Advancing Health Equity & Measuring Success with Community Health Workers

July 19, 204

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THE UNIVERSITY OF VERMONT EXTENSION

Bridges to Health
Puentes a la Salud

Agenda

Migrant Health Programs

Bridges to Health CHW Program Overview

Identifying Needs and Tracking Progress

Opportunities for Collaboration

Q & A

Migrant Health Programs

Develop, coordinate, implement and support community-based outreach initiatives and services which contribute to health and health equity within designated migrant communities at local and statewide levels.

- Farmworker Mental Health Assessment
- Advisory boards and task forces
- Huertas & Food Access Projects
- Vermont Early Childhood Fund (VECF)/Family Room Collaboration
- Bridges to Health Community Health Worker Program

Migrant Health Programs Team

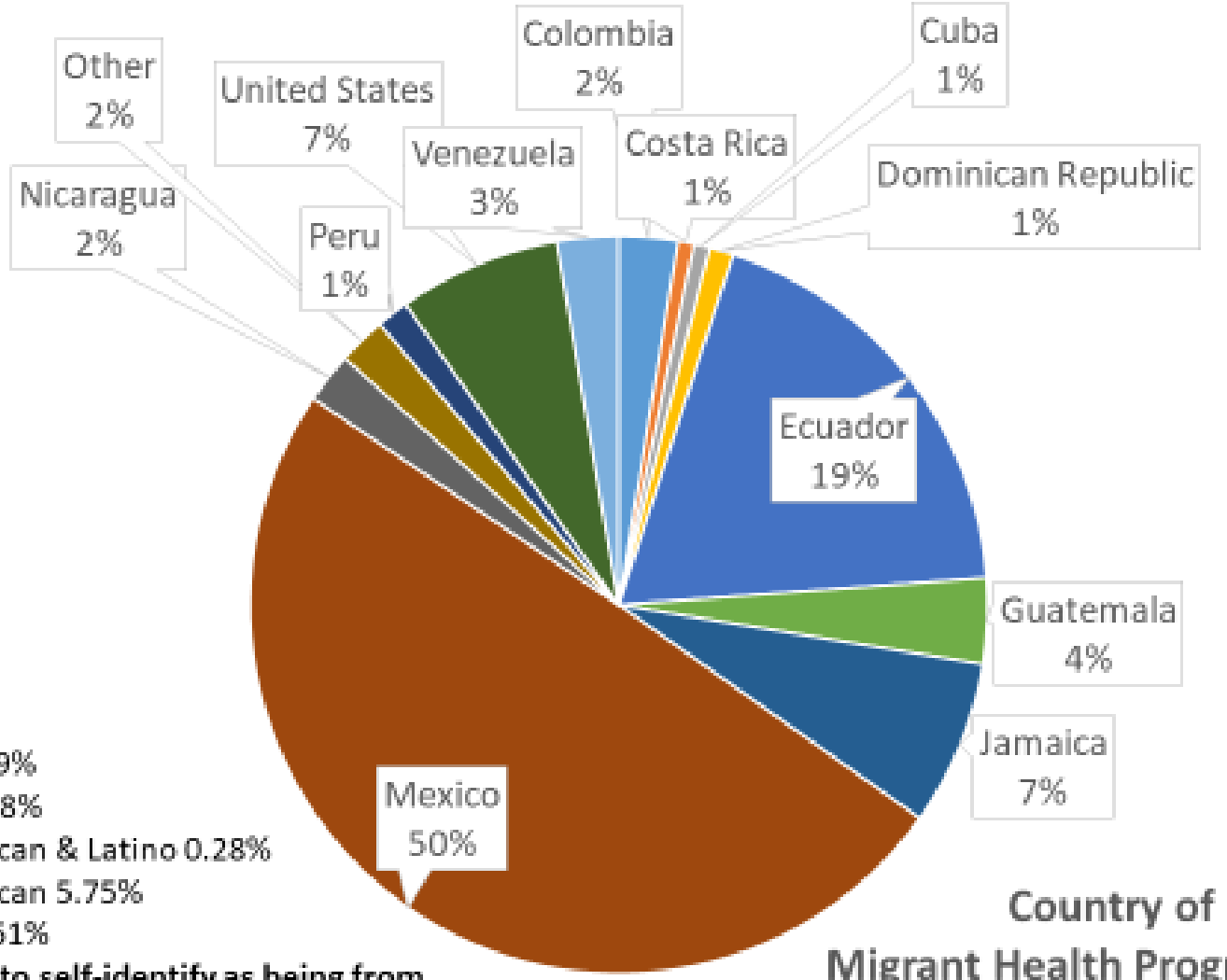
Migrant Health Programs which includes Bridges to Health's Community Health Worker team is comprised of:

