EVALUATION OF

HEALTHCONNECT IN OUR COMMUNITY:

FINAL REPORT

Submitted to:

The Children's Trust of Miami-Dade

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EXECUTIVE SUMMARY

In 2005, the Children's Trust of Miami-Dade County initiated the HealthConnect program, designed to improve the health of children and adolescents in the county. One of three components of HealthConnect is HealthConnect in Our Community (HCiOC). HCiOC—through contracts with six health and social service community-based organizations around the county[1]—uses two types of workers (community health workers and health navigators) to reach out to underserved children and their families. Community health workers (CHWs) perform community outreach to identify families that need assistance or to give them health education. They either provide that assistance directly or refer the family to health navigators (HNs) for assistance. HNs, in turn, help families by providing enrollment assistance or health navigation (i.e., helping the family make appointments for health care).

In 2006, the Trust contracted with the Urban Institute and three local consultants to conduct a formative assessment of HCiOC in its first year of operation. We conducted a six-day site visit in February 2007 during which we interviewed 26 key informants across Miami-Dade, observed program operations in 19 separate locations, and conducted five focus groups, three with clients and two with program staff.

The key findings and recommendations from this evaluation are presented below, with more detail presented in the body of the full report:

Findings

1. The HCiOC program was implemented relatively rapidly, building well on precursor efforts. The program design is appropriate to filling an important gap in services in Miami-Dade County.

2. HCiOC contractors have generally attracted a committed staff who have the experience and skills for their jobs, although there is a need for more training in some areas.

3. The program is culturally sensitive, which is critical for reaching the most underserved children and families in Miami-Dade.

4. Clients of the program are very satisfied with the HCiOC services they receive (although they usually do not recognize the program by name).

5. There is substantial variation in the way the HCiOC "model" is implemented across contractors, resulting in unevenness in the type and quality of program services.

[1] The contractors are Citrus Health Network, Community Health of South Dade, Economic Opportunity Family Health Center, the Haitian Neighborhood Center, the Human Services Coalition, and the Public Health Trust.

6. The current reporting systems for the HCiOC provide inconsistent and, at times, misleading results. The reporting also provides some unintended incentives to provide less intensive services than desirable.

Recommendations

1. The Trust should target the activities of the HCiOC contractors more closely to the program's goals. Program services should give priority to the needs of children, both their health and their immediate social service needs.

2. The Trust should strengthen the training and skills of staff in performing application assistance, health navigation, and health education. Both CHWs and HNs should be cross-trained in health insurance application assistance, in order to avoid "missed opportunities" to enroll children.

3. The Trust should provide more clarity to contractors about the expected roles for CHWs and HNs. The Trust should clarify services areas for the program and assure that all service areas receive the full range of HCiOC services.

4. To facilitate shared learning and referrals, there should be better opportunities for networking between HCiOC contractors and between HCiOC and other programs of the Trust (particularly HealthConnect in Our Schools and HealthConnect in the Early Years).

5. The Trust should improve its reporting requirements for contractors, making the functions more useful for program monitoring and less burdensome for contractor staff.

6. The Trust should reexamine the data flow between CHWs and HNs, so that clients are asked personal questions only once and in a private setting.

We hope that these recommendations are useful to the Trust as it plans improvements to the HCiOC program and in other similar efforts to improve the health of children and adolescents in Miami-Dade County.

Background

In the 1980s, momentum developed among advocates and policy makers in Miami-Dade County to address the needs of low-income children. These efforts culminated in a successful ballot initiative that implemented a tax dedicated to funding programs for children. The funds are administered by the Children's Trust (the Trust), which in turn provides grants to over 75 community-based organizations that serve children throughout the county.[2]

During this same period, national and Florida-wide efforts led to the establishment of new health insurance programs for children, under the umbrella of "KidCare." These four programs are funded by either Medicaid or the State Children's Health Insurance Program (SCHIP). Miami-Dade's KidCare enrollees are almost 20 percent of the total state enrollment in these programs. Most enrollees are minority children, reflective of the county's ethnic diversity. Even with KidCare, a high percentage of children in the county remain uninsured, from 15 to 20 percent depending on the ethnic group.[3] In 2002 the Mayor's Health Care Initiative released a report showing that the uninsured do not have adequate access to health care, particularly preventive and primary care.[4]

Recognizing that many children are not enrolled in programs they are entitled to, and do not have access to preventive or primary health care, The Trust initiated HealthConnect in 2005. HealthConnect has three components: HealthConnect in the Early Years (HCiEY), focused on access to services for pregnant women and young

[2] A full list of grants is available on the TCT web site: www.thechildrenstrust.org.
[3] Paul Duncan, et al., Miami-Dade County Health Insurance Survey, June 2003. Commissioned by the Public Health Trust.
[4] Health Council of South Florida, Mayor's Health Care Initiative Outcomes Report, May 2002.

children; HealthConnect in Our Schools (HCiOS), providing school health services; and HealthConnect in Our Community (HCiOC), the subject of this report. The goal of HealthConnect is to have the healthiest children possible in Miami-Dade County, and the logic model for HealthConnect—posted on the Trust's web site—states that the long-term goal of the program is to "Improve Child and Adolescent Health."

HCiOC is designed to work towards the goals of HealthConnect by identifying underserved children and their families through outreach, and then providing them with enrollment assistance, health care navigation, and health education. The model for HCiOC was developed through collaboration with representatives from many organizations, both public and nonprofit agencies. In particular, the design of the HCiOC program evolved from several precursor efforts underway in the county in the decade preceding HealthConnect implementation. These include

- *The CAP program*: The Community Access Program (CAP) was a five-year grant (ending in February 2007) to the Public Health Trust Foundation from the federal Health Resources and Services Administration. The goal of CAP was to reduce the rate of uninsurance in the county, and improve access to services for uninsured adults and children. A concept for two types of outreach/enrollment workers ("Community Health Workers" and "Health Navigators," described further below) was developed under CAP and implemented in various settings throughout the county late in the period of the CAP grant.

