Sinai Chicago | Sinai Urban Health Institute

Advancing High Quality Care: Community Health Worker Pilot Project

Evaluation Report for Year 2

February 2021

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. 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, high quality 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 initiative, CHWs and supervisors participated in a learning collaborative to engage with one another and 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 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 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 implementation evaluation of the effort.

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

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 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 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 and advocacy. 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 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 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, SUHI is implementing a phased outcome evaluation framework. 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.**

In this second project year, we focused on measuring progress toward overarching collaborative activities and integrating lessons learned from the initial pilot year. An unexpected but key component of year 2 has been organizations' responses to what *Psychology Today* referred to as

the "twin pandemics of COVID-19 and structural racism."[2] At the end of this project year, HMPRG and the SUHI Evaluator met with sites one-on-one to develop measurable goals. In year 3, the Evaluator will be tracking metrics specific to each site's unique programmatic goals.

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

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

Evaluation Outcomes

A. Project-Wide Indicators	***Baseline, April 2019***	***Year 1, December 2019***	***Year 2, December 2020***
# of Contacts	875	5,932	54,211
# of New clients	636	805	2,926
# of Existing clients	95	1,124	2,537
# of New Referral Locations	23	87	121
B. Referrals			
# of Referrals by Referral Type			
Substance Use	0	2	16
Mental Health	3	59	151
Housing	0	44	175
Food/Meals	0	134	1,010
Benefits Assistance	0	29	333
Workforce Development	0	38	40
Transportation	0	20	33
Medical	37	204	544

[2] Kolod, Sue, and Jack Drescher. "The Twin Pandemics of Racism and COVID-19." *Psychology Today*, American Psychoanalytic Association, 16 June 2020, www.psychologytoday.com/us/blog/psychoanalysis-unplugged/202006/the-twin-pandemics-racism-and-covid-19.

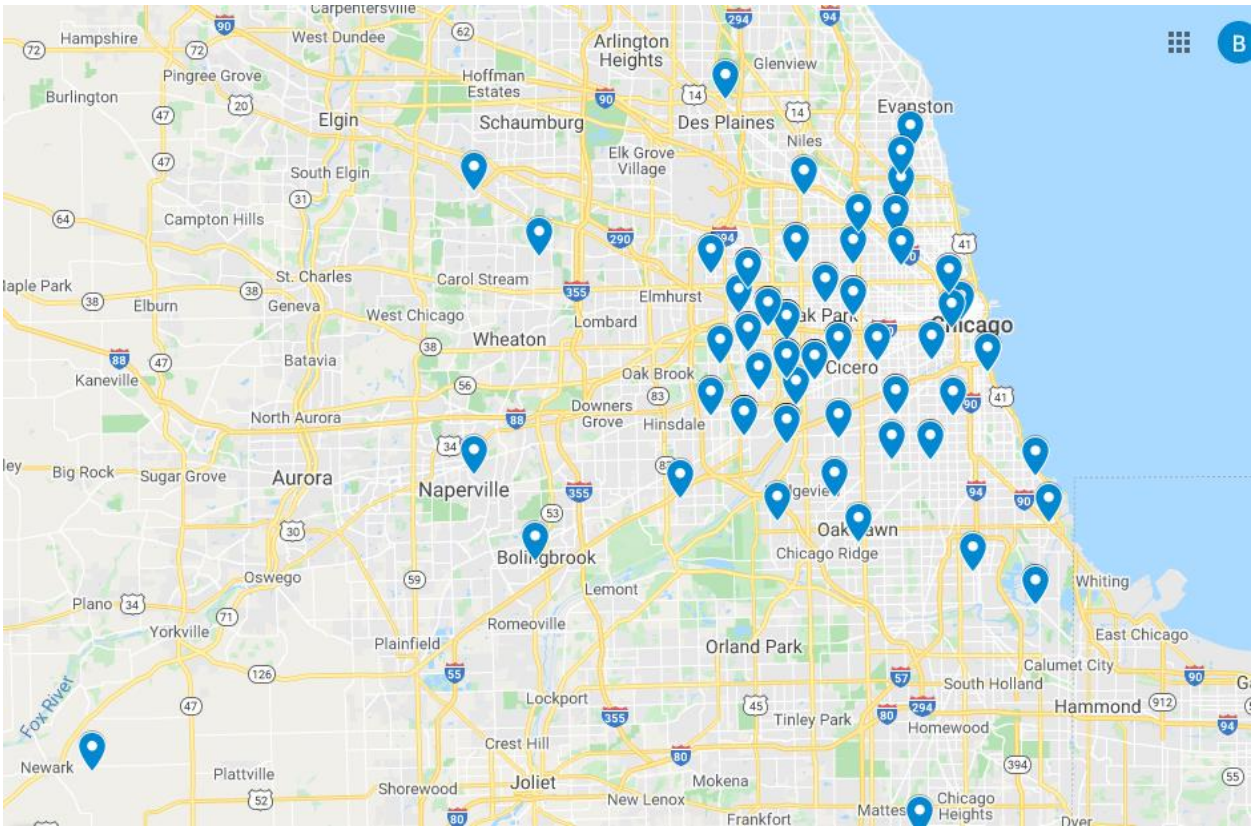
Other, specify:	0	192*	276*+
Total Number of Referrals Made	40	954	2,578
# Referrals resulting in accessing service(s)	24	247	1,834
Total Number of Outreach Events	38	193	453

