



A Proud Member of Sinai Health System

## Avon Safety Net Grant: Sinai Health System Funding Patient Navigation for Women with Abnormal Imaging and Breast Cancer Funded by the Avon Foundation for Women



### What is Navigation and Why We Need Such a Program:

- Navigation is technique used to assist women with overcoming barriers to making and keeping appointments related to breast health.
- There is evidence that breast health navigation in a clinic setting can improve the quality of care and decrease loss to follow-up for mammography screening and breast cancer treatment, which would contribute to improvements in overall health outcomes such as stage at diagnosis and mortality.
- Prior to starting this navigation program women were lost to follow-up after they had an abnormal mammogram. This was know by the staff but never quantified. In addition, women being seen for cancer treatment often had to find their appointments without much assistance. Often those appointments are in different buildings among the Sinai campus. Patients would get frustrated and choose not to return.

### Our Program:

*Purpose:* To improve breast health services by using a patient navigator to facilitate imaging, diagnosis and treatment of breast cancer.

- A Navigator is a Lay Health Educator that is similar to our patients with respect to language spoken, culture and residence.

*What we do:* We assist women with scheduling appointments, navigating through the hospital to appointments, assisting to overcome barriers with such matters as transportation, social support, referrals to support groups, follow-up on all breast cancer diagnoses and treatment planning, etc. We do this by:

- Literally walk patients from place to place
- Assist patients during procedures
- Reduce any controllable barriers, e.g. transportation
- Educate patients about breast health
- Facilitate follow-up and patient centered care, e.g. attend consults, attend biopsies, assist in obtaining referrals for follow-up care and treatment
- Acquire comparison films

### Objectives:

- To reduce the loss to follow-up after the initial abnormal mammogram
- To improve the timeliness of breast cancer diagnosis and treatment
- To reduce barriers to diagnostic tests and treatment of breast cancer

### Outcomes:

- Since 2005 (our baseline year) we have decreased our loss to follow-up rate for women with abnormal mammograms from 33% in 2005 to 7% by 2009.
- We have decreased our loss to follow-up rate for women with breast cancer from 22% in 2005 to 4% by 2009.
- We monitor over 10,000 mammograms each year to identify women with abnormal findings.
- We identify and navigate approximately 100 women with breast cancers each year.
- In 2010, we provided breast health messages to 3,059 individual women.
- We have encountered over 2,100 patients with unique 6,500 encounters for navigation services (e.g.) escorting, referrals, appointments assistance... in the last 6 months of 2010 (Jul -Dec).



## Sinai Pediatric Asthma Program: Helping Children Breathe and Thrive Ten years of Community Health Worker Asthma Interventions in Chicago and Illinois

Asthma is the most common chronic disease of childhood, affecting 13% of children nationally and in Chicago. In some predominately minority Chicago communities, as many as one in four children have asthma as revealed by the Sinai Improving Community Health Survey ([www.suhichicago.org](http://www.suhichicago.org)). Since 2000 the Sinai Urban Health Institute and Sinai Children's Hospital have been working together to reduce the burden of asthma on the communities which the Sinai Health System serves. The following provides a brief description of each of SUHI's four comprehensive asthma interventions and their outcomes, showing the improvement that these programs have made in the lives of several hundred children, their families, and the community. The Community Health Worker (CHW) Model is an integral part of each of the interventions. CHWs do not need to have any prior experience in the field as they are trained by the program to teach children and their families how to more effectively manage asthma. Each of the three completed interventions has been associated with significant decreases in asthma related morbidity and mortality as shown in the table below. Significant increases in Quality of Life, Self-Efficacy, and Asthma Knowledge scores were tested and shown in the later interventions. In short, the lives of the families served by the projects and the CHWs have dramatically improved. A brief synopsis of each project follows in chronological order.

### Pediatric Asthma Initiative - 1 (PAI-1)

Sinai launched PAI-1 in 2000. The central hypothesis of this sequential randomized clinical trial was that the most economic and effective path to maximizing the health status of inner-city children with asthma is through a process of case specific, one-on-one reinforced health education combined with case management services. Participants in all study groups utilized significantly fewer emergency health care services in the follow-up year. Averaged across all three groups, the magnitude of the decline in utilization was enormous. The PAI-1 project also proved to be cost-effective, resulting in an estimated \$4,778 saved per patient/year over costs incurred during the baseline year. This translates to \$13.29 saved per dollar spent on the intervention.

