Leveraging Community Health Workers to Support Refugee Health

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Sarah Clarke (SC): Hello, everyone, and welcome to today's webinar on leveraging community health workers to support refugee health. My name is Sarah Clarke. I'm the Executive Director for the Society of Refugee Healthcare Providers, and I will be facilitating the webinar session today. Before we get started, I'd like to take just a moment for our wonderful speakers to introduce themselves briefly. Adrian, would you like to go first?

Adrian Matadi (AM): Hello, good afternoon and good morning for those who have time changes. My name is Adrian Matadi. I am a Technical Advisor to the Society, and also I am one of the Refugee, Immigrant, and Newcomer Project Specialists. Thank you very much.

Tavia Mirassou-Wolf (TMW): Hi, my name is Tavia Mirassou-Wolf. I'm with the Colorado Department of Public Health and Environment and the Colorado Center of Excellence in Newcomer Health. I'll be speaking about the public health model for engaging navigators or community health workers today. Charmaine?

SC: Oh, Charmaine, you're on mute.

Charmaine Jackson (CJ): Hi, I'm Charmaine Jackson. I'm a Nurse Supervisor out in Phoenix, Arizona, at Valleywise Pediatric Refugee Clinic.

SC: Thank you so much, and thank you for being here. For the learning objectives today, we're hoping that by the end of this session, you will be able to identify five key barriers to health care access that communities whose preferred language is other than English are experiencing, to compare three care navigation models to select the best approach to addressing challenges in your own work. Then to take what you've learned today and apply real-world strategies to your own work with refugee and newcomer communities to help them overcome health care access barriers.

1. Key Health Care Barriers Experienced by Preferred Language Other than English (PLOE) Communities

SC: Before we talk about the care navigation models, we're going to review what are some of the key health care barriers that refugee and newcomer communities face. I know that many of you in the audience are quite familiar with the barriers clients are experiencing, so we'd love to hear from you. To do this, we have an interactive tool called Slido that we're going to use throughout today's webinar. You can join today's Slido session in two ways, either by scanning the QR code on the screen with the camera on your mobile device or by going to slido.com and entering code 3150 569, which is also on the screen.

I note that you can keep this Slido page up because it's automatically going to update to the next questions that we'll be asking throughout the webinar today, and that way, you don't have to rejoin for every question. For our first question, we're

interested for you to share, in your experience, what barriers to health care do communities whose preferred language is other than English encounter. We've got paperwork challenges, red tape, lack of culturally competent providers is a big one, language barriers, not appropriate translation, transportation, yes, language and cultural differences, health literacy. Yes, a lot about language, translation, transportation. Systems navigation, yes, the healthcare system is incredibly complex.

SC: Transportation to appointments, insurance, culture and deference, yes, understanding the healthcare system, cultural assumptions, not having citizen status. Rescheduling, yes, that's a hard one when appointments have to be rescheduled. Finding Medicaid providers, that's also extremely difficult, especially for specialists. Fear is definitely a big factor right now. Bills, especially if they're bills that Medicaid should have covered, and then there's confusion about whether they should have covered it or not. Fear of immigration repercussions, yes, losing Medicaid soon, knowledge of preventative care. Yes, we'll talk about that as well. Lack of knowledge.

SC: All right. I think I'm not seeing any new responses. Thank you for that. Yes, those were all really important examples of the many barriers that refugees and newcomers face when accessing health care services. What we see as providers is also backed up by the research, where research has consistently shown that people whose preferred language is other than English, they have reduced health care access and higher hospitalization rates. You all listed many of these barriers already, but just to recap for those who might not be as familiar with working with refugees and newcomers.

Some of the barriers they face are lack of access to cross-cultural health services. What we mean by that is that access to interpretation or to translated written materials that you guys talked about. Not only access to interpretation, but that it's culturally appropriate interpretation, and that the interpreter is trained in how to be a medical interpreter. You guys talked about the issues with insurance, finding care after the initial medical screening, trying to follow up with a specialist, difficulties navigating the fragmented and unfamiliar U.S. health care system, the variability of what resources and benefits are available to people based on their immigration status or where they're located.

SC: You guys noted the lack of access to transportation, the cost. Then we also talk about how there's factors outside of the immediate health care system that also create barriers, such a—health is just one part of settling into a new country and just one part of many competing priorities that a person might have in their early resettlement period. They're also maybe trying to learn a new language or trying to find a job, or getting their kids enrolled in school. They might not have a lot of social support that they were used to in the past, with family members who would help.

Health just isn't always the top priority for people when they're first coming. Then also, as you guys noted, newcomer communities might have different expectations of the health care system and of what preventative care means or how important it is based on what they experienced in other countries. They might not trust the health care system. Then, on top of that, if newcomers have complex medical or mental health needs, the barriers can be quite significant. On the next slide, we're now going to go to a case scenario with a fictitious client named Claudine to help us think through some of the points we'll cover today.

SC: Claudine is a 35-year-old woman. She's from the Democratic Republic of the Congo. She arrived in the U.S. as a refugee six months ago, and she has four young children. After completing an initial health screening, Claudine begins experiencing ongoing stomach pain. She receives a referral to a specialist, but no interpreter is present during the visit, and the instructions are not translated. Unsure of what the referral means or how to schedule the appointment with the specialist, Claudine does not follow up. Although she has health insurance, she's unsure what it covers and how to use it, and so, instead, she continues to focus on her more urgent priorities, which includes enrolling her children in school and finding a job.

However, her stomach pain continues, and someone from her community suggests an over-the-counter remedy. We're going to go back to the Slido, and can you please let us know by voting on these choices, what are some of the barriers that Claudine is experiencing in accessing health care in this scenario? Yes, one of the big barriers is access to linguistically appropriate materials. She didn't have an interpreter for the appointment. They didn't translate any of the instructions or follow-up for her. Competing priorities. She's trying to get her children enrolled.

She's a single mother, so she needs to find a job and support her family. Navigating the U.S. health care system is definitely an issue. I'll give people one more second. Yes, looks like the biggest barrier you guys see is the access to linguistically appropriate materials. All right, thank you. I will now turn it over to our speaker, Tavia, to discuss some different terms in care navigation and how providers have been able to help clients overcome some of these healthcare barriers that we just talked about. Tavia, over to you.

2. Care Navigation Models: Selecting the Best Approach to Addressing Challenges in Your Own Work

TMW: Thanks, Sarah. As Sarah just mentioned, we are going to launch into discussing some ideas and strategies you might use to address health care navigation barriers with people who prefer a language other than English in newcomer communities. Next, we do have another discussion question using Slido. If you could please answer the question, what strategies might you use to address health care navigation barriers with people who prefer a language other than English in newcomer communities? Interpreter services, yes, trained interpreters.

You could use role-play scenarios, set up an interpretation program. Seeing a lot of interpretation here. Patient advocates and orientation. Yes, absolutely. Multilingual resources on key information like finding insurance and providers. Matching a community health worker that meets the patient's cultural and linguistic needs. Teaching providers how they can utilize an interpreter over the phone. Referring a client to providers that match their needs. Absolutely. You all have provided a lot of strategies here that could definitely help with addressing health care navigation barriers.

TMW: Then, before we move on to the actual panel presentation and presenting different models of care navigation, we did want to go into terms that we will utilize throughout these presentations. The first term is community health workers. Community health workers work in communities, and they work outside of a fixed

health care system. They assist community members in adopting health behaviors, and they also provide health-related outreach and advocacy. Community health workers generally receive training related to the tasks that they perform. Historically, they do not have professional certificates or degrees.

The next term is patient navigator. A patient navigator is a member of the health care system, and they're also part of the health care team. They guide patients through the health care system and help them to overcome barriers that prevent them from getting the care that they need. Their primary role is really to address those barriers. They also coordinate patient care, connect patients with resources, and help patients understand the health care system. Lastly, cultural navigators. Cultural navigators 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, and they're often members of the communities themselves.

TMW: They are uniquely positioned to bridge cultural and linguistic knowledge gaps for health departments. The three different models of care we will be discussing today are patient navigators in a safety net health system model, cultural navigators in the public health model, and patient navigators in a pediatric refugee health clinic. Our first presentation is myself, Tavia Mirassou-Wolf, and I will be discussing the cultural navigation model for public health. In the public health model, we engage cultural navigators for public health initiatives and public health interventions.

Specifically, from a state health department perspective at the Colorado Department of Public Health and Environment, I'm going to be breaking up the roles into four main categories. I also want to mention that this model can be adapted for local public health agencies and other agencies that are conducting public health activities, especially response activities. First, we contract with community-based organizations that organize cross-cultural outreach and educational events and campaigns. Our contracted community-based organizations also recruit and hire navigators who are really embedded in the community.

TMW: Secondly, we engage cultural navigators in public health interviewing when it's been identified that there could be a cultural barrier. More information regarding this aspect will be provided on the next slide, where I'll go into more depth regarding the role of a navigator in a public health interview. Third, cultural navigators attend community clinics and provide support for public health efforts that may include providing support for testing, vaccination, and outbreak response. This generally looks like a navigator partnering with the public health team to educate community members on why a specific service is important, and also to help provide a warm handoff to the public health team.

In some cases, we've seen more uptake of services with navigators being the first ones to connect with community members. Navigators often will answer questions and utilize motivational interviewing to better understand what hesitations may exist and where the hesitations are stemming from. Some examples of this might include misinformation, not having access to information in the community member's preferred language, and fear of engaging with a governmental system. From that point, if a community member wants more clinical information or if they're ready to

receive services, the navigator can provide a warm handoff and an introduction to the clinical team or the public health team that's on site.

TMW: Lastly, we bring in navigators to really help strategize with public health teams, which might include reviewing and/or providing input on public health messaging, public health outreach, and/or data collection strategies. I wanted to give two examples of how we've engaged navigators on these type of initiatives in the past. One example is that our team has created several promising practice documents [that include] cultural considerations when working on an outbreak response in specific communities. All of those documents and strategies have been fully vetted by navigators, and we've created those with navigators.

Another example I'd like to provide is we were engaged in an outbreak response that was primarily affecting one specific newcomer community. We were able to engage navigators from that community to really help public health better understand what would be the most effective outreach locations and how could we engage in outreach messages that the community would identify with. We really highly engaged navigators in the entire process for that outbreak response activity. Now I'm going to talk more about the public health interviewing aspect of our program. I want to mention that the steps that are on this slide are a simplified version of a graphic that the host put a link to in the chat.

TMW: I highly recommend you opening up that link and looking at it. It really goes more in-depth about the role of a navigator, and how the role of a navigator differs from an interpreter and the public health interviewer themselves. As I just mentioned, it is really important to note that navigators have a distinct role in the interviewing process. Navigators are engaged to really help build rapport and build bridges between community members and public health teams. They can help public health teams better understand if there are any cultural nuances that should be considered.

While interpreters provide word-for-word interpretation, navigators can really help word those messages in a way that is easier for community members to understand and also in a way that is more culturally appropriate and relevant. There are a few different models for engaging a navigator in a public health interview, which can include having a navigator on the interview call, and/or providing a pre or a post-call. The pre-call really [is] to help introduce the public health team and to help introduce the goals of the public health interview. Then the post-call is really geared towards clarifying any concepts and/or gathering additional data that might have been missed during the interviewing process.

TMW: While it's really ideal to engage navigators from the very beginning of the interview process to help build that trust and that rapport from the beginning, we've also seen several successes connecting with community members and gathering important information when navigators are engaged after the challenges have presented themselves. One example I wanted to provide of this specific scenario is, during an investigation of a measles case in a specific community, a navigator was engaged toward the middle of the process when the public health team was really about to lose trust and communication with the religious leader that they were working with.

TMW: The religious leader was the gatekeeper for the community. However, through engagement of the navigator, the public health team learned key information about beliefs of the community, one of which being that this specific community didn't really think that measles was an urgent situation because, in their country of origin, they stated that people got measles all the time and there was never engagement from the government. They were really confused and fearful about why this was such an urgent situation. This information, along with other information that the navigator presented to the public health team really helped build trust between the community and the public health team and really helped them to work together to address the current situation.

You can go ahead and highlight all of those steps. I'm not going to go directly into the steps, but really just to provide the information that I've already provided regarding the role of a navigator during the interviewing process. Then I wanted to speak a little bit more generally about what a day in the life of a cultural navigator might look like. This question is actually pretty difficult to directly answer because it drastically depends on what's going on in the public health situation of a given area. It also depends on how the person is funded and funding allowability.

TMW: Generally speaking, during an outbreak scenario or situations, majority of the time will be spent supporting outbreak response activities and efforts. However, without an active public health response going on, they may spend 50% of their time supporting immunization clinics, maybe 25% of their time doing independent community outreach, and 25% of their time providing consultations to public health teams. Our program is currently federally funded. However, we are looking at other methods of funding as well. Then, to speak a little bit to the challenges and successes of our program, one of the largest challenges is definitely funding and really diversifying funding to allow navigators to work on a variety of different activities.

Then another challenge, which has been maybe a more surprising challenge, is really engaging public health teams and advocating for why it is important to engage a navigator, particularly at the very beginning of a public health response. Just making sure that public health teams know the role of a navigator and the value that they bring to those response activities. Then, in terms of successes, we're really excited to be connecting with so many different communities and so many different community members to start building trust and engagement with public health as a whole.

Then, lastly, we are working on a full evaluation. However, we've received a lot of feedback from both public health team members and community members that engaging with a navigator has been extremely helpful and has resulted in better outcomes. With that, I'm going to turn it over to Adrian, who will be speaking about a patient navigation model in a safety net health system.

AM: Thank you very much, Tavia, for a wonderful explanation. Now I will be talking more about our system here in Colorado, Denver. Basically, our navigation team has over a decade of experience providing multilingual, culturally-responsive navigation for primary care patients with a preferred language other than English, PLOE, and with refugee health screening, forensic medical, and mental health asylum evaluation, immigration medical exams, including quality improvement initiatives and

enterprise-wide cultural consultation. More than 50% of our team is staffed by individuals who reflect the community that we serve, prioritizing the recruitment and the training and also advancement of team members who share the lived experience, languages, and cultural background of our patients.

AM: Our interdisciplinary team consists of navigators, project specialists, clinicians, strategists, and administrators. We collectively speak Amharic, Arabic, English, French, Karen, Kikongo, Lingala, Mai-Mai, Somali, Spanish, and Swahili, and we totally represent five countries and [have] invaluable cultural insight and also community connection. I will go deep [a] little bit to explain here. Our navigators are a hybrid between a health care navigator and a community health worker. The navigators are usually embedded in health system, are more clinically integrated and focused on individual medical navigation, and are less likely to be from the same culture or community as the patient.

Our CHW system operates within the community, and we focus on public health, education, and social support. Our navigation does both by being from the community that we serve. That means our members are coming from the community, and most of us are trusted member within the community. We speak many of the languages that our patients speak, and we share similar life experiences. Most of us came as refugees. That means we are more suited to be the cultural bridge and also assisting the patients in alleviating all the barriers that they face.

