Sinai Chicago | Sinai Urban Health Institute

Advancing High Quality Care: Community Health Worker Pilot Project

Evaluation Report for Year 3

February 2022

Introduction

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.[1]

Issue

As the Western Suburbs of Cook County diversify with families moving from the city of Chicago to the surrounding suburbs, healthcare services must expand to equitably meet community needs.

Background

In 2017, **Community Memorial Foundation (CMF)** and **Healthy Communities Foundation (HCF)** collaborated to fund models of healthcare delivery that utilize CHWs, thus improving access to care and growing the healthcare workforce in the western suburbs of Chicago. Following an RFP process, CMF and HCF funded five organizations with diverse missions and target populations to address the *Regional Health and Human Services Agenda* priority to create communities with accessible, highquality health and human services for all. Specifically, this CHW pilot **seeks to address the ongoing local need to increase awareness of health and human service resources and connect people to needed services**. As part of this pilot project, CHWs and supervisors participated in a learning collaborative to facilitate engagement and content experts to strengthen participant skills and knowledge.

Health & Medicine Policy Research Group (HMPRG), a policy think tank with a long standing commitment to the intrinsic value of the CHW skill set, and recognition of and reimbursement of their services, is the Project Coordinator for this program, serving as the backbone of the work

[1] https://www.apha.org/apha-communities/member-sections/community-health-workers, 2018

and a key convener throughout the process. HMPRG engaged **Sinai Urban Health Institute (SUHI)**, the unique, nationally-recognized community research center of Sinai Chicago to train CHWs, provide support to CHW supervisors, and lead the process of conducting a formative and process evaluation of the effort.

Goal

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. For this pilot, CHWs provide ongoing peer support and case management services for clients 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 lived experience similar to members of the community in which they 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, advocacy and linkages to care. As patient advocates, many of the CHWs serve as both translators and interpreters for community members that speak English as a second language or no English at all. The role of the CHW is informed by and integral to health equity.

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. CHWs 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)

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)
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)
Mujeres is an empowerment organization that works primarily with Latinas and any others demonstrating need, 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 immigrant communities served by both foundations. *Mujeres Latinas En Accion, 7222 W Cermak Rd, North Riverside, IL 60546*

Evaluation Approach

In order to demonstrate the value of the *Advancing High-Quality Care: CHW Pilot* project, we implemented a phased formative and process evaluation. We approached it in a spirit of collaboration, with involvement from the CHWs, supervisors, conveners from Health and Medicine Policy Research Group and our Learning Collaborative facilitators. The evaluation objectives of each project year are intended to build upon the work and findings from the previous year culminating in **a mixed-methods approach to compiling lessons learned, documenting the contribution of CHWs to their organizations and to participants' health and wellbeing, and identifying best practices for sustainability.**

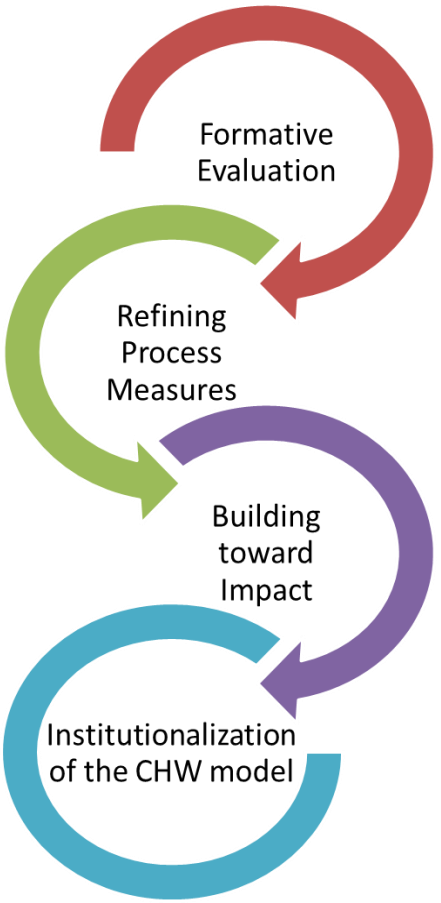
Year 1: Formative Evaluation

In Year 1, we completed a formative evaluation in order to describe the program and provide evaluation capacity building and training for the CHW supervisors. The evaluation team captured data from each organization on:

- CHW and supervisors' engagement in the Learning Collaborative
- Effectiveness of the Learning Collaborative model
- Development of visibility and partnerships with local agencies and coalitions
- Engagement of CHWs in training activities
- Engagement of CHWs with clients within their communities.