### Pediatric Asthma Initiative - 2 (PAI-2)

In 2004, SUHI and SCH implemented an intervention which sought to: (1) decrease asthma-related morbidity; and (2) improve quality of life. CHWs visited the homes of clients 3-4 times over a six month period. The CHW also served as a liaison between the family and the medical system, encouraging caregivers to regularly see their child's primary care physician. Our findings suggest that the intervention results in cost-savings of \$5.58 to be saved per dollar spent on the intervention. Our findings suggest that individualized, one-on-one asthma education provided by a trained, culturally competent CHW in the home environment is an effective means of improving asthma management among inner-city, African American children with poorly controlled asthma.

## Controlling Pediatric Asthma Through Collaboration and Education: a Statewide Initiative (CPATCE)

The promising results of PAI-2 led the Illinois Department of Public Health to include the PAI-2 CHW model as a key component of a larger IDPH initiative. CPATCE sought to improve asthma management among high risk children in Illinois thereby reducing asthma-related healthcare expenditure, asthma-related morbidity and mortality. Six target areas within Illinois were chosen based on their having asthma hospitalization rates. The expansion required that more CHWs be hired and trained; therefore, SUHI developed an Asthma Education Training Institute to coordinate the training of CHWs. 455 children were enrolled into CPATCE statewide between October 2006 and June 2008. Sinai, Chicago Asthma Consortium, and Decatur sites all saw a significant decrease in urgent health resource utilization and symptom variables. There was also a significant increase in regular asthma clinic visits (Sinai 40% increase, Decatur 32% increase). These increases lend power to the notion that the SUHI CHW model bridges the gap between patients and Primary Care Physicians.

### Sinai Pediatric Asthma Program Intervention Outcomes

	PAI-1	PAI-2	CPATCE (Sinai)	CPACTE (Sinai, CAC & Decatur)
Asthma ED Visits	64% decline*	73.5% decline*	47.6% decline*	62.3% decline*
Asthma Hospitalizations	81.0% decline*	71.4% decline*	50.0% decline*	59.0% decline*
Urgent Health Resource Utilization <sup>^</sup>	67.6% decline*	69.3% decline*	50.0% decline*	66.0% decline*
Nighttime Asthma Symptoms	-	51.6% decline*	63.6% decline*	50.4% decline*
Quality of Life	-	Increased by 0.8* <sup>¥</sup>	Increased by 0.43*	Increased by 0.61* <sup>¥</sup>
Cost-savings/\$ spent on the program <sup>∞</sup>	\$13.35	\$5.58	\$4.18**	-

\*Statistically significant p<0.05

ED = Emergency Department

<sup>^</sup> Sum of ED visits, hospitalizations, and urgent clinic visits

<sup>¥</sup>An increase of 0.5 is clinically significant

<sup>∞</sup> Cost Savings per \$ spent = Healthcare Cost Savings/Cost of Program

\*\* Preliminary analysis

### Healthy Home, Healthy Child: The Westside Children's Asthma Partnership (HHHC)

Ten years of experience aimed at improving asthma management among children has led us to two important conclusions: (1) CHWs are effective in establishing a relationship of trust with the families they serve, and consequently are in a position to comprehensively address the barriers families face in properly managing a child's asthma; and (2) the social and economic issues that impede a family's ability to manage asthma are complex and often require expertise that goes beyond that of a medical professional.

Therefore, in September 2008 with funding from the Centers for Disease Control and Prevention, we initiated our latest and most comprehensive initiative.. HHHC focuses on children with poorly controlled asthma living on the Westside of Chicago. CHWs deliver asthma education in the home environment tailored to the specific needs of the individual families. The home visits focus on improving asthma management by educating caregivers and children to better manage asthma medically, while also addressing the disproportionate presence of asthma triggers in the home environment. Partners in this endeavor include the Chicago Asthma Consortium, Health & Disability Advocates, the Metropolitan Tenant's Organization, and the Sinai Community Institute. A Community Advisory Board comprised of community leaders, representatives, and residents has been assembled to inform the project and its approach. Preliminary results show a significant decrease in asthma-related emergency department visits and missed school days. Final study results will be available in fall of 2011.