AM: Also, we are being fully trained and integrated into the health care enterprise structure while we focus on both individual and public health interventions. We focus more on health navigation for patient with a preferred language other than English. First of all, we have been providing health navigation on a topic like latent tuberculosis infection, LTBI in short, by assisting the patients who have doubts about the treatments and also hesitation and also having issues with stigma because we have been trained, and then we provide culturally sensitive phrases or wording that will help the patient to make a critical decision on the treatment.

Also, the health navigation will continue on providing medical home and special connection to those who need. That means connection to medical home for newly arrived refugees and other patients with PLOE, ensuring they have access to ongoing health care while reducing the barriers to that care, while also we encourage them to be self-sufficient. Despite the current changing to federal funding and policy, we anticipate a number of SIVs, [meaning] Special Immigrant Visa individuals who will be resettled here in Colorado and will need a screening exam and also a connection to ongoing care.

AM: As a team, we have provided more than 13,000 [non-English speaking] outreaches during the pandemic COVID-19. Then that helped us really improving the vaccination rate because when COVID-19 came up, most of our population received the second-hand messaging that was already distorted, and then they didn't have any trust about the vaccination. As a team, we came up with different wording, and then we did outreaches. Then, at last when the vaccine came, when we went back and then talking to them, they were more open to accepting the messages, and also we have seen a variation between the first quarter of those who were vaccinated.

AM: The [non-English speakers] had a lower margin, but after our intervention about our culturally responsive navigation, most of them, the non-English and non-Spanish speakers, they had a higher rating. That was really a success, and also our health navigation provides INS exams. We coordinate the I-693 exams for eligible Afghan and Ukrainian humanitarian parolees who are seeking to adjust their status here. Lastly, we also provide cultural consultation. We have been consulted in developing vaccine safety materials that will be suitable for those who don't speak English or Spanish, based on using a culturally appropriate rewording that will make the parents at ease to really decide if they would like the vaccine or not.

We also developed a special population handbook on what to do in case there is an outbreak. All these things, we have been consulted with, and also we came up with a TB, a tuberculosis tip sheet in showing what languages to [use] when you are just in front of a patient who is not from here. I remember one of the Congolese refugees when he was told that, "Oh, you have the germs of tuberculosis in you," then he [started] panicking. For him, it was severe. He could not think that he has it, but after I went in, I explained to him what it means, that means the germs are just sleeping, in a language that he understands better, he felt at peace.

AM: After that, he accepted the treatment, and now he was really, really happy at last. Also, we provide health messaging, what to do, or whenever you need care, how to receive the messages that will guide you on a good path to access care. Also, ask where, if you have a question, who to contact and where to get the correct information. Lastly, we also developed some individual patient situations, taking into account, and all these social determinants of health are completed. Because for a new refugee who has some health issues, but seeing that he has to pay the rent, he has to take children to school, what is the priority for him?

Most of them, they prefer to go to work, neglecting to reach out for their own health. We have to take into account if all these social determinants of health are all met for a patient, or for a refugee or non-English non-speaker patients has to decide upon. For now, I think I will stop there. I will pass it to my colleague, Charmaine, who will talk little bit about the program. Thank you.

CJ: Hi. Thank you so much. How is everybody? It always feels weird when we're remote. I'd like to talk about our clinic, which is Valleywise Refugee Pediatric Clinic in Phoenix, Arizona. Talking about CHNs, our CHNs, we have five CHNs in our clinic. Between the five of them, they speak Arabic, Swahili, Kirundi, French, Kinyarwanda, Burmese, Thai, Karen, Dari, Farsi, Pashto, Rohingya, Somali, and Mai-Mai. We have quite a lot. With those languages, we are able to help so many people by having our cultural health navigators. I always say they're like my walking angels because they're navigating.

They're not just interpreting; they're navigating this crazy health care system that we have in America. They're helping families when they're newly arrived, first coming in, where to go, where the elevator is, even. It can be so confusing and so overwhelming. By [being] able to use our navigators, it helps track them. My first slide that I want to talk about is some data that we'd actually-- I don't know if it's popped up or not. I don't know if I can get it to pop up. There we go. Thank you. Some examples here of what the benefits have been from having our navigators.

CJ: We track this through our EMR system, which is EPIC. We use EPIC, which I think EPIC is phenomenal. I know not all hospital systems, and especially clinics, they're not going to have that. If people can then track it themselves, especially if you're trying to get funding for having a navigator, because I know that's the biggest battle, especially now with getting funding for anything nowadays, it's hard. If you can justify the reasoning for having cultural health navigators, I think something like this can actually present it very well, because it has reduced our no-show rates tremendously.

I know for a lot of clinics, hospitals, that's one of the big barriers with refugees is showing up for appointments, transportation issues, all of these things. As you can see in this slide, where the pros are, as you can see across the board, and we've been tracking this since 2017, is showing that having a cultural health navigator's assistance has just improved our no-show and decreased our no-shows tremendously. For example, when I think about how our navigators assist our families, let's, for example—and I'm pediatrics, so we have a mom who's reaching out to my navigator because baby is sick.

