and advocate for change with MNsure and saw changes being made in response to their energies. They also reflected back upon the coalition’s ability to speak with one voice to MNsure on issues that affected several coalition members. As one person put it:

[Through Insure Duluth] we can see what problems we are having in common and the ones we are having differently and we can really focus on which problems we are going to send up the chain...not just getting a peppering of problems, we can really hammer in...we are all stronger when we can go through a channel and just direct a message.

Theme 4: Sustainability

Participants discussed how to sustain the work of Insure Duluth in the future. This theme came up organically from the question about what is needed right now and speaks to the desire to sustain the work. Comments centered on what could be done at the state and local levels in order to reach more people.

Marketing and how to get to those without computers get word out and reach difficult-to-reach populations

Continue to push on public opinion, get a public option included

As Insure Duluth continues its work to reach hard-to-reach populations, participants felt it would be necessary to fill gaps in enrollment including young adult “invincibles,” rural populations, those without computer access, and those with low health and/or health insurance literacy. As one person put it,

We still have uninsured [people], but we don’t know where to find them...At the food shelves people have Medical Assistance, it was hard to find someone needing [assistance], we’ve come to the conclusion that there are some middle of the road group in their 20s, 30s, 40s that have been without insurance for so long...no fire to get them to do it.

At the same time, interview participants felt able to provide education and health insurance enrollment to help meet the needs of these populations. Again, they cited high levels of trust and support among individuals and businesses and are eager to build off of it.

It was also noted that having the state fund administrative expenses related to running a coalition would be helpful. Some agencies were already working to conduct outreach on health insurance options and had received money from other funding sources to do this. So when MNsure did not allow for administrative expenses related to running the coalition,

Generations decided to cover these expenses and use the state funds to augment existing outreach and enrollment efforts in the community.

Theme 5: A Community Culture of Working Together

Community context refers to aspects of the larger community in which coalition activities take place. It can be discussed at local, state, or national levels. Under the umbrella of community context, the themes discussed by participants included a long-term history and culture of working together and geography.

Since the early 1980s, the Duluth community has been an innovator when it comes to how a community works together to address domestic violence. Multiple agencies have worked together to share policies and practices that keep victims safe and hold abusers accountable. This model has demonstrated positive outcomes in reducing domestic violence and has been replicated internationally (Duluth Model, 2011). Insure Duluth members have had experience with this model and through this “we have a culture of collaboration and working together, history”. In addition, meetings were convened throughout the community prior to the availability of grant money to identify and clarify community need for health insurance. These meetings also served the purpose of developing buy-in on the need for increased health insurance within the community. As one person mentioned “We worked with Generations on a couple of things, we were involved in a community-facilitated forum early in the process”. The availability of funding from MNsure and the federal individual mandate served as the impetus for formalizing coalition work. However, these were viewed as less important than existing local efforts; participants already knew their organizations would need to address such issues even without funding. Finally, the fact that Duluth is a smaller metropolitan area surrounded by a larger rural area may have helped to keep the scope manageable. As one person put it, the “bounded” nature of Duluth’s location may have lended itself to coalition approaches.

Discussion

The themes identified through the interviews provide lessons learned for other communities interested in developing and implementing a coalition approach to enrolling persons in health insurance marketplaces. Specific lessons learned from the development of Insure Duluth are instructive for building and sustaining effective coalitions to increase access to health insurance. These include fostering leadership and coordination from a single organization, having clear roles for partner organizations, developing a shared mission, inclusion of all stakeholders, using data to drive decisions and processes, and consistent and proactive communication. These factors are similar to what others have found. For example, a review of the literature on coalitions found that formalization of procedures, leadership style, membership participation, membership diversity, agency collaboration and group cohesion were associated with improved coalition functioning and some policy and community behavior change measures (Zakocs & Edwards, 2006). Further, the findings support the idea that the leadership and support of a lead agency is critical (Evans et al., 2014; Hanleybrown et al., 2012).

