Strategies for Providing Culturally Responsive Care: Three Different Community Health Worker and Patient Navigator Models

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Minnesota Center of Excellence in Newcomer Health

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Agenda

- Introductions
- Definitions, History
- Why Community Health Workers/Navigation Programs are Necessary
- Model 1: Wyss Wellness Center, Philadelphia, PA
- Model 2: Denver Health and Hospital Authority, Denver, CO
- Model 3: Colorado Department of Public Health and Environment, Denver, CO
- Q&A
- Wrap Up

Learning Objectives

- Define problem of health care access in newcomer community
- Understand history of patient navigation and community health worker program
- Review multiple culturally responsive patient navigator/community health worker models in clinical and public health settings
- Identify first steps in building a tailored sustainable navigation system within a public health or clinical setting

Today's Speakers

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Colorado Department of Public Health and Environment

Jenna Gosnay, MSW, LSW
Megan Barry, MSN, RN, CEN, CNL

Wyss Wellness Center

Betsy Ruckard
Rasulo Rasulo, MBA
Marisol Garcia Ramirez

Denver Health

Kristi Knuti Rodrigues, MD, MPH

Denver Health

(Moderator)

Community Health Worker Definition

- Community health workers (CHWs) work in communities and outside of fixed health care systems
- Assist community members with adopting health behaviors and provide health-related outreach and advocacy
- Receive limited training related to performed tasks
- Historically have not have professional certificates/degrees

History of Community Health Workers

- First CHWs 1920s in China (record births and deaths, vaccinations, health education and public health talks, basic medical care)
- CHW programs began to spread globally in 1960s (e.g., promotores)
- CHWs in the United States for >70 years

Patient Navigator Definition

- Member of the health care team (part of the health system)
- Guide patients through the health care system and overcome barriers that prevent them from getting the care they need
- Primary role is addressing barriers
- Coordinate patient care, connect patients with resources, and help patients understand the health care system

History of Patient Navigation

- First patient navigation program established in the 1990s in Harlem, New York
- Shown to improve cancer screening rates and decreased time to cancer diagnosis and treatment initiation
- Also improve outcomes for other chronic health conditions (especially care processes)
- Cultural and linguistic concordance between the patient and navigator suggested important factor in the success of navigation

Newcomers Access to Health Care

Newcomers is a broad term encompassing **refugees**, **immigrants** and **migrants**; persons who have moved from one place to another voluntarily or involuntarily

- Over one billion worldwide

Barriers to Health Care:

- Language/interpreter access
- Complex American health care system
  - Fragmentation, insurance, specialists
- Variability of resources
  - Resettlement agencies
  - Geography
- Getting connected to health care
  - Insurance status
  - Finding care after initial medical screening
  - Specialist follow up
- Vulnerability to mental health conditions (adjustment disorder)
- **Health care is small part of integration process**

Why Navigation is Necessary

- Previously mentioned barriers can affect a particularly vulnerable population
- Encourages health promotion and chronic disease management
- Promotes self-sufficiency when client/patient is engaged in the process
    - For patient -> with patient -> patient independently
- Increased numbers of refugee arrivals can mean more health care resources required
    - 11,000 in 2021
    - 25,000 in 2022
    - 125,000 in 2023
- Health care providers unfamiliar with newcomer health considerations may be providing care
- Improve patient outcomes
- To ensure continuation of health care services after resettlement

Patient Navigation: A Clinical Partnership Model

Wyss Wellness Center

Jenna Gosnay, MSW, LSW
Megan Barry, MSN, RN, CEN, CNL

Wyss Wellness Center

- Opened in 2021 through a partnership between TJUH and Philadelphia based non-profit SEAMAAC, serving 3500 patients since opening
- The center provides full spectrum of care and services with a focus on Philadelphia's newcomer population
- As clinic is establishing itself in the community and sustainable funding is secured, patient navigation model utilizes an interdisciplinary collaboration with resettlement agencies to fill gaps and fulfill best practices

