Enos Park Access to Care Collaborative, Springfield, IL

Year One Impact Statement (Oct. 2015-Sept. 2016)

The Problem: The 2015 Sangamon County Community Health Need Assessment conducted by HSHS St. John's Hospital, Memorial Medical Center, and Sangamon County Public Health Department involved a community survey, community forums, advisory groups and other data collection activities. Access to care was one of the identified top priorities. The two hospitals decided to address this as a joint collaborative and invited the participation of Southern Illinois University School of Medicine's Center for Family Medicine (a federally qualified health center).

Goal: To improve access to health care in Springfield's Enos Park neighborhood, a vulnerable, low-income neighborhood.

Population: Approximately 2,300 residents living in the Enos Park neighborhood.

Objective: Create a Community Health Worker (CHW) program to increase access to health care for residents through a collaborative of MMC, HSHS, and SIU CFM.

Strategy: Implementation of a Community Health Worker program to work with individuals living in the Enos Park Neighborhood to address access and health using a holistic approach. Funding for the program is split between the two hospitals.

Outcomes: In October 2015, the collaborative team began the journey of implementing the project by hiring Dr. Tracey Smith, Director of Population Health Integration and Community Health with SIU Center for Family Medicine, as the project director, and hiring the first Community Health Worker. By the end of September 2016 the Enos Park Access to Care Collaborative had organized a Steering Committee (meets monthly); a Community Advisory Group (made up of neighborhood residents, meets monthly), and a Provider Alliance Group (local social service agencies, meets quarterly). By April 2016, two additional part-time CHWs joined the team.

Measurements set for the project include: resident enrollment, primary care provider engagement, emergency room utilization decrease, and community outreach. The goals were met for each quarter of the project's first year. Additional support totaling $2,000 was received from Friends of Memorial and the MidWest Dairy Council to fund community outreach projects.

The Access to Care Collaborative focuses on connection with the Enos Park residents individually and the Enos Park neighborhood as a whole, including service providers to the Enos Park neighborhood.

Residents: 455 People Reached

(The program impacted a total of 455 individuals. Some were assisted more than once through various services.)

- 111 clients enrolled with Community Health Workers
  - Spent 41,070 minutes (685 hours with these 111 clients)
- 19 youth (aged 9 to 14) through Bike Club
- 27 youth (aged 9 to 14) through Summer Enrichment Program
- 560 people through community outreach activities (i.e. Trunk 'R Treat, McClernand School Health Fair, National Night Out, etc.)
- 12 families (28 people) through the Memorial Behavioral Health's MOSAIC Program
- Reached a diverse population:
  - Gender: 58% Male, 42% Female
  - Age: average age is 34
  - Race: 36% black
- Reached Special Populations:
  - 26 people who were parolees
  - 15 people who were homeless

Increased Self-Sufficiency Measures

- Employment by 50%
- Income by 200%
- Food and nutrition by 50%
- Health care coverage by 50%
- Life skills by 40%
- Mobility by 100%
- Community Involvement by 67%
- Physical Health by 25%

Increased Access to Health Care Services

- 100% selected a primary care medical home (increase of 51%)
  - 409 primary care provider appointments made
  - 96% of our patients saw a primary care provider at least once in the past year
  - 83% show rate (national avg. 60-80%)
- 100% health insurance enrollment (increase of 56%)
- 38% reduction in unnecessary emergency department visits
- 19 patients attended 40 dental appointments, resulting in more than 40 cavities addressed and completion of seven full dental extractions
- 44 received mental health services

Addressed Other Needs

- Worked with patients 121 times to address housing needs, resulting in a 150% improvement in the safety of their housing (housing rental, advocacy, rent, utilities, etc.)
- Made 151 social service agency referrals
- Connected 10 patients to veteran services
- Provided transportation to clients 983 times
- Accompanied clients to 290 physician visits
- Partnered with more than 40 other community agencies
- CHWs educated 15 students (medical, social work, other CHWs) on provision of this kind of care and social determinants of health
- Worked with patients to gain disposable income of $50,800 since February through disability or reinstatement of benefits

Neighborhood Connections

- 11 meetings held with community residents leading to 27 different activities being held including:
  - Summer Bike Club
  - Summer Enrichment Program
  - McClernand Elementary School Parent Group
  - Northside Children's Library Friend Program
  - Mature Club
  - Central Illinois Food Bank fresh food distribution
  - SIU School of Medicine's Medical Students' Day of Service
  - SIU School of Medicine's New Medical Student Experience (*A Journey Through Your Patient's Health*)
  - Simmons Cancer Institute Colorectal Cancer Screening
  - MMC/YMCA Pre-diabetes Screening at Hildebrandt Housing site
- 5 meetings held with Provider Alliance Group leading to:
  - Trainings on insurance enrollment, medical legal partnerships, and social security enrollment

Discoveries

The Good	The Challenging
• New Collaborative Partners: o Enos Park Neighborhood Improvement Association o Springfield Police Dept. Neighborhood Police Officers o Memorial Behavioral Health MOSAIC program o Third Presbyterian Church o McClernand Elementary School o Central Counties Health Center (FQHC) o HSHS St. John's Caregiver Interfaith Volunteer Services o Numerous social service agencies	• The overall need is great!
• New model for housing	• Data access is complicated.
• Effect on recidivism (parolees returning to prison) o 19% vs. 56.7% nationally	• Developing a data base is complex.
• Reduction in neighborhood crime o 89% reduction in police calls to housing units we help manage o Police report 13% overall reduction in calls to Enos Park since the program began (from 1,260 to 1,092 calls)	• Transient nature of the neighborhood's super utilizers (people who frequently use hospital emergency departments as their primary source of health care services)
• System changes o Development of a different clinic to address needs of clients o Ability to work with local agencies to address policy changes	• Lack of housing, employment and parolee support programs

First-Year Impacts

Three major areas were impacted during the first year: Enos Park residents; the overall Springfield health care system; and community health workers themselves.

Enos Park Residents: Nearly 20% of residents in Enos Park were impacted by obtaining increased access to care, including access to dental services, primary care, and mental health services.

Springfield Health Care System: One of the major challenges with utilizing community health workers is there are very limited opportunities to bill Medicaid or insurance companies for the services CHWs provide, making these programs very expensive to operate. The clients themselves are not charged for the services. Building a sustainable program is difficult.

A new clinic model at SIU Center for Family Medicine was developed that established a strong team approach between mental health specialists, primary care provider, pharmacists, and medical-legal partners. This clinic has a 100% show rate and high level of billing by both the primary care provider and mental health specialists. The program is in the early stages of becoming an income-generating clinic that provides comprehensive care while helping its patients decrease their use of hospital emergency departments.

Community Health Workers: The Enos Park Community Health Workers have participated in more than 150 hours of training and are helping to develop a new workforce in the Springfield area. Because of the work started by this program, a grant from the United Way of Central Illinois is funding a similar CHW project in the Brandon Court neighborhood on Springfield's east side, in collaboration with Central Counties Health Center. This has led to the employment of three more CHWs.

Summary and Future

Year two will see expansion of current programs plus a larger emphasis on increased billing and outreach to super utilizers who depend upon emergency departments rather than seeing their primary care physicians for health care services. Dr. Smith and the Springfield Police Department are exploring new models of collaboration with our community health workers to assist residents that both of them serve. We are excited to continue to identify ways to work with local agencies, engage Enos Park residents, build new relationships, and disseminate results of this program.

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