Year 2: Refining Process Measures

In Year 2, with the formative evaluation complete, we focused on measuring progress toward overarching collaborative activities and integrating lessons learned from the first year. An unexpected, but key component of year 2 was the nimbleness of organizations to respond to the COVID-19 pandemic. At the end of Year 2, the evaluation team along with HMPRG worked with pilot sites 1:1 to develop measureable goals that we tracked in Year 3.



Year 3: Building toward Impact

Year 3 is a culmination of prior years' activities critical to evaluating the vitality of the CHW model and identifying pathways for sustainability. Process measures describing the success of the collaborative as a whole were collected and analyzed similarly to Years 1-2. In addition, we worked with pilot sites to track metrics specific to their unique programmatic goals, adding a dimension of the evaluation ***across*** all sites and ***within*** each organization. A key component of Year 3 is the integration of qualitative data, with evaluators taking on the role of documentarians. Quantitative metrics tell part of the story, however talking directly with CHWs, participants, and stakeholders is necessary for understanding the impact of the pilot. This provides a deeper and more meaningful context as well as documenting individual impact.

Objectives

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

1. Increased quality of contacts 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. Strengthened organizational capacity for delivery of services
5. Participation in all learning collaborative trainings
6. Development of program-specific outcome objectives

In Year 1, we collaboratively created a data collection tool for tracking metrics related to project-wide and referral indicators. Supervisors at each organization submit data to HMPRG on a monthly basis. HMPRG then shares the data with the SUHI evaluator.

Findings

A. Project-Wide Indicators	***Baseline, April 2019***	***Year 1, December 2019***	***Year 2, December 2020***	***Year 3, December 2021***
# of Contacts	875	5,932	54,211	26,978
# of New clients	636	805	2,926	3,158
# of Existing clients	95	1,124	2,537	2,455
# of New Referral Locations	23	87	121	351
B. Referrals				
# of Referrals by Referral Type				
Substance Use	0	2	16	9
Mental Health	3	59	151	106
Housing	0	44	175	717
Food/Meals	0	134	1,010	218
Benefits Assistance	0	29	333	601
Workforce Development	0	38	40	95
Transportation	0	20	33	263
Medical	37	204	544	1,860
Other, specify:	0	192*	276*[+]	411*[+]
Total # of Referrals Made	40	954	2,578	4,280
# Referrals resulting in accessing service(s)	24	247	1,834	3,638
Total # of Outreach Events	38	193	453	155

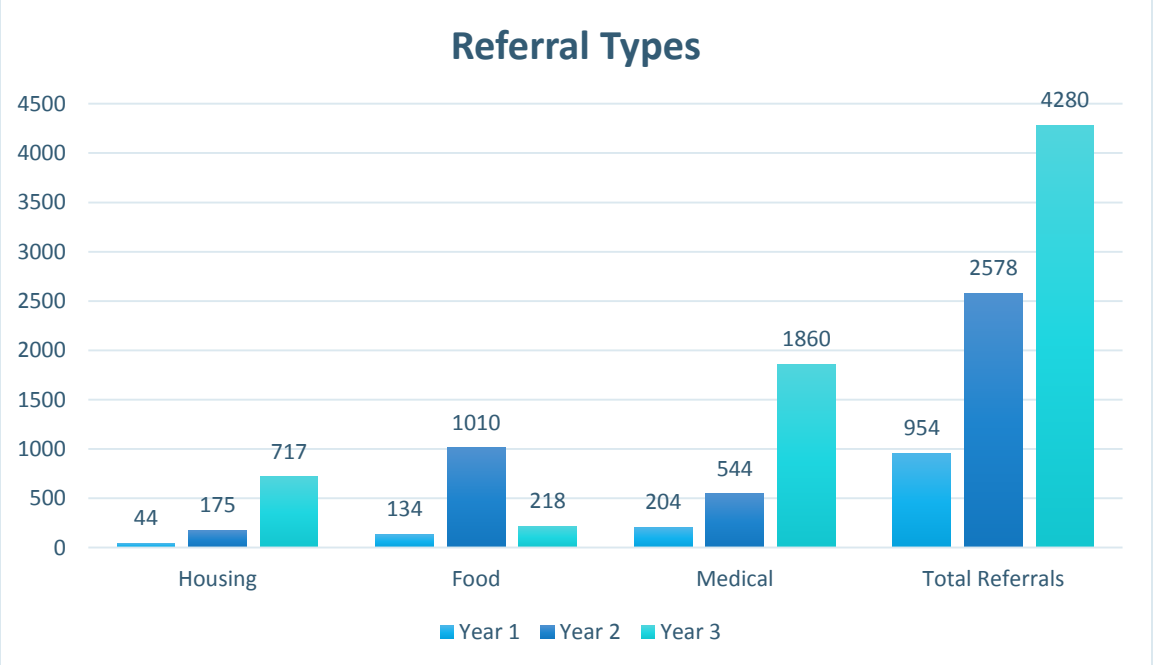
*Legal resources, public charge, parenting resources/classes, hair salons, faith-based resources, pathways to citizenship