Wyss Team

- **CLINIC**
  - Core clinic staff
  - SEAMAAC, legal
  - Learners (AmeriCorps, residents, RHP, nursing students, pharmacy)
  - Part-time CHWs as funding allows; currently have one

- **RESETTLEMENT AGENCY**
  - Liaisons assigned specifically to Wyss patients
  - Case managers assigned to specific programs
  - Liaisons can be staff, interns or Americorps

Wyss Wellness Center

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Refugee Resettlement Agency Responsibilities

Reception Services:

- Airport pickup
- Pocket money
- Housing
- Hot culturally appropriate meal
- Basic furnishings and household items
- Culturally appropriate food staples (until food stamp case is opened)

Core Services:

- Social security cards (w/in 10 days)
- Welfare benefits (w/in 10 days)
- **Medical screening (w/in 30 days)**
- Enroll children in school (w/in 30 days)
- ESL referral (w/in 10 days)
- Employment referral (w/in 10 days)
- Home visits (24 hr, 30 and 90 days)

Cultural Orientation

- Role of agency
- Housing
- Transportation
- Hygiene
- Budgeting and finances
- Public benefits
- Safety
- Travel Loan repayment
- Selective service registration
- Change of address

Wyss Wellness Center

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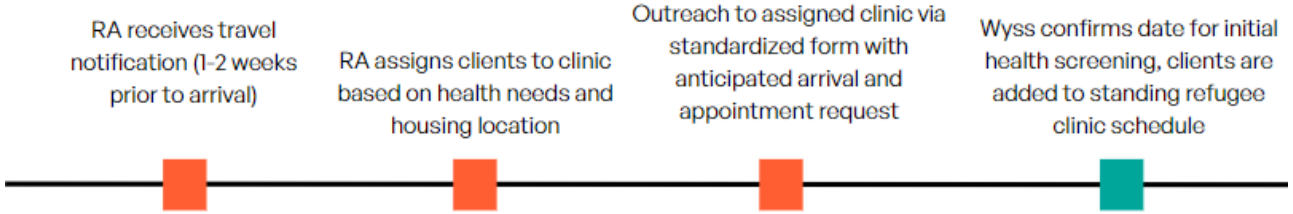
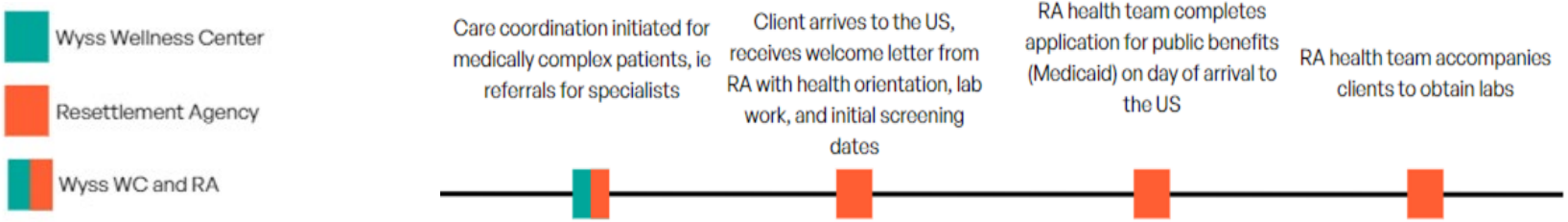
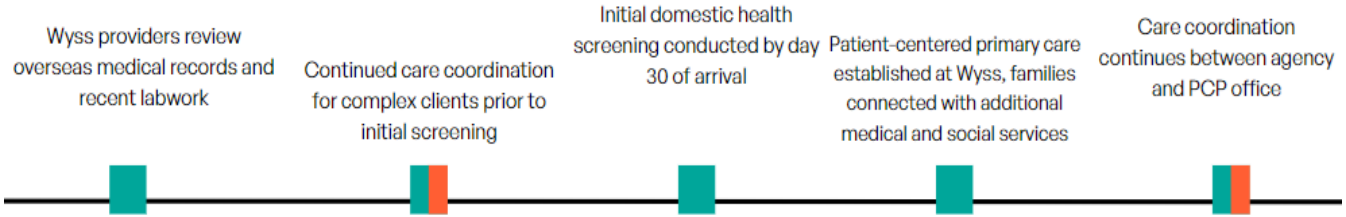


Patient navigation is collaborative from the beginning!





