Enos Park Access to Care Collaborative, Springfield, IL

The Problem: The 2015 Sangamon County Community Health needs assessment conducted by HSHS St. John’s Hospital, Memorial Medical Center, and Sangamon County Department of Public Health 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 2300 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 collaboration with MMC, HSHS, and SIU FCM.

Strategy: Implementation of a Community Health Worker program to work with the 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 and second year. Additional support totaling $78,000 was received from Friends of Memorial and the MidWest Dairy Council to fund community outreach projects among others.

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: 640 People Reached in Year 2 (455 were impacted in Year 1)
(Some were assisted more than once through various services.)

- 300 clients enrolled with Community Health Workers since Oct 2015
  - 136 new clients enrolled in year 2
  - 164 clients enrolled since inception have graduated from the program
  - 67 children enrolled since inception
  - 116 clients active at the end of year 2
  - Spent 143,830 minutes since inception with clients (2,397 hours); 102,760 of these minutes occurred in year 2

- 43 youth (aged 9 to 14) through Bike Club and Summer Enrichment Program
- 504 people through community outreach activities (i.e. Trunk ‘R Treat, National Night Out, etc.)
- 8 families through the Memorial Behavioral Health’s MOSAIC Program
- 39 parolees
- 33 individuals who were homeless
- 7 veterans

Increased Self-Sufficiency Measures in Year 2

- Employment by 64%
- Income by 52%
- Food and nutrition by 31%
- Health care coverage by 8%
- Life skills by 8%
- Mobility by 14%
- Community Involvement by 7%

Increased Access in Year 2

- 100% selected a primary care home
  - 599 primary care provider appointments made
  - Accompanied clients to:
    - 237 specialty appointments
    - 253 physician visits
  - 93% of our patients saw a primary care provider at least once in the past year
  - 81% show rate (national avg. 60-80%)
- 100% health insurance enrollment
- 22% reduction in unnecessary emergency department visits
- 46 dental appointments, resulting in more than 22 cavities addressed and completion of three full dental extractions
- 172 mental health service visits received and Community Health Workers accompanied clients to 103 of these visits

Addressed Other Needs in Year 2

- Worked with patients 209 times to address housing needs, resulting in a 74% improvement in the safety of their housing (housing rental, advocacy, rent, utilities, etc.)
- Made 479 social service agency referrals in year 2 and accompanied clients to 238 referrals
- Provided transportation to patients 2,891 times
- Partnered with more than 40 other community agencies
- Accompanied clients 124 times to the food pantry
- CHWs educated 22 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 $251,606 through disability or reinstatement of benefits or employment
• Assisted 30 people to obtain an ID
• 34% of the time when a patient calls before going to the emergency department an emergency department visit was avoided

**Neighborhood Connections in Year 2**

• 38 client referrals from other agencies
• 10 meetings held with community residents leading to 18 plus different activities being held including:
  - Summer in The Park Program (16 community sponsors- 9 weeks in length and free)
    - Garden Club
    - Construction Club
    - Bicycle Club
    - Read 5 Club
    - Boy Scout Club
    - Art Club
  - Food Bank Fresh Food Distribution
  - SIU School of Medicine Medical Students’ Day of Service
  - 94 radon kits places, 49 collects, 7 initial elevations, 3 needing mitigated
  - SIU School of Medicine’s New Medical Student Experience (A Journey through Your Patient’s Health)
  - Christmas Pajama Party at neighborhood library
  - Purpose Built Communities Meeting
  - Truck N Treat
  - Delivery of food to shut ins at Hildebrandt High Rise
  - Presents for Clients
  - Thanksgiving Meals Delivery
  - Baby Shower for client at Kumler Church
  - Meal train participation for community member who was ill
  - Sewing Club
  - Club for Seniors
• 17 meetings held with Provider Alliance Group or its members leading to:
  - Trainings on Mental Health First Aide (3 separate trainings) and Trauma Informed Care (1 training) offered
  - Kumler Church to develop new programs (Sewing, Seniors, Recycling) (3 meetings) and Cleaning Classes for Hildebrandt High Rise (2 meetings)
  - Community Garden meetings with SIU and HSHS (3 meetings)
  - Illinois Emergency Management Agency to develop radon program in Enos Park (4 meetings)
  - Meetings with Community Connection Point (1 meeting)

**Discoveries**

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<th>The Good</th>
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<td><strong>Expanding Partnerships</strong></td>
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<tr>
<td>Enos Park Neighborhood Improvement Association</td>
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<td>Springfield Police Dept. Neighborhood Police Officers</td>
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<td>Memorial Behavioral Health MOSAIC program</td>
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- Third Presbyterian Church
- McClernand Elementary School
- Central Counties Health Center (FQHC)
- Numerous community and social service agencies

**Effect on recidivism (parolees returning to prison)**

- 0% post release in year 2 (average period of time out of prison currently is 6 months)- average for the demographics we serve is a 25.6% recidivism rate at one year post release

**Reduction in neighborhood calls to police**

- During Year 1, the police experienced a reduction in calls from the Enos Park neighborhood, which continued in Year 2. Overall from Oct. 2015-Sept. 2017 there has been a 22% reduction in calls to the Springfield Police Department from this neighborhood.

<table>
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<th>The Challenging</th>
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<td>The overall need is great!</td>
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<td>Data access is complicated.</td>
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<td>Developing a data base is complex.</td>
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<td>Transient nature of the neighborhood’s super utilizers (people who frequently use hospital emergency departments as their primary source of health care services)</td>
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<td>Lack of housing, employment and parolee support programs</td>
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**Second-Year Impacts**

Three major areas were impacted during since inception of the program: Enos Park residents; the overall Springfield health care system; and Community Health Workers themselves.

**Enos Park Residents:** Nearly 38% 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 greater than 90% show rate and high level of billing by both the primary care provider and mental health specialists. The clinic has expanded from 2x/month to 6x/month due to the demand and acceptance of this clinic model by clients.

SIU has implemented a new documentation in the electronic health record to capture elements around providing care facilitation services. The Springfield Police Department has implemented a new pilot of
having a behavioral health consultant from SIU FCM ride along (3 hours/week) to follow up on clients with mental health concerns and has demonstrated a 89% reduction in repeat 9-1-1 calls by those being visited (still in pilot). Also Helping Hands Homeless Shelter has contracted with SIU Center for Family Medicine to increase mental health access for their clients (10 hours/month) based upon the relationship built through work with them on the Enos project.

Community Health Workers: The Enos Park Community Health Workers have participated in more than 250 hours of training.

Dr. Smith presented 14 times including locally (4), regionally (6), and nationally (4) on the project. The Enos Park Project was covered also in 3 interviews and highlighted in 6 articles during Year 2 of implementation.

Summary and Future
Year three 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. 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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