COMMUNITY CLINICAL LINKAGES
Grantee Examples from NBCCEDP

This documents accompanies two others, the CCL strategy infographic and *Applying an Outcomes Driven Approach to Community-Clinical Linkages: Guidance for Grantees*. It includes grantee examples that align with CDC guidance, specifically:

1) Identifying high-need individuals in the community, facilitating their access to clinical services, and ensuring screening completion.

2) Focusing on meeting individuals through community outreach and partnership.

3) Evaluating through screening completion, using medical records.

It is important to emphasize that these examples are promising, not perfect. Most are in the early stages of implementation or evaluation, or both. Hopefully they can stimulate thinking about how you might implement CCL strategies. So you can learn more, we have included grantee contact information.

We encourage you to leverage the experiences, expertise, and resources of others in your state, tribe, territory, or jurisdiction. This may lead to a more cost-effective approach to CCL. During planning and assessment, identify potential collaborators. That is, collaborators from other programs, organizations, or groups that are both experienced and effective in the community-clinical linkage arena.

CHWs at Health Department Conduct Community Outreach and Refer Women - Nebraska

The Nebraska program conducts statewide outreach through a network of 19 "Community Health Hubs," which are mostly local health departments. Community Health Workers (CHWs), funded through the hubs or local health departments, connect with women in the community and navigate them to more than 400 screening providers. They document contacts and risk assessments for each woman in an electronic *CHW Encounter Registry*. If a woman is deemed eligible for Nebraska's program, the CHW assists her in completing an enrollment form, which is then sent to the program for review and follow-up. The program uses the *Encounter Registry* data to assess the type of outreach or navigation provided to non-program eligible women and determines if they complete screening at one of their provider sites. The program has a CHW training curriculum for program-affiliated CHWs and manages the *Encounter Registry* to monitor community outreach progress. To learn more: Melissa.Leypoldt@nebraska.gov

Grantee Staff Conduct Outreach and Navigation at Community-Based Organization - Louisiana

The Louisiana State University program partners with six *Second Harvest Food Bank* pantries in New Orleans. The program's navigator and nurse practitioner conduct outreach and education, navigating eligible women to four breast and cervical cancer screening providers in the area. Methods for education and outreach depend on the pantry's food distribution operations and may include group and/or 1:1 education activities, stationed in or near the waiting area. The program initially conducted an assessment at each pantry. Among the information collected was the number of women and federal poverty level served, the best days to conduct outreach, the availability of space (for education and outreach), and whether the women had a primary care provider. Since grantee personnel are providing the navigation, they are able to enter data into the program's data management system, Catalyst, used to report MDEs and PN-Only MDEs. The community navigation program will be expanding to additional parishes in 2019. To learn more: Jasmine Meyer, jmeye6@lsuhsc.edu

Tribal Health Educator Conducts Outreach and Clinic-Based Navigators Follow-Up - Cherokee Nation

The Cherokee Nation program serves a 14-county area in Oklahoma. The tribe manages their own health system consisting of nine facilities. Their public health educator conducts outreach at community venues in the 14-county area, including at clinics. She provides the names of women she has met in the community to the clinic-based case managers. The case-managers follow-up with the women to schedule their screening. To learn more: Andrea-Carpitcher@cherokee.org

External Partner, YWCA, Conducts Outreach and Navigation - New Mexico

In the last grant cycle, the New Mexico program implemented a community outreach and navigation program, funding multiple contractors. During this time, the program developed standardized reporting processes, policies, forms, and a short training for these contractors. Among them was the YWCA. Many of the women navigated by the "Y" were identified through their own 20-year database which included over 3,000 women. The New Mexico program and providers could refer women for navigation as well. The "Y" used a voucher/coupon system to determine if women were screened by their screening providers and reported this data to the program. To learn more: Beth.Pinkerton@nm.state.us

Navigators Housed at Program Screening Providers Conduct Outreach, Follow-up, and Navigation - Wisconsin

The Wisconsin program currently supports three navigators that are housed at three health systems including the largest health system in Wisconsin; a health system focusing on rural communities; and the University of Wisconsin's Cancer Center Health Disparities initiative. In addition, another navigator, based at the City of Milwaukee Health Department, serves both NBCCEDP and WISEWOMAN clients. The program also supports a community health worker at the Milwaukee Consortium for Hmong Health. The navigators and community health worker conduct community outreach, follow-up, and navigation. To learn more: Gale.Johnson@dhs.wisconsin.gov

Partnering with the Hepatitis C Program to Schedule Screening at their Outreach Event - Cherokee Nation

The Cherokee Nation program is in the early phases of partnering with the Hepatitis C Program. The latter program is piloting a project to provide education and screening at food distribution centers. Referred to as "food warehouses", low-income people shop for free at these grocery-like stores. The breast and cervical program's health educator and clinic-based case manager will work alongside the Hepatitis program staff. While screening will be provided on-site for various health maintenance screenings such as HbA1c, cholesterol, Hepatitis C, and HIV, the breast and cervical program will schedule appointments on the spot for cancer screening. To learn more: Andrea-Carpitcher@cherokee.org

Facilitating Referrals through Direct Mailings to Women Denied Medicaid - Maine

In Maine, individuals who are denied Medicaid receive an automated letter that identifies alternate state Department of Health and Human Services resources. Monthly, the breast/cervical program receives a list of the denied women, ages 40-64 years, and sends them "direct mail". Approximately 50% of the program's new enrollees identify "direct mail" as the reason they enrolled. This is a low-cost strategy for Maine. While this strategy is not community-based in a physical sense, they are still reaching their eligible population. Please consider this "systematic referral" strategy with community-based partners or those serving your priority populations. To learn more: Maryann.M.Zaremba@maine.gov

Using Non-Traditional Partners, such as Emergency Medical Services.
We heard through the grapevine of an effort with Emergency Medical Services (EMS). On their "down time," EMS workers conduct outreach for the program. If this is your program, tell us about it, so we can learn about your successes and challenges and how women are connected to screening.

KEEP IN MIND…

We hope these examples are helpful to your planning efforts. As you explore these and other strategies, it may be fruitful to consider:

- Developing a three-way agreement between your program, community-based partner, and health system/clinic to link women to screening, and share data and referral information. Public health is a valuable partner to healthcare systems by helping communities access needed care.
- These three-way partnerships may offer a mechanism for continuous feedback and demonstrating outcomes (i.e. obtaining requisite data on screening outcome) and the importance of such partnerships.