for Me, for Us

Bridging Communities and Clinics

Pilot Summary and Outcomes

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Utah Department of Health

Office of Health Disparities

UTAH DEPARTMENT OF HEALTH

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Bridging Communities and Clinics

Project Overview

The Utah Department of Health Office of Health Disparities began planning the "For Me, For Us: Bridging Communities and Clinics" outreach model in December 2011, with expected implementation of a pilot program between April and October 2012.

The "Bridging Communities and Clinics" (BCC) model was designed to address the demonstrated inadequacies and ineffectiveness of the "traditional" health fair approach to community health outreach. Moving beyond distribution of brochures and basic health indicator screenings, the BCC employs evidence-based best practices to address themes of access to health care, preventive wellness promotion, and cultural competency by providing (1) a trained, diverse Outreach Team comprised of clinical outreach assistants; (2) clinically relevant screening tests for blood glucose and cholesterol, hypertension, BMI, and health risk factors at no cost; (3) individual referrals to free, reduced-cost, or income-based primary care services through local clinics; and (4) post-screening follow-up to assist participants with scheduling appointments, basic health questions, language barriers, etc.

Targeted demographics within the service population included communities affected by significant health disparities and groups historically identified to be at high risk for obesity, unfavorable birth outcomes, and barriers to health care access – including the uninsured/underinsured, low-income populations, African Americans, Hispanics/Latinos, and Native Hawaiian/Pacific Islanders.

At the conclusion of the outreach stage of the pilot program in October 2012, the Bridging Communities and Clinics model had been successfully implemented in 24 outreach events coordinated through a dynamic network of 12 referral clinics and 22 community partners in Salt Lake, Summit, Utah, and Weber counties.

Outreach Team

The BCC Outreach Team was comprised of eight clinical student interns who were tasked with implementing the BCC outreach model through the 24 outreach events mentioned before. The objective of forming an Outreach Team was to ensure that outreach events were conducted by a diverse group of skilled, trained personnel who would adhere to consistent protocols and professional standards. Outreach Team interns received over 15 hours of in-person, online, and community-based training in clinical screening procedures, culturally competent medical care, transcultural communication, medical interpreting, and culturally and linguistically appropriate service standards. During the course of the BCC pilot, individual interns each provided between 32 and 72 hours of screening services and preventive health promotion in diverse communities.

As a central component of the BCC model, the Outreach Team was shown to be highly effective and efficient in conducting BCC outreach events. The standardized training of Outreach Team interns as a cohesive team facilitated the successful implementation of the BCC program in an efficient and consistent manner throughout the duration of the pilot. At each outreach event, one or two interns acted as coordinator overseeing the setup, takedown, and operations of the event. Outreach interns assisted participants in filling out pre-screening questionnaires

and reviewing potential risk factors (such as smoking and family medical history), as well as assessing health care access needs (such as insurance coverage and length of time since previous health checkup). Interns provided screenings for blood glucose, total cholesterol, blood pressure, and body mass index (BMI), and referrals to BCC clinical partners were offered to any participant whose screenings warranted further medical follow-up.[1] Participants were given a Health Passport to take with them, which contained their results and an explanation of their screenings as well as useful information on finding affordable health care resources and free information.

Outreach Team interns were also responsible for following up with referred participants by placing telephone calls (or sending emails in a few cases) 15 days after receiving the referral; if a participant was unable to make an appointment or required further assistance (including non-English language assistance), interns would act to remedy the situation and make a further follow-up call at 30-days post-screening.






1. Screening thresholds for clinical referrals followed guidelines published by the National Institutes of Health (NIH)

Community Health Worker Involvement

This pilot demonstrated that using lay community health workers (CHW) had a significant impact on the success of outreach events in quantitative and qualitative terms. CHWs were involved in six outreach events, primarily fulfilling roles as on-site "navigators" who personally invited attendees to participate in screenings, assisted with filling out pre-screening questionnaires, and facilitated participant transitions between pre-screening, screening, and referral/follow-up stages. Several CHWs were also instrumental in providing linguistic interpretation and cultural brokering assistance.

The mean average screening frequency[2] of each outreach event was 3.0 screenings per intern-hour; all six of the events coordinated with the help of CHWs were shown to be more time and cost efficient, with individual interns able to conduct an average of 4.7 screenings per hour (and at one event, as many as 6.5 per hour) with the assistance of CHWs. CHWs were highly effective in promoting participation among attendees by providing a "familiar face" degree of familiarity and relativity to outreach events that directly resulted in reported increases in participant and intern satisfaction, as well as the effectiveness and efficiency of the screening process. This was appreciably evident in outreach events among African American and Hispanic communities, where sociocultural and linguistic barriers were effectively bridged and mitigated with the help of community-based CHWs.

It has been demonstrated that the integration of CHWs into the Bridging Communities and Clinics model is correlated with observed increases in screening frequency[2] and procedural efficiency, as well as increased success in outreaching to underserved and diverse communities. Increased utilization of CHWs as community promoters, on-site navigators, and referral follow-up assistants is projected to significantly increase outreach efficiency, reach, and effectiveness.

2. Screening frequency was calculated for each event by dividing the total number of participants by the number of Outreach Team interns conducting the screenings and the hourly time frame of each event.

