



A STAFF REPORT OF LESSONS LEARNED:

**MOBILIZING YOUR COMMUNITY TOWARDS
100% ACCESS-ZERO HEALTH DISPARITIES**

May 2002

INTRODUCTION

Ten United Ways were selected as demonstration projects to develop a strategic plan to implement a 100% Access-Zero Health Disparities Campaign. The 100% Health Access Campaign is a community-based movement that calls into action local communities to come together and develop local solutions. The 100% Health Access Campaign was originally created by the Bureau of Primary Health Care (of the Health Resources and Services Administration, Department of Health and Human Services) to ensure that every person in America has access to primary and preventive healthcare. United Way of America's partnership with the Bureau focuses on improving healthcare access and reducing health disparities among diverse populations, particularly pregnant women and young children from birth to age six.

In addition to these United Ways, other communities around the Nation are implementing innovative healthcare models to improve health access and eliminate health disparities for the uninsured and underserved. In Wichita, Kansas, *United Way of the Plains* played a pivotal role in establishing Project Access, which currently provides free medical care to more than 3,000 uninsured patients, and has leveraged more than \$15 million in pro bono care and medicine since 1999. In Indianapolis, *United Way of Central Indiana* is the convener and facilitator of the School Wellness Collaborative that provides school-based health services to 37 schools in Marion County. *United Way of Greenville* in South Carolina has successfully established the Community Health Alliance (CHA) to reduce the number of medically underserved persons in Greenville County. Currently, there are 180 doctors participating in the program who will provide 1,700 patients with a medical home by 2002.

The first year of United Way of America's involvement in the 100% Health Access Campaign has provided key learnings that may help in the planning of a 100% Health Access Campaign in United Way service areas. Below are the lessons learned:

➤ **LESSON #1: STAY FOCUSED.**

Focusing on the vision and mission of the 100% Health Access Campaign will allow United Ways and their partners to create a plan that is outcome-focused, and allow them to remain on course. *United Way of Lee County* in Ft. Myers, Florida convened stakeholders from the profit, non-profit, medical and faith-based organizations, and local government for this purpose. All of these partners were enthusiastic about improving healthcare access and eliminating health disparities in Hendry and Glades counties. However, they wanted to include everyone and to finish the plan quickly. Although United Way staff were pleased with their enthusiasm, they facilitated the meetings focusing on a target population group: pregnant women and families with children from birth to age six, and taking the group through a step-by-step outcome-focused planning process. As a result, the group was able to discover their assets and resources, and use them to make concrete and clear commitments in order to advance the 100% Health Access Campaign in Hendry and Glades counties. These commitments included: medical services from Lee Memorial Hospital; personnel from Southwest Florida Children’s Fund, Healthy Start and Florida Gulf Coast University; mental health services donated by Ruth Cooper Center and Hendry/Glades Mental Health; van maintenance from GoodWheels; and, funding from the Southwest Florida Community Foundation. During the development of the strategic plan, United Way staff also learned to keep their partners focused on one element of the plan at a time while working diligently to get all partners to take ownership of the most relevant parts of the strategic plan.

United Way of Blount County in Maryville, Tennessee is focusing on children’s mental health. As United Way and its partners began the planning process, they felt frustrated by the current condition of the mental healthcare system in Blount County. Significant concern was voiced regarding the restrictions of TennCare and other third party insurance providers, as well as the inadequacy of services available for young children. The solution to this challenge was not only to affirm the common struggles of these partners but also to help them focus on the mission, the desired outcomes for children, and solutions to existing systems barriers. This has allowed the partnership to focus on developing realistic outcomes that will enable partners to shift from problems to opportunities. Their mission is: “the 100% Health Access Campaign of Blount County will work to increase access to emotional health services for children ages birth to six years old” --- linking it with the Success By 6® initiative. In order to achieve this mission, the partnership developed the following long-term outcome: “Isolated children in Blount County have access to

emotional health assessments and referrals to emotional health services”. As a result, four teams have been created to address systems changes that will enable children to have access to mental health services: childcare, integrated care system, TennCare, and education. By focusing on this long-term outcome, new partnerships have emerged that have led to increased inter-agency referrals which will improve children’s mental well-being.

Collecting data and information on the healthcare system, roles of various community organizations, local programs, existing healthcare models, etc., can be overwhelming as United Ways and their partners organize and analyze this wealth of information. *United Way of Metropolitan Tarrant County* in Fort Worth, Texas encountered a similar experience as they reviewed data and information on children’s healthcare. However, they kept focused on the targeted outcomes for young children and pregnant women to identify systems they wanted to impact. As a result, they developed a mission of: “Tarrant County children will be born at full- term with adequate birth-weight and appropriate Apgar scores”. The partnership will focus on improving health outcomes for children in zip code 76105 by increasing the percentage of pregnant women who receive prenatal care in the first trimester and reducing deficient prenatal care reports.