- Bilingual Program Lead
- **Bilingual Community Health Worker Program Coordinator**
- **Seven bilingual English/Spanish CHWs**
- Administrative Support
- 40-60 community based volunteers
- 3-4 interns per year

Who we serve through Bridges to Health

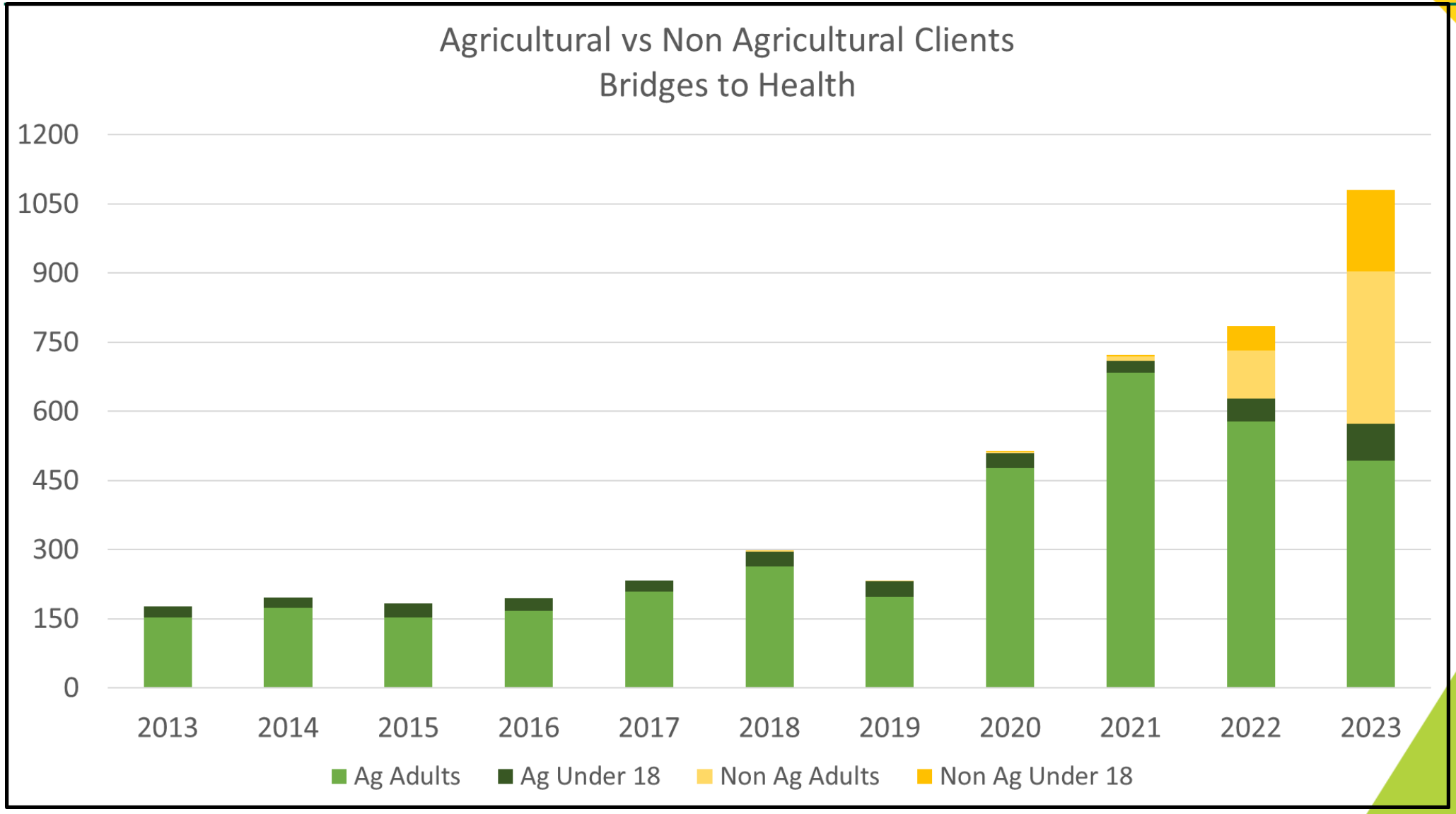
Migrant and Immigrant Communities