Outcomes

Total screenings conducted: 833

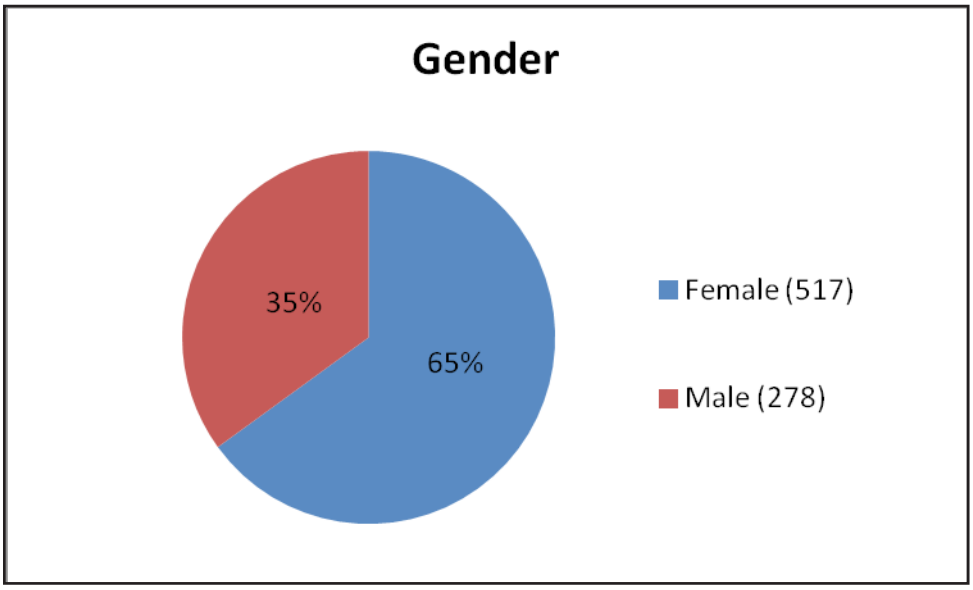
Total referrals for follow-up: 178 individuals referred for clinical follow-up

Follow-up contact rate: 35.4% of referrals received telephone follow-up

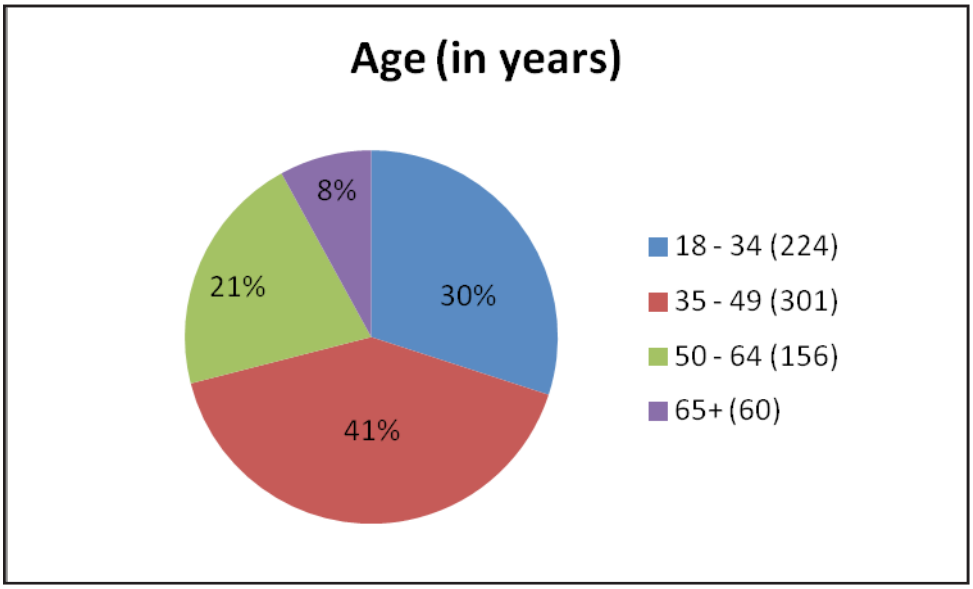
Clinical encounter rate: 56% seen in clinic within 30 days

Demographic Data[3]