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## Helping Her Live Program Utilizes Community Health Workers to Promote Breast Cancer Screening on the Westside of Chicago

Helping Her Live (HHL) is a comprehensive community navigation program funded by AVON since 2007 that aims to improve breast health for all and to eliminate the very large Black-White disparity in breast cancer mortality in Chicago. All of the women we are serving are Black and Hispanic, live in some of the poorest communities in the city, and have little or no access to insurance and routine breast health care. During the last two years HHL has successfully reached over 25,000 women in these communities and linked nearly 1,750 of them to breast health services and mammograms. HHL's accomplishments stem from it being the only program of its kind to approach women "where they are" and by the efforts of our community health workers (CHWs). Our CHWs are women who reside in the communities that we target—North Lawndale and Humboldt Park. CHW's on our project provide outreach and education, enroll women into our program, ensure all women obtain routine screenings, assure that abnormal mammograms are resolved as quickly as possible, and help women obtain and adhere to needed treatment in timely and effective manner.

HHL has begun to serve as a model for navigating women through a fragmented system of health care, particularly for the uninsured. Between 2008-2010, we developed 10 unique targeted channels of communicating with women in two vulnerable communities on the Westside of Chicago. These efforts included but were not limited to 3 broadly defined categories: *Outreach*, including one-on-one canvassing, visiting households' door-to-door, and setting up information tables. *Events* including recruiting women for our planned events and attending health fairs, and *Workshops* defined as small group educational sessions facilitated by a CHW. On average, we encountered 3,000 women a month, recruited 100 of them and assist 30 in their getting a mammogram.

Community navigation has proved to be an effective means of reaching those who are underserved and navigating them through the health care system. It is a model for linking at-risk and uninsured women to preventive services, particularly in light of national health care reform. We are optimistic that a project like this, in some of Chicago's most vulnerable communities, is the way to eliminate disparities in breast cancer mortality and pursue health equity for all.



# Project CURA: The Community United to Challenge Asthma

Molly A Martin, MD; Joann Lugardo, MPH; Dorian Ortega, BA; Adriana Rodriguez, RN

## Project Summary

This is a research study that compares a community health worker (CHW) self-management intervention to standard asthma education in high-risk Puerto Rican children in elementary and high school. During home visits, the family will be educated using a standard asthma core curriculum which is tailored to individual needs, strengths, and beliefs. Our first aim is to assess the ability of the CHW intervention to reduce home asthma triggers and increase medication adherence in Puerto Rican children and adolescents with asthma. Our second aim is to determine if any changes in triggers and adherence associated with this intervention are sustained 8 months after the completion of the active intervention. The efficacy of this intervention will be tested using a behavioral randomized controlled trial design featuring 50 elementary school participants and 50 high school participants.

## Community Partners:

- *Rush University Medical Center*
- *The Puerto Rican Cultural Center*
- *The Greater Humboldt Park Community of Wellness*
- *West Town Leadership United*
- *Women Living with Hope*
- *New Life Covenant Church*

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## Our Accomplishments

To date, 13 local residents received 12-15 hours of training to be asthma community health workers. The curriculum included information on asthma pathophysiology, symptoms, triggers, environmental control, management, integrated pest management and medications. This training also addressed how to approach families and keys to successful home visits.

Project CURA hosted a community forum that featured an asthma disparities researcher from Puerto Rico.

We are now in the process of providing education for 101 Puerto Rican families of children with asthma. All families are offered an educational asthma intervention, allergen skin testing for the children, home assessments for asthma triggers and payment for their time.





