Community Health Workers:

A Strategy to advance Health Equity

October 30, 2024

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Today's agenda

- Introduce you to our community
- Community Health Workers: evolution of implementation
- Health Equity Strategy: A quality improvement approach
- Shared results: Alignment and Integration of efforts

Milwaukee County, Wisconsin

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- *Population is near 1M with about 25% representing children under age 18.*
- *Distribution of racial and ethnic demographics for children: 44% white, 34% African American, 23% Hispanic or Latinx.*
- *Infant Mortality Rate is 8.7 deaths per 1,000 live births; particularly high for African American infants.*
- *Poverty rate for the county is 18% with some zip codes over 60% of families living in poverty.*
- *One of the most segregated counties in the nation.*

Source: Health Compass Milwaukee

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Our Vision:

The children of Wisconsin will be the healthiest children in the nation.

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Community Health Workers

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Continued commitment: an evolution of efforts

2012

- Recognized SDoH and related research
- Established in 2012 in three neighborhoods to address social determinants of health and health equity.
- Expanded to 2 additional neighborhoods in 2017
- Primary Reach: partner neighborhoods residents

2016

- Beginning to receiving referrals from Children's primary care offices
- Access to EHR established
- CHW's recognized as a part of care team
- Primary Reach: growing mix of primary care and neighborhood residents

2022

- Established in multiple clinical areas
- Identified as contributors to health equity strategy
- Formally acknowledged SDoH as a community health priority
- Primary Reach: balanced mix of patient and non-patient families

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Program overview

- Community health advocates are **certified community health workers**
- Program aims to build individual and community **capacity** by increasing health knowledge and **self-sufficiency**
- **Voluntary** participation by families
- Identifies needs, barriers, assets and strengths of families and neighborhoods
- Offers **one-on-one support** to families and assists with family goal setting
- **Collaborates** with internal and external partners

Program overview: **Our Team**

- Represents individuals with lived experiences, strong ability to build relationships and trust, knowledge of community resources, commitment to serve families and community
- Training includes community health worker certification, motivational interviewing, data literacy, EHR documentation and cultural awareness
- Case loads vary on complexity of social needs; average is ≈ 30

Program Overview: **Populations served**

- Families; patient and non-patient
  - Milwaukee County
  - Emphasis on partner neighborhoods
- Referrals from community based organizations and clinical partners
- Families can self-refer
- Service and support provided until case is closed; average is 9-12 months

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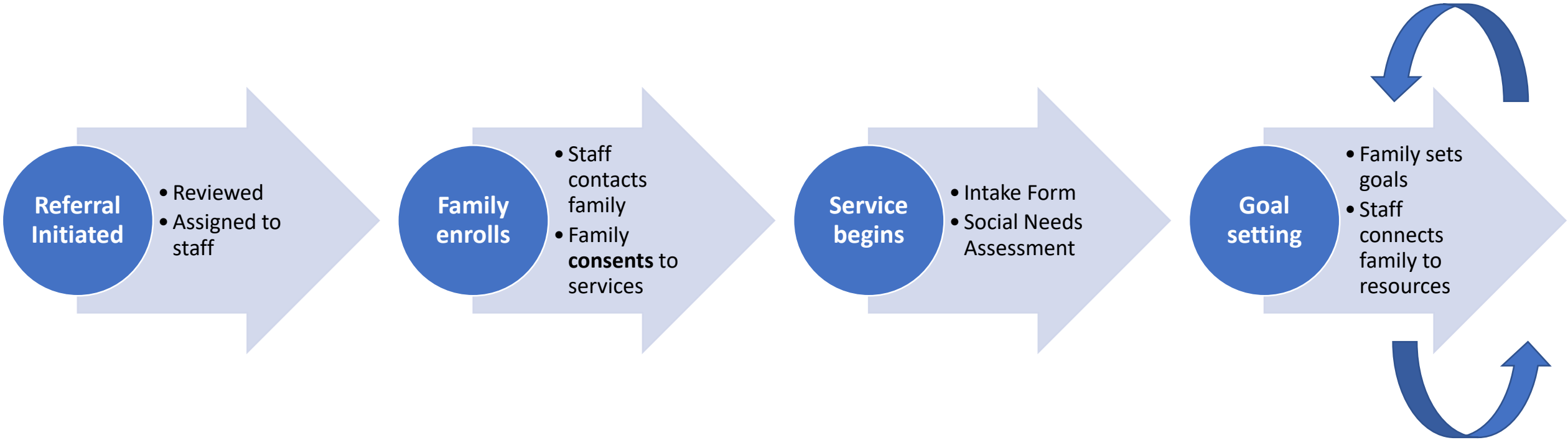
Program Overview: **Referral process**