Gender



Date of Birth

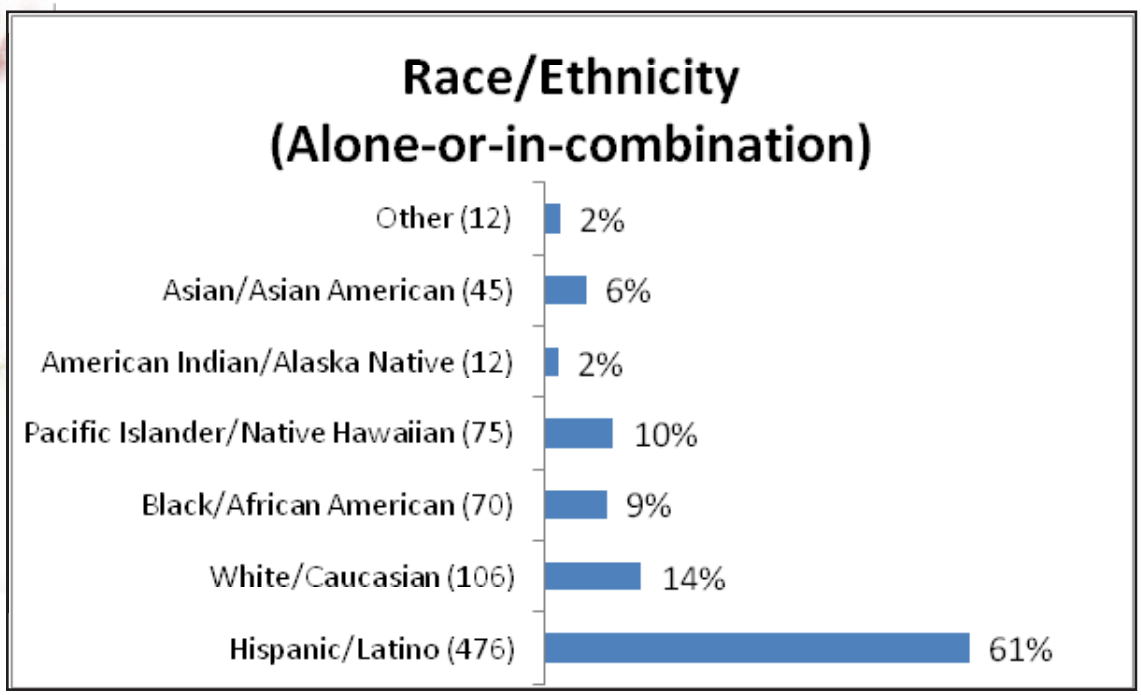


3. Obtained from *Pre-Screening Questionnaire* collected by all screening participants.

Bridging Communities and Clinics

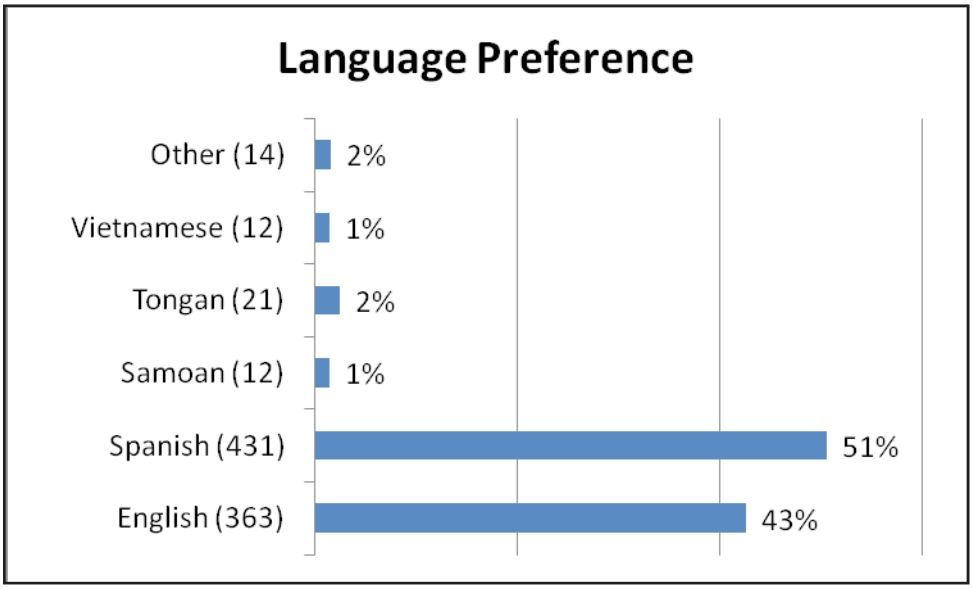
How do you identify yourself? (Check all that apply)

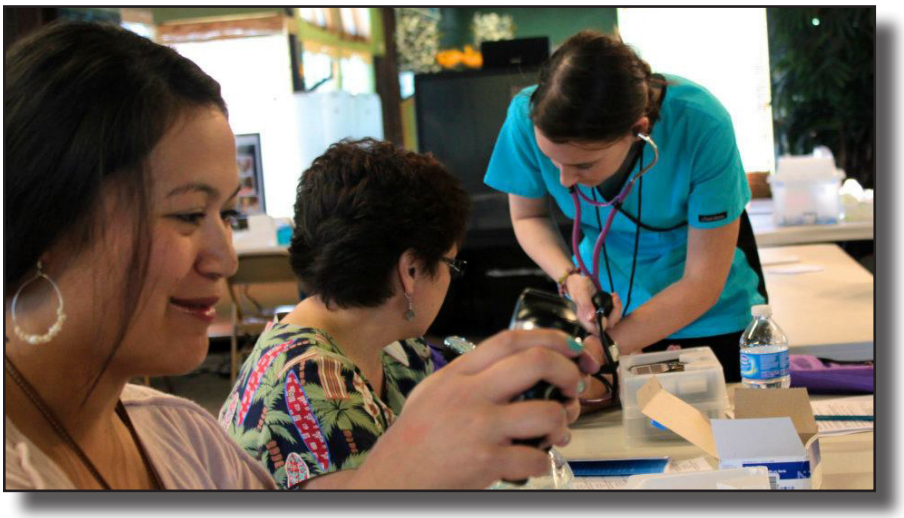
All of the ethnic and racial communities that were targeted by the BCC approach were reached through outreach events, with over half of all participants self-identifying as Hispanic (all races, alone-or-in-combination). Compared to US Census 2010 data, African Americans, Asians, and Native Hawaiians & Pacific Islanders were all overrepresented among BCC participants, as was initially expected. Participants could indicate any combination of races/ethnicities, either alone or in combination.



What is your preferred language?