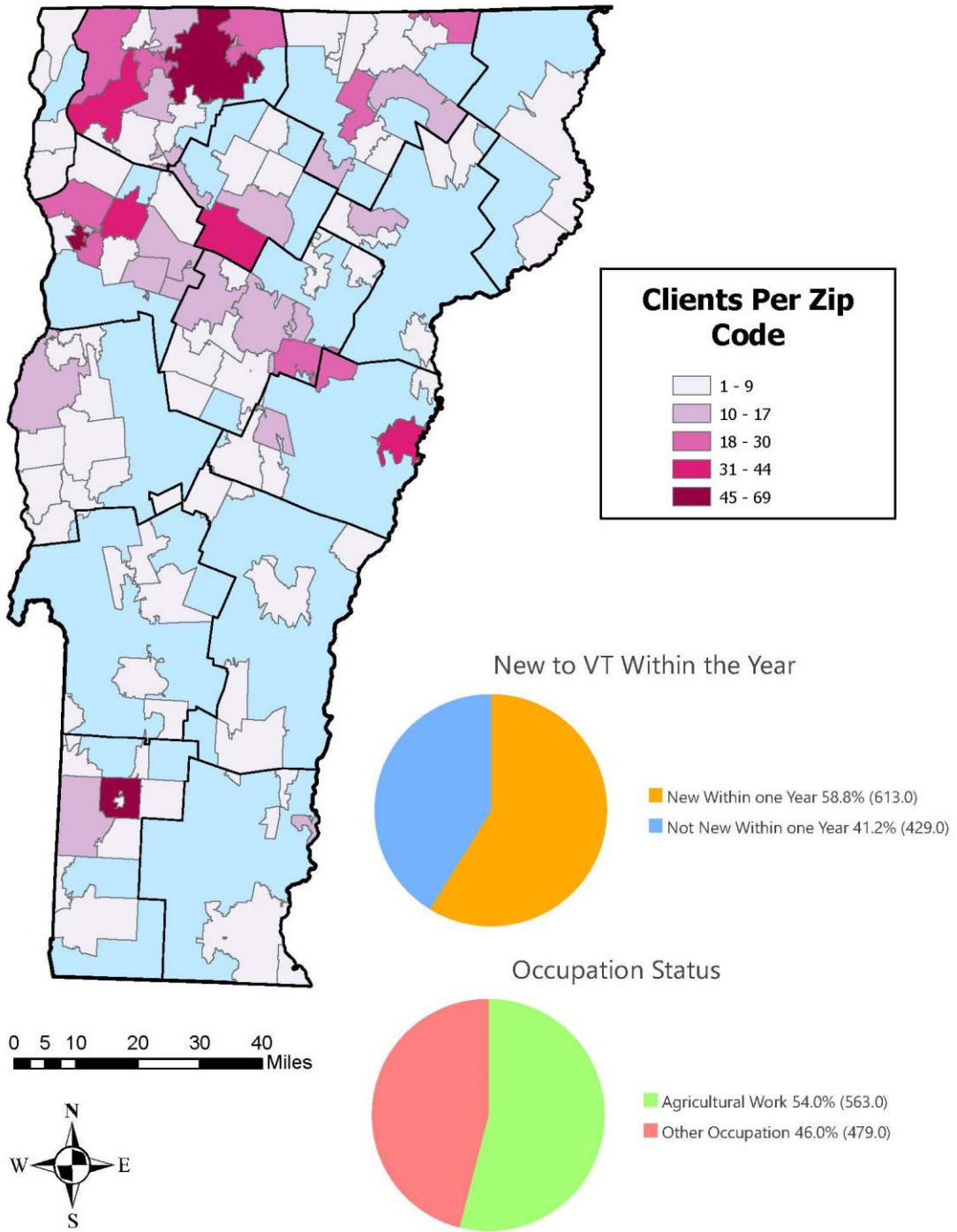
- Currently living in Vermont
- Not otherwise supported by existing funded infrastructure
  - Seasonal & Year Round Agricultural Workers, Seasonal and Year Round Service Industry Workers
- Face barriers to health care on an individual and/or systems level