[+]*PPE, COVID-19 testing sites, vaccine education*

At the conclusion of Year 3, CHWs across all organizations held 155 outreach events, and engaged with 26,978 new contacts, resulting in 4,280 referrals. CHWs initiated relationships with 351 new organizations during this year.

In Year 1, we discovered that organizations faced challenges in determining the outcome of a referral. These challenges included the lack of an integrated system for tracking what happens after a referral is made and, in many cases, confidentiality compliance. In the second year, we incorporated the use of Aunt Bertha's HealthConnect HUB, a widely used social care network designed for collaboration within community-based organizations. With this integration, we found that organizations were able to connect directly with referral locations for a warm hand off and more easily track if a client received the services they need. As a result, ***referrals resulting in clients accessing services increased from 26% in the first year to 71% the second year and 85% this third year***. We hypothesize this increase has more to do with a robust system for documenting the outcome of referrals, rather than an actual increase in clients accessing services, although it is likely that it's a combination of both. Year upon year, we've seen documented improvements in "closing the loop," although it varies greatly between organizations. Direct follow-up calls with clients remains the best way of identifying whether a client has accessed services.

Since the pandemic hit in early 2020, CHWs and their organizations have made dramatic shifts in their outreach strategies, demonstrating nimbleness in shifting focus. CHWs continue to play a vital role as social work extenders and connectors of community members to needed resources. Year 2 saw a rapid shift to online modalities, with corresponding broad reaches via community webinars and live social media presentations. The wide-reaching programs resulted in less conversions to referrals for contacts. In this third year, we've seen an increase in the *quality* of contacts, with corresponding increases in client engagement and referrals, despite the ongoing chaos brought on by the pandemic. As the impacts of the pandemic continue, it's not surprising that 43% (n=1,860) of referrals are medical-related. Additionally, 17% (n=717) of the referrals are for housing-related services.



Year 3: Building Toward Impact

> *"We need community health workers to stick around because of what we all know, which is that 80% of what happens to a person's health happens outside a doctor's office."*
>
> Denise Octavia Smith, ED of the National Association of Community Health Workers

As the COVID-19 crisis has highlighted persistent inequities, CHWs saw their role as even more critical for advancing health equity, with an integrated response to needs of the community. In talking with key stakeholders, including organizational leadership, community members and CHWs (n=28), stories emerged of the multi-dimensional aspects of CHWs' work with clients and the variety of needs that are supported. Take for example this composite, taken from several stories of clients engaging with CHWs, which illustrates the complexities of CHWs work. Although it's a composite of several stories, it's derived directly from real-life experiences that the CHWs navigated with clients.

The client, let's call her Maria, is undocumented, speaks solely Spanish and is fleeing an intimate partner violence situation with her young adult daughter with profound disabilities. She's referred by a medical provider to a CHW. The first thing she needs is transportation to a safe space. The CHW, who speaks Spanish, contacts Maria and her daughter, picks them up and takes them to a safe place. They are immediately provided with emergency food services as well as a list of accessible food pantries for sustaining care. In the following days, Maria is connected with a behavioral health specialist for an assessment and with community support services for parents of children with disabilities. In the following month, Maria receives a referral for immigration services and emergency funds for a mobile phone. About 7 weeks after the initial contact, the CHW working with Maria and her daughter connect the two of them with another organization providing free COVID-19 vaccines in a laundromat. In the course of 2 months, Maria and her daughter received:

- Emergency transportation
- Culturally competent care
- Emergency food services
- Referrals to food pantries
- Behavioral health resources
- Community support services
- Immigration support services
- Emergency funds for communication barriers
- COVID-19 vaccine education
- Vaccine referral

Although this is an account drawn from the experiences of several clients, what emerges is a picture of trust and reliance on CHWs to provide up-to-date resources and hope in the midst of difficulties. While the goal of working with a client is for them to access the services they need in the moment, what often happens is that a relationship and rapport develops, with the client returning again and again and eventually accessing what they need. The client-centered approach by the CHWs ensures that they are trusted allies which increases engagement and

brings clients back when they need additional help and support. Clients also spoke about the lack of reliable information related to COVID-19 vaccines and the pandemic in general. In the absence of information from trusted sources, they resorted to getting information from social media platforms, rife with disinformation. Several clients spoke about their confidence in vaccines increasing as a result of their relationship with a CHW and connecting with vaccine outreach services.