Because the BCC program was intended to reach underserved populations, limited-English proficiency (LEP) considerations were anticipated; pre-screening questionnaires and Health Passports were translated and made available in English and Spanish, while Outreach Team interns and BCC community partners were capable of providing language assistance in other languages including Portuguese, Russian, Samoan, Tongan, and Vietnamese. Participants who selected the "Other" primary language option indicated a preference for languages such as Chinese, Armenian, Fijian, and Vietnamese.[4]

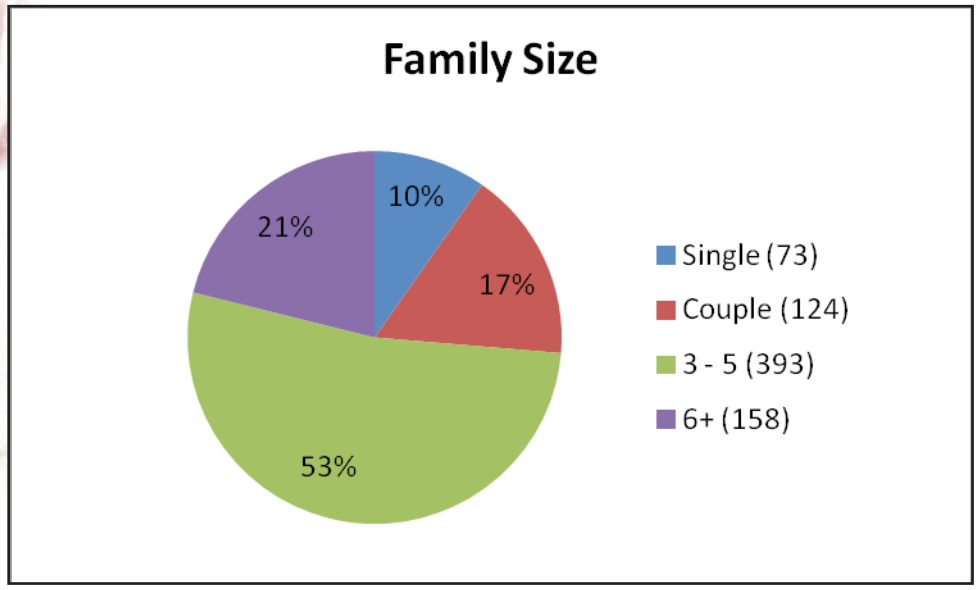




4. "Vietnamese" was consequently calculated as its own category, as shown in the graph "Language Preference."

Family Size (Parents and dependents living at home)

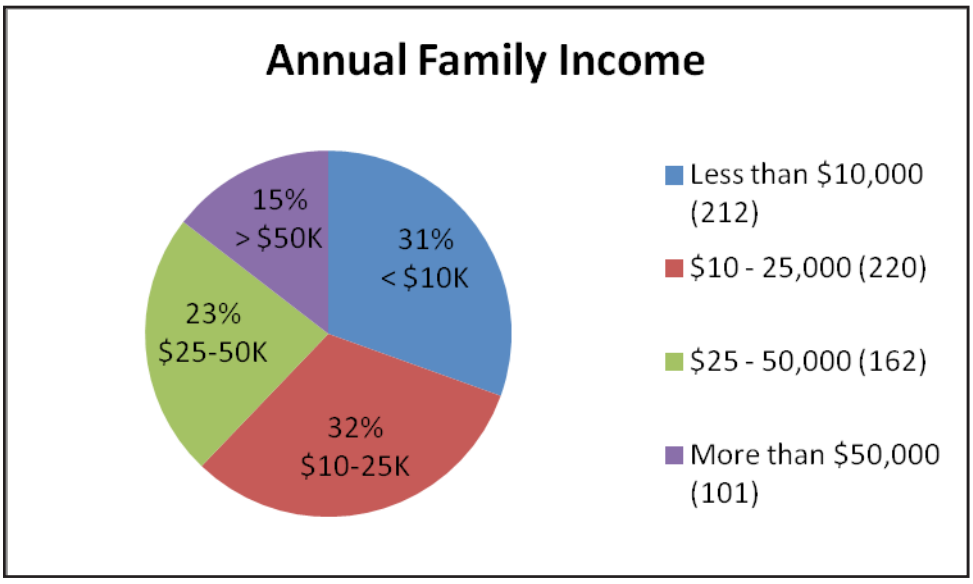
Since multiple families may often reside in the same household/residence, information regarding "family size" was collected. Nearly 75% of BCC participants came from families comprising three or more persons, with 21.1% reporting a family size of six or more persons. The average Utah household in 2011 consisted of 3.1 persons.

