# EVALUATION AND ASSESSMENT

## A Brief Guide to Useful Strategies and Tools

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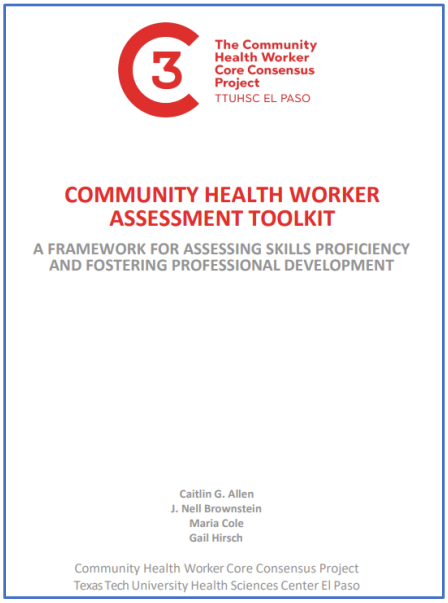
**As part of the work conducted for the**
***Oklahoma Community Health Worker Coalition***


# RECOMMENDED TOOLS AND MEASURES

## The C3 CHW Assessment Toolkit




This toolkit provides a framework and tools to assess CHW skill proficiencies tied in with the C3 Project.

CHW skill proficiencies should be evaluated to *(see p. 2)*:

- *Reduce CHW turnover*
- *Improve CHW capacity to deliver interventions with greater fidelity*
- *Enhance effectiveness in working with community members and team members*

The assessment toolkit is available here:
https://www.c3project.org/_files/ugd/7ec423_c3c4b559904d417e851c5dfb5ab25bc8.pdf

## CHW Common Indicator Project

**CHW Common Indicators Project: Proposed Indicators for Priority Constructs (version 02-18-2023)**
(References available upon request.)

The CHW Common Indicator (CI) Project developed a grid with constructs to be measured, their definition, rational for measuring, and how to operationalize the measurement. The most recent indicator grid is from February 2023:

- CHW Common Indicators Project: Proposed Indicators for Priority Constructs (version 02-18-2023) https://cdn.ymaws.com/www.nwrpca.org/resource/resmgr/chw_webpage/2023-02-18_chw_common_indica.pdf

A 2021 publication describes the CHW Common Indicators, and how CHWs were able to contribute to the integrity, sustainability, and practicality of CHW programs by collaborating with the development and adoption of common process and outcomes constructs and indicators for CHW practice and program implementation.

- Rodela K, Wiggins N, Maes K, Campos-Dominguez T, Adewumi V, Jewell P, Mayfield-Johnson S. The Community Health Worker (CHW) Common Indicators Project: Engaging CHWs in Measurement to Sustain the Profession. Front Public Health 2021; 9:674858. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8258143/

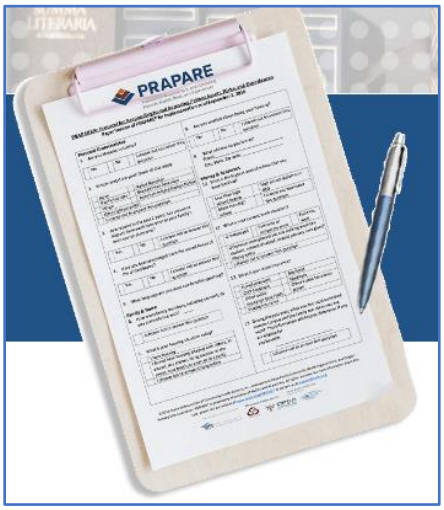
In a 2022 webinar, the Leadership Team of the CHW CI Project shared the purpose, goals, and history of the project, introduced the indicators and how to use them, and stresses CHW leadership in evaluation.

- Leadership Team Members, CHW Common Indicator Project. Using the CHW Common Indicators in Your 2109 Evaluation. Recorded Webinar (1:08:20), February 8, 2022. https://www.youtube.com/watch?v=cYlDBZZfnQQ

Information on the CHW Common Indicators Project by the Northwest Regional Primary Care Association is available here:

- Northwest Regional Primary Care Association (Alaska, Oregon, Idaho, Washington)
  CHW Common Indicators Project https://www.nwrpca.org/page/CHWCommonIndicators

## Assessment Tools Used by CHWs can be Used for Evaluation of CHW Impact




PRAPARE™ – Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. Implementation and Action Toolkit, 2022.

Information about the tool is available at https://prapare.org/wp-content/uploads/2022/09/Full-Toolkit_June-2022_Final.pdf

The PRAPARE™ tool is available at https://prapare.org/the-prapare-screening-tool/

## Return of Investment Studies

CHW programs have shown good Returns on Investment (ROI). One study found that every dollar invested in a CHW intervention returned $2.47 to an average Medicaid payer within the fiscal year.

- Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Affairs, 2020, 29(2). https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981

The Association of State and Territorial Health Officials (ASTHO) published a document compiling evidence of CHW effectiveness, including ROI studies:

- Community Health Workers: Evidence of their Effectiveness https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf

MHP Salud (mhpsalud.org) describes and demonstrates the excellent ROI of CHWs, and provides an ROI Toolkit and ROI Training on its website:

- Community Health Workers and Return on Investment (ROI)
  https://mhpsalud.org/programs/community-health-workers-roi/

## Community Health Worker Success Stories

Sharing stories can be a powerful tool to demonstrate the positive impact of CHWs. The CDC, for example, has included stories about the positive impact of CHWs in their collection of success stories. In these stories, the CDC shares information of the problem that needed to be addressed, what intervention or strategy was implemented, what the result was, and what the next steps would be. The stories are available here: https://nccd.cdc.gov/nccdsuccessstories/searchstories.aspx

A collection of CHW success stories from the Community Health Council (CHC) of Wyandotte County, Kansas are accessible here: https://www.wycohealth.com/chc-home/chc-initiatives/community-health-workers/chw-success-stories/

# CHW EFFECTIVENESