Sinai Urban Health Institute

Health & Medicine Policy Research Group (HMPRG) Community Health Worker (CWH) Pilot Project

Community Health Worker (CHW) Pilot Evaluation Report

January 2020

Introduction

In 2017, Community Memorial Foundation and Healthy Communities Foundation collaborated to fund models of healthcare delivery that utilize Community Health Workers (CHWs), thus improving access to care and growing the workforce. Following an RFP process, 5 organizations with diverse missions and audiences and employing 11 CHWs were funded and incorporated into a learning collaborative, by which CHWs and supervisors engaged with one another and with content experts to strengthen their skills, referral networks, and knowledge.

Health & Medicine Policy Research Group (HMPRG) a policy think tank with a long standing commitment to CHWs, is the Project Coordinator for this program, serving as the backbone of the work and a key convener throughout the process.

HMPRG engaged Sinai Urban Health Institute (SUHI), the unique, nationally-recognized community research center of Sinai Health System to train CHWs, provide support to CHW supervisors, and lead the process of conducting a formative and implementation evaluation of the effort. SUHI strives to achieve Sinai Health System's mission of achieving health equity among communities by employing a community-driven process to identify and address inequities in some of the most underserved communities in Chicago. Founded in 2000, SUHI has grown to a diverse staff of approximately 35 epidemiologists, project managers, research assistants, and community health workers. While the majority of our funding comes from private foundations and government grants, we are increasingly called upon to provide practical, evidence-based consulting services to community-based organizations, health care systems, and foundations. SUHI's work is focused on empowering partners, including community leaders, residents, and the public health workforce, with the knowledge and tools necessary to meaningfully improve health.

Sinai Urban Health Institute's (SUHI) Evaluation and Technical Assistance (ETA) team serves as evaluators for HMPRG's CHW Pilot project. The goal of this project is to **improve access to care and advance health equity for individuals living in the Western Suburbs of Cook County**.

Participating Organizations

Five organizations serving the Western Suburbs were selected to participate in this program. Below are brief descriptions of these organizations' CHW projects:

Aging Care Connections

Aging Care Connections' Aging Well Neighborhood program strives to improve community health by addressing health barriers and social determinants, improving self-sufficiency for the community's older adults. CHWs serve as the on the ground outreach to improve service utilization. Aging Care Connections' collaborations with health providers and human service organizations in the region are strategic and assist the agency in addressing the growing need for coordinated basic needs and health services for older adults. Community health workers give the organization the push that it needs to take their work to the next level and increase their impact. *Aging Care Connections, 111 W Harris Ave, La Grange, IL 60525*

Alivio Medical Center

Alivio is a Federally Qualified Health Center that strives to improve community health by offering a broad range of services in a bilingual and bicultural approach for the Latinx communities in southwest Chicago and the suburbs. Alivio has a long history of utilizing CHWs and is committed to the model. Alivio's goal with this initiative is to build their capacity in the western suburbs, working out of its Berwyn location. They are specifically focused on building their resource network to improve their capacity to connect the community to care and services. *Alivio Medical Center, 6447 Cermak Rd, Berwyn, IL 60402*

BEDS Plus

BEDS strives to improve community health through homelessness prevention and the promotion of self-sufficiency. Their services include emergency overnight shelters, daytime support centers, rapid rehousing services, and transitional and permanent supportive housing. BEDS Plus utilizes CHWs to develop stronger relationships with partner organizations, to increase resource utilization and access to services for their clients. *Beds Plus, 9601 E Ogden Ave, La Grange, IL 60525*

Healthcare Alternative Systems (HAS)

HAS provides a continuum of multicultural and bilingual behavioral health care and social services. HAS launched a new Living Room in September of 2018, as an alternative

to Emergency Department visits for community members experiencing heightened mental health symptoms. They leverage CHWs to increase utilization of their services as well as resources connectivity to other local services in the service area. *Healthcare Alternative Systems, 1913 Roosevelt Rd, Broadview, IL 60155*

Mujeres Latinas en Acción

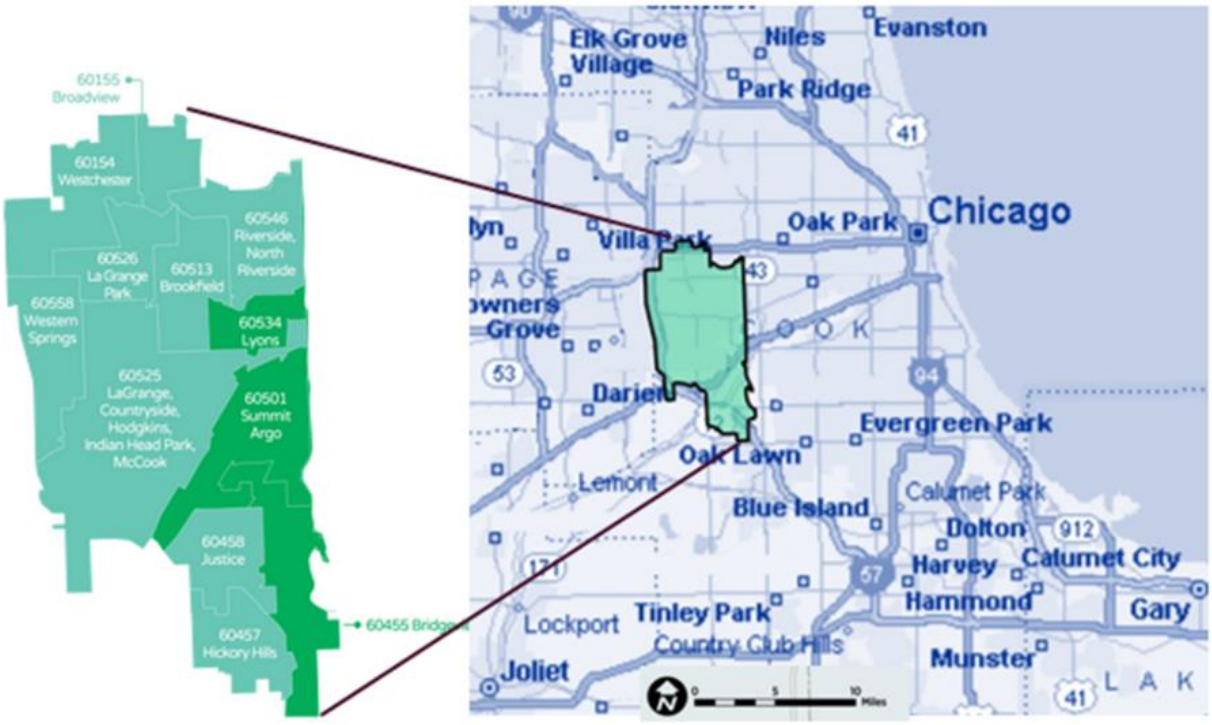
Mujeres is an empowerment organization that works with Latinas through crisis intervention, parenting support, economic empowerment, leadership development, and advocacy programs. The organization has a long history of utilizing CHWs and is committed to the model. For this project, Mujeres built on its existing capacity and experience of improving health outcomes for the changing communities served by both foundations. *Mujeres Latinas En Accion, 7222 W Cermak Rd, North Riverside, IL 60546*

Reach

This initiative serves:

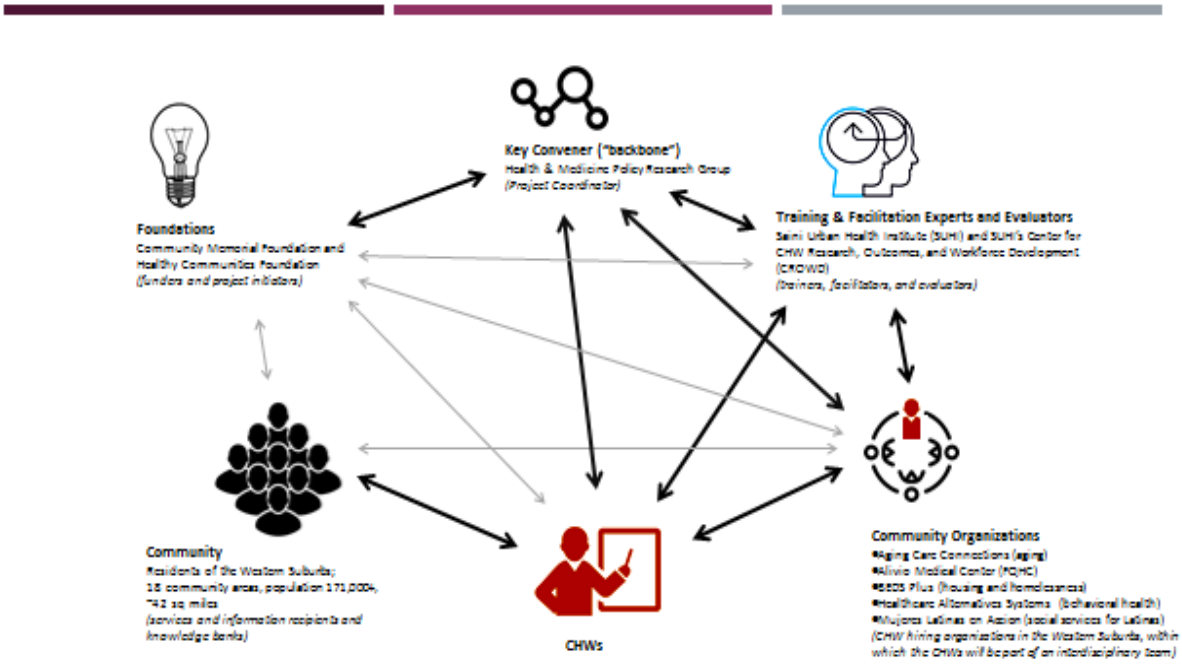
- 18 community areas
- a population over 171,000
- 42 square miles
- a diverse and changing population as Latino families move from the city of Chicago to the surrounding suburbs