Country of Origin
Migrant Health Programs Data 2023
(N 856)

Race/Ethnicity*
Southeast Asian 0.19%
American Indian 0.28%
Black/African American & Latino 0.28%
Black/African American 5.75%
Latino/Hispanic 93.51%
***Strong preference to self-identify as being from Country of Origin vs a particular race and/or ethnicity**


Agricultural vs Non Agricultural Clients
Bridges to Health
1200
1050
900
750
600
450
300
150
0
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
Ag Adults
Ag Under 18
Non Ag Adults
Non Ag Under 18



<u>1079 individuals served in 2023</u>

54% agricultural workers

- 86% dairy workers
- 8% Jamaican H2A workers

- 46% non agricultural workers
  - Service industry: Roofing, construction, restaurants cleaning

59% new to VT in 2023

125 newly arrived in 2024

- 60+ children

The University of Vermont

Navigating Health & Social Service Systems

- 83% of clients do not have their own transportation
  - 653 rides provided/coordinated in 2023
- Majority of adults, some youth and all new arrivals do not have a PCP or Dental Home
  - 634 clients new to VT in 2023
- Many private practices do not have interpreter services
  - 266 appointments interpreted in 2023

"It has been so helpful to have Bridges to Health. We arrive without knowing how to find or navigate health care services. I suffer from high blood pressure and do not have health insurance. Upon arriving here, I needed a doctor to check my blood pressure and prescribe my medications. Bridges to Health helped me find a low cost clinic and they helped me get to my appointments. Now my blood pressure is under control." Hospitality Worker - Rutland County