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Model/Description

- Clinical Partnership model is rooted in the relationship between primary care hub and resettlement agency, as well as utilizing volunteers, learners and CHWs when available
- Designated weekly appointments reserved for initial medical screenings and follow-up specifically for resettlement agencies clients
- Standardized email communication for notification and scheduling of new arrivals
- Designated resettlement agency clinic liaison, Wyss social worker and RN team facilitate patient navigation and build rapport through consistent presence
- Expedited care coordination for medically complex patients (class b, or flagged after initial screening seen within 1 week of arrival)
- Consistency- all steps done in 2-3 weeks and transitions to navigation PRN
- Continued collaboration beyond initial health screening to ensure routine follow up, escalate urgent needs to clinic providers or other services i.e mental health
    - Ongoing navigation primarily RN, social worker and RA liaison in absence of additional CHW support

Establishing a culturally responsive approach- know your resources!

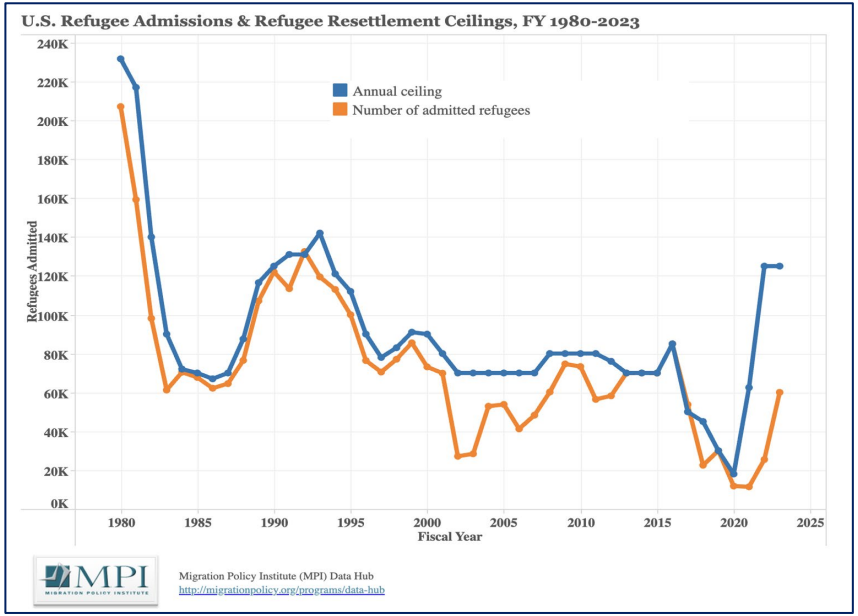
- Culturally competent providers and staff familiar with newcomer health needs Culturally appropriate resources and interpreter services
- Family-oriented approach and use of larger time blocks for initial visit; having RA onsite for appointments
- Inclusive activities, outreach, education
- Being mindful of cultural norms while integrating individual autonomy
    - Concept of time and American health care system
    - Using approach for the patient, with the patient, patient independently
- Using resources available outside of a typical 20-minute appointment slot, ie CHW, nursing, SW
    - Use of CHWs, volunteers with similar languages or backgrounds

Barriers to Navigation

- Funding
  - Complicated by multiple partnerships
    - Unclear who will pay for CHWs
  - Inconsistent funding

- Staffing issues
  - Understaffing, in clinic or RA
  - Short-term staff roles (i.e., internship or service term)

- Trends of new arrivals
  - Staffing, volume can exceed capacity



Successes

- Optimizing use of volunteers and learners allows for core staff to work at highest level of role
- Having an Afghan CHW during Operation Allies Welcome, maintaining part-time CHW for Vietnamese community
- Getting patients with complex medical issues looped into services expediently
- Standardization of flow, efficiency of process lets medical providers focus on medical care while RN and SW focus on patient navigation
- No loss of health care access after graduating from RA services, established in long-term primary care