FIGURE 1: Map of Service Area in Western Suburbs of Chicago



Organizational Structure

FIGURE 2: Organizational Structure of the CHW Pilot



Core Assumptions for the Initiative

The American Public Health Association (APHA) defines a community health worker (CHW) as a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (*apha.org 2018*).

For this initiative, CHWs are expected to provide on-going peer support and case management to navigate access to health care and achieve collaboratively developed health goals. CHWs are responsible for performing duties as part of an integrated interdisciplinary care coordination team. The CHW has life experience similar to that of members of the population with which he or she is assigned to work, and builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as resource and system navigation, outreach, community education, informal counseling, social support and advocacy. The role of the CHW is informed by and integral to health equity.

Key Outcomes

The overall objectives of the CHW pilot and each individual grantee's efforts include:

1. Increase number of residents reached within the target service area
2. Increase rate of referrals to other services
3. Increase number of referral organizations to strengthen referral network
4. Strengthen organizational capacity for delivery of services
5. Participate in all learning collaborative trainings
6. Develop program-specific outcome objectives as a result of learning collaborative activities

Evaluation Framework

Individual Level (Impact on CHA/Client/Family)			
Concept	Process Measures	**Concept**	Outcome Measures
Are CHWs culturally competent and well trained?	# of CHWs completing training	**Does the CHW program have effects on clients?**	Changes in health knowledge, attitudes, beliefs, practices and behaviors Personal changes – self-esteem, self-efficacy
What specific CHW interactions with clients are measurable?	# of visits, referrals, contacts, screens	**Is the health status of clients affected by CHW contact?**	Changes in health status measures
What kinds of services do program clients need?	# and type of assistance and advocacy efforts provided	**Are clients receiving appropriate health care or treatment after seeing a CHW?**	Changes in level of treatment and care
Program/Organizational Relationships			
Concept	Process Measures	**Concept**	Outcome Measures
Management/Program planning	Existence of strategic and action plans, timelines, monthly reports, attendance at learning collaborative meetings	**Management/Program planning**	Met timeline objectives, submission of monthly reports
Management – Recruitment and retention of CHWs	# of CHWs recruited and hired	**Management – Recruitment and retention of CHWs**	Turnover of CHWs and administrators
Are the services in demand and relevant to	# of clients contacted and receiving services,	**Are CHW services offered to those that are needed**	Improved health status indicators, improved

the community?	assistance, referrals, or education # of client appointments kept	**and relevant to the community?**	health outcomes, increased service utilization
Community/Agency Relationships			
Concept	Process Measures	**Concept**	Outcome Measures
Is the CHW program developing visibility and working in partnerships with other local agencies and coalitions?	# collaborative planning activities, evidence of diverse participation in partnerships	**Are referral resources to and from the CHW program used?**	# of networks, referrals (to and from CHWs), issues, agencies that referred to CHWs, agencies to which CHWs referred clients
		Are there reductions in barriers related to access to health services?	Clients engaging in new health care activities