CJ: They get ahold of the navigator. The navigator goes to my triage nurse and says, "This is what's happening with the baby." The nurse talks to my navigator, and Mom gets more information. Let's just say we need baby to come in today to be seen. That navigator is instrumental because they're then going to arrange with the transportation through the health plan. They get the taxi arranged. It's seamless for the families. They're able to go right outside of their apartment complex or their home, get in that taxi, come right to us. Especially if they're newer arrivals, we meet them down at their appointments, bring them up for that visit, which again, they're showing if it's something more emergent, we're able to assist them with emergency services or bringing them over to our emergency room.

There's various aspects that really help our families when it comes to having that navigator. Another great thing that helps as well is our navigators are able to help if it's a medication issue. We give medications, which can be so confusing to our families, especially if you're a newer arrival and your child's on four different medications. That's confusing for the family. It's confusing for me. We're able to bring those prescriptions in. We can color-code those medications for the families so they have some understanding of how to give them, when to give them, and make it seamless for them.

The other benefit, too, is again that no-show rate. It's just so instrumental for our families. If I can get to the next slide. Next slide. Oh. Okay, maybe not. [laughs] I'm sorry. I thought I had another slide after here. Sorry. Oh, there we go. One of the things that I think is also so helpful is our trained interpreters. We can have trained interpreters, but again, sometimes it's hard to find trained interpreters. Sometimes we use family members. Again, that's not ideal, but if you have to, you have to by law, sometimes we have to, and that helps our families. I would say, if you can get a trained interpreter, please make sure that you're using what's appropriate for our families.

CJ: Also, make sure that our families are understanding all aspects of their care. When they come in for their visits, they're coming in confused, and having that interpreter is going to help build that trust with our families, making sure that they

really understand what's going on with their care, where they can ask questions, they can feel comfortable. That's where the navigators are key to all aspects of having a successful visit, and for them to follow back up for their appointments. Hopefully, that gives you a little bit more clarification with having our cultural health navigators. Moving forward, I have a few more slides after Adrien speaks again. Adrien?

AM: Yes. Now I would like us to record the scenario about Claudine that Sarah has presented based on all these scenarios you heard from Tavia, from Charmaine. Basically, she's a single mom with children and also had difficulties with navigating. After learning about all these navigation types and programs, what different care navigation techniques could have been used to support Claudine? You can go back to your Slido, and then you can put your comments, and then we'll see.

[pause]

AM: Yes, we are still using the same Slido that we have been using from the beginning. The question is what different care navigation model techniques could have been used to support Claudine better? Interpretation system. That's one of them.

[pause]

AM: Interpretation, assisting her with a cultural navigator. That's correct.

[pause]

AM: Teach back. Providing outreach and using a qualified interpreter in translating material. Identifying her for interview, and also giving priority to language support and checking for understanding and the paperwork in a primary language. Language learning solution. Health orientation. These are really good points that you mentioned. Number one, I would like to focus is prioritizing the language support and checking for understanding, and also using assistance while scheduling, and making sure that the patients understand.

Also matching Claudine with a navigator who understands the language and also the culture, and also identifying the barriers. Yes, I think all these points are very important. Now I will pass it back to Sarah and who will go ahead-- Sorry, my video was off, and who will continue talking about how to overcome the PLOE care access barriers. Thank you very much. Sarah, it's your turn.

3. Overcoming PLOE Health Care Access Barriers: Applying Lessons Learned to Your Own Work

SC: Thank you so much, Adrien. Now those are really inspiring examples of care navigation models and action. I know every time I hear you guys talk, I just wish we could take what you're doing and replicate it across the country. We're now going to think about how can everyone in the audience apply care navigation in your own work. We first have a question for you. If you can go back to your Slido and let us know in your experience, what are some of the challenges that arise with trying to have health care navigation models?

SC: You might know this from experience because you have your own health care navigation model, or maybe you were listening to Adrien and Charmaine and Tavia talk about their models and how you would want to implement it in your scenarios, but maybe there are some challenges you were already thinking of. Just let us know what are some of the challenges you could foresee. Confusion about roles. Yes, I was thinking that too, especially if you're using both interpreters and cultural health navigators. Insufficient support, expenses, figuring out where to have them in the workflow in the refugee clinic, stigma, funding.

Yes, it's definitely a big one. Comfort and trust. Transportation. What does the reimbursement look like? Timing, miscommunication about requests. Yes. Stigma. No interpreters for certain language. Like Charmaine mentioned, sometimes you do your very best to find an interpreter for a language, and it's just a very rare language. It might be hard to find a cultural health navigator. Communication between the care team, insurance. Figuring out is it one-to-one or is it with the whole family. Yes, and needing to maximize efficiency.

SC: The varying training requirements, more training in health care. Yes, thank you. These are all great examples of some of the challenges that you face when you're trying to implement something like a community health worker or cultural health navigator. All right. I'm going to turn it back to Charmaine now. She's going to talk a little bit about some of the keys to success for care navigation.

CJ: Again, back to our beautiful navigators, our little angels. As I had shared before, about not wanting to use family members, personally-- If you can click that slide and get the little things to pop up, that'd be great. Using trained interpreters, obviously, that's ideal. No babies, no kids to interpret. I think a big factor that really helps is collaboration. Collaborating with other agencies, other hospitals. If you're a clinic, other clinics that you're referring your families to. Getting a sense of community with other providers.

If it's an imaging department, if it's a pharmacy, dentist's office, anywhere that you're sending your families, making a personal contact with these places that you're referring your families to, it's a lifeline for your families because it can be so confusing and overwhelming for them. Sometimes, just having one person at a facility that can help navigate them if they see them lost, if they see them struggling, can really be instrumental. I would definitely say trying to get your families, or not your families, but getting your communication with any of these resources will definitely help you.

CJ: Partnering with those agencies, like I said, those hospitals, dental offices, it's a key for your success, absolutely. Communicating with your families. Building trust is another big factor for our families. When you're helping them with transportation, you're helping them in those key moments that they need help, they need to get seen for an appointment, they need any assistance that we're able to help them with for their health care needs. The prescriptions, helping them understand how their prescriptions work, really sitting down with the families and putting that extra time in, helps them.

CJ: When you're building that trust with them, what happens is when there's maybe an issue that comes up, that they're a little apprehensive of a procedure, "Am I

needing this medication," because sometimes our families say no to things, but it's because they just don't understand, and they don't have the trust of the person. I'll give you an example. We had a baby who needed a G-tube placement, and we got a new GI provider. Because she was a new provider, she hadn't built that trust up with our mama, and the baby needed this G-tube.

When the doctor went in, Mom refused immediately, "No, I don't want it. We'll figure it out," where this is a life-saving procedure that this baby needs. Mom was very adamant on not having it done because, again, she didn't really feel that trust with that provider. Once myself and my team went in, she saw us, she saw how we-- She knows us. She felt comfortable with us because we built that trust over time with her. Once we then sat down, explained it to her, then the fear subsided, and she was able to then go ahead and agree to having this procedure done.

CJ: That's where trust really comes in key. Again, building that trust starts with the little baby steps of helping them with the transportation, helping them with the medication refills, helping them with any little thing that they might really be struggling with. I always say this when I'm teaching to outside clinics and other facilities, our families get confused with just something simple as our medications. Think about AM and PM. Give this medication in the AM and PM. What does that mean? [laughs] It can be so confusing. Sometimes you have to change your verbiage of “when the sun comes up,” “when the moon comes up.”

You have to give different examples that's going to make more sense for our families and really get them to understand what's going on. Having, again, that communication and that trust, making sure that families understand you're there for them, being informed, informed health for having great outcomes, it's having that communication. When they have that trust, they're going to share more with you.

CJ: Sometimes, asking questions-- It might seem redundant sometimes, but not everybody understands the question the same way. Sometimes you've got to also come at a question in a different format, explain it a little bit different. I think of another example where a mom was coming in for a regular appointment, and she had expressed that they were really hot in the house. We dug a little bit deeper, where a lot of people would have just brushed over it and said, "Explain to me what you mean."

Now, we live in Arizona, so Arizona gets up to-- I think we're 110 right now. We can get up to the 120s. We're asking these questions. "What do you mean by it's hot?" Come to find out, their air conditioning had been out. They had a special needs child, and their air conditioning had been out for two months. The apartment complex had not been assisting with this complaint, which once we found this out, I called, and we got the solution solved.

CJ: Again, it's finding out what's going on with your families and really digging in and trying to find out what's going on with them in all aspects and all levels. If you can go to my next slide. Thank you. Again, by doing all of these things, you minimize so many issues with our-- Oops, I think I just lost my camera. Oops. Sorry, guys. By doing this, we can minimize so many effects that can happen. Having those improved patient outcomes, that's key for families. Making sure that the navigators

really understand what's going on with our families helps tremendously in all aspects. Now I'm going to turn it over to Sarah.

SC: Thank you so much. Now it is your all's turn to ask speakers. Oh, first, sorry, we have one more Slido question for you. What did you learn today that you can implement in your context? We're curious to hear. I'll give everyone a minute.

[pause]

SC: Thinking outside the traditional box. I like that. Connecting with the navigator to help families overcome language barriers. The importance of trust. How appropriate advocacy is. Expanding collaboration and communication with CHNs and families. Importance of interpretation. Yes, it's so important to work with a trained interpreter. Evaluating no-show rates has been on the back burner, good reminder to prioritize it. Yes, often collecting the information around impact is hard. It is helpful when you're trying to showcase how important your programming is. Recruiting navigators and outreach to the communities is key. Yes.

Thank you, everyone. Now it's your turn to ask any questions you have for the speakers, such as if you want to talk more about some of the challenges you guys brought up on the previous Slido, or if you want to hear more about a particular program. I know we have two questions already submitted. I have one, which is for Charmaine. The person would love to hear more about your workflow structure and or any visual tools you've used with your patients.

CJ: Oh, I have lots of visual tools. [laughs] I don't know if I can send them to you guys and you guys can post them on anything, but I do have like little stickers that I use for their medications. I have some other visual-- Medications is a big one for sure, that I could definitely pass along that have the pictures with the sun, the moon, when you give the medications. What was the other part of that question? There was two parts to that.

SC: Your workflow structure, I guess, in terms of the CHNs, like at what point are they engaged?