The literature supports the idea that providing support functions (e.g., fiscal oversight, communication) are critical for coalition leaders (Butterfoss, Lachance, & Orians, 2006). In addition, Durlak and Dupre (2008) discuss how community, provider, and support system factors influence the dissemination and implementation of innovations. We find support for these in our interviews. The findings suggest how coalitions working on health insurance enrollment can be better supported. Other communities working on outreach and enrollment

may need to focus on capacity building within coalition partners or on engaging organizations whose constituencies reflect those most likely to need enrollment assistance within a community. Likewise, at the state level training and technical assistance can be provided to support coalition efforts. Specific to outreach and enrollment in Maine's health insurance marketplace, connecting navigators within the same region was valuable in spreading information on updates and resources and motivated them to do work that was often challenging (Brostek, 2014). Their work, like ours, sheds light on the value of using collaborative approaches to enrolling persons in health insurance and suggests promise for a regional approach.

Study Limitations

A limitation of the evaluation stems from the use of interviews. Critiques of interviews center on the premise that interviews are reconstructed accounts of reality and that such subjectivity calls accuracy into question (Charmaz, 2014). At the same time, Charmaz points out that interviews can give participants a chance to reflect and even analyze events in ways that can be very insightful. In my research, results were presented back to the entire coalition for discussion in order to prevent the subjective feelings and experience of one speaking for the coalition. Coalition meeting minutes were also reviewed and help verify the themes identified. Certainly, future research ought to expand beyond interviews.

Another limitation of the evaluation stems from the fact that the research was conducted in one community. At the same time, the Duluth area is not unique in being a mid-sized city surrounded by a larger, more rural area. Research suggests there is value in learning more local drivers of uninsurance as the issue itself is not homogenous and that learning about the variation in health insurance dynamics can help tailor enrollment strategies for state health insurance exchanges (Graves & Swartz, 2013). Currently, however, it is unclear to what extent these themes would be found in other areas of the state or country and as such similar studies in other areas would be appropriate areas for future research.

Policy and Practice Implications

This research points to important practice and policy implications for those working on increasing access to health insurance. Local coalitions can use this information to develop their work. It is important to note that depending on whether organizations have a history of working together or not, that some up-front work may be needed to create relationships among various organizations. Going back to a common mission of improving health care access may be helpful. Likewise, using existing data (or gathering data) could help facilitate buy-in and drive activities. Maine's experience suggests that connecting and coordinating people doing similar work is beneficial to conveying information and inspiring motivation (Brostek, 2014). As such, funding needs to be available for coordination.

There is some evidence that health policymakers are also favoring collaborative approaches. MNsure's RFP for the 2014-2015 open enrollment period encourages collaborative/coordinated community approaches. MNsure is also now hosting regional networking events among navigators. Our data support these efforts. MNsure, as well as other states' health insurance exchanges, could also support coordinated community approaches by providing technical assistance based on the findings herein. Specifically they could help communities with developing the leadership and technical competency necessary for "hub" functions and supporting such functions financially. Of importance is the need to have a strong exchange platform and we are encouraged by recent news that many states, including Minnesota, are working to do this.

Despite the progress made in reducing the numbers of uninsured, there is still much work to be done. There are on-going technical and policy challenges to be worked out. Some states have relied on a federal exchanges, while others states have decided not to expand their Medicaid programs, leaving gaps among some of the most vulnerable populations (see the Kaiser Family Foundation's Health Reform website for the most up-t-o-date information on ACA implementation at the state level). The health care environment is still very volatile. Further, it is unclear what changes will be made by state policymakers, federal agencies, and health insurance companies over the next several years. Innovations to address reaching people with critical information and health insurance services will continue to be key. Early research such as this will allow communities to consider ways to reach diverse populations that fit the community and geographic contexts of their own states and localities.