> *"Misinformation is a barrier to care."*
>
> CHW supervisor, reflecting on the spread of misinformation involving COVID-19 vaccines in the Western Suburbs.

Value of the Community Health Worker

Key stakeholders at each organization emphasized the vital role that CHWs play in their organizations by raising awareness of community needs, enhancing organizational visibility through the connections the CHWs make with other organizations, establishing new relationships, sharing messages that connect with older adults (such as a series of placemats for chronic health conditions). In reflecting on their value, one supervisor shared that "CHWs are the voice and ears of the community."

> *"We have found during the pandemic a new appreciation for our CHWs from our Senior Leadership."*
>
> CHW Supervisor

> *"CHWs are the voice and ears of the community."*
>
> CHW supervisor, reflecting on the value of CHWs

Others reflected on how the CHW role has evolved within their organizations. Initially, the CHWs connected people with resources and conducted outreach. The role has grown to increasing each organization's visibility within the region. The role has also grown in complexity; CHWs work with clients to establish stable housing and achieve attainable goals related to their needs.

Organizational Goals

As mentioned previously, at the end of Year 2, we met 1:1 with each site to develop measurable goals for this final year of the pilot.

Table 1: Year 3 Pilot Organization Goals and Outcomes

Organization	Goals	Outcomes
Aging Care Connections	1. Reach at least 900 unduplicated participant encounters through outreach at locations where older adults gather and with those who support older adults (e.g. villages, first responders, food pantries) 2. Provide individualized referrals and research to 50 individuals who need more detailed information 3. Provide clinical support to 30 individuals, using intake protocol and referral to care coordinator who will conduct in-home consultation and develop a care plan with referrals and service linkages 4. Establish relationships with at least 4 new community organizations	Achieved Over 1000 client encounters reported, referrals for over 50 individuals, clinical support for 30 individuals and 5 new referral locations identified.

Organization	Goals	Outcomes
Alivio Medical Center	1. Reach at least 700 unduplicated participant encounters 2. Reach at least 20 organizations who will participate in at least 1-2 events per month 3. At least 70% of participants will receive health education and referral information	Achieved Over 3000 contacts, 20 organizations participating in 94 outreach events and 84% of contacts receiving referral information and education
BEDS Plus	1. Reach and provide referrals to at least 250 unduplicated individuals 2. At least 180 unduplicated individuals will successfully follow through on referrals	Achieved Over 1200 referrals made to over 300 clients with 91% receiving recommended services
HAS	1. At least 250 unduplicated individuals will receive referrals 2. At least 100 unduplicated individuals will follow through on referrals 3. At least 60% of participants will demonstrate	Achieved Over 1500 contacts with 313 individuals receiving referrals and 208 receiving services. Through surveys, 75% of clients demonstrated increased knowledge

Organization	Goals	Outcomes
	increased knowledge regarding HIV/AIDS, issues facing older adults and be able to access services such as Medicaid.	
Mujeres Latinas En Accion	1. Generate at least 50 referrals to domestic violence/sexual assault services; of these, at least 20 will follow through on referrals 2. Host 6 Café en Accion/Community Forums, engaging at least 50 residents 3. Host 6 trainings on Know Your Rights, public charge, and other pertinent immigration topics, engaging at least 50 residents	Achieved Over 900 referrals with 82% of referrals resulting in accessing services. Hosted 10 Community Forums with 100 participants. Hosted 6 trainings.

Conclusion

In times of continued uncertainty, this pilot demonstrates the synergy between coming together and meeting the moment. These outcomes demonstrate the importance of the CHW model in advancing healthy equity and improving access to care for community members living in the Western Suburbs of Chicago, with opportunities toward expansion.

Table 2: Key Outcomes Overall

Objective	Metrics
Number of residents reached within the target service area	87,996
Rate of referrals to other services	7,852 referrals made
Number of referral organizations to strengthen referral network	582 new referral locations
Strengthen organizational capacity for delivery of services	10 CHW roles retained
Participate in all learning collaborative trainings	90% participation overall
Develop program-specific outcome objectives as a result of learning collaborative activities	All organization developed and met program specific objectives