- *Community Voices*: This two-phased grant from the Kellogg Foundation to the Collins Center began in 1998, and has a similar goal to that of the CAP program (improving access to care for people without health insurance). Much of the work to develop the model for Community Health Workers, and to train a cadre of such workers across the county, has been centered at Community Voices. The project also focuses on improving planning of health services for low income people. Community Voices also organized a school-based health service coalition, which led to some of the planning for HCiOS.

- *Healthy Start*: The Florida Healthy Start program links low-income pregnant women and their infants to appropriate health and social services. It is closely related to HCiEY, but includes a more substantial health education component than the other precursor programs.

- *KidCare Outreach*: In Florida today, all children under 200 percent of the federal poverty level who do not have private insurance can be covered by one of the four Florida "KidCare" programs. Although enrollment grew rapidly after new KidCare programs were developed, enrollment declined beginning in 2004,[5] in part because the state had ended funding of outreach activities designed to identify uninsured children and enroll them in appropriate programs. Such programs were housed in many community-based organizations, in order to reach immigrant and minority group members, a model followed by HCiOC.

In addition to these precursor efforts, other collaborators in the development of HCiOC include a network of community-based health and social service organizations that provide an important safety net for low-income people in Miami-Dade. These organizations are located across the county and are responsive to the needs of diverse cultures. Their missions are community-driven, and they often employ people of the same language and ethnicity as the organization's clients. It is natural that some of these organizations—particularly those with experience in community outreach and health navigation--would be chosen to deliver HCiOC services, just as had been done under some of the precursor programs listed above. The model HCiOC program uses two types of health workers to accomplish the program's goals:

- *Community Health Workers (CHWs)*: CHWs, often from the same community as clients, meet families in various community settings and try to identify and overcome their barriers to receiving health care. These "lay workers" may not have specific formal education or training beyond high school, but they must have strong interpersonal skills and usually have experience working in similar programs.

- *Health Navigators (HNs)*: These individuals generally work in fixed locations and are responsible for completing applications for assistance and formally linking families to health services, through making appointments and tracking receipt of services. They generally have a college education.

[5] Florida KidCare Coordinating Council: 2007 Annual Report and Recommendations, www.floridakidcare.org.

The model assumes that CHWs and HNs will work in teams and refer clients to each other. Particularly, CHWs should identify individuals who need application or health navigation assistance and refer them to an HN conveniently located near their home for an appointment. The workers should also provide health education to their clients. The target populations for these efforts are uninsured and underserved children and their families.

HCiOC contractors were selected through a request for proposals (RFP). The RFP was released in December 2005, with proposals due shortly thereafter. After proposals were received, there were further negotiations with bidders concerning the scope of each program. These negotiations resulted in agreed-upon targets for both the number of CHWs and HNs to be employed, and the output of those workers, as shown in Table 1.

Table 1
Year One Contracted Staff and Service Contact Targets

	Citrus Health Network	**Community Health of Santa Dade**	**Economic Opportunity Family Health Center**	**Haitian Neighborhood Center**	**Human Services Coalition**	**Public Health Trust**
Staff Size						
CHWs	2	4	4	3	6	0
HNs	2	4	4	0	4	10
Contact Targets: CHWs.						
Preventive Education	700	6000	2160	1000	3300	
Outreach	1440	6000	2160	1000	3300	
Screening	1200	6000	2160	1000	3300	
Linkage to Health Navigators	960	6000	2160	800	2000	NA
Eligibility Screening	888	6000	2160	NA	1500	
HNs						
Health Navigations	360	3000	2160		1200	27,000
Follow-up	360	3000	2160	300	1000	8100
Training	4	8	8	3	9	12

Contracts were awarded to six health and social service organizations in May 2006, as follows:

- *Citrus Health Network*: An FQHC[6] that was founded as a mental health provider in 1979 and began providing general health services in 2005. This organization is also an HCiOS provider and primarily serves Cuban, as well as some other Hispanic, clients.

- *Community Health of South Dade (CHI)*: An FQHC founded in 1971 to provide health care to the uninsured and underinsured indigent population of South Dade. It is one of the largest such organizations in the country, operating six primary care clinics, five school-health centers, a mental health center, and many outreach programs. CHI is also a HCiOS provider. About half of its clients are Hispanic and about a third are African-American.

- *Economic Opportunity Family Health Center (EOFHC)*: An FQHC, founded in 1967, and providing health services in six primary care clinics, schools, and other sites. EOFHC is also a HCiOS provider. About 70 percent if its clients are African-American, with the remainder being primarily Hispanic.

- *Haitian Neighborhood Center (Sant La)*: A neighborhood resource center for the Haitian community of Miami-Dade founded in 2000. It provides a range of application and employment assistance, as well as referrals to health and social services. A regular television program and library provide information in Creole to foster civic engagement in the Haitian community.

- *Human Services Coalition (HSC)*: A social services agency and advocacy organization, primarily providing services through referrals to, or sub-contracts with, other organizations. Under HCiOC, the HSC subcontracts with seven organizations, three of which are health clinics. Their clientele is quite mixed depending on the service area of the sub-contractor.

- *Public Health Trust (PHT)*: A large integrated public health system that includes Jackson Memorial Hospital, two other hospitals, 12 primary care centers, 16 school based health clinics, and numerous other provider sites. The organization is one of the largest public health providers in the U.S.

[6] FQHC: Federally Qualified Health Center, funded by the federal government's Health Resources and Services Administration.

The sizes of their grants for the first 14 months of operation under HCiOC are as follows:

- Citrus Health Network: $244,389
- Community Health of South Dade (CHI): $497,681
- Economic Opportunity Family Health Center: $587,410
- Haitian Neighborhood Center/Sant La: $262,687
- Human Services Coalition: $614,575
- Public Health Trust: $1,079,946

A key feature of the negotiated contracts is that contractors are assigned service areas from which they draw their clients.[7]

In December, 2006 The Trust contracted with the Urban Institute, along with three local consultants, to conduct a formative evaluation of HCiOC. This report summarizes the findings from the evaluation. More detail is available in three previous reports.[8]

METHODS

We used qualitative research methods to evaluate the first year of operation of HCiOC. In February 2007, we conducted a six day intensive site visit to Miami-Dade County in which we interviewed nine stakeholders from related organizations who had been involved in the development of HCiOC, or who could provide a context for understanding the health care delivery system and related outreach programs in the county. These interviews were followed by one full day spent with each contractor in which we interviewed the executive director, the program coordinator, and the data

[7] Some service areas overlap, and the PHT does not have a specific service area, since it draws clients from around the county.