Program Overview: **Social Needs Assessment**

Social Needs Assessment

1. Financial Stability
2. Food Insecurity
3. Transportation
4. Housing
5. Health & Wellbeing
6. Social Support
7. Safety/Violence
8. Parenting/Child

Levels of Self-sufficiency:

- Self-sufficient
- Stable
- Vulnerable
- In crisis

Program Overview: **Measuring our impact**

Community Engagement Dashboard 2024

Community Connector and Community Health Advocate Programs

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Kids deserve the best.

Community Engagement is an initiative within Children's Wisconsin led through the Department of Community Health & Education, encompassing Community Health Advocate and Community Connector programming. The initiative works to achieve health equity by addressing social determinants of health in neighborhoods across Milwaukee, through assessment, empowerment, and partnership with community members, organizations, and internal teams and leaders.

Community Need: Through Children's partner neighborhoods and a state grant for county-wide services, Community Engagement teams work with children and adults across Milwaukee County. Many of these households have unmet needs, putting them in a state of crisis or vulnerability and preventing their opportunity for health.

Six domains of social need are assessed at the beginning of services for Community Health programs

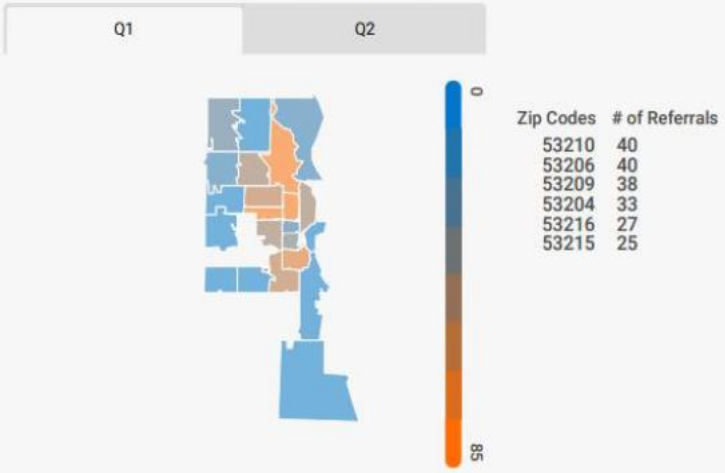
In Q1, the greatest level of crisis and vulnerability was Financial Stability (82%).

Social Needs Assessment domain distribution across levels of self-sufficiency

Data source: Updated (2021) Social Needs Assessment (Q1 intake n = 79)

Community Engagement teams serve households across Milwaukee County.

In Q1, the zip codes with the greatest referrals were 53210 (40), 53206 (40) and 53209 (38).