## **The Community United to Raise Awareness: Asthma and Active Living (CURA 2)**

Humboldt Park has some of the highest pediatric asthma and obesity rates ever reported. The associations in prevalence and morbidity between asthma and obesity suggest that interventions targeting comorbid asthma and obesity may lead to greater success in controlling both conditions. The Community United to Raise Awareness: Asthma and Active Living (CURA 2) is a partnership between investigators at Rush University Medical Center, Children's Memorial Hospital, and Northshore University Healthcare System and community organizations in Humboldt Park which include the Puerto Rican Cultural Center, the Greater Humboldt Park Community of Wellness, Women Living with Hope, New Life Covenant Church, and the Consortium to Lower Obesity in Chicago Children. CURA 2 aims to develop an intervention for comorbid asthma and obesity in children.

The first phase of this study is to define the intervention using qualitative methods. We will then design and implement a training for community health workers on pediatric asthma and obesity. During Years 2-4, we will conduct three proof of concept studies testing a community health worker family intervention in the home, a school-wide intervention, and a combined home/school intervention.

This study is part of the Rush Center for Urban Health Equity and is funded by the National Heart, Lung, and Blood Institute of the NIH. (1P50HL105189-01, Lynda H. Powell, Principal Investigator)

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# PATIENT NAVIGATION PROJECT

## The Need:

Nationally, there are large disparities in the cancer care continuum by race, ethnicity, socio-economic status and gender. This can be directly traced to late-stage cancer diagnosis and/or incomplete treatment. With the current efflux of the urban poor and new immigrants settling in the suburbs, this research seeks to enhance community based safety nets.

## Funding:

This research project is funded by the National Institute of Health (NIH).

## The Partners:

- Northwestern University  
Department of Obstetrics and Gynecology
- Robert H. Lurie Comprehensive Cancer Center
- Access Community Health Network
- Access DuPage
- DuPage Health Coalition
- DuPage Community Clinic
- DuPage County Health Department

## Co-Principal Investigators:

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## Patient Eligibility:

Access DuPage and DuPage County Health Department Breast and Cervical Cancer clients with abnormal breast or cervical screening tests will be eligible for enrollment in the study.

## Patient Navigators:

Participants will be pro-actively managed by a patient navigator in concert with a health department public health nurse or case manager. Navigators will begin assistance when an abnormal screening occurs and will guide the patient through diagnostic resolution or completion of cancer treatment.

The patient navigation team, in conjunction with the staff from the DuPage County Health Department, will anticipate and resolve barriers to the timely receipt of care. The team consists of two social work navigators and three lay navigators.



## Navigator Responsibilities:

If patients need additional follow up after initial screening, a patient navigator will:

- Provide emotional and social support
- Provide culturally appropriate health education and educational materials and educate patients about tests, test results and treatment options
- Listen to and address patient concerns
- Identify and link patient to supportive community resources

Other Navigation Services May Include:

- Occasionally accompanying patients to health care visits
- Scheduling/ re-scheduling necessary tests, procedures and clinic visits.
- Helping patients find available resources for Transportation, Interpretation, Child/Elder Care, Housing and Financial Assistance.



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## Mexican American Trial of Community Health Workers

The MATCH study (Mexican-American Trial of Community Health Workers) tests the hypothesis that the use of indigenous Community Health Workers (CHWs), recruited from the target community and trained to provide culturally appropriate diabetes education, can promote proactive self-management among inner-city dwelling Mexican-Americans with Type 2 diabetes mellitus. The study aims are to demonstrate that a CHW, compared to an attention control, will: 1) result in improvement in short term physiologic outcomes (Hemoglobin A1c levels and blood pressure), and 2) result in increased frequency of self-management behaviors (daily self blood-glucose monitoring, medication adherence, adherence to diet and physical activity recommendations). The study design is a single site, partially blinded, randomized controlled trial of 144 patients with Type 2 diabetes mellitus.

Eligibility criteria include a diagnosis of Type 2 diabetes, residence in target community areas in the Chicago area, and Mexican or Mexican-American ethnic heritage. Participants are randomized to either an experimental group receiving 36 home visits over a two year period in which a CHW delivered diabetes education and self-management skills training, or to an attention control consisting of 36 bilingual diabetes education newsletters covering the same curriculum as the CHWs. The curriculum covers recommended diabetes self-management behaviors including glucose self-monitoring, responding to abnormal blood glucose levels, working effectively with health care providers, medication adherence, foot care, daily physical activity, and reducing fat content of diet. CHWs also deliver training in behavioral skills of self-monitoring, environmental restructuring, engagement of social support, stress management, and problem-solving skills to facilitate the self-management activities. Consistent delivery of the CHW intervention is documented by audiotapes and Documentation of Intervention worksheets.