[8] "Building Information System Capacity for HealthConnect in Our Community: Issues and Recommendations," Sommers, et al., March 2007; "HealthConnect in Our Community: Successes and Issues Identified in the Evaluation Site Visit of February, 2007," Howell, et al. April 2007; "HealthConnect in Our Community: What Do Health Navigators, Community Health Workers, and Families Say About the Program?" Palmer, et al. November 2007.

manager. Following the interviews, we observed the work of 20 different CHWs or HNs. A list of all those interviewed and observed is contained in Appendix A.

In order to have uniformity in the issues covered, we developed a flexible guide to follow in both interviews and observations of program operations. Two-person teams conducted the key informant interviews; each team summarized notes from the discussions according to the structure of the interview guide.

In addition to these interviews and observations, we conducted five focus groups. Three of the groups were with clients of the HCiOC programs. The other groups were held with program staff, both CHWs (one group) and HNs (one group).

A key goal for the client focus groups was to achieve geographic and ethnic diversity of the participants and to reflect the variety of locations where HCiOC is being implemented. Three of the contractors (Citrus Health Network, Community Health of South Dade, and the Sant La/ Haitian Neighborhood Center) each recruited clients for a focus group at their site. Together these contractors serve areas around the county, as well as all the major ethnic groups in the county. Clients who participated were paid a stipend of $40 for their time, and were offered refreshments and child care.

Supervisors from each of the six contractors assisted with identifying staff to attend the two worker groups. Each agency had at least one HN and one CHW at each session, except for the two organizations that employed only CHWs (Sant La) or HNs (Public Health Trust). Participants in the worker groups were not paid a stipend, since they participated as part of their job. The result of this recruitment effort was that 34 clients participated in the focus groups (across three groups), 7 CHWs participated in one group, and 7 HNs participated in one group.

It is important to note that this recruitment method did not rely on a random sample of possible participants. Consequently, there may be some bias in the findings from the groups, if people who are either more supportive or more critical of the program chose to participate.

A topic guide was developed for use by the focus group moderator.[9] The Urban Institute Institutional Review Board reviewed and approved the protocols and recruitment methods.

An experienced English-speaking focus group facilitator was assisted by both a Spanish-speaking and a Creole-speaking translator. Tapes of focus group discussions—which were conducted in a mix of Spanish, Creole, and English, depending on the setting—were transcribed and translated. All of the notes and transcripts were reviewed and summarized according to themes for analysis.

The findings, presented below, are organized according to the key findings from interviews, observations, and focus group discussions.

FINDINGS: PROGRAM IMPLEMENTATION

Finding One:

The HCiOC program was implemented relatively rapidly, building well on precursor efforts. The program design is appropriate to filling an important gap in services in Miami-Dade County. [10]

At the time of our site visit, according to program data generated from contractor reports, over 15,000 clients were served by HCiOC. At that time about 45 percent of

[9] Protocols are available from authors by request.

[10] At the time of our site visit and focus groups, about nine months had passed since the HCiOC contractors received their first year of funding, so they were still in the early phases of implementation. Consequently, our findings provide an early look at the program, but do not reflect the program's development since February, 2007.

clients were Hispanic and a similar proportion African-American and/or Haitian (program reports do not allow for a clear distinction between these two ethnic categories).[11] Thus the program was reaching a large number of clients from diverse and high-need populations.

A particularly positive feature of the program design is that it builds well on precursor efforts. Key informants agreed that this facilitated the quick and efficient implementation of HCiOC, and complemented The Trust for receiving broad input from key stakeholders in the program design.[12] In addition, HCiOC fills a gap created by the decline in KidCare outreach funding and the ending of the CAP grant. Since the model for HCiOC includes (in concept) both strong health navigation (service linkage) and health education components, it builds on but also strengthens those precursor efforts.

There was agreement among all those interviewed and the focus group participants that the program is meeting an important need. For example, participants in each of the three client focus groups discussed the urgent unmet health needs in their communities, for both children and adults, and spoke about the importance of affordable health care for themselves and their children. Focus group participants also discussed their wide range of social needs being met by the program. Program staff agreed, and commented that they wished the program were more widespread throughout the county because of this great need.

***Finding Two**:*

HCiOC contractors have generally attracted committed staff who have the experience and skills for their jobs, but there is need for more training in some areas.

Site visitors observed that most CHWs and HNs appeared quite capable of performing their jobs as assigned by HCiOC. We were told that none of the organizations had difficulty identifying and recruiting experienced supervisory and line staff. All projects but one (which experienced some recent turnover) were fully staffed at the time

[11] See information later in the report concerning possible inaccuracies in the contractor reports. There is both over- and under-reporting of clients, so this number is a rough estimate.
[12] While a few respondents felt that their input was not considered in the program design, this was a rare response from the large number of people whom we interviewed.

of the site visit, and all staff had been through a 40-hour mandatory CHW/HN training program sponsored by The Trust.[13] Staff generally have the tools and knowledge to do their jobs well, and many seemed to possess these skills even before being hired by HCiOC. Indeed, the precursor programs provided a "training ground" for knowledgeable and committed individuals, from whom the staff of this program has been drawn.

The 40-hour mandatory training course--developed and implemented by Community Voices and sponsored by The Trust--ensures some uniformity in the skills of CHWs and HNs. The current training course is particularly useful for providing an understanding of cultural sensitivity and how to reach out to clients. One focus group participant commented:

> *"The Miami-Dade (training course) just basically taught us not to judge, how to deal with people with different cultures."*

The training program does not have a strong component that addresses several key aspects of HCiOC activities. This leads to unevenness in the quality of services.