Zip Codes	# of Referrals
53210	40
53206	40
53209	38
53204	33
53216	27
53215	25

Data source: Program Services Flex Report, Connectors and Navigators

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Program Overview: **Measuring our impact**

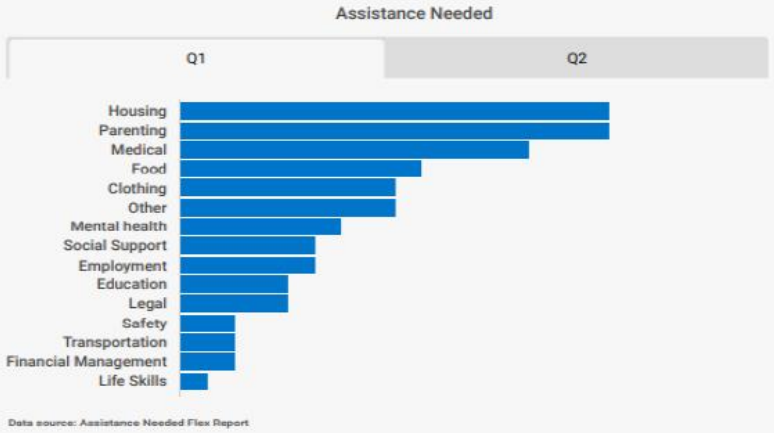
Our teams establish regular communication with families.

Staff completed 2,684 points of contact in Q1 and 2,810 points of contact in Q2, primarily carried out by phone or text messages.

Data source: Program Services Flex Report Connectors and Navigators

We build community partnerships to meet household needs.

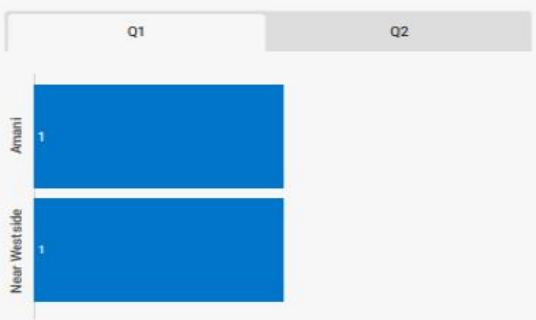
In Q1, of the 123 clients with documented assistance needed, the majority of referrals provided were for housing.



Data source: Assistance Needed Flex Report

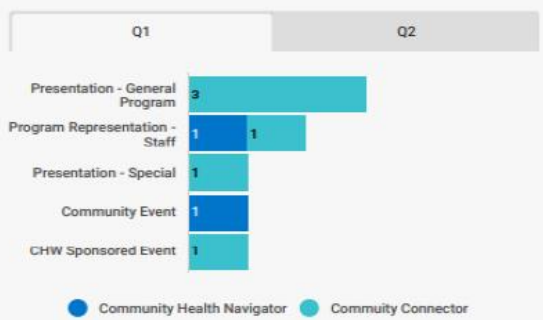
We engage in community events with our partners.

In Q1, we engaged in 8 community events, the majority taking place in the Amani and Near West Side neighborhoods.



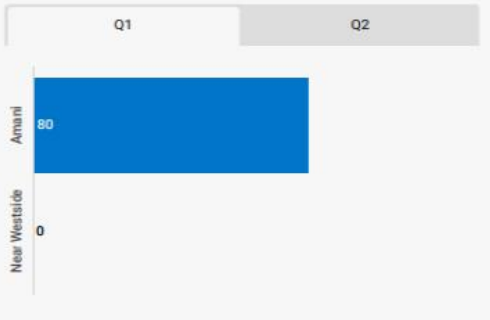
Data source: Community Events Flex Report
*Note: Location outside our partner neighborhoods.
**Note: Events had no neighborhood listed data (Q1 n=6; Q2 n=6).

In Q1, we engaged in 5 types of community events, the majority were general presentations.



Data source: Community Events Flex Report

In Q1, we reached 254 individuals through community events, the majority in the the Amani neighborhood.



Data source: Community Events Flex Report
*Note: Location outside our partner neighborhoods.
**Note: Events had no neighborhood listed: (Q1 n=6 events, 174 ppl; Q2=6 events, 298 ppl).