➤ ***LESSON #2: RESEARCH AND PARTNER WITH OTHER COMMUNITY INITIATIVES.***

An important feature of strategic planning is to research what other programs, projects, initiatives, community organizations or partnerships are implementing so there is no duplication of efforts. When *United Way of Santa Fe*, New Mexico and the Executive Leadership Committee¹ (ELC) first began work on the 100% Access- Zero Health Disparities Campaign, they discovered that numerous health planning groups in Santa Fe were already working on addressing health access issues. Each of these groups was working independently of each other and minimal linkage existed. United Way and the ELC brought together the consultants that were supporting the various health planning efforts to develop a strategy for consolidating and coordinating planning efforts. During this process, they found that one of the consultants was already conducting a needs and assets assessment for the Santa Fe County Health Planning Commission. By working with this consultant, United Way was able to eliminate a separate community assessment for the 100% Health Access

Campaign and avoid the corresponding costs. The assessment report, which was made public in November 2001, has become the single-source document for all community-wide decisions related to healthcare.

As a result of bringing these healthcare planning groups together, United Way is now combining and linking numerous health planning efforts. Under one proposed option, the Health Planning Commission will provide oversight of the community-wide health plan. The St. Vincent Community Services Network Advisory Committee will address access to primary healthcare. United Way and the ELC 100% Health Access Campaign, which focuses on primary and preventive healthcare and referrals delivered through community schools, will work with the St. Vincent Community Services Network Advisory Committee and develop and implement the community schools plan. The CARE Connection has taken on the responsibility for the behavioral health planning. It is currently conducting strategic planning in order to develop a new coordinated system to deal with behavioral health issues more seamlessly while focusing on decreasing the number of people in jails and emergency rooms with behavioral health problems. A newly formed, yet-to-be named collaboration will plan and develop an integrated service continuum for elderly people, focusing on developing alternatives to institutional care. By encouraging coordination and collaboration, these multiple health planning efforts have become assets instead of barriers. They now have an entire community that is mobilizing to address critical healthcare access issues.

Orange County United Way in Irvine, California had a similar experience. Orange County's mission for the 100% Health Access Campaign is to educate and empower families with children (from birth to age six) to utilize services their healthcare programs provide to ensure that children enter school ready to learn. When members of the health committee researched existing educational materials for parents of children ages 0-6, they found that there were no educational pieces that focused on the targeted population group. Members met with representatives of the Association of Life and Health Insurance, and health plans for the Healthy Families Program (HFP), which further emphasized the need to develop and disseminate these educational materials. While making this discovery, the 100% Health Access committee established a partnership with the HFP health plans and Blue Cross/Blue Shield, which asked to collaborate in the rollout of Healthy Steps to Success--

¹ The ELC partnership includes St. Vincent Hospital; Presbyterian Medical Services; Santa Fe Community College; the College of Santa Fe; Santa Fe Public Schools; Santa Fe County; the City of Santa Fe; IBM; Public Service New Mexico (the State's largest utility company); and, United Way. ELC also leads Santa Fe's 100% Health Access Campaign.

United Way's educational piece. By collaborating with United Way, Blue Cross/Blue Shield will learn from United Way's experience and possibly integrate this handbook into their existing health plans. In addition, United Way's involvement in the 100% Health Access Campaign has enabled United Way to mobilize new partners and become more fully integrated with the County's efforts, which include serving on the select steering committee for Orange County Children's Health Access Initiative.

Partnering and collaborating with existing community initiatives avoids duplication of efforts, while moving an initiative forward. This has been the case with the partnership between *United Way of the Central Savannah River Area (CSRA), Inc.* and the CSRA Partnership for Community Health in Augusta, Georgia. The CSRA Partnership represents 45 health groups including seven area hospitals. The Chair of the Partnership also serves as a board member for United Way of the CSRA while United Way's Vice President for Community Impact serves on the Partnership's Executive Committee. The focus of the CSRA Partnership is improving indigent care in Richmond County.