Takeaways

- Frequent and consistent communication, building rapport with RA and patients is vital for success
- Be mindful of promoting autonomy and self-sufficiency with care navigation by keeping patient/client involved in process as much as possible
- Know what resources are available to you and what is not
- When experiencing CHW gaps, maximize use of other personnel (Americorps members, learners, resettlement agency partners, etc.) to allow core staff to operate at highest level of their role
- Patient navigation is all about addressing barriers, whether it's CHWs, social work, nursing or collaborative effort

Safety Net Health System Model: Culturally & Linguistically Responsive Navigation

Refugee, Immigrant, Newcomer Health Services, Denver Health
Betsy Ruckard, RIN-HS Program Manager
Rasulo Rasulo, MBA, RIN-HS Project Specialist
Marisol Garcia-Ramirez, RIN-HS Navigator
Kristi Knuti-Rodrigues, MD,MPH, RIN-HS Medical Director

Introduction to Setting

- Founded in 1860
- Integrated safety net health system in Denver, Colorado
- Primary, specialty, and acute care services
  - Level one trauma hospital (level two pediatric)
  - Emergency department and urgent cares
  - Inpatient and outpatient behavioral health
  - Neighborhood federally qualified health centers (FQHCs)
  - Denver Health Paramedics
  - Public Health Institute
  - School-based Health Centers at Denver Public Schools
  - Rocky Mountain Poison and Drug Safety Center
- Colorado's primary safety-net institution, provides billions of dollars in uncompensated care, national model for other safety net institutions
- >9,000 employees
- >930,000 total patient visits annually

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est. 1860
FOR LIFE'S JOURNEY

Introduction to Setting

Denver Health Refugee, Immigrant, and Newcomer Health Services (RIN-HS)

- Kristi Knuti Rodrigues, MD, MPH (Medical Director)
- Betsy Ruckard (Administrative Director)
- Daniel White, MD (Clinical Services Lead)
- Erica Blum-Barnett, MPH (Operations Manager)
- Sara Foster Fabiano, MD (Clinical Services and Education)
- Jessica Zha, MD (Clinical Services and Education)
- Stacy Morsch, NP (Clinical Services)
- Adrien Matadi (Project Specialist, Community)
- Health McFeron (Project Specialist, Patient Access)
- Rasulo Rasulo, MBA (Project Specialist, Navigation)
- Marisol Garcia Ramirez (Navigator)
- Wendy Moran-Ibarra (Navigator)
- Pa Saw Thee (Navigator)
- Abbie Steiner, MS, MPH (RIN-HS Data and Quality Improvement)
- Kelley Burns (Project Management, PRN)

Introduction to Setting

Denver Health Refugee, Immigrant, and Newcomer Health Services

- Domestic Medical Examinations (DMEs) - Refugee Health Screening
- Immigration and Naturalization Services (INS) Exam Support
- Culturally & Linguistically Responsive Navigation
- Forensic Medical Examinations (FMEs)
- Data and Quality Improvement
- Cultural Consultation and Content Expertise
- Education and Training
- Newcomer Workgroup
- Hiring, Training, and Career Promotion of a Workforce that Shares the Life and Cultural Experience of Denver Health's Patients

Introduction to Team

- Part of Denver Health Refugee, Immigrant, Newcomer Health Services (RIN-HS)
- Two project specialists, three navigators, and one administrative professional
- Collaborates with
  - other RIN-HS team members
  - clinic and hospital staff
  - community groups
  - resettlement agencies
  - city and state planners
  - quality improvement and research teams