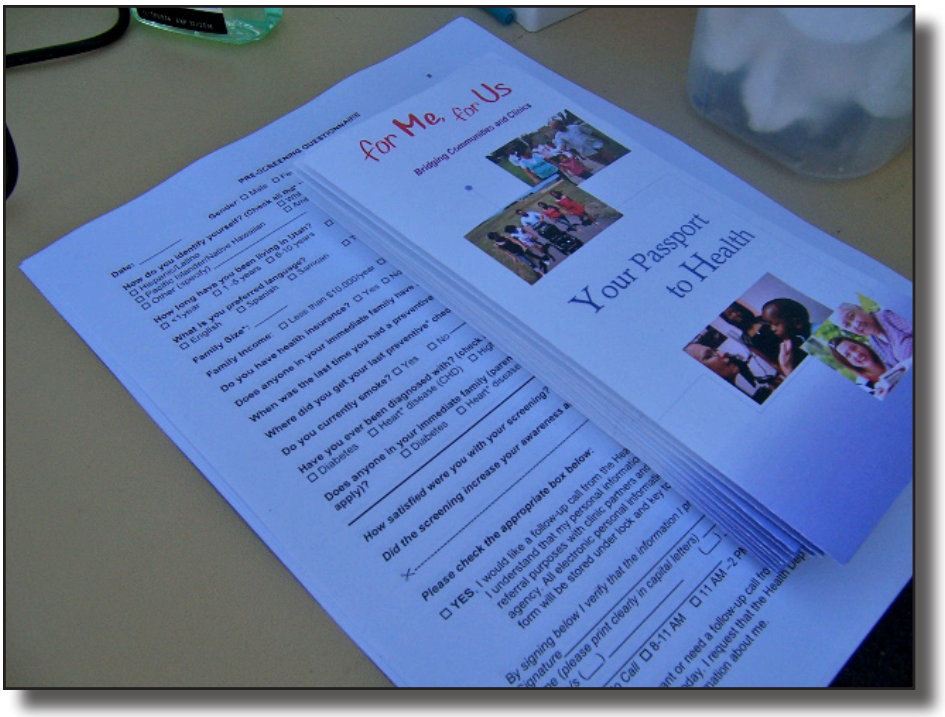


5. US Census Bureau, 2011 American Community Survey.

Annual Family Income[6] (Parents and dependents living at home)

For 2011, the median household income in Utah was $55,869.[7] Pre-screening questionnaires requested information on estimated "family income" (rather than "household income"), revealing that BCC outreach events were largely attended by individuals with considerable financial disadvantages. More than 85% of respondents declared an annual family income of $50,000 or less, with 30% indicating family income of less than $10,000 a year.





6. At the request of one community partner, this question was omitted in 23 pre-screening questionnaires.
7. US Census Bureau, 2011 American Community Survey.

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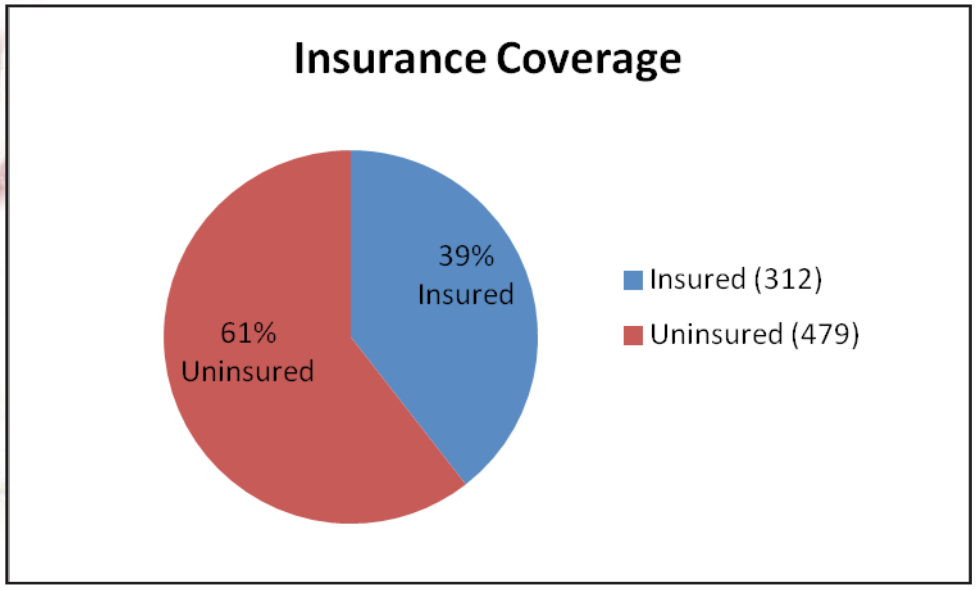
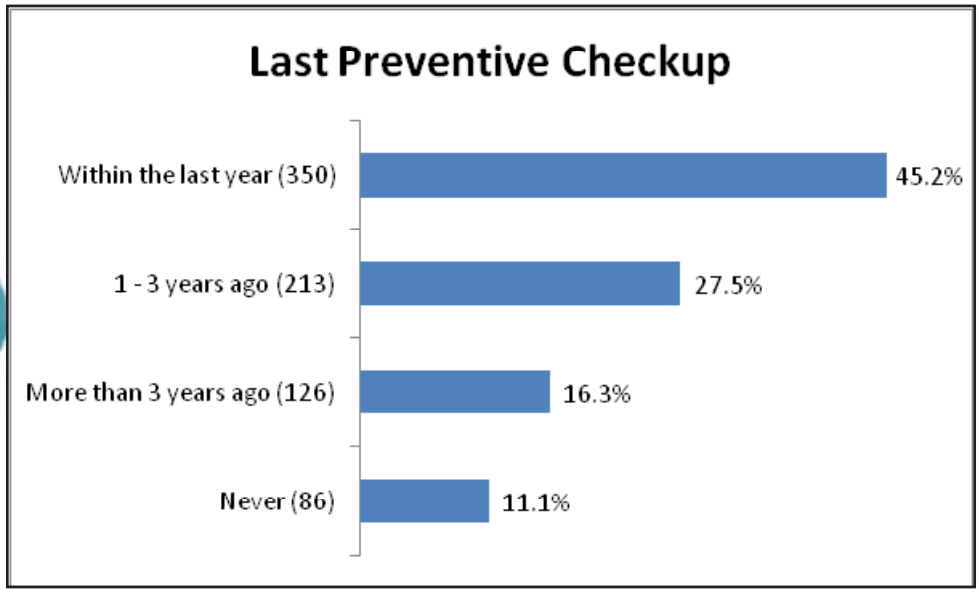
Do you have health insurance?[8] (Including Medicaid, Medicare, PCN, etc.)

The proportion of Utah's total population that is uninsured was estimated to be 13.4% in 2011.[9] The uninsured rate among BCC participants was more than four times the overall uninsured rate for the state of Utah.