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2024* Highlights

287 new families referred

Over **300** new participants enrolled

126 cases co-managed

3,500+ contacts with families

253 goals established

- Over **50%** were **achieved** or are **in-progress**

More than **1,500** resources provided

* Data represents through Q3 2024

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A Journey to Stability: Ms. Jackson's Story

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Overwhelming Challenges

- Family homeless, living in the car.
- Son taken to the ED three times in one week for asthma.
- History of evictions and limited income.
- Difficulty finding a landlord willing to rent.
- Children's social work refers family to the community health worker program.

Photo Source: The New York Times

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Seeking Help and Finding Support

- Ms. Jackson reached out to 211 for housing help but was still waiting.
- Met with community health worker in a Walmart parking lot to discuss her situation; enrolled in program.
- Community health worker mapped out resources and mobilized community partners to assist the family.
- A potential home was identified.

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Finding a New Home

“Is this our new home?”

- Moved into stable housing.
- Son’s asthma improved.
- A safe, stable environment helped the family heal and move forward.

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A New Chapter for Ms. Jackson's Family

- Ongoing housing support through the Children's community health worker.
- Continued assistance ensures the family remains housed and stable.
- Additional goals can be identified and supported.

Health Equity Strategy

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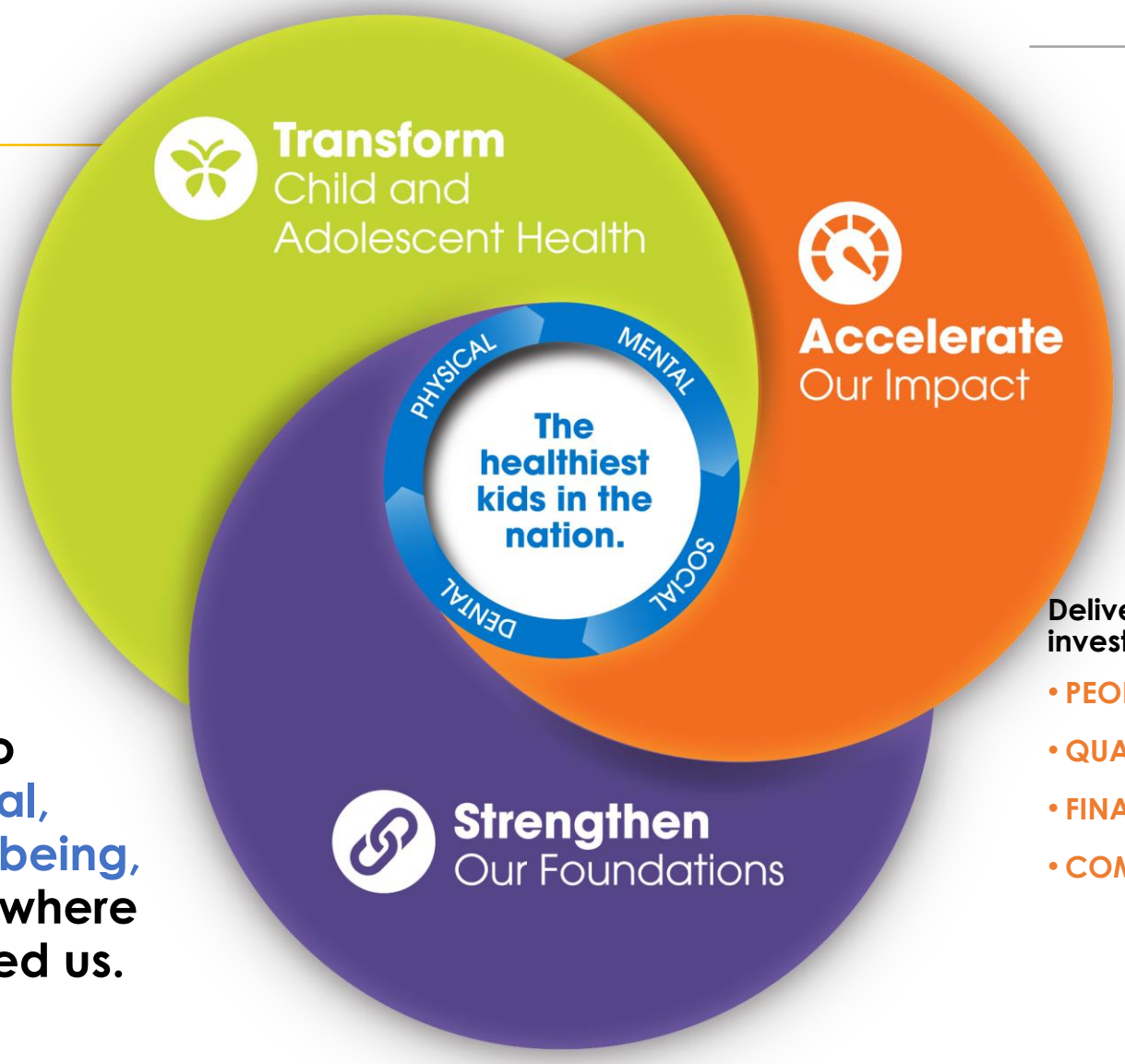
2023-2027 STRATEGY