It appears to be particularly limited in some of the skills needed by HNs, including thorough training in enrollment assistance and health navigation. As an example, we observed one HN who did not know how to complete all types of KidCare applications. Some HNs reported that they needed additional training from the Department of Children and Families (DCF) to learn the application procedures for the Department's various programs.

> *"We went to DCF training to understand how to apply for the patients …the training helped us a lot to know what we do for the patient, how to get in the system for things like KidCare."*

[13] Many workers had been on the job for several months before having the formal training.

There is also a gap in the adequacy of training to provide health education. We observed some CHWs who had some training in health education topics and felt confident enough to provide education to clients, but other workers told us they did not feel they had adequate training in this area.

Most CHWs and HNs must have additional on-the-job training after the one week course, and most key informants reported that experience is more important than education.

> *"I think the best experience is out there in the field. Because the class teaches certain things but (it doesn't) prepare you for the reality that is out there."*

In spite of these gaps in their preparation, CHWs and HNs participating in our focus groups reported considerable job satisfaction. Their main area of frustration was the large unmet need in the community and their lack of ability to meet all of their clients' needs, due to the large number of contacts they were required to make each month to meet contract requirements.

> *"Somebody figured that we could spend only fifteen or ten minutes with a client. Impossible."*

There also were some complaints about the salary levels (from CHWs). It is too soon to know whether high job satisfaction will overcome some of these other job concerns, and lead to good retention of staff.

Finding Three:

The program is culturally sensitive, which is critical for reaching the most underserved children and families in Miami-Dade.

A very important positive feature of HCiOC is that the program is, with very few exceptions, culturally and linguistically appropriate for reaching the families in greatest need of help. The contractors working in neighborhoods with Spanish-speaking families have Spanish-speaking staff, and those working with Haitian families have Creole-speaking staff. These are usually native-speakers, often with personal roots in the communities where they work. Thus barriers to trust that are common, especially in immigrant communities, are more easily overcome. One contractor staff member said:

> *"We know the community well and the community knows us, so this makes us well-suited to implement HCiOC."*

Participants in the client focus groups unanimously felt the services they receive from their CHW or HN are culturally competent. Almost all participants said they can get access to staff who speak their language and that there are no feelings of cultural tension.

> *"They've all been sensitive to the culture."*

> *"Their workers are very compassionate and have been able to understand the culture and the language."*

Finding Four:

Clients of the program are very satisfied with the HCiOC services they receive (although they usually do not recognize the program by name).

Clients who participated in the focus groups were unanimous in their appreciation for the services they received under from their CHW or HN. They said that prior to this assistance they often had unmet needs that the CHWs and HNs worked hard to meet, such as helping them to find ways of paying for health services. When asked if they were satisfied with the services CHWs and HNs provide, participants unanimously answered "yes." They said their CHW and/or HN was knowledgeable, helpful, easy to contact, and

consistent in following up with their progress. All participants said they would refer friends to the same CHW or HN (or the organization where the worker was placed).

> *"I know many people have problems and I always refer them to come here, to receive the services they want."*

However, we found a consistent lack of recognition of the "Health Connect" program name across focus group participants. Thus, although the program is a source of valued help, its brand name recognition appears to be quite low, at least according to the persons who participated in the focus groups. Some of this may be due to the fact that the program is still quite new.

Finding Five:

There is substantial variation in the way the HCiOC "model" is implemented across contractors, resulting in unevenness in the type and quality of program services.

While each HCiOC provider generally follows the "model" HCiOC program design, there is considerable variation in scale and implementation. This is likely due both to variation in the capacity of HCiOC providers--ranging from a small community-based organization (Sant La) to one of the largest health care organizations in the U.S. (PHT)—as well as to differences in the historic missions of the contractors. Most are health care organizations, but some have an advocacy and/or social service orientation. Some variation is good since experimentation can reveal new successful approaches. But at the time of our visit there had been little shared learning of best practices between contractors.

The variation in implementation from the original program model is most pronounced in the following areas: (1) the role definitions for CHWs and HNs in particular service areas; (2) the health navigation component (which links clients to

health services and a medical home); (3) the health education component; and (4) program boundaries concerning who receives services and the types of services. Each is discussed in turn below.

CHW and HN roles. According to the HCiOC model, CHWs are to perform community outreach and health education, and HNs are to work in fixed sites primarily providing enrollment assistance and health navigation. However, in practice these roles are less well-defined in many settings. For example, in focus groups the CHWs reported that they often undertook health navigation activities such as making medical or dental appointments for clients. Similarly, some HNs provide outreach and health education.

In those places that have both types of workers, particularly in the community health center sites, the CHW and HN roles are usually consistent with the HCiOC model definition. In focus groups, those CHWs reported conducting office-based administrative duties only about 20 percent of the time, while spending most of their time conducting outreach in the field at a wide array of community sites, including schools, stores, churches, laundromats, construction sites, and door-to-door. CHWs have flexibility in deciding where to conduct outreach, and reported being most productive when given the freedom to move from place-to-place as changing circumstances dictate.

> *"A lot of times we move on, sometimes we go to one shopping center, there's nothing, and we move to another place, and we also do the traditional type of outreach where you meet people anywhere and initiate conversation with them."*

In the settings with well-defined roles, the HNs spend the majority of their time (roughly 90 percent) at their desks or on site at health clinics. HNs sometimes go out into the community, but much less frequently than CHWs. Home visits are very rare for either type of worker.

> "*Primarily we're situated in an office…since you're dealing with confidential information, you have to lock files…but if there's any need for outreaching, you would go out of your office…but primarily, 90 percent of the time, we're in offices.*"

The implementation of the original HCiOC model is most varied in the two contractors that do not employ both types of workers (Sant La, with only CHWs, and PHT, with only HNs). While the concept is that the CHWs at Sant La are to refer clients to HNs in other settings, in practice they usually provide a fuller scope of services to clients themselves than do other CHWs, including both outreach and enrollment assistance. The calendar for one worker at Sant La showed her to be office-based about half the time, to provide enrollment assistance and other help in that setting, and half time in the field conducting outreach. This is practical for Sant La clients, since they do not have to go elsewhere for application assistance. (CHWs in other sites may provide application assistance at times for the client's convenience as well, but typically they do not.) At the same time, clients at Sant La do not generally receive help from health navigators (such as making appointments or tracking whether the appointment is kept). The CHWs may refer a client to a clinic for this help, but cannot track their services.