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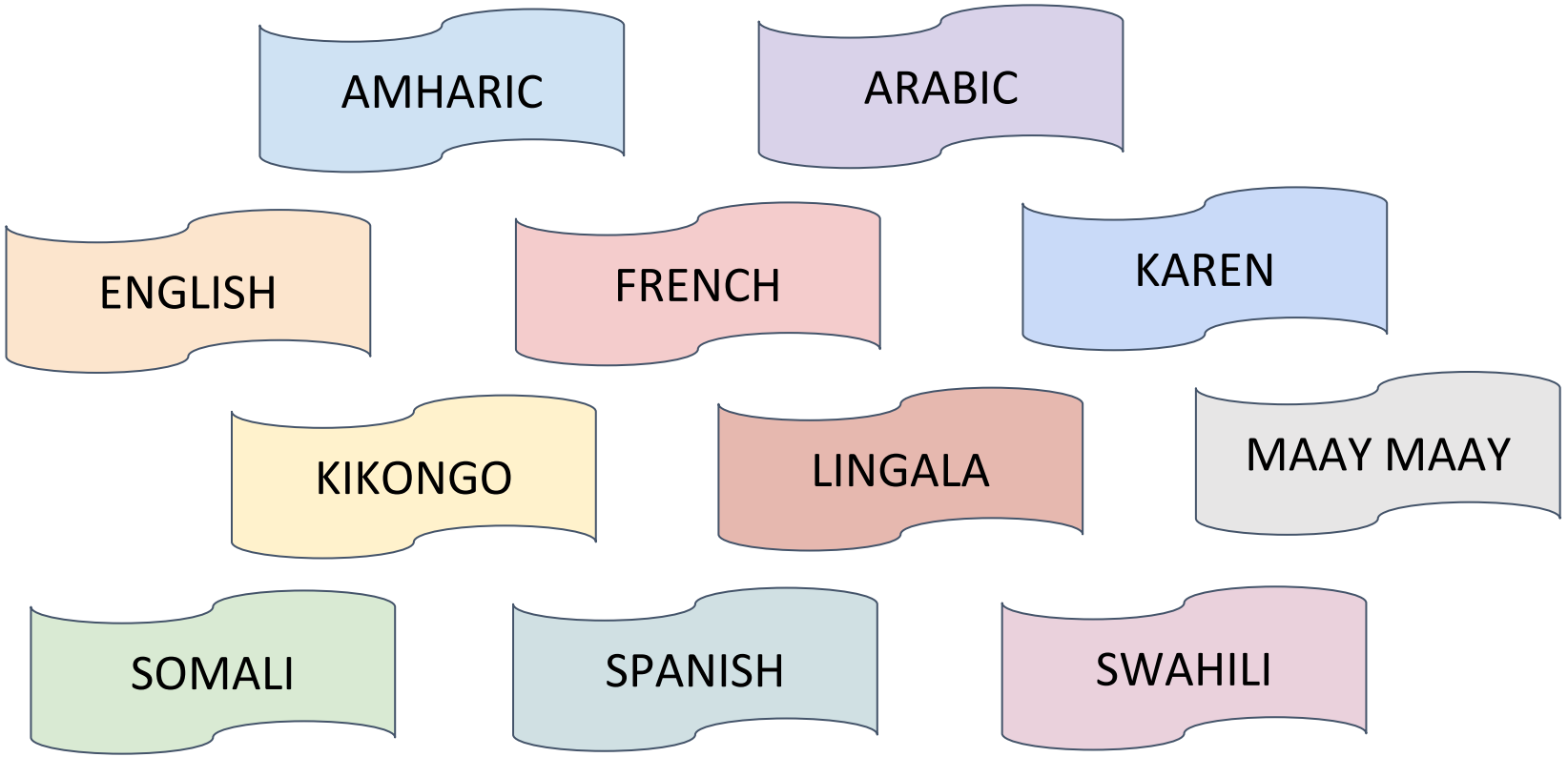
Languages Spoken



Description: What is RIN Navigation?

> Health System Navigation and Resource Coordination	• Engage and re-engage patient follow-up in primary care, routine preventative care, adherence to treatment plans, self-management of chronic conditions • Coordinate initial connection to primary care for newcomers • Orient newcomers to U.S. health system and support self sufficiency
> Health Education and Training	• **For patients:** Increase awareness of practices that have proven effective in avoiding illness and/or lessening its effects based on medical best practices • **For care teams and learners:** Present cultural considerations to medical professionals impacting health outcomes while supporting the education of the next generation of health care professionals serving our communities
> Health Promotion, Coaching, and Advocacy	• Screen for health-related social needs, set goals and create action plans, provide information, health coaching, and advocacy

Description: What is RIN Navigation?