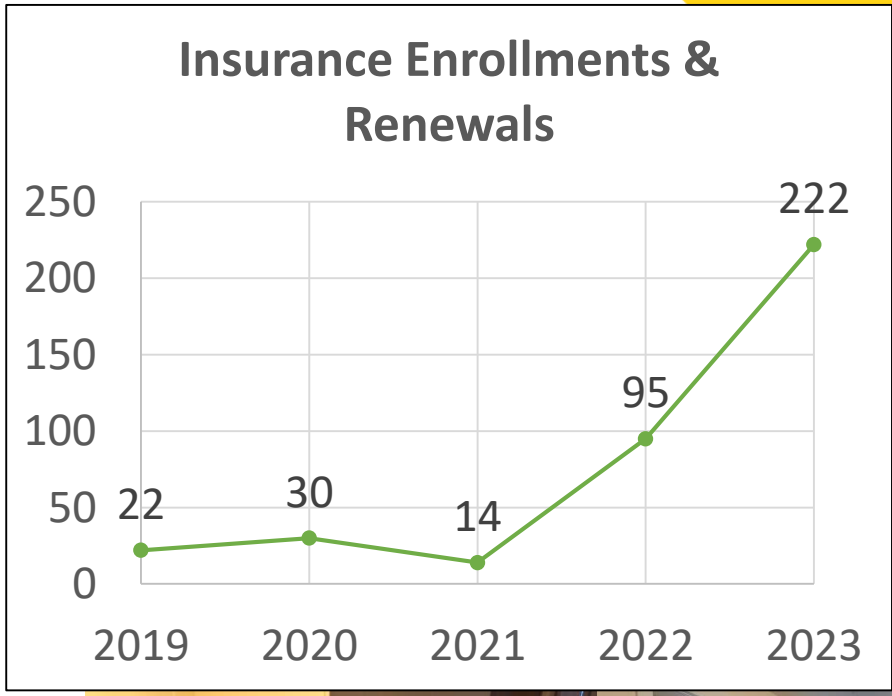
Health Insurance & Financial Assistance

- 91% of adults and 6% of minors do not have health insurance

- BTH enrolled or renewed health insurance for **222 clients** in 2023
  - 142 pregnant women & children enrolled in IHIP in 2023*
  - 3-5 hours per paper application
- 53 children & pregnant women enrolled in Medicaid

- 275 successful financial assistance applications

*85% of total IHIP enrollees at the state level through BTH
** 141 submissions in first 6 months of 2024 (and a handful of renewals)



"I had a tooth that would hurt when I ate and the cold weather caused pain too. I am grateful to Bridges to Health for helping me with a dental appointment. First, for helping me apply for financial assistance and then providing transportation to the appointment. I do not have a car so would have had no other way to get to the clinic. Thanks to them, I was able to make an appointment and take care of my tooth that was really bothering me." Farmworker - Franklin County

Health Outreach – Community Collaborations

- 287 Community Based Health Consults & Screenings
  - Volunteer Providers
  - Free Clinics & FQHCs
  - UVM MC Medical Residents

- 689 Vaccines
  - Flu, Covid, Tdap & more
  - 50 farm/business based clinics
  - Department of Health District Offices, UVM MC, FQHCs

"The level of outreach, education, understanding, and access [Bridges to Health has] brought to our farm, to help us and our employees has been integral in being able to operate a fair, healthy, and productive work environment for all. Whether it be intricate navigation of a complex health system for the underserved, helping to organize and communicate care, to hosting on farm vaccine clinics that surely went above and beyond protecting all in Vermont, this group has grown into an essential, trusted resource for our farm, family, and employees." Dairy Farmer – Chittenden County

Food Security

- 190 farmworker beneficiaries of CSA and/or food delivery programs
- 98 pregnant women & children enrolled in WIC
- 75 adults & 19 children supported through Huertas – the kitchen garden project




"The Hardwick Area Food Pantry's partnership with UVM Extension and the Vermont Foodbank has been essential to expanding and improving our services to our migrant farmworker neighbors. The assistance we received from [the Community Health Worker] was critical in allowing us to overcome language barriers, cultural differences, and clearly understand the food needs and desires of this subset of our community Additionally, being a small organization facing more and more demand generally, the assistance that we receive for coordinating volunteers who deliver food to these households has been an enormous help in reaching these vulnerable and remote households. It is partnerships like these that strengthen the fabric of our community and improve and enrich all of our lives." Director ~ Hardwick Area Food Pantry

Identifying Needs, Tracking Progress, Reporting Outcomes

Community Health Workers – Proving ROI

- Increased awareness of CHW roles
- Increase in recent research demonstrates effectiveness
- CHWs see impact in small tangible outcomes everyday
- Numbers of people served do very little to tell the story of impact
  - Low resource pregnant client vs high resource pregnant client
- At a program level - inconsistent process for tracking progress and outcomes
- Challenging to analyze impact within an organization and at local/state level
- Funding implications if we don't have the data to "prove" impact

Identifying Needs, Tracking Progress, Reporting Outcomes

Pathways Model

- Originates from the Community Health Access Project in Ohio
- "Community care coordination approach focused on reducing modifiable risk factors for high risk individuals and populations"
- Developed into the Pathways Community Hub Model for reimbursement based on outcomes*
- Find-> "Treat" -> Measure
- Each identified risk factors (needs) is tracked through a standardized Pathway
- End goal of providing an intervention for each pathway that has the pre-identified positive health outcome.
- Focus of work is on
  - value of the work not number of people served
  - comprehensive approach to care coordination

Identifying Needs, Tracking Progress, Reporting Outcomes

Identifying Needs:

Self-referrals and Community Based Referrals usually result of already identified need!