When was the last time you had a preventive checkup?

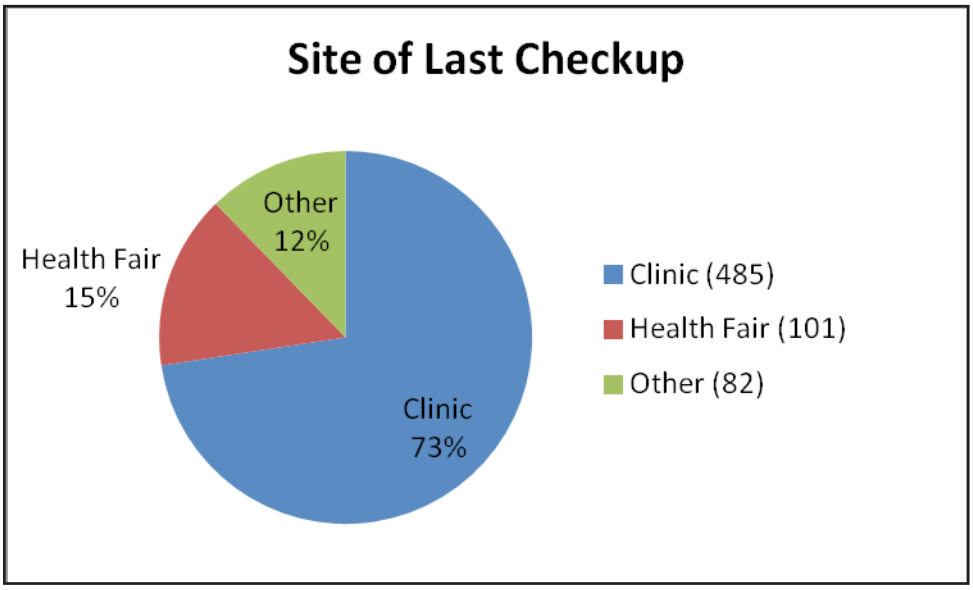
Pre-screening questionnaires revealed that more than half of participants (55%) had not had a medical checkup within the 12 months prior to being screened at a BCC outreach event. More than 11% reported never having a received a checkup before.



8. At the request of one community partner, this question was omitted in 23 pre-screening questionnaires.
9. Utah Department of Health, Utah Behavioral Risk Factor Surveillance System, 2011..

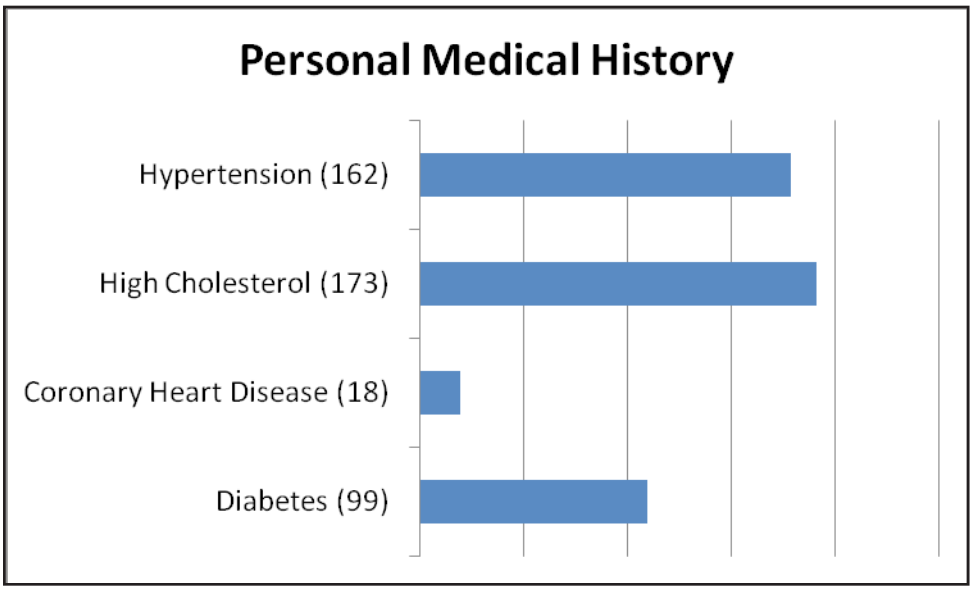
Where did you get your last preventive checkup?

The vast majority of those who reported having a previous preventive checkup were seen at a clinic or private provider's office. Responses written under the "Other" category included traditional/alternative medical practices, workplace screenings, foreign countries, military medical facilities, etc.