Advancing every aspect of child & adolescent health

Addressing every aspect of health and providing a connected experience.

- WHOLE CHILD & ADOLESCENT HEALTH
- PREVENTION & EARLY INTERVENTION
- CONNECTED CARE EXPERIENCES
- ACCESS & GROWTH



Investing and growing in critical areas that will evolve our care.

- DATA & ANALYTICS
- IMPROVEMENT & BREAKTRHOUGHS
- DIGITAL & TECHNOLOGY EVOLUTION
- PURPOSEFUL PARTNERSHIPS

Delivering top-quality care through sustained investment in our core performance areas.

- PEOPLE & CULTURE
- QUALITY OUTCOMES
- FINANCIAL & OPERATIONAL PERFORMANCE
- COMMUNITY & EXTERNAL ENGAGEMENT

We are redefining the pediatric experience to include physical, mental, social and dental well-being, while meeting families where they are when they need us.

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Transform Child and Adolescent Health

Pursue opportunities that improve whole child & adolescent health and provide a connected experience.

Whole Child & Adolescent Health

Advance physical, dental, ***social*** and mental health — ***equitably*** for all children and adolescents

Connected Care Experiences

Provide proactive, seamless and personal experiences at every encounter

Prevention & Early Intervention

Identify and treat children and adolescents earlier in the care continuum to ensure overall well-being

Access & Growth

Targeted service expansion to serve more families and fulfill our mission

How does Children's Wisconsin define health equity?

- To achieve our vision of Wisconsin kids being the healthiest in the nation, we must support **all** kids in meeting their full health potential, especially those **at risk for poor health outcomes**.
- According to the Robert Wood Johnson Foundation, health equity means that everyone has a fair and just **opportunity to be healthy.**
- Health equity tells us that different kids and families may need more or different things to achieve the same health outcomes. Understanding individual health-related social needs can be critical for designing **patient-centered** care plans that achieve highest quality outcomes.