CJ: They start from the beginning with our families, and because they're also part of the community, that's a big help as well. It's word of mouth. With a lot of our community members, they know each other, they know, "Hey, you got to go here." Again, our resettlement agencies, when they're first arriving, the resettlement agencies, that is another key partnership that we have. Our families, once they're seen at the county health departments, public health, they then pretty much, for most pediatrics, they come to our clinic. From there, they're immediately tied into their, based off of their language, a cultural health navigator.

From that point, initial arrival, they will be communicating with them. They communicate with them via WhatsApp, because I know that's another big barrier for the phone system for our families is they won't answer regular calls or calls they don't know, but they're familiar with WhatsApp. Getting our organization to tie on with that was a big piece of this, having that WhatsApp. Our cultural navigators have their own phones for our hospital, and then that way they're able to communicate with our

families. That's definitely a big plus. Then from there, they're going to work our streamlined process flow. Good question.

SC: We have another question around, regarding the roles such as cultural navigators, patient navigators. The person is wondering who is qualified to assume this position. Are these social worker roles? Tavia or Adrien, I don't know if you want to talk more. Adrien, I think you've talked a lot about the-- In Colorado, there's a test you have to take now, right?

AM: Yes. Yes, there's a test to become a CHW. It's going on, and I've already passed the test. Once you pass the test, you are now on our public health registry. Soon, once the program will be launched, so CHW will be able to charge Medicaid for services. I think [Tavia] will give us more information about that.

TMW: Yes. To add on to that as well, I know it varies per state for the training and certifications that you need to be a community health worker. Colorado has decided to lump all the terms under the umbrella term of community health workers. These navigators, et cetera, et cetera, are actually now all considered community health workers. There's been a lot of efforts, which Adrien talked about, to get people to be certified community health workers. What I will say is that this has definitely been an evolution, at least over the time that I've been in this role, which is four and a half years. It's probably been going on even longer than that.

Specifically, to cultural navigators, many-- We have one cultural navigator that's actually hired through our Department of Health, and the rest of our navigators are contracted through community-based organizations. They really have a wide array of experience. What we're really looking for are individuals who are embedded in the community and who have experience working with community members, along with trainings in motivational interviewing and different things like that.

We really rely heavily on our community-based organizations to identify people who are qualified to build trust in the community and with community members. Then we provide the specific public health-related training. Historically, it's been COVID. We also have now integration of immunizations, both for COVID and routine vaccines. We've been able to provide those add-on trainings that are more specific to the public health intervention that they're working with public health teams on. I think it just depends on where in the country you are and what specific entity you're working with.

SC: Thank you. Charmaine, do you want to add anything about how you guys train your CHWs?

CJ: Yes. We have similar testing within our hospital system. For our CHWs, our Interpretation Services Department has a pretty large testing curriculum. I'm sure it's similar to what Colorado is doing. I think that's amazing what Colorado is doing. I'm actually writing notes myself here because I think that's awesome that they even have maybe a billing piece, it sounds like, that you guys are doing. I'd be very interested in learning a little bit more on that. I might be reaching out to you guys regarding that. I would say ours is smaller compared to Colorado's for sure.

SC: Right. Oh, Adrien, would you like to add anything?

AM: Yes, I would like to add in on the question that Charmaine answered earlier about the contact about navigation.

SC: Sure.

AM: For our team, basically, once refugees are scheduled for [a] domestic medical examination, and the navigation team, one of us will be in contact before even they reach the clinic, making sure that they know they have appointment, they have transportation, and if language is needed, what language and what dialect, because some people might speak Arabic, but they would love to speak Arabic from Darfur, Masalit, or Zaghawa. We need to know all this ahead of time in order for us to prepare for an interpretation. The navigation piece goes on. Each family will be matched with a care navigator who will see them through until after the DME is over.

Also, we basically slow down once they are connected to the medical home, because after the screening is over, we need to make sure that they come back for follow-up based on what the screener will recommend. If it is after one month, after three months, after six months, we need to stick with them until these appointments are scheduled and transportation is provided, and also they have the language support that they need. If they have some specialty needs, and then we have to make sure that these families are connected to the specialty care clinics by making sure that they are scheduled, and also they go through.

If they miss, at least we can go back once or twice to review what is the reason, and then most of the time, "Oh, I found a job." We tell them that once you find a job, if you already have an appointment, take that appointment paper to your manager and say that "I have an appointment at this time" because your health is important, and they will give you a day off on that time. This is how really we successfully provided good services to our families. Thank you.

SC: Thank you. Also, going back to the last question about who is appropriate for these roles, are they social workers? I know the examples we have today is from a public health department to clinics where they have a wonderfully formalized role for community health workers. Just reassuring people in the audience that also resettlement agencies and community-based organizations have also implemented community health worker models very successfully, where the person you choose for the CHW doesn't necessarily have to have formal social work or health care background, but it's more about what is the initial training that you're giving them, and then also what support and supervision are they provided with as they are doing their roles.

I'm sure all of our speakers would be happy to share thoughts and materials if you guys are thinking of trying to do a CHW model, but you're not necessarily with a clinic. We have another question about how do you avoid duplication of work or coordinate with outside partners like case managers at resettlement agencies? Anyone want to take this one?