**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 2, CHWs across all organizations held 453 outreach events, and engaged with 54,211 new contacts, resulting in 2,578 referrals. CHWs initiated relationships with 121 new organizations during this year.

Figure 1: New referral areas by zip code



In year 1, we discovered the challenges organization's faced to determine 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 this 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***. We

hypothesize this increase has more to do with a more 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. While there has been improvements in "closing the loop," the process is still somewhat clunky and varies greatly between organizations. Direct follow-up calls with clients has been the best way of identifying whether a client has accessed services.

Year 2: "Unprecedented Times"

Following the World Health Organization's declaration of the novel coronavirus in early March 2020, along with the Illinois Governor's stay-at-home order shortly after, CHWs at four of the project sites began working remotely. Staff at BEDS Plus continued meeting with clients in the community and at their primary location. As the COVID-19 crisis has highlighted persistent inequities, CHWs, as trusted members of the community saw their role as even more critical for advancing health equity, with services to community members continuing throughout the crisis.

The shift to remote work presented unique challenges for the CHWs, especially around technology needs. HMPRG and the SUHI Evaluator met with organizations individually in early May, offering technical assistance and exploring needs. We quickly learned that a "one-size-fits-all" approach would not adequately address needs (i.e. providing tablets or stipends for internet services). We assessed a wide variety of technology needs, which were addressed through additional funding from CMF and HCF.

The pandemic highlighted unique challenges and creative adaptations as each organization rapidly shifted operations and adjusted workflows.

Rapid shifts to virtual modalities: With in-person meetings with clients no longer advisable, organizations responded rapidly and creatively by offering a range of virtual programming, beyond their usual content. Programs ranged from educational sessions to telehealth appointments to online cooking demonstrations to interactive webinars.

Increased demands on CHWs: Members of the community rely on CHWs to assist in navigating complex systems and connecting them to much needed resources. With COVID-19 disproportionately impacting communities of color, these areas were magnified in this time of crisis. In addition to navigating the uncertainties of COVID-19 with their clients, CHWs also grappled with and grieved the loss of their own family members and neighbors.

Preparing for the new normal: With challenges, comes the opportunity to adapt, which was evident for each organization. With programming shifting to virtual environments, some of the organizations experienced expansion of their service lines, along with increased visibility. Alivio tracked their increased social media posts and reported 292,737 views of their posts since March. Aging Care Connections generally pauses outreach activities during the winter months, but with the move to online program delivery, they expanded their outreach to include programming throughout the year. However, the crisis has highlighted the digital divide, with organizations also reporting that they have lost contact with many of their clients seen regularly in person prior

to the onset of the pandemic, who lacked the resources to connect in the emerging virtual environment.

Looking Ahead to Year 3

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

Table 1: Year 3 Pilot Organization Goals

Organization	Goals
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
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
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
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 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

Conclusion

In a year of uncertainty, with continual adaptions, this second year of the pilot demonstrated achievement of the key objectives.

Table 2: Key Outcomes

Objective	**Metrics**
Increase number of residents reached within the target service area	54,211 individuals served
Increase rate of referrals to other services	2578 referrals made
Increase number of referral organizations to strengthen referral network	121 new referral locations
Strengthen organizational capacity for delivery of services	11 CHWs 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 program specific objectives