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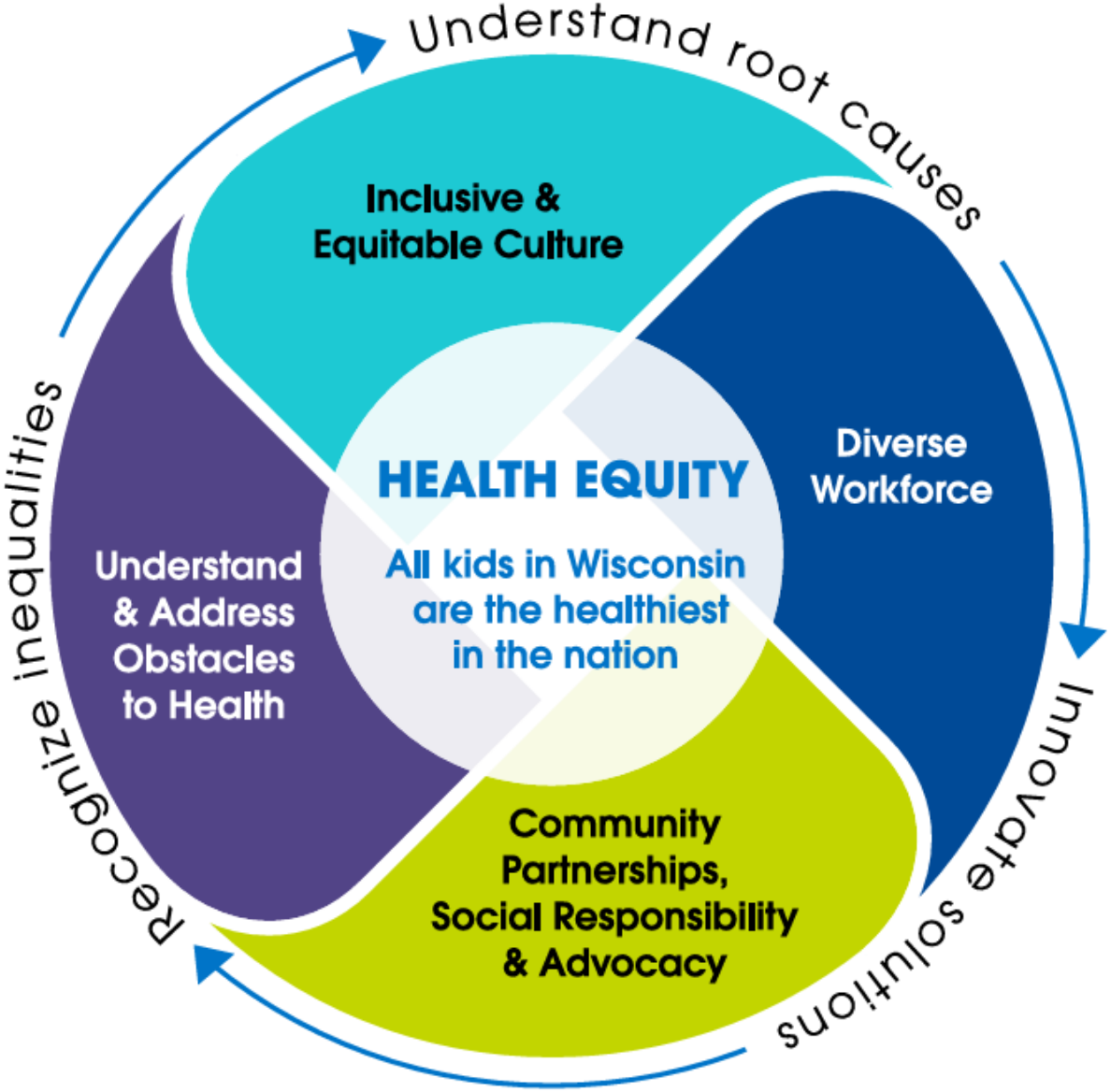

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Integration and Alignment

Prioritized, Integrated Efforts

- Integrated Lead Program
- System Asthma Program
- Social Drivers of Health
- Health Navigation