> Team-based Approach that Values Cultural Expertise	• All team members participate in project development and design • Diverse team member experience and input core to all work • Cultural liaison between care teams/health system and patients
> Pipeline Program	• Create professional growth opportunities for navigators hired from the communities we serve

Safety Net Health System Model: **Barriers**

- Reliance on grant funding
- Staff and health system capacity limitations
  - Access to care due to wait lists for primary care
  - Need for Saturday events to address referral volumes
  - Denver's recent newcomer influx
  - Magic time (aka unfunded) to build program infrastructure
- Scope Creep
  - Grant focused projects prevent navigators from being able to address all staff requests for assistance
  - Expecting navigators to fill other roles (i.e. routine appointment scheduling, giving clinical results)
- Setting boundaries when out in community

Safety Net Health System Model: **Successes**

- Reliance on grant funding
- Pipeline program
- Staff retention
- Training and growth opportunities
  - development of onboarding and ongoing support for navigators
- Improved patient outcomes
- Team-based approach
- Ability to collaborate with other teams and departments
- Work community
- Adaptability and flexibility

Safety Net Health System Model: **Successes**

COVID-19 outreach

- >13,000 non-English, non-Spanish speaking (NENS) patients outreached since March 2020, mostly while working remotely and via telephone
- NENS COVID-19 vaccination rates started lower and surpassed English and Spanish rates for primary series

Latent tuberculosis infection diagnosis and treatment initiation for RIN patients with positive interferon-gamma release assay (n=320)

- Group randomized to navigation (n=161) had higher rates of:
  - Chest radiography (89% versus 76%, p=.002, RR 1.17 [95% CI: 1.06-1.30])
  - Treatment initiation (60% versus 37%, p=.0001, RR 1.62 [95% CI: 1.28.-2.06])

Public Health Model: Cultural Navigation

Tavia Mirassou-Wolf
Cultural Navigation Unit Supervisor
Division of Disease Control and Public Health Response, CDPHE
Colorado Center of Excellence in Newcomer Health

Introduction to team

- Colorado Department of Public Health and Environment and Colorado Centers of Excellence in Newcomer Health
- Division of Disease Control and Public Health Response
- Four employees in unit
- Partner with three community based organizations (CBOs)

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Disease Control and
Public Health Response
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Background