References

- Battye, K. M., & McTaggart, K. (2003). Development of a model for sustainable delivery of outreach allied health services to remote north-west Queensland, Australia. *Rural and Remote Health, 3*, 194. Retrieved from <http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=194>
- Bencivenga, M., DeRubis, S., Leach, P., Lotito, L., Shoemaker, C., & Lengerich E. J. (2008). Community partnerships, food pantries, and an evidence-based intervention to increase mammography among rural women. *Journal of Rural Health, 24*(1), 91-95.
- Berkowitz, W., & Wolff, T. (2000). *Community coalitions can create conditions to improve health: The spirit of the coalition*. Washington, DC: American Public Health Association.
- Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research, 42*, 1758-1772.
- Brostek, E. R. (2014). *Regional assister roundtables: Maximizing enrollment success by creating a community of assisters*. Consumers for Affordable Health Care. Retrieved from http://familiesusa.org/sites/default/files/product_documents/140602-RT-REPORT.PDF
- Butterfoss, F. D., Gilmore, L. A., Krieger, J. W., Lachance, L. L., Lara, M., Meurer, J. R., ... Rosenthal, M. P. (2006). From formation to action: How allies against asthma coalitions are getting the job done. *Health Promotion Practice, 7*, 34S-43S.
- Butterfoss, F. D., Lachance, L. L., & Orians, C. E. (2006). Building allies coalitions: Why formation matters. *Health Promotion Practice, 7*, 23S-33S.
- Charmaz, K. (2014). *Constructing grounded theory*. Thousand Oaks, CA: Sage.
- Clark, N. M., Lachance, L., Doctor, L. J., Glimore, L., Kelly, C., Krieger, J., ... Wilkin, M. (2010). Policy and systems change and community coalitions: Outcomes from allies against asthma. *American Journal of Public Health, 100*, 904-912.
- Collins, D., Johnson, K., & Becker, B. J. (2007). A meta-analysis of direct and mediating effects of community coalitions that implemented science-based substance abuse prevention interventions. *Substance Use and Misuse, 42*, 985-1007.
- Duluth Model. (2011). *The Duluth model: Social change to end violence against women*. Retrieved from <http://www.theduluthmodel.org/about/why-works.html>
- Durlak, J. A., & DuPre, E. (2008). Implementation matters: A review of the research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology, 41*, 327-350.

- Evans, S. D., Rosen, A. D., Kesten, S. M., & Moore, W. (2014). Miami thrives: Weaving a poverty reduction coalition. *American Journal of Community Psychology, 53*, 357-368.
- Families USA. (2013, June 18). Outreach and enrollment lessons from Massachusetts. *Conference Call Series Podcast*. Podcast retrieved from http://sas-origin.onstreammedia.com/origin/infiniteconferencing/WAVFiles/Families_USA_121912/Families_061813_0300pmET.wav
- Fetterman, D. M. (1996). Empowerment evaluation: An introduction to theory and practice. In D. M. Fetterman, S. J. Kaftarian, & A. Wandersman (Eds.), *Empowerment evaluation knowledge and tools for self-assessment and accountability* (pp. 3-48). Thousand Oaks, CA: Sage.
- Fisher, E. B., Strunk, R. C., Sussman, L. K., Sykes, R. K., & Walker, M. S. (2004). Community organization to reduce the need for acute care for asthma among African American children in low-income neighborhoods: The neighborhood asthma coalition. *Pediatrics, 114*, 116-123.
- Granner, M. L., & Sharpe, P. A. (2004). Evaluating community coalition characteristics and functioning: A summary of measurement tools. *Health Education Research, 19*(5), 514-532.
- Graves, J. A., & Swartz, K. (2013). Understanding state variation in health insurance dynamics can help tailor enrollment strategies for ACA expansion. *Health Affairs, 32*, 1832-1840.
- Hanleybrown, F., Kania, J., & Kramer, M. (2012). Channeling change: Making collective impact work. *Stanford Social Innovation Review, 20*, 1-8. Retrieved from http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work
- Kaiser Family Foundation. (2013 September). *Getting into gear for 2014: Insights from three states leading the way in preparing for outreach and enrollment in the Affordable Care Act*. Menlo Park, CA: The Henry J. Kaiser Family Foundation. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8480-getting-into-gear-insights-from-three-states.pdf>
- Kaiser Family Foundation. (2015). *State health facts, health reform*. Retrieved from: <http://kff.org/state-category/health-reform/>
- Kreuter, M. W., Lezin, N. A., & Young, L. A. (2000). Evaluating community-based collaborative mechanisms: Implications for practitioners. *Health Promotion Practice, 1*(1), 49-63.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Maxwell, J. A. (2012). *A realist approach for qualitative research*. Thousand Oaks, CA: Sage.
- McLeroy, K. M., Kegler, M., Steckler, A., Burdine J., & Wisotzky, M. (1994). Editorial: Community coalitions for health promotion: Summary and further reflections. *Health Education Research, 9*, 1-11.
- Optum. (2014, January). MNsure Assessment Summary. *PowerPoint Presentation*. Retrieved from <https://www.mnsure.org/images/Bd-2014-01-22-OptumPresentation.pdf>
- Patton M. (2001). *Qualitative evaluation and research methods* (3rd ed.). Newbury Park, CA: Sage.
- Plastrik, P., & Taylor, M. (2006). *Net gains: A handbook for network builders seeking social change*. Boston, MA: Network Impact. Retrieved from <http://networkimpact.org/downloads/NetGainsHandbookVersion1.pdf>