Integrated Lead Program

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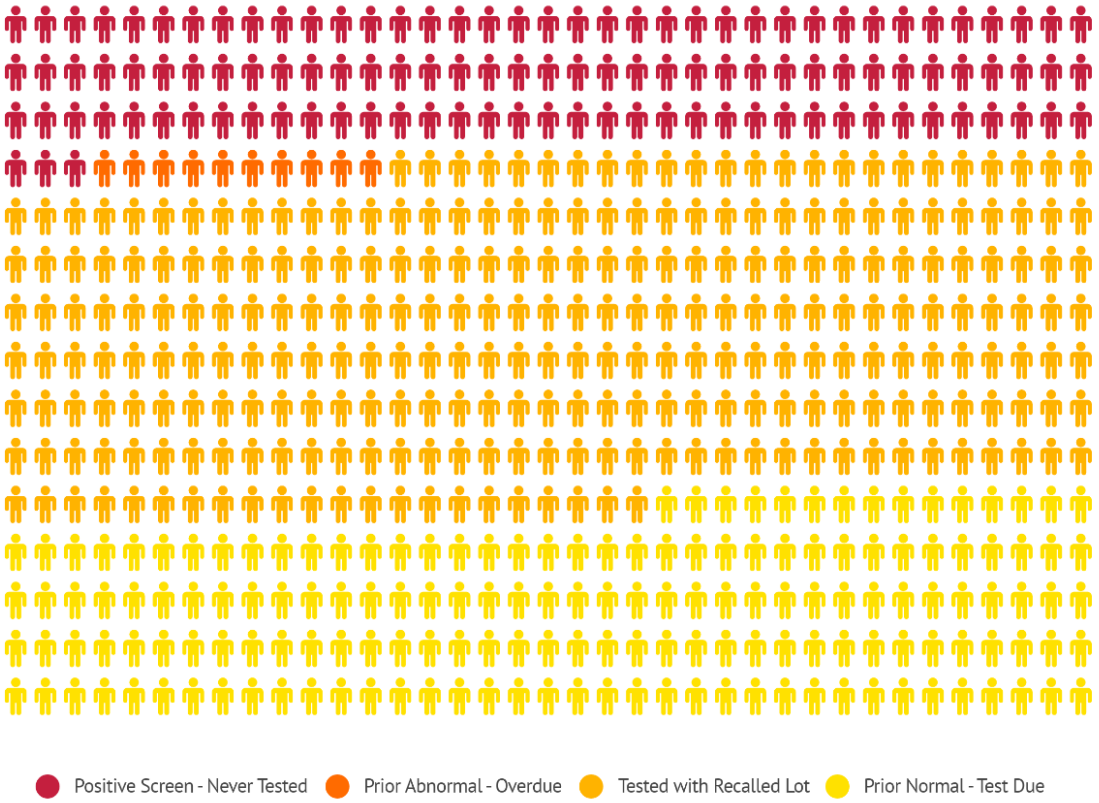
Problem Statement

9,600+

Children's primary care patients are **overdue for lead testing** due to the Magellan point of care lead testing device recall. An unknown number may be experiencing **lead toxicity.**



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Who all is working to address the crisis?

Community Partners

- Sixteenth Street Community Health Center
- Social Development Commission
- La Causa
- Kenosha/Racine Lead-Free Communities Partnership
- Sherman Park Community Association
- Coalition on Lead Emergency (COLE)
- WIC
- IMPACT 2-1-1
- Community Advocates
- Safe Kids Wisconsin
- Health Connections

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System Asthma

CHAMP
(Community Health Asthma Management Program)

- **Who are we serving?**
- Focus =
  - Children **AND** adults with poorly controlled asthma
  - Child must be <18 years old enrolled in state Medicaid program OR
  - Pregnant women enrolled in state Medicaid program OR
  - CCHP client (high healthcare utilization, hx of uncontrolled asthma)
- Top zip codes served include 53216, 53206, 53209, 53215, and 53218
- 68% of kids are < age 11
- 90% identify as Black or Hispanic
- 75% live in rental housing

What are we doing?

- Service includes at least 2 **in-home visits** with follow up calls at two weeks and three months.
- Personalized asthma education, home environmental assessment, remediation supplies for identified asthma triggers
- Asthma action plans
- **Home improvements** (carpet, mold, fans, smoke detectors)

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Results: Improved health, reduced healthcare utilization

- Asthma Control Test scores improved
  - Largest gains among those in poor control

- Emergency department and urgent care visits reduced
  - Largest gains among those in poor control