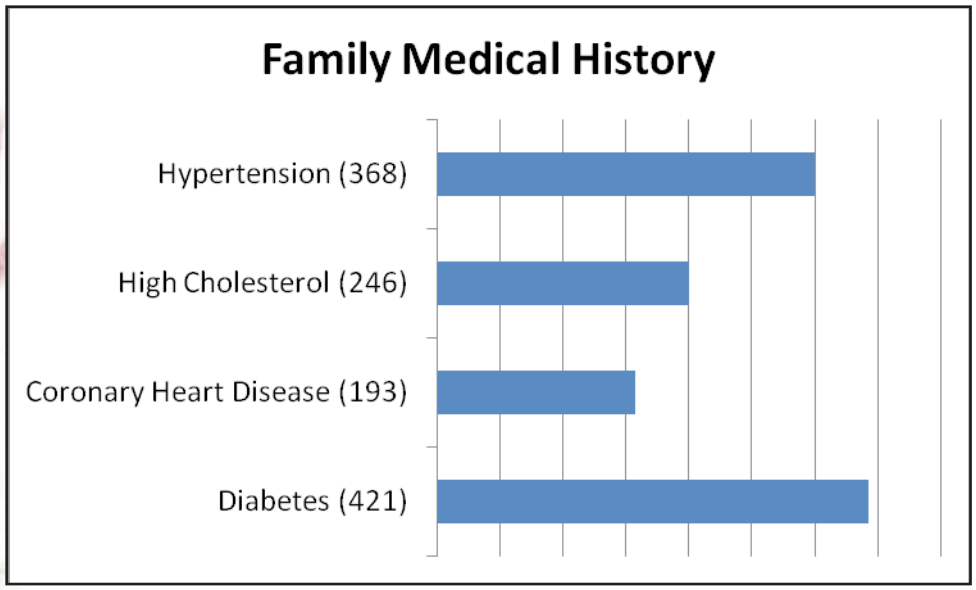


Have you ever been diagnosed with … ? (check all that apply)

The most commonly self-reported conditions among BCC participants were high cholesterol, hypertension, and diabetes; these were also the most frequently reported conditions among participants' immediate relatives.

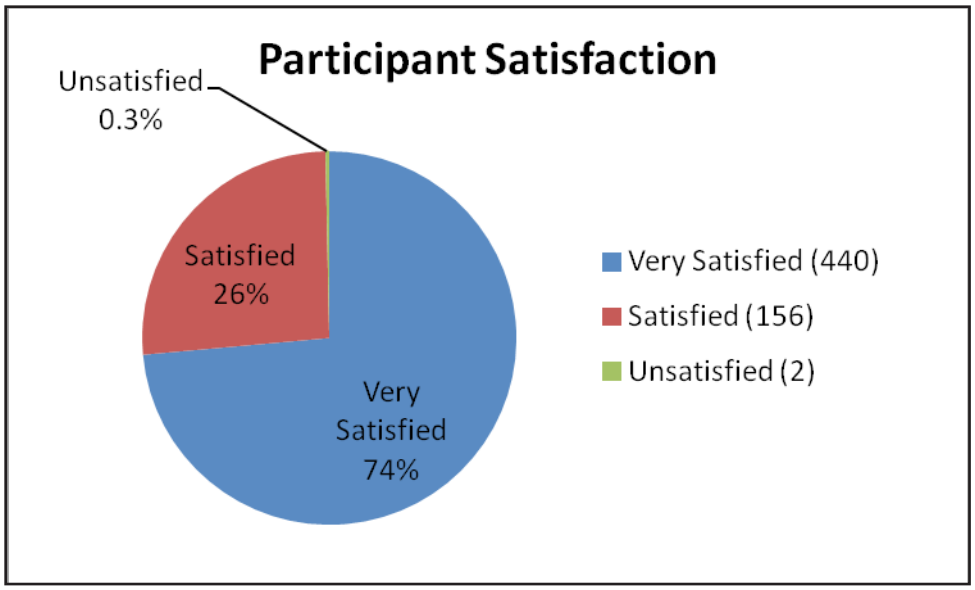


Does anyone in your immediate family (parents, grandparents, siblings) have a history of … ? (check all that apply)



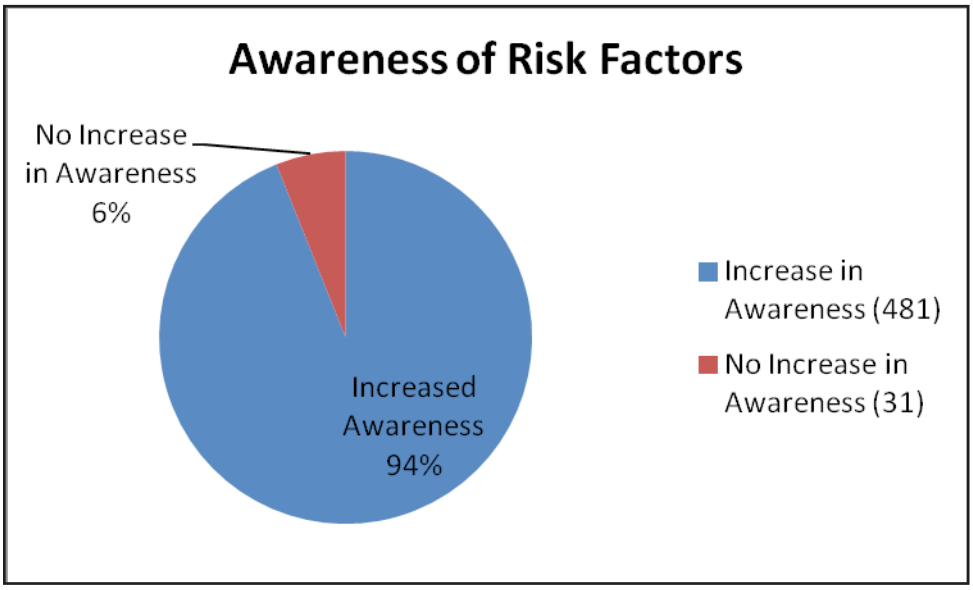
How satisfied were you with your screening?

All but two participants who provided evaluation of their screening experience reported that they were either "satisfied" or "very satisfied" with the quality of the screenings.



Did the screening increase your awareness about your health risk factors?

The vast majority of respondents indicated that their screening experience (including explanation of results and discussion of potential risk factors with outreach interns) raised their level of awareness regarding health conditions for which they may be at-risk.