CJ: I would say communication. Communication is key to make sure you're not having-- Because we have had situations where maybe a caseworker wasn't sure that the family was being seen with us and put them over at maybe our children's

hospital, and the families are then confused. It causes chaos in that aspect. That's why definitely we do a referral system that is in place now.

When a caseworker from the resettlement agency has new clients, they then send a formalized referral to us, stating, and with all of their documents from the county health department. We have everything in hand to try to alleviate those *oops*es that happen along the way. Again, I think communication, making sure a referral process is in place, will help alleviate those errors that can happen.

AM: Yes. I think I can add into that. I think to avoid a duplication of services, and I am really grateful to have EPIC. It is very good. The key point here, it is documentation. Once you are assigned to see the family, everything you do, you should document, because anyone who will come after me for that, if I'm not around, I am on vacation, my colleague can come back and look at the notes and see what services are provided and what is needed.

Then from there, we can go, so that we don't call the same person twice, and then some people they get mad, especially with our TB program. We need to make sure that you look at the documentation, you review the chart, and see what steps has been done, so that you avoid duplicating. Thank you.

TMW: Just a quick note on that, from the state health department perspective, we have definitely worked in collaboration with resettlement agencies to have messaging delivered. For example, if we need to deliver messaging regarding information on Ebola, a newcomer coming from a place that was affected by that, we've worked with resettlement agencies, so that the case manager can help us with that communication, so that they are not also receiving this information from public health departments.

We really do try to ensure that we're working with partners that are already connected to newcomers to really help alleviate incoming communications and then also any confusion that might happen there. Then also, when it comes to trust, those case managers likely already have that trust with these community members.

CJ: Yes. I'm going to jump into that little piece at the end there that you said, Tavia, because that is key too. We also are partnered with public health. If there's situations where they need to be seen right away, there's some health concerns, that communication, again, is fluid between public health and ourselves, for sure.

SC: Thank you. We have another question about have you heard of any remote cultural navigator positions? Have you ever successfully used that, or is it all in person?

CJ: Ours are all in person. We have interpretation services for some of our rare languages that we can't have our in-person interpreters for. I will say it's not as successful. Having that one-on-one in person, it's a game-changer, for sure.

AM: Yes.

TMW: Yes. The nature, I'll just-- Oh.

AM: Go ahead.

TMW: Do you want to go first, Adrien?

AM: Yes. With our team, I think we do have the hybrid system where we go to the clinic whenever there is a medical screening going on, but most of the time we do navigation remotely. We work from home and it has worked so fine. There's no problem. Thank you.

CJ: I think that works specifically too for each type of clinic, because you're with public health, I think, when you're now in your medical care home, having that in-person work… I think it's going to be based on each system, almost, a clinic or hospital setting.

TMW: Yes, I agree with that, Charmaine. I'll say, from the public health perspective, it depends on the activity, like what you were saying. If we're having navigators attending a vaccination clinic, they would need to be in-person for that to really connect with community members. They're doing education and outreach that needs to be in-person. However, we have worked a lot with navigators virtually, like if there's a public health interview being done over the phone, and or if we are working with a navigator on outreach messaging, or having them review some things that we have proposed, we will do that virtually. It really depends on the activity.

SC: Thank you. We have time for one last question, which is around reimbursement. This person wants to know how do you address some of the uncovered clinic visit if the insurance is not covering all of the visit for the community health worker, or cultural health navigator? Do you guys not experience that? I know Colorado, you guys are in a golden state where it is covered by Medicaid, right?

CJ: It's great that they have that covered. I think for us, we're at FQHC, so it's all one cost. Again, our hospital is funding our cultural health navigators. Initially, when we started our clinic in 2012, it was grant-funded. That's how we started, for probably about eight years was fully grant-funded for our cultural health navigators. Then our hospital system realized what benefit our CHNs were, and so they put them into our actual hospital system funding-

SC: Oh, nice.

CJ: -which is nice, yes.

SC: Thank you, everyone, for your questions. That's all we have time for today. We hope that you were able by joining this webinar to identify the key barriers that refugee and newcomer communities are facing, that you've been introduced to maybe three different care navigation models that you might consider implementing in your own work, and that we've helped you think through how to overcome some of the challenges with implementing these models and overcoming healthcare barriers.

Before we end today, just a request to please, please take a moment to fill out this survey. We promise it's really, really quick. You can do it by clicking on the link in the chat or scanning the QR code on the screen. This helps our lovely partners at Switchboard with their trainings. I will just wait a minute to give you guys a chance to complete the survey now, if you can.

[pause]

SC: Lastly, here are some resources that you might be interested in that the Society wrote with Switchboard. It discusses overcoming health care barriers, tips for collaboration with health care providers, et cetera. Then lastly, for more training and technical assistance, please stay connected with Switchboard. On the screen are the different ways you can contact them. On behalf of the speakers today and the Society of Refugee Healthcare Providers and Switchboard, thank you for being here with us, and we hope to see you again soon. A big thank you to our speakers. Take care, everyone.

TMW: Thank you.

CJ: Bye.

TMW: Bye.

AM: Thank you.

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