- Provan, K. G., & Kenis, P. (2007). Modes of network governance: Structure, management, and effectiveness. *Journal of Public Administration Research and Theory, 18*, 229-252.
- Roussos, S., & Fawcett, S. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health, 21*, 369-402.
- State Health Access Data Assistance Center (SHADAC). (2014). *Early impacts of the Affordable Care Act on health insurance coverage in Minnesota*. Minneapolis, MN: State Health Access Data Assistance Center. Retrieved from <http://www.shadac.org/MinnesotaCoverageReport>
- Trickett, E. J., Beehler, S., Deutsch, C., Green, L. W., Hawe, P., McLeroy, K., ... Trimble, J. E. (2011). Advancing the science of community-level interventions. *American Journal of Public Health, 101*(8), 1410-1419.
- U.S. Census Bureau. (2014a). *Model-based small area health insurance estimates (SAHIE) for counties and states*. Retrieved from <http://www.census.gov/did/www/sahie/data/interactive/>
- U.S. Census Bureau. (2014b). *State and county quick facts*. Retrieved from <http://quickfacts.census.gov/qfd/states/27/2717000.html>.
- Wakerman, J., Humphreys, J. S., Wells, R., Kuipers, P., Entwistle, P., & Jones, J. (2008). Primary health care delivery models in rural and remote Australia – A systematic review. *BMC Health Services Research, 8*, 276.
- Wolff, T. (2001). Community-coalition building – contemporary practice and research: Introduction. *American Journal of Community Psychology, 29*, 165-172.
- Zakocs, R. C. & Edwards, E. M. (2006). What explains community coalition effectiveness? A review of the literature. *American Journal of Preventive Medicine, 30*(4), 351-361.

Appendix A

Sample Interview Guide

1. Tell me about your organization's role in the coalition. Your specific role.
2. What have been the benefits of participating in the coalition?
3. What has been the impact of the coalition's work on your work/site? (Probe for: organizational or community changes)
4. Thinking back through the development of the coalition, what has worked well? (Probe for biggest success)
5. What has been challenging? (Probe for how challenges have been overcome)
6. What could you have used to make your work easier? What is missing?
7. What would be helpful to support your on-going work?
8. How have things been between the local coalition and MNsure? (Probe for what has worked well? What can MNsure improve upon?)

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