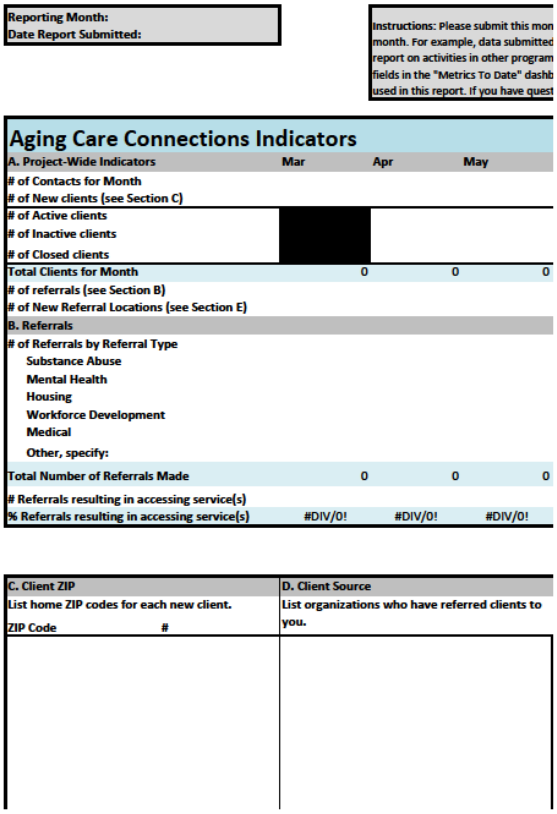
Evaluation Data Collection

At the onset of the pilot project, SUHI's ETA team created a data collection tool to assist all participating agencies with data collection efforts. Each agency was trained on the tool, with technical assistance provided throughout the duration of the year-long pilot. Lead contacts at each agency were responsible for submitting data to HMPRG on a monthly basis. The tool tracked the following indicators:

- Project-wide
  - Number of contacts
  - Number of new clients
  - Number of existing clients
  - Number of new referral locations
- Referrals
  - Number of referrals by referral type
    - Substance Use
    - Mental Health
    - Housing
    - Food/Meals
    - Benefits Assistance
    - Workforce Development
    - Transportation
    - Medical
    - Other

- Total number of referrals made
- Number of referrals resulting in accessing service
- Total Number of Outreach Events

FIGURE 3: Data Collection Tool



Reporting Month:	
Date Report Submitted:	

Instructions: Please submit this mon
month. For example, data submitted
report on activities in other program
fields in the "Metrics To Date" dashb
used in this report. If you have quest

Aging Care Connections Indicators

A. Project-Wide Indicators	Mar	Apr	May
# of Contacts for Month			
# of New clients (see Section C)			
# of Active clients			
# of Inactive clients			
# of Closed clients			
Total Clients for Month		0	0 0
# of referrals (see Section B)			
# of New Referral Locations (see Section E)			
B. Referrals			
# of Referrals by Referral Type			
Substance Abuse			
Mental Health			
Housing			
Workforce Development			
Medical			
Other, specify:			
Total Number of Referrals Made		0	0 0
# Referrals resulting in accessing service(s)			
% Referrals resulting in accessing service(s)	#DIV/0!	#DIV/0!	#DIV/0!

C. Client ZIP	D. Client Source
List home ZIP codes for each new client.	List organizations who have referred clients to you.
ZIP Code #	

Evaluation Outcomes

A. Project-Wide Indicators	*Baseline, April 2019*	*Project End, December 2019*
# of Contacts	875	5932
# of New clients	636	805
# of Existing clients	95	1124
# of New Referral Locations	23	87
B. Referrals		
# of Referrals by Referral Type	0	0
Substance Use	0	2
Mental Health	3	59
Housing	0	44
Food/Meals	0	134
Benefits Assistance	0	29
Workforce Development	0	38
Transportation	0	20
Medical	37	204
Other, specify:	0	192*
Total Number of Referrals Made	40	954
# Referrals resulting in accessing service(s)	24	247
Total Number of Outreach Events	38	193

**Legal resources, public charge, parenting resources/classes, hair salons, faith-based resources, pathways to citizenship*

By the end of the project year, the CHWs across all organizations engaged with over 5,900 new contacts, which resulted in 954 new referrals, and participated in a total of 193 outreach events. CHWs created 87 new referral pathways during this project year.