- Tooth ache, childhood immunizations, prenatal care, food access need, a million papers sent via mail

Self Identified Needs + Opportunities

- Mirian just moved to new county and reaches out because her child has a tooth ache and dad has back pain. We identify that they could benefit from establishing a local PCP, renewing health insurance, and connecting to school enrollment counselor.
- Sarita is pregnant and would like help getting connected to prenatal care. We identify that she is also eligible for WIC and the Immigrant Health Insurance Plan and her 6 year old could benefit from a PCP, Dentist, and Health Insurance.
- Winston, who works in Vermont 10 months a year has run out of blood pressure medication and would like a refill. We identify that a Good Rx coupon would cut his cost in half.

Identifying Needs, Tracking Progress, Reporting Outcomes

Identifying Needs:

Questionnaires/Screenings

- Uncovering unmet needs and unknown opportunities to improve health & wellbeing
- Need to fully understand context of those you are working with
  - i.e. Food security questions focused on $ not access – a farmworker family or an elderly individual may have $ but no way to get to the store
- SDOH screening tools
  - Essential to ensure resources & capacity exist to help respondents address identified needs over time
- BTH not utilizing screening tool due to lack of capacity to address needs beyond direct health & food access needs

Identifying Needs, Tracking Progress, Reporting Outcomes

Our Modified Pathways Model

Connected with other CHW Programs to hone our plan

- Health Insurance Pathway - new, renewal, and additional health insurance coverage
- Social Services Pathway - any non-medical linkage or service that removes a barrier to health
  - Education, Food, Community Based Organization (DV, legal, Housing, Clothes), Internal Social Service Support
- Medical Referral/Services Pathway – medical or behavior health referrals
- Medical Home Pathway – health or dental
- Pregnancy Pathway
- Health Management & Education: Complex Needs

Identifying Needs, Tracking Progress, Reporting Outcomes

Measuring Success

Start with knowing what is desired outcome for each unique pathway (standardized outcome) and then identifying steps to reach that outcome (unique to each client).

Mirian's family

- Medical referral pathway for child's dental need – >Desired outcome is successful encounters with dentist that addresses dental pain
  - Registration paperwork, making appointment, coordinating transportation, ensuring interpretation, support for picking up antibiotic, 2nd appt to for a filling.
- Medical home pathway for child - > Desired outcome is establishing with a pediatrician
  - Transferring any records that may exist, making appointment, coordinating transportation, ensuring interpretation…
- Health insurance pathway for child -> Desired outcome is enrolling in insurance
  - Insurance application, collection of supporting documentation, responding to additional requests, applying for retroactive coverage, reporting number to dentist

Identifying Needs, Tracking Progress, Reporting Outcomes

Measuring Success

Start with knowing what is desired outcome for each unique pathway (standardized outcome) and then identifying steps to reach that outcome (unique to each client).