The vision of both partners is to target systems changes in order to increase healthcare access in Augusta-Richmond County. So far, this collaborative effort has been instrumental in initiating two, and soon to be, three health centers in Richmond County that had more than 12,000 visits in 2001. These centers provide primary care to all, including those without insurance, on a sliding fee basis. Patients also have access to secondary care through a partnership with the Augusta State University Hospital. The CSRA Partnership has assisted in obtaining funding for the centers while increasing collaboration with other key community agencies. United Way of the CSRA supports the activities of the CSRA Partnership, participates in fundraising activities sponsored by the Partnership, and encourages usage of the clinics through its member agencies located near the health centers. In order to increase the services and impact of these community health centers, United Way of the CSRA and the CSRA Partnership conducted a survey to investigate why children, youth, and pregnant women are not attending these health centers. More than 2,000 respondents were surveyed from October – December 2001. With regards to children's health, almost 94% of the parents surveyed indicated that their children received medical check-ups. However, medical conditions most often listed were frequent ear infections, asthma, bronchitis, pneumonia, and frequent sore throats. Most common reasons cited for not taking children to a

doctor for regular check-ups included: lack of transportation, cost of healthcare services, not knowing where to go for care, waiting too long to get an appointment, and no need to go if the child is not sick. As a result of the survey, United Way will use the data to collaborate and partner with organizations to plan and coordinate activities and programs that will benefit the community at-large. Also, the results will be used in determining future funding for United Way initiatives such as Success By 6®. United Way will also serve as a depository of information gathered from the survey so that health planners determining gaps and duplication of healthcare services can use this information easily.

➤ ***LESSON #3: BE FLEXIBLE.***

As United Ways bring different type of stakeholders to the table, they must learn to be flexible so their mission for the 100% Health Access Campaign IS achievable while making sure that it connects with the United Way's overall vision for the community. *United Way of the Bay Area* in San Francisco has introduced the 100% Health Access Campaign in four of the seven counties it serves: Alameda, Contra Costa, Solano, and San Mateo. The United Way has restructured to reflect four key interest areas, one of which is health. As United Way staff surveyed their service area to participate in the 100% Health Access Campaign, Alameda County seemed the most appropriate location. However, as Alameda County worked on passing a health insurance initiative, United Way's 100% Health Access Campaign needed to wait in order to fit into the County's new health insurance structure. As a result, United Way was in a much better position to significantly contribute to the County's new healthcare delivery structure through a retention and utilization model (i.e., retention of health insurance and utilization of the medical system). United Way and Alameda County are currently partnering to create an insurance premium sponsorship fund that will cover families that "fall through the cracks" (i.e., undocumented people, and those earning more than 250% of the FPL, California's cut-off rate for the Children's Health Insurance Program.). This fund will be structured to allow Alameda County employees to donate through their federated campaign to the fund. By being flexible and patient as well, United Way was able to take advantage of the new environment in Alameda County while making sure they were fulfilling their community vision.

➤ **LESSON #4: SERVE AS THE NEUTRAL CONVENER.**

United Way's main role in the 100% Health Access Campaign has been as facilitator and convener bringing different partners and stakeholders to the table so a plan can be created to increase healthcare access and eliminate health disparities. *United Way of Central Georgia* and the Central Georgia Perinatal Coalition are addressing better health outcomes for women and young children with a focus on reducing infant deaths (mortality) and illnesses (morbidity). By collaborating with the Perinatal Coalition, United Way has partnered with more than 100 individuals from private nonprofit agencies, hospitals, childcare, health providers, businesses, educational institutions and government agencies. The concerted efforts of the United Way and the Perinatal Coalition and their collective evolution to creating change have been the most exciting accomplishments. The political and geographical barriers have been the most challenging aspects of this process since the service area includes 14 counties; (United Way and the Coalition are focusing on just 4 counties for the 100% Health Access Campaign). Although local health and human service providers do not "speak the same language" and often lack respect for each others' opinions, United Way has been the neutral partner and cohesive spirit that brings everyone together. As a result, United Way has established new partnerships including new members for the Success By 6® Advisory Committee as well as new sources of information for a community assessment in support of the 100% Health Access Campaign. In addition, Health Care Central Georgia², a network of health care and pharmaceutical providers and local government, has representation on the Perinatal Coalition and has United Way representation on its board. Health Care Central Georgia, through their funding from the Robert Wood Johnson Foundation and a Community Access Program (CAP) grant, is partnering with United Way to develop a universal access system for providers to share information about patients and avoid duplication. United Way has joined in that partnership to identify means of providing similar services to parents and expectant mothers. By working with this health care initiative, United Way hopes to gain knowledge of and experience in the existing systems and work to change them.

As in any other partnerships, a collaborative atmosphere is both essential and challenging. Turf battles, competition, lack of communication, and other issues can become obstacles to strengthening and continuing a partnership. However, by constantly reminding partners of United

Way's role as a convener or facilitator, and the partnership's mission will keep the group committed to the work ahead. *United Way of Chaves County* in Roswell, New Mexico performed a review of funding resources for primary care for children in Chaves County as part of the 100% Access Campaign strategic plan. Included in that assessment was a review of Medicaid eligibility standards and barriers, a review of funding through Public Health called the Healthy Kids Fund, Children's Medical Services for children with chronic illness, and Chaves County indigent funding. While staff and volunteers administered this assessment, key players became defensive as their programs were being evaluated. This became a challenge as United Way brought additional stakeholders to the table. United Way was able to keep stakeholders in the partnership by constantly reiterating the mission of the 100% Health Access Campaign and its benefit for children. Also, it did not deter United Way from publishing a "Community Report Card" for Chaves, Curry, and Roosevelt Counties. The report examines data related to education, health, and child and family welfare for the three counties while highlighting programs for each county that are currently making a difference. The report card was prepared and distributed as a tool to be used in partnership communities by both policy makers and community members. It is also intended to serve as a data resource for each community, as a "wake-up call" regarding issues of health disparity, and as a celebration of programs that are improving the health of these communities.