FIGURE 4: Map of zip codes of new referral areas

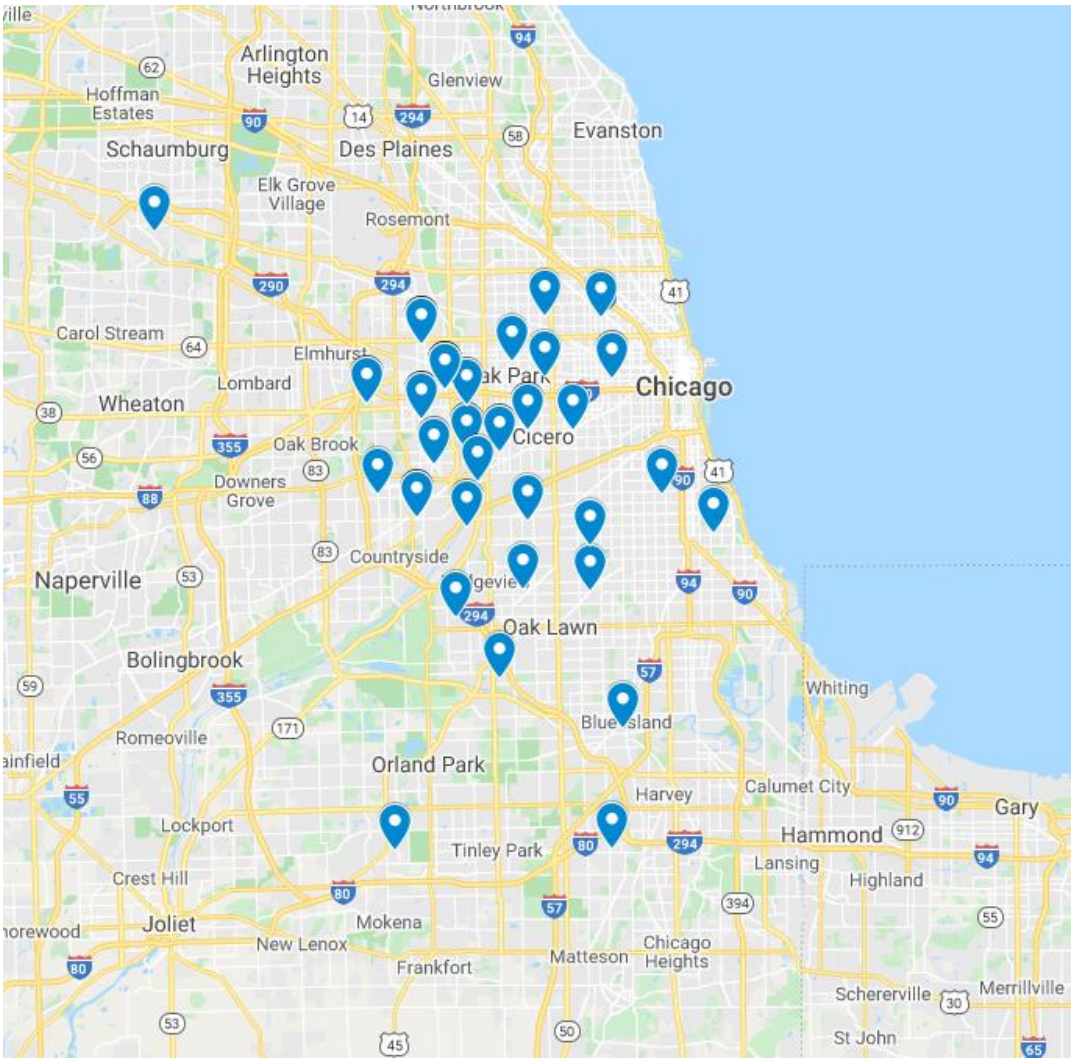
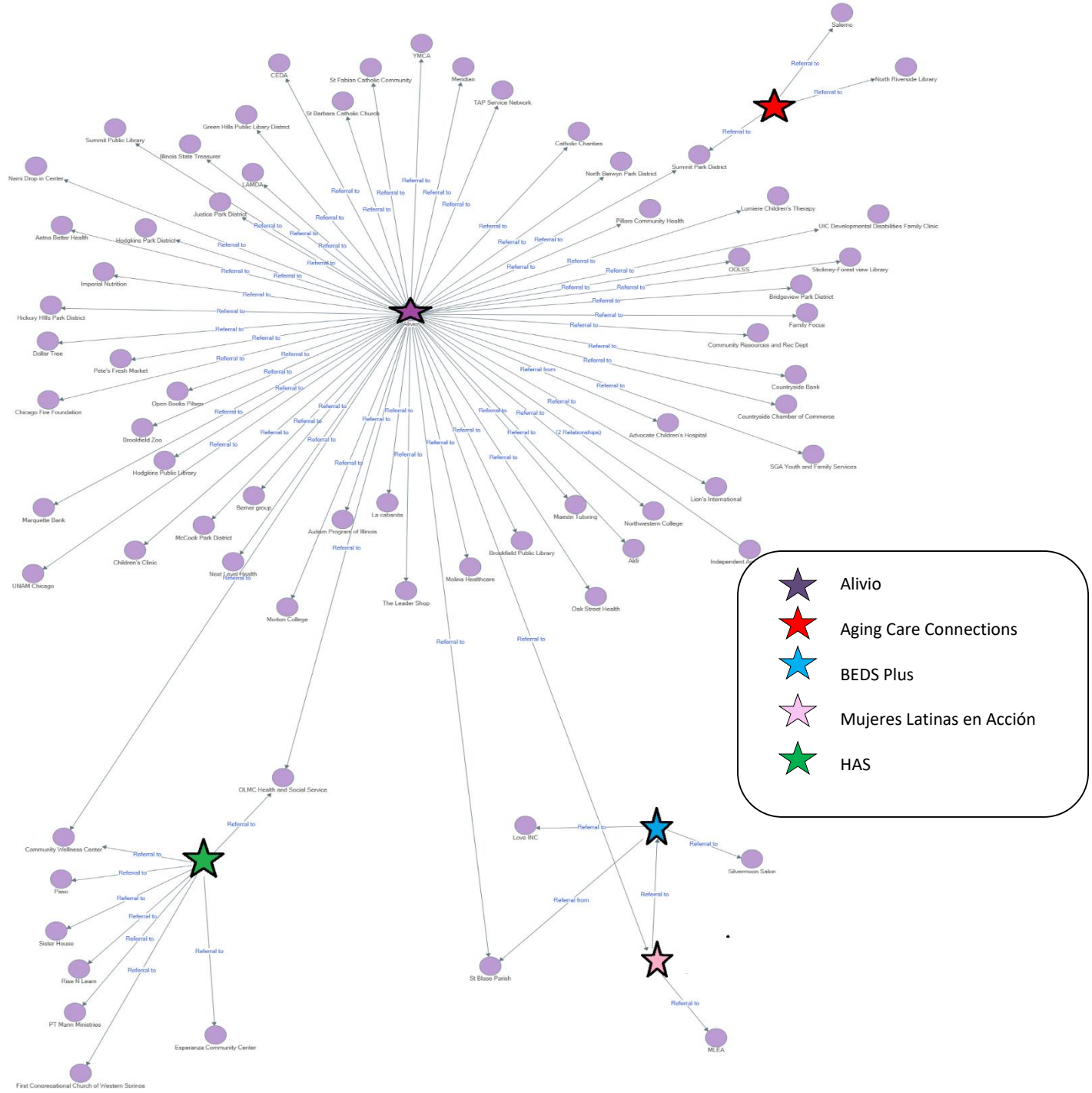