At the PHT, only HNs are employed because the CAP grant was still in operation at the time of the proposal, and thus CHWs were already in place and could conduct outreach for HCiOC. (This is no longer the case.) Also, we were told by one staff member that she had no great need for CHW referrals, because many clients needing help come to their health facilities. In addition, the worker said that the few referrals that she receives from CHWs outside of PHT can be ineffective because of time delays. However, another PHT HN reported having to do her own outreach because she did not otherwise have enough clients to make her monthly contact targets. Even in other settings with both

types of workers, one HN told us that only about 50 to 75 percent of his referrals are from CHWs, while the rest come from a wide range of sources, including HCiOS. In addition, in places with both CHWs and HNs on the staff, there may be is some blurring of roles, particularly concerning application assistance. This was confirmed in client focus groups, where clients did not usually distinguish between the two positions, whom they generally referred to as "social workers," and not by the workers official titles.

> *"If I forgot a document or I was supposed to come that day for an appointment (but forgot with whom) she (the "social worker") knows who it is, for me and for my kids."*

While we heard that this type of sharing of roles can be good for clients and workers, we also observed that the program seemed to be operating most smoothly in those sites with both types of workers and where role definitions were clear. At the same time, we also observed some "missed opportunities" when CHWs referred a client to an HN for enrollment assistance which resulted in a delay and possible inconvenience for the client. If CHWs and HNs could be cross-trained, particularly in application assistance, some clients would benefit from not having to go to a different places for help. One HN recommended that CHWs and HNs regularly go together to observe each other's job and help each other, to facilitate cross-training.

The original CHW/HN model assumes that CHWs will identify clients living in specific service areas and refer them to HNs in those same areas, regardless of whether the HN works for the same contractor. In practice, there are very few cross-referrals from clients of one HCiOC contractor to another. This means that a client is not always referred to the HN nearest their home and that some service areas are not covered as well as others. We were told in interviews that the CHWs and HNs may not pay close

attention to the zip codes where clients live (defining the service areas), and reach out to all potential clients. This issue was also discussed in worker focus groups:

> *"Each person is assigned to a specific zip code. So we try to work within our zip code targets. But that does not mean we will work exclusively in our zip code."*

Health Navigation. Having health insurance does not ensure that a child will receive appropriate preventive or primary care. Health "navigation," in addition to application assistance, is a critical component of HCiOC. It includes such activities as linking clients to medical homes, making appointments for them, and tracking them to see if they attend their appointments. In our observations of HCiOC service delivery, we saw a lack of emphasis on this component of the program across most settings, and particularly in the non-clinic settings. While in some clinic settings the workers have access to appointment scheduling databases which allow them to make appointments for clients, in most settings (including some of the clinics) they do not have this resource. In the work of the contractors that are not medical providers, there do not appear to be appropriate linkages in place to refer clients to medical providers. In such settings, we did not observe that CHWs/HNs were asking clients about whether they had a primary care provider, or discussing how to obtain one.

In addition to the lack of ability to make appointments in many cases, with the exception of one contractor (Citrus Health Network) none of the CHWs/HNs maintain good tracking information to let them know whether their clients are keeping appointments. From our observations, they appear to rarely check on this, even when they might potentially have access to such information in clinics (although again this varies from setting to setting).

Health Education. Another area of variation from the original program model, and across sites, concerns the type, frequency, and content of health education. We found tremendous variation in the content and quality of the education being provided. Some contractors were providing brief health education sessions to every client they encountered, others were passing out a variety of health education materials (without directly discussing them with clients), and others were providing health education in one-time group sessions.

From both the interviews and observations, we conclude that at the time of the site visit health education strategies were designed more to meet the terms of the contracts for "health education contacts" than according to well-defined plans or using well-constructed guidelines and curricula. One example that we observed involved a brief health education session provided by a CHW who administered a short "pretest" (required by their contract with the Trust) of 10 multiple choice questions about a variety of health education topics. The client answered only one question correctly. The worker then read the client a brochure covering all the topics. After this the worker administered the "post-test" with the same 10 questions which the client answered correctly. While some HNs provide one-on-one health education, health education is generally the responsibility of the CHWs. In focus groups, CHWs gave some examples of how they provide health education. They said they encourage clients to make more frequent well-health doctor's visits and explain the benefits of early disease detection.

> *"You are trying to engage the person, talk to them and identify their needs and see how best you can help them…To me, outreach encompasses education, the linkage, the advocacy, everything."*

"I see my role as a community health worker to educate the client on different issues… I'm not a healthcare professional, but with the trainings that we go to, we learn the basics of health issues, like say the importance of getting a mammogram."

Still, we observed that CHWs generally lacked the skills they need to provide high quality health education, since these staff often provide information on topics for which they have little knowledge or training. In addition, there have been few guidelines from The Trust about how to provide health education, including when it should be provided, on which topics, and by whom. Uniformly, contractors requested more guidance on this component of the program.

Program Boundaries. One area of program design that remains controversial among key respondents is the boundaries for the program, in particular whether the HCiOC has an exclusive focus on health for children and their families. While there is a general consensus that HCiOC is a program for children and their families (because of the source of funding and the mission of The Children's Trust), the way the program is implemented varies within and between contractors on this score. We saw many examples of this. Health education is often provided to childless adults and on topics that are not closely related to children's health. We observed services being delivered to adults without any children (for example, an HN helping an elderly couple apply for Medicare or outreach in places where most people were adults without children). In settings with a mixture of adults with and without children (such as health clinics), we generally saw that CHWs and HNs did not distinguish between the types of individuals they helped.

Some workers regard families with children as the primary focus of their work, but others said they divide their attention "fifty-fifty" between assisting families with children and single adults. In general, CHWs do not turn anyone away.