Outreach Team Evaluation and Feedback

Outreach Team interns provided online feedback of the BCC program through an online survey intended to evaluate the pilot in terms of logistic considerations, coordination and organization, procedural efficiency, and the quality of training received. Successful facets of the program that were identified included user-friendly screening questionnaires and efficient screening procedures. Outreach Team members also thought highly of the quality and applicability of the trainings (clinical skills, cultural and linguistic competency, medical interpreting, etc.) that were offered throughout the course of the pilot. When asked about the relevance of outreach events to their future medical careers, all of the interns stated that the real-word, hands-on experiences they gained through the outreach program were highly relevant and beneficial to their academic and professional goals. Some areas of improvement were also identified, such as the need for more on-site language assistance and clearer communication between community partners.

Pilot Evaluation and Recommendations

The RE-AIM model of public health program evaluation was utilized as an external framework to assess the reach and effectiveness of Bridging Communities and Clinics. Qualitative and quantitative analyses were also utilized to determine whether initial objectives of the pilot program were satisfied.

Reach:

The pilot program was effective in reaching the intended target populations, specifically individuals and families without health insurance coverage, the economically disadvantaged, and ethnic/racial minorities. Over 85% of participants had an annual family income of less than $50,000, compared to the average household income[10] in Utah of $56,330 per year in 2011.[11] Whereas 13.4% of Utahns were not covered by health insurance in 2011,[12] over 60% of participants reached through BCC outreach events reported being uninsured by any private, group, or governmental insurance policy. Ethnic and racial minorities in Utah bear disproportionate burdens of health conditions and the BCC pilot was shown to be effective in reaching individuals from underrepresented communities; self-identification of race and ethnicity collected from screening questionnaires revealed that 87% of responses indicated a non-White, minority background.

10. Household income and family income are not equivalent as multiple families may reside in one household. Bridging Communities and Clinics participants were asked to state family income rather than household income.
11. US Census Bureau, 2011 American Community Survey.
12. Utah Department of Health, 2011 Utah Behavioral Risk Factor Surveillance System; US Census Bureau 2011 ACS estimates Utah's uninsured rate at 15.3%.

Effectiveness:

Outcome measures were assessed in terms of scope (how many screenings were conducted), follow up (how many referrals were contacted post-screening), and compliance (how many referrals led to clinical visits). The initial goal of providing 1,000 free screenings was not met, although 883 screenings were provided, yielding an 88% attainment rate. Clinical referrals were offered to 178 participants, and attempts were made to subsequently follow up with all referrals via telephone and/or email within 30 days of screening. Accounting for wrong/disconnected telephone numbers, unreturned voicemails/personal messages, and unanswered attempts, 63 participants (35% of those who received a clinical referral) were reached for follow up. Of those participants, 34 (56% of contacted referrals) were reported to have visited a medical provider in relation to the screening they received through the BCC.

Adoption and Implementation:
The BCC model was piloted in 24 different venues in a variety of settings including, a neighborhood block party, cultural celebrations, faith-based activities, and screening booths on-site at health clinics and ethnic supermarkets. The integrity and working framework of the BCC model was consistently maintained in all venues and settings, with minor adaptations implemented as needed. Overall, the BCC model was observed to operate successfully at all outreach sites and with a variety of diverse community partners and clinical agencies.

Maintenance:

The BCC pilot has effectively established a network of community and faith-based organizations, clinical facilities, medical providers, and civic advocacy groups that are committed to long-term health-related interventions. This collaborative effort was crucial to the successful implementation of the BCC pilot. It is noted that there was no systematic component within the pilot to monitor participants' clinical outcomes beyond the 30-day post-screening follow up period. Considerations for sustainable maintenance of the BCC program beyond the pilot stage include recruitment and training of highly qualified Outreach Team interns, sustainable funding sources, and expansion of the BCC collaborative network.

Recommendations:

Given the demographic background of the majority of BCC participants, it is strongly recommended that future outreach efforts be closely integrated with the Division of Workforce Services insurance eligibility and enrollment personnel.

Community health workers (CHWs, promotoras, etc.) should be utilized to enhance overall efficiency and effectiveness of outreach events.

Extending the referral follow-up protocol (beyond 30 days post-screening) will provide more information about the establishment/utilization of "medical home" services.



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Acknowledgments and Thanks

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Clinical Partners

Salt Lake County
Utah Partners for Health, Exodus Network
Health Clinics of Utah – Salt Lake City
Intermountain – Lincoln Elementary
Intermountain – Rose Park Elementary
Intermountain – North Temple
Intermountain– Sorenson Center

Utah County
Intermountain – Dixon Middle School
Health Clinics of Utah – Provo
Mountainlands Community Health Center

Summit County
The People's Health Clinic
Weber County
Midtown Health Center
Health Clinics of Utah – Ogden

Community Partners

Salt Lake County
Ka Lama Mohala Foundation
Lincoln Community Learning Center
The Queen Center
Sorenson Unity Center
Community Faces of Utah
Unified Vietnamese Buddhist Association
National Tongan American Society
Alliance Community Services
Calvary Baptist Church
Midvale City – Community Building Community
Hawaiian Cultural Center
St. Patrick's Catholic Church
Rose Park Community Council
Utah Pacific Islander Interfaith Health Council
MANA Fitness Challenge
Binational Health Week Coalition

Utah County
Centro Hispano
Community Health Connect
UT Migrant Seasonal Farmworker Coalition

Summit County
Holy Cross Ministries

Weber County
Project Success
Delta Sigma Theta Sorority