➤ ***LESSON #5: SELECT APPROPRIATE MODELS.***

Another key feature of a successful strategic plan is to select an existing model that is appropriate for your community and targeted population group. In order to do so effectively, research and site visits are needed. *United Way of Miami-Dade* in Florida is implementing the 100% Health Access Campaign in East Little Havana where there are substantial health disparities among the Hispanic population compared to the county as a whole.

Due to the recent immigrant population in East Little Havana, United Way and its partners decided to use a culturally-appropriate health model that trains indigenous health promoters to create "family health" records while monitoring healthcare status and generating healthcare plans. This model is based on the "Proyecto Uni Trujillo", a Kellogg Foundation project in Peru, that teams lay health promoters with public health nurses to perform surveillance focused on improving the

² Health Care Central Georgia has focused on increasing access to health care for a specific adult population with one or

health status of the entire family unit. Although the idea to use this model seemed appropriate at the beginning, adapting and replicating a model from a developing country needs much more time for planning and implementation. The Peruvian model is intimately related to the medical school in Trujillo³, and is based on a medical-nursing model, in which the nurses actually complete the health record, and both physicians and nurses make the home visits and assist with case findings. The role of the health promoters in Peru is much more limited than what was envisioned and is required for East Little Havana. Some of the risk factors identified in Peru have no relevance for East Little Havana such as lack of running water and indoor plumbing. The healthcare standards and immunizations in Peru are also different from those in Miami-Dade County.

The East Little Havana model was predicated upon the health promoters doing all the case finding, outreaching, peer counseling and helping access resources. The role of the primary healthcare professionals was to be integrated to the initiative by providing healthcare and collaborating with the health promoters when the latter sought resources and/or information for participants. The replication model never intended for physicians and/or nurses to actually complete the health records for the initiative or do home visiting. Therefore, the training was more limited in scope than originally anticipated. It consisted of an overview of the local project, with a brief comparison to the Uni Trujillo project, and detailed information on the risk factors, the completion of the Family Chart (or family health record), and the expected outcomes. A total of 18 health promoters were trained and a health coordinator was hired to coordinate the work of the health promoters, manage the data and the project, and to report on the progress of the project. Once the Peruvian trainers were able to travel to Miami (after encountering travel delays due to the events of September 11th), they were able to experience the project in action, which resulted in a rich exchange of experiences and information about project development and implementation.

The commitment of the health promoters varied significantly, although a small stipend was awarded for each completed Family Chart. The number of active health promoters dwindled to a low of 4, however, that number began to rise slowly to nearly 50% of the group that was trained. Some health promoters did not feel comfortable making the initial contact, but agreed to do follow-up visits. In a way, this became a second training approach, since some health promoters built their

more chronic health conditions or risk factors.

³ Trujillo is a city in Northern Peru.

confidence through these follow-up visits and eventually became involved in the initial contact. In order to make home visits manageable, promoters performed their outreach on the same neighborhood where each health promoter lived, or among those neighborhoods known to them. It has, however, been difficult to obtain the cooperation of some families especially among illegal immigrants who are fearful of the changes in the law due to the September 11th events. As a result, many are even reluctant to speak to their own neighbors. The word “migración” (Migration) was removed from the Family Chart to eliminate any potential misinterpretation of the project’s goals. Therefore, approximately 200 families have been linked to needed health services.

In the course of providing support and referrals for the families, health promoters have sometimes encountered barriers to accessing care. These barriers have included excessive documentation requirements, high co-payments, long waits for appointments, confusing referral procedures, lack of transportation, and rude or culturally insensitive service, among others. The health promoters have spoken out at public meetings, written letters and met with representatives of the clinic and other service providers to discuss their concerns. The result is a growing sense of empowerment, a belief that they can help to create the healthcare delivery system they need in their neighborhood.

The implementation of this model has been successful to date. Some anticipated difficulties never emerged, and the unexpected challenges that were encountered have been met with creativity and cooperation. The modifications that had to be made to the Trujillo model have made United Way and its partners extremely aware of the many changes that are required when replicating a model in another cultural context. This project has presented the very rare opportunity of reversing the replication of a model, since it is usually U.S. models that are replicated abroad.

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