> *"It's a mixed [client] group. Fifty-fifty* [families with children: single adults], *I would say."*

> *"Even though we focus on children, we have to help anybody who comes to us."*

The other boundary that is also not being regularly observed in many settings is that between the provision of help with health services vis-à-vis non-health-related social services. In the encounters we observed, most CHWs and HNs were as likely to provide help with social services as with health services.

In focus groups, clients were asked about the types of services they receive under the program. They mentioned many non-health-related services, such as assistance with immigration applications for family members, furniture and housing, financial recovery after a hurricane, referrals for domestic violence and child abuse, applications for WIC, and food stamps, disability benefits, child care assistance, and transportation assistance.

CHWs and HNs in the focus groups talked about how important they feel it is to help clients with the full range of their needs. They find it stressful to put boundaries around their job when it comes to helping families.

> *"The people that I interact or engage with (in the community) will tell you bluntly. 'I'm not worried about health care, I need my life saved'."*

> *"People come to you, they have problems paying their electricity bill. And we refer them where they can pay their bill. If they have problems for housing, we let them know where they can go for Section 8 Application."*

> *"The main goal is to connect them with a medical home and then provide them social services they need … whether it's daycare applications or whatever."*

In spite of this substantial social services component, clients in focus groups unanimously agreed the most important help they had received from a CHW or HN was regarding health care, whether that was accessing health insurance, or assistance making and keeping appointments.

One reason for the confusion about these boundaries comes from the context in which HCiOC is operating. The program builds on previous efforts, such as CAP, which provided assistance to all uninsured people, including childless adults. HCiOC also builds on the efforts of social service assistance programs in the county. According to most key informants, because they have adapted and integrated their programs into existing efforts of their organizations, they prefer more open boundaries (for example, allowing CHWs and HNs to serve all individuals, regardless of age). Still, while the services provided by HCiOC are needed and valued by clients, many (possibly up to half in some settings) of these services do not clearly contribute directly to achieving the ultimate HCiOC program goal to "Improve Child and Adolescent Health."

FINDINGS: PROGRAM MONITORING AND DATA

As part of this formative evaluation of HCiOC, we also examined the data and reporting systems contractors use. The purpose was to determine the feasibility of studying program outcomes and to make recommendations for improving the reporting systems so that outcomes could be examined in the second and subsequent years of the HCiOC program.

HCiOC providers vary greatly in their management information resources and data expertise to support ongoing system operation and development.[14] Each contractor has designed and implemented an MIS for generating the required HCiOC reports to the Trust. However, most contractors have adopted simple reporting systems, and there is untapped potential for more sophisticated management information systems (MIS). In particular, an important goal of a successful MIS is adaptability to multiple management needs, such as tracking clients over time to determine whether they have kept appointments. Some of the contractors' MIS do have features that help contractors manage the HCiOC program, but none appears to maximize its full capacity. The contractors are reluctant to establish more elaborate MIS systems without further guidance from the Trust.

Reporting Inconsistencies. We observed that the HCiOC providers were confused about some of their reporting requirements, leading to inconsistencies in reporting. These inconsistencies confound The Trust's ability to monitor productivity and progress toward program goals. Some of the key areas of inconsistency include the following:

- *There is inconsistency in how contractors count "outreach contacts."* Sometimes each member of a group outreach event is counted as a separate contact. Because of duplication (clients being counted multiple times when they have multiple contacts), most of the systems overstate the number of individuals assisted by HCiOC.
- *Race/ethnicity data are inconsistent across contractors.* Consequently, current reports likely undercount Haitians.
- *Definitions for types of outreach activity vary.* The trust provides targets for each contractor and requires a count of client contacts for seven activities: preventive health education, outreach, prescreening, linkage, eligibility screening, navigation, follow-up, and CHW training. Yet no definitions of these activities

[14] More detail on the specific capabilities of HCiOC contractors is available in an earlier report and Appendix B.

were provided to contractors, and thus contractors tend to interpret the categories differently.

- *All but one HCiOC provider is counting all individuals assisted as contacts, including childless adults.* Some contractors count all members of a family as a contact, regardless of how many are actually assisted. This likely explains the large number of adults reported on monthly HCiOC reports.
- *Pretest/posttest data on health education is inconsistent across contractors, and is generally not useful for monitoring HCiOC.* Each contractor is collecting such information in a different manner, and site visit informants uniformly reported that they saw no benefit to administering the pre- and posttest evaluation.

Data Reporting Burden. CHWs and HNs reported in interviews and focus groups that they feel their reporting requirements are excessive and burdensome, and that reporting activities interfere with the time they spend with clients. There also was a consensus among HNs that excessive paperwork and constantly shifting reporting requirements created a stressful environment early in the program. However, respondents also reported the job became easier over time as they adjusted to the data requirements.

"Once you get the flow going, it's pretty easy after that."

Unintended Consequences of Reporting Process. As mentioned, the Trust's six HCiOC contracts set contractor-specific "productivity" goals, thus requiring each organization to make a certain number of contacts within a specified period of time (see table 1). The goals for each organization vary depending on the number of CHWs and HNs hired under its contract. The contractors report the aggregate number of contacts monthly to the Trust. Because, according to CHWs and HNs, the goals are very high, there is an incentive to plan and document program activities in order to obtain the largest number of contacts possible, in order to "make the numbers."

For example, contractor goals do not differentiate between different types of outreach. Usually individuals are counted in the same manner regardless of whether they are contacted at group outreach events or in one-on-one situations, where in-depth help and education are provided. As an extreme example, a home visit, which might take two hours and provide in-depth help to a child, would count as one contact, while a group outreach event taking the same amount of time could be counted as 30 contacts.

Our observations and discussions with contractor staff reveal that much of the help being offered by CHWs (and even some HNs) is of the "light" type (for example, in large group outreach events), while success at enrolling children and their families, linking them to services, and tracking whether they receive services (all outcomes that are important for achieving the program's goals) often takes more time. Thus, is it possible that the Trust's contracting goals and reporting requirements, in particular the lack of clarity of certain definitions, has led to a less intensive program model than originally designed.