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Model Description

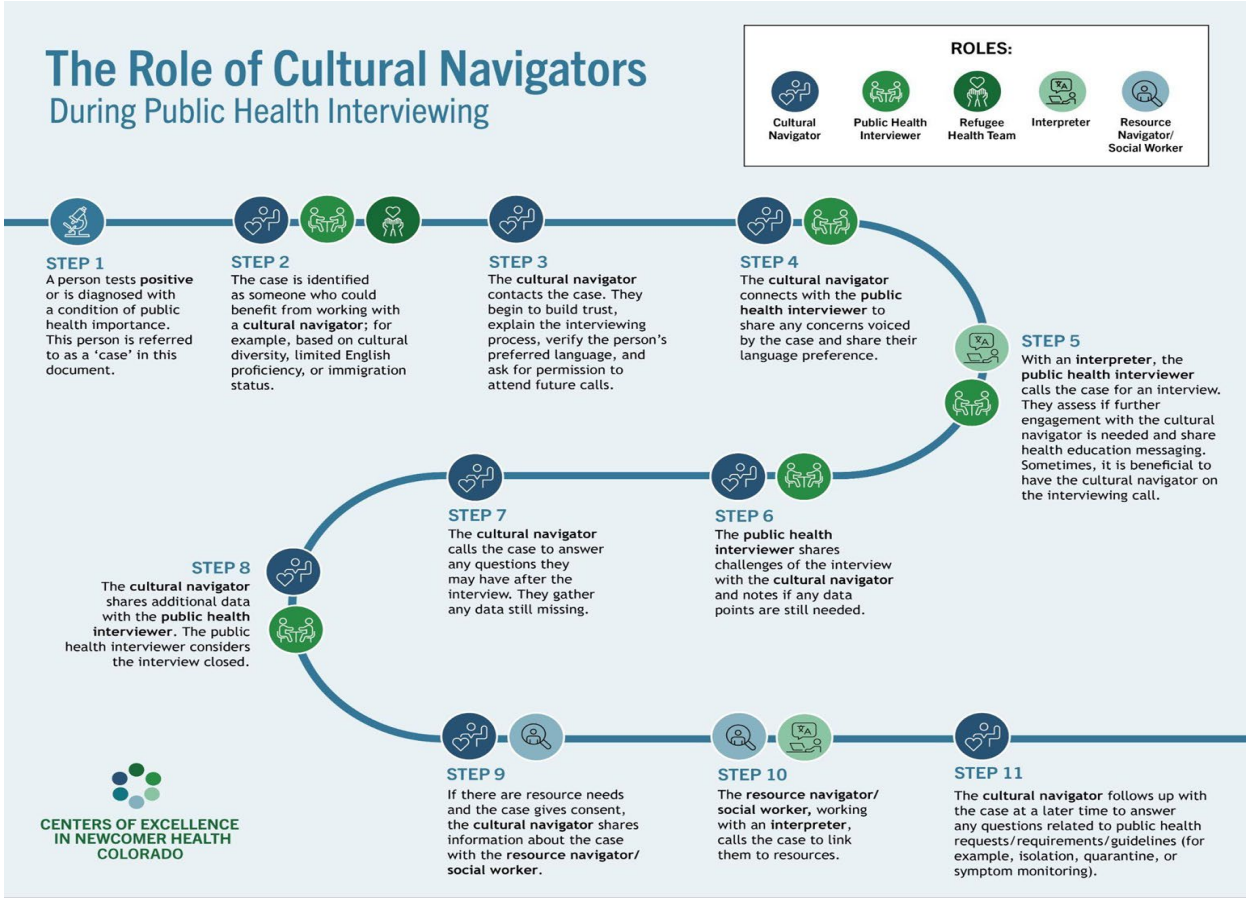
- Cultural Navigators (CN) are community partners who serve as a trusted and confidential source of information between community members and public health.

- **Cultural Navigators are deeply rooted in their communities, often members of the community themselves**, and are uniquely positioned to bridge cultural and linguistic knowledge gaps for health departments.
  Colorado COE in Newcomer Health: About Cultural Navigation
  (https://sites.google.com/state.co.us/refugeecoe/resources/cultural-navigation_1/about-cultural-navigation)

CN Roles

- **Prime community members:** Attend and organize culturally responsive outreach and educational events and campaigns.
- **Partner for public health interviewing**: Coordinate navigators to assist with public health interviews.
- **Attend community clinics**: Provide testing, vaccination, and outbreak support.
- **Strategize**: Review of and input on public health messaging, outreach, and data collection strategies.

Public Health Interviewing



Public Health Interviewing

STEP 1
A person tests **positive** or is diagnosed with a condition of public health importance. This person is referred to as a 'case' in this document.