For more information, contact Steve Rothschild: [steven\\_k\\_rothschild@rush.edu](mailto:steven_k_rothschild@rush.edu).

Funded by the National Institutes of Health: R01DK061289

ClinicalTrials.gov identifier: NCT01067092

# Chicago Community Health Worker Research and Sustainability Project

**CHW/Promotor Survey and Mapping Project Collaborative:** The CHW/Promotor Survey and Mapping Project Collaborative arose from a priority area in the *Chicago Plan for Public Health System Improvement 2006-2011*, a community health assessment and plan developed by the Chicago Partnership for Public Health and the Chicago Department of Public Health. The Chicago Partnership connected with the Chicago CHW Local Network and other agencies, and initiated the CHW/Promotor Survey and Mapping Project Collaborative to strengthen the Chicago CHW Local Network and to gain more knowledge about the work of CHWs

The main objectives of the CHW/Promotor Survey and Mapping Project Collaborative are: 1) to examine and map the infrastructure for delivering public health and human services in Chicago neighborhoods through CHWs; 2) to gather vital information that may improve the quality of life of community residents; and 3) to strengthen the connection and commitment among participating partners. To achieve these objectives, the Collaborative was designed to map and collect data on CHW programs including: 1) Where services are provided; 2) Topics and services covered; 3) Funding sources; 4) Training needs; 5) Public health and safety concerns in the community; and 6) Policy recommendations from the CHW administrators.

**The CHW/Promoter Survey and Mapping Project Collaborative Pilot Study:** The Collaborative is currently undertaking a pilot project in Rogers Park, a diverse Chicago community area. Start-up funding for the pilot was obtained from HealthConnect One. Subsequent funding was then granted by the Northwestern University Alliance for Research in Chicago Communities.

Pilot Design: There are four major goals of the pilot project: 1) To pilot the specific questions, survey approach, and GIS, database management, and statistical methodologies used towards the development of the citywide survey. 2) To allow for better estimates of the number and cost of surveying CHW's and CHW administrators in order to better plan the citywide survey methods. 3) To help build the CHW Local Network, as well as the experience levels of individual CHW's and health researchers through academic-community connections within it through partnerships in developing and analyzing the surveys. 4) To work with Rogers Park partners to collect, analyze, and disseminate information about the specific health and social service needs of Rogers Park residents and compare these to the specialties of the CHW's within this community.

**Chicago Community Health Worker Research and Sustainability Project:** Our proposal goal is to build a sustainable mechanism for city-wide collaborative research development, implementation, and dissemination. Our proposal has two specific aims: (1) To conduct a survey and create a dynamic map of CHW programs in Chicago; (2) To establish the CHW Local Network as an agency for collaborative research facilitation. To accomplish Aim 1, a city-wide survey of Chicago academic centers, public agencies, and community organizations will be conducted to determine the number and capacity of CHWs, their geographic coverage, specific health programs, and needs for sustainability. Through this process, more CHWs will learn about the CHW Local Network. The linkages established by the survey form a dynamic database that will provide an ongoing system for connecting academic centers, public agencies, and community-based organizations around CHW services. This database also serves as an avenue for communication to inform future research, policy, and programming related to CHWs. Aim 2 will be met by generating guidelines and tools for collaborative research with CHWs. These will serve to instruct and support researchers interested in working with CHWs and establish a pathway for CHWs to initiate research partnerships. CHW trainings will also be conducted to create research-orientated curriculum models for future research. Ultimately researchers will be able to approach the Network for advice, training assistance, or staff requests and CHWs will be able to search for additional research opportunities. The achievement of these aims will result in a sustainable data system and independent resource organization which will reduce health disparities through more research, better research, and community empowerment. This project is currently NOT funded. We are applying for funding from the NIH.

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