Finally, there is a concern regarding confidentiality of data collection in public places and at group events. To complete reports, and thus "make their (contract) quotas," workers must report all contacts—even those in group events and public events—according to demographic characteristics. One HN reported,

> "*I have to collect names in order to make our numbers. We can't make our numbers by just handing out materials without the names.*"

Yet this data-collection requirement could work against the goals of the program, since a person merely receiving a health education brochure might be reluctant to give their name in such a public setting.

CONCLUSIONS AND RECOMMENDATIONS

In this first year formative evaluation of the HCiOC, we observed several important positive features of the program as it was operating in February 2007, including the following:

- The program meets a great need in the community.
- The major program goal—improving child health—is simple and well understood.
- The program builds well on precursor efforts, allowing it to be implemented rapidly.
- The contractors have attracted a committed staff with good skills.
- The program is culturally sensitive to the needs of the diverse population of Miami-Dade.

At the same time, we heard of and observed several areas of the program that need further development, including the following:

- The program model is being implemented very differently from setting to setting, and there is unevenness in the type and quality of services provided.
- The boundaries for the program are poorly defined concerning the target population and the services they should receive. Consequently, many HCiOC activities are inconsistent with the program's primary goal of improving child and adolescent health.
- Program staff sometimes lack the guidance, skills, and tools they need to do their job, particularly concerning application assistance, health navigation and health education.
- Some program reporting requirements are unclear and burdensome. Much of the data being collected is not useful for monitoring program activities.

As a result of these observations, we have the following recommendations to the Trust for improving HCiOC.

Recommendation One

We recommend that the Trust target the activities of the HCiOC contractors more closely to the program's goals. Program services should give priority to the needs of children, both their health and their immediate social service needs. Since the resources for HCiOC are limited, it seems appropriate to reemphasize the boundaries for the program in terms of client age/family status and service type. For example, CHWs and HNs should be encouraged to emphasize the primary thrust of their jobs: providing outreach, health insurance application assistance, health navigation, and health education to improve the health of children and their families. In the case of help with social services, or for adults who are not in families with children, contractors should be instructed to provide referrals to assistance for those populations and services. The Trust should revise the way outcomes are monitored, reducing the emphasis on "counting contacts" regardless of the age of the client or the purpose of the contact.

Recommendation Two

The Trust should strengthen the training (and, as a result, the skills) of staff in performing application assistance, health navigation, and health education. While HNs should remain the primary application assistors, CHWs should be cross-trained in health insurance application assistance as well, to avoid "missed opportunities" to enroll children.

The health navigation component of HCiOC needs more emphasis. Training of HNs and CHWs should include the concept of a "medical home," and CHWs/HNs should be aware of local providers that offer medical, mental health, and dental care, as well as related services such as WIC. Contractors should share information about how they are

successfully linking clients to health services. More monitoring of certain critical outcomes, such as the proportion of children attending preventive care visits, would help track progress in this critical area. To accomplish this, the data systems of contractors should be modified to allow workers to track clients (as outlined in recommendation five, below).

The Trust should develop, in consultation with its contractors, a plan for health education that is consistent with the goals of the program and the training of the staff implementing the program. We recommend that, under the current program structure, this educational program incorporate simple public health messages appropriate for young families—based on known effective social marketing strategies—that the current staff can deliver when they are providing other assistance to families.

The content and format of these messages could be modeled on those developed and tested by nationally recognized health organizations (for example, the Centers for Disease Control and Prevention). See appendix C for suggested topics and guidelines for health education.

CHWs can deliver health education, but they will need enough time, training, and materials to do so effectively. Training for these kinds of simple messages could be incorporated into the HCiOC required training program. More complex health education is beyond the scope of the HCiOC program, as currently designed.

Recommendation Three

The Trust should provide more clarity to contractors about the expected roles for CHWs and HNs, and should assure that all service areas for the program receive the full range of HCiOC services. This may involve adding workers to the contractors that do not employ

both types of workers, and/or strengthening the links among contractors so that referrals can be made between contractors. In addition, CHWs and HNs should be cross-trained in each other's jobs (especially for application assistance), and encouraged to take on activities that further the overall goals of the program when appropriate.

Mandatory training for CHWs and HNs should be expanded to include more emphasis on the Trust's required functions for the HCiOC program, such as application assistance, helping clients establish a medical home, data reporting, and health education. After several days of "core" training, there could be separate training for specific functions (perhaps as part of on-the-job training). Contractors should share "best practices," since some are using CHWs and HNs separately and some are using them interchangeably, to learn from the experimentation happening in the field.

Recommendation Four

To facilitate shared learning and referrals, there should be better opportunities for networking between HCiOC contractors and between HCiOC and other programs of the Trust (particularly HealthConnect in Our Schools and HealthConnect in the Early Years). This could occur through occasional joint meetings, conferences, or workshops; shared materials; or possibly a joint newsletter. When programs are serving the same geographic service areas, more intensive networking would be especially desirable. A set of materials on sources of referrals for health and social services should be developed for all CHWs and HNs. Concern should be given to maintaining the functions and increasing use by CHWs and HNs of the Trust's 211 Helpline database system that currently serves as an on-line and telephone-based referral resource.

Recommendation Five

The Trust should improve the type of reporting it requires of contractors, to make it more useful for program monitoring and less burdensome for contractor staff. We recommend that the Trust require reporting on a small set of items that can be measured consistently and with relative ease across providers. Below we outline such measures for two types of clients (type 1 and type 2). Collecting such data consistently will provide a foundation for an evaluation of short-term program outcomes.

Type 1 clients are those who have individual face-to-face contact with a CHW and/or HN for individual assistance. We recommend the following data elements for each of these clients.

- Age
- Gender
- Language spoken by client
- Race/ethnicity (according to a common classification across contractors)
- Zip code of residence
- Whether a referral was made to an HN by a CHW
- Number of referrals to nonmedical services/agencies
- Number of medical appointments arranged
- Number of applications submitted by KidCare program
- Number of one-on-one meetings for health education (in private settings)
- Number of home visits

While all providers have the capacity to collect these measures, some providers will need to redesign their forms or reporting templates. In addition, because of the importance of beginning to report some outcomes from HCiOC efforts, we recommend that (on a phase-in basis) the following two outcomes be collected on all type 1 clients:

- Whether enrolled in a KidCare insurance program (by program type)
- Number of medical visits kept (for those with an appointment arranged)

Such reporting would require close collaboration between the CHW and HN, or separate records for each type of worker that could be developed and linked according to a client identifier. These changes in reporting requirements should begin after close consultation with the contractors about the methods for obtaining the information, clear definitions of outcomes, and a phase-in period. The health care providers should be the focus of this effort to collect outcomes initially, as it may not be feasible for the two contractors that are not health care providers to report outcomes without further MIS development.