FIGURE 5: Referral Network



Value of the CHW Pilot Initiative

> ***"All of our meetings and trainings were very helpful and effective to our future success."***

~Current CHW reflecting on the value of being part of the CHW Pilot initiative

Throughout the duration of the project, CHWs and their supervisors were surveyed and given opportunities to provide feedback with their thoughts, experiences and suggestions for improvement. CHWs reported high satisfaction with the Learning Collaborative overall, and found the sessions motivating. Participants continually remarked on the ability of the facilitators to provide meaningful opportunities to engage with and learn from their fellow CHWs. The cohesion of the group was evident, with CHWs forming referral networks amongst themselves and openly sharing successes and challenges.

Several themes emerged regarding the value of the initiative:

Mutual Support for CHWs

Lived experiences of the CHWS

- The ability to relate to clients
- Regarded as trustworthy to clients

Referral opportunities

Immediate resource for clients

Increased capacity for outreach within the community

Increased capacity for linkages to services

Opportunity for organizations to raise their profile in their service area

Opportunities for Improvement

A few of the CHWs had conflicts for the Learning Collaborative meeting times and were unable to participate in some of the session. In order to mitigate that for the next project year, HMPRG surveyed the entire collaborative regarding availability and most importantly, dates that will not work to meet for the following year.

Conclusion

The CHW pilot project demonstrated achievement of the key objectives.

Objective	Metrics
Increase number of residents reached within the target service area	5932 clients reached
Increase rate of referrals to other services	954 referrals made
Increase number of referral organizations to strengthen referral network	87 new referral locations
Strengthen organizational capacity for delivery of services	11 new CHWs hired
Participate in all learning collaborative trainings	90% participation overall
Develop program-specific outcome objectives as a result of learning collaborative activities	All organization developed program specific objectives