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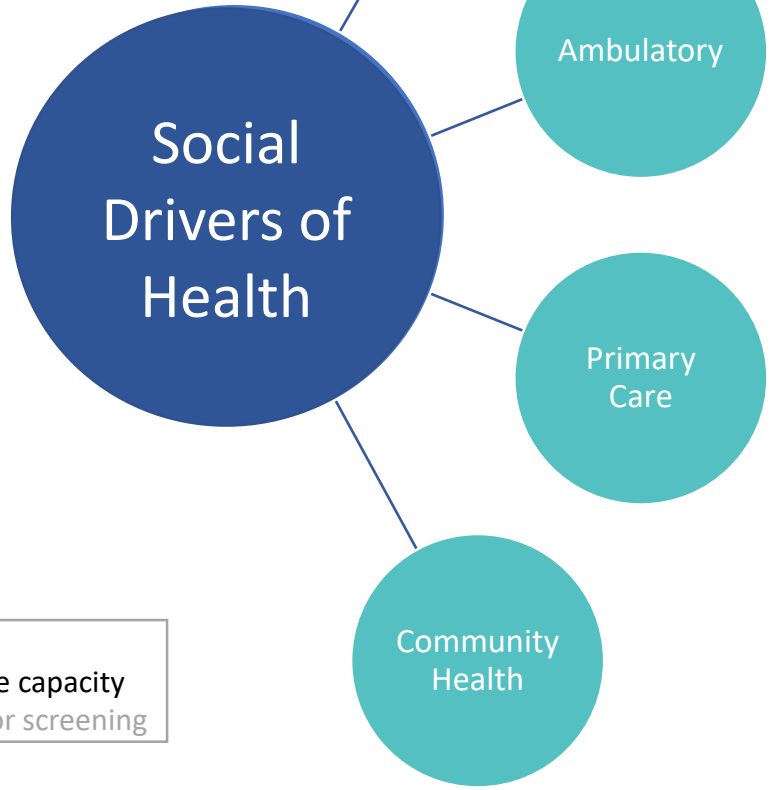
Social Drivers of Health

Current State Screening



- Emergency Department
- NICU
- PICU
- Inpatient/Hospitalists/Dieticians
- Surgery

- Spina Bifida
- Renal
- Child Advocacy Centers
- Diabetes
- Neonatal Hope & Dream Clinics
- Sojourner Peace Center
- Sickle Cell
- ENT
- Asthma Plus

- Midtown
- Forest Home
- Metro Region Locations

Key

- Currently screening in some capacity
- Requested tools/support for screening

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SDoH Efforts

- Advance universal social health screening and intervention recommendations in alignment with our vision of improving whole child & adolescent health
- Bring clarity to roles with key responsibilities involved in screening and intervention workflows
- Test and integrate SDoH workflows into existing operational workflows, supported by tools and technology
- Identify and create closed loop referral pathways to internal and external resources to meet social health needs
- Develop and implement KPIs and impact outcome measures
- Seek and incorporate feedback and voice from patients/families to design interventions around social health screening and intervention

Health Navigation

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Vision and Strategic Intent

Vision: *Achieve whole child health through innovative services and collaborations that create a reliable and personalized experience for our patients and families. Facilitate healthy, sustainable relationships with our team to serve as a foundation for providing equitable, high-quality care.*

2028 Strategic Intent

Improved patient and client outcomes by enabling equitable and efficient access to needed care and services from Children's WI and others that are informed by and responsive to our patients and families.

We will work to identify and remove barriers that impact either a family's ability to optimize their use of available health resources and care or their ability to achieve their health and well-being goals.

Strategic objectives

Consistent, family-oriented processes to help patients / families to address social drivers of health (SDOH) that impact their child's overall well-being

Systems and processes that increase access to care or services that advance whole health for the child and family

Consistent services across primary care that enable a convenient "one-stop-shop" for patients and families

Digital tools that optimize care team communication and enable identification and monitoring of at-risk patients or populations

A continuous improvement and shared learning environment that leverages emerging research and patient/family experience

Community outreach that results in multi-directional learning among us, community and advocates for issues that directly impact whole-child health

Scalability and sustainability of the program

Contact Information

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