Type 2 clients are those encountered in group or public settings. We recommend that the following measures be collected on such outreach contacts:

- Number of attendees at a group outreach or health education event
- Type of event (with standard definitions provided to contractors)
- Type of location of the event (with standard definitions)

The Trust should work with contractors to design standard reporting definitions and forms.

For both types of health education contacts (type 1 and type 2), the pre-post reporting approach should be dropped. The quality of health education could be monitored qualitatively through observations**.**

Recommendation Six

We recommend that the Trust reexamine the data flow between CHWs and HNs so that clients are asked personal questions only once and in a private setting. Exactly how this is achieved should be based on discussions with contractors. As an example, CHWs could collect only very limited data needed to make a referral, such as names and telephone numbers. If no referral is made at the time of an outreach contact, no personal information would be collected. (Instead, data collection would follow the type 2 model outlined above.) The Trust might consider obtaining a review of procedures from an Institutional Review Board, in order to develop more consistent cross-contractor procedures for data collection that do not risk a violation of client confidentiality.

We hope that these recommendations are useful to the Trust as you plan improvements to the HCiOC program and in other similar efforts to improve the health of children and adolescents in Miami-Dade County.

Appendix A
Site Visit Interviews and Observations

Background Interviews

1 Manuel Fermin, CEO, Healthy Start Coalition of Miami-Dade
2 Marty Lucia, Office of Countywide Healthcare Planning
3 Joyce Nunez, Director, Community Access Program of Miami-Dade
4 Leda Perez, Director, Community Voices, Miami
5 Janet Perkins, Executive Director, Office of Countywide Healthcare Planning
6 Marta Pizarro, Independent Consultant
7 Joseph Rogers, Senior V.P., North Broward Hospital District
8 Victor-Jose Santana, Community Voices, Miami
9 Mark Welsh, Community Access Program of Miami-Dade

Contractor Interviews

	Citrus Health Network	**Community Health of Santa Dade**	**Economic Opportunity Family Health Center**	**Haitian Neighborhood Center**	**Human Services Coalition**	**Public Health Trust**
Executive Director	Mario Jardon	Brodes Hartley	Annie Neasman	Gepsie Metellus	Daniella Levine	Sandy Sears, VP
Program Coordinator	Vivian Jardon	Hermine Pollard	Pearl James	-	Frances Penha	Ebeneezer Boakye
Data Manager	Mike Milian	Rashida Biggs (of HealthChoice Net)	-	-	Melissa Bohler	Dayna Lopez
Other Staff	-	-	-	Josette Josue Fedra Orelus	-	-

Program Observation

CHWs	2	2	2	2	1	0
HNs	2	2	2	0	1	4

Appendix B: Key Features of HCiOC Contractor Management Information Systems

I. MIS Feature	Citrus Health Network	Community Health of South Dade	EOFHC	Sant La/Haitian Neighborhood Center	Human Services Coalition	Public Health Trust/Jackson
Employs a data manager	Yes	Yes – by subcontract to HCN	No	No	Yes	Yes
TCT data collection is manual, electronic, or both	Both-manual forms by CHW then entered into electronic web-based application by HN	Paper log entered into Medical Manager system	Paper log entered into EXCEL master log	Paper intake form used to update paper log	Paper log entered into EXCEL master log	Paper intake form then entered into EXCEL master log
TCT report production is manual, electronic, or both (software)	Electronic (SQL)	Manual, but is developing report capacity	Electronic (EXCEL)	Electronic (EXCEL)	Electronic (EXCEL)	Electronic (EXCEL)
Unduplicates clients for TCT report	Yes-database searched before new entry	No	No	No	No	No
Counts only children and families for TCT report	Yes	No	No	No	No	No
MIS currently supports program management	Yes	No	No	No	No	Yes
MIS currently tracks clients for follow up	Yes (live on-line)	Yes (live on-line)	One CHW uses EXCEL to track clients	No	No	Only through periodic internal EXCEL reports

Source: Site visit conducted in February 2007 by the Urban Institute for The Children's Trust and review of MIS documents.

Appendix C
Suggested Guidelines and Topics for HCiOC Health Education

Health-education materials should be provided in multiple languages at or below the 7th-grade reading level. Targeted messages and CHW/HN training could be provided in the following domains:

- *Preventive Care and Developmental Surveillance*: The CHW/HNs could receive training in the recommended American Academy of Pediatrics (AAP) schedules for immunizations and preventive-care doctor visits. CHW/HNs could also provide reminders about the importance of talking and reading aloud to young children and components of high quality early childhood education.

- *Nutrition and Physical Activity*: Families could be advised to eat well, following the USDA's food pyramid and "5 a day" guidelines, as well as the AAP's guidelines regarding quantity/quality of television viewing and outdoor activity.

- *Safety*: Car seat, bicycle helmet, CPR training, home safety, gun safety, and water safety messages could be provided, in partnership with Injury Free Prevention for Kids Miami, the American Heart Association, and other local organizations.

- *Mental Health and Substance (including Tobacco) Abuse Prevention*: Staff could be trained in addressing postpartum depression, reducing child exposure to tobacco smoke, and reducing the risk of other substance use.

- *Oral Health*: CHWs/HNs could emphasize the need for children to have a dental home by age 3 and to adopt good oral hygiene practices by age 1.

- *Resources for Children with Special Health Care Needs*: CHWs/HNs should be trained in how to offer guidance to parents of children with special health care needs, and be aware of where to refer children for specialty medical care, case management, and other programs. HealthConnect should strengthen its partnership with existing state- and federally-funded programs, such as Children's Medical Services.