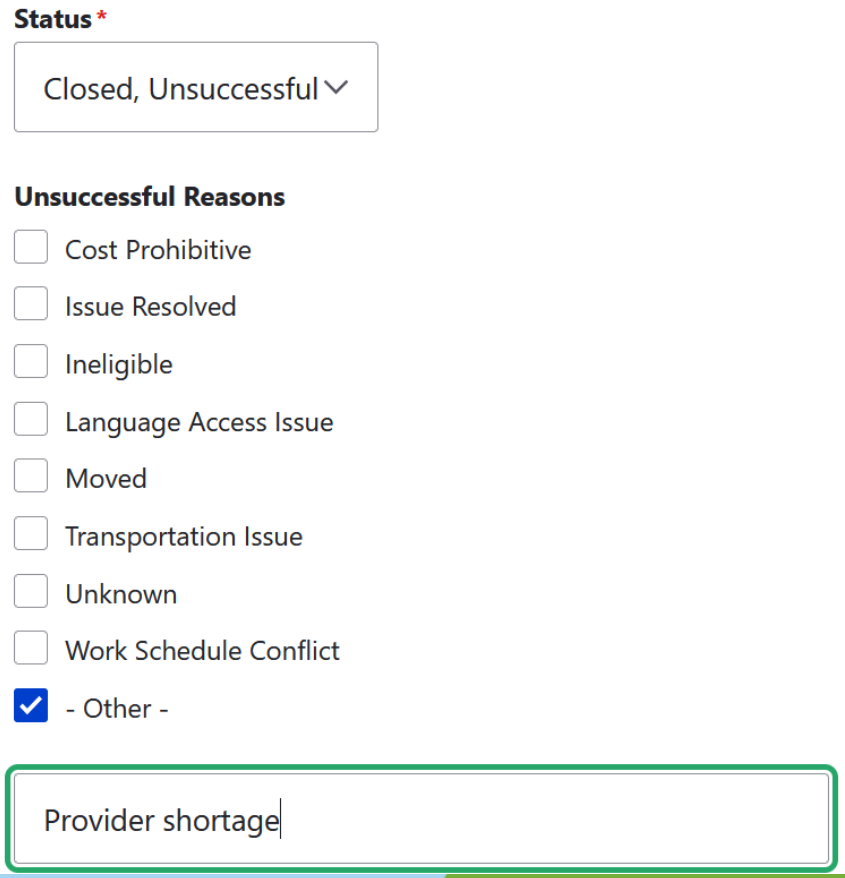
Mirian's family – notes for each step of the way. All pathways closed either successfully or unsuccessfully.

- School referral pathway for child -> Desired outcome is school enrollment
  - Make referral, send in copy of immunization records, confirm with family that child is enrolled
- Medical referral pathway for dad -> Desired outcome is resolution to back pain
  - PCPs are scheduling 3 weeks out so referred to urgent care, urgent care referred to PT, conflicts with work schedule – Pathway closed unsuccessful
- Social services pathway (internal support) for dad -> Desired outcome is reduction in cost of medical bills
  - Complete FA application, communicate with boss for income documentation, 75% discount provided, help dad understand how to pay remainder

Identifying Needs, Tracking Progress, Reporting Outcomes

Unsuccessful Pathways (for Debbie ☺)

- Staff can feel badly about unsuccessful pathways so it is important to emphasize that it is expected that there will be unsuccessful pathways and many time it is out of our control.
- Data related to why a pathway is unsuccessful is important.
  - Quantifies barriers to access
  - Highlight opportunities for program improvements
  - Can lead to systems change



Identifying Needs, Tracking Progress, Reporting Outcomes

Reporting

- Even though numbers do not tell the whole story, we still report numbers!
  - Unique individuals served
  - # transports provided/coordinated, # of appointments made, # of appointments interpreted etc
- % of successful pathways per quarter (can break it down to umbrella categories i.e. health insurance, medical home etc)
- LOTS of client stories that identify needs, highlight barriers, effort on all sides to result in desired outcomes

Unaccompanied Minor: We received a referral from Milk with Dignity about a 16 year old with dental pain. Carlos was here on his own, working long hours and sending money home to his family. Over the previous year, we had been in touch with him sporadically but with no success. Interns reached out informing him that he was likely eligible for the Immigrant Health Insurance Plan. He originally responded but when it came to set up a time to meet, he left the messages on read with no response. He reached out in the fall of last year about dental pain but then didn't respond to additional requests for information from the Community Health Worker. By the time we heard from Milk with Dignity, he was on his third farm in a year and he had changed his number. By a stroke of luck, I was on the phone with the dental office trying to reschedule someone else's appointment, when they got notified of a cancellation……*

Opportunities for Collaboration

Any intersections in our work?

Contact Information

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