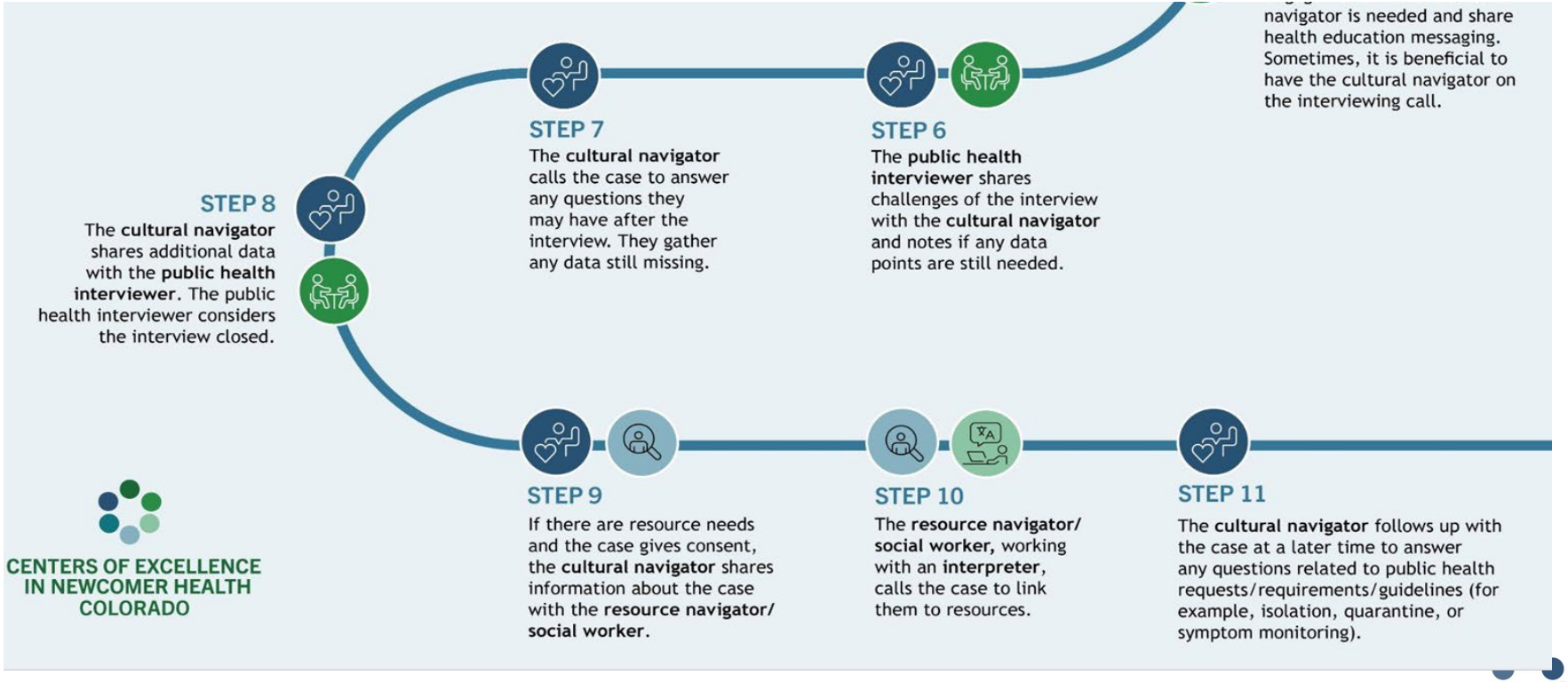
STEP 2
The case is identified as someone who could benefit from working with a **cultural navigator**; for example, based on cultural diversity, limited English proficiency, or immigration status.

STEP 3
The **cultural navigator** contacts the case. They begin to build trust, explain the interviewing process, verify the person's preferred language, and ask for permission to attend future calls.

STEP 4
The **cultural navigator** connects with the **public health interviewer** to share any concerns voiced by the case and share their language preference.

STEP 5
With an **interpreter**, the **public health interviewer** calls the case for an interview. They assess if further engagement with the cultural navigator is needed and share health education messaging. Sometimes, it is beneficial to have the cultural navigator on the interviewing call.

Public Health Interviewing



Barriers

- Siloed funding
- Responding quickly without ‘blanket funding’
- Process change and building during response efforts
- Authentic community engagement and responding to needs

Successes

- Build trust with communities
- Respond in a culturally appropriate manner
- Proof of concept and successful integration into initiatives
- Increasing areas of engagement

Resources

Colorado COE in Newcomer Health: Toolkit of Resources
(https://sites.google.com/state.co.us/refugeecoe/resources/cultural-navigation_1/toolkit-of-resources)

Toolkit resources:

- Cultural Navigation: Strategic Brief
- Engaging Cultural Navigators in Public Health Surveillance and Education
- Role of Cultural Navigators in Public Health Interviewing

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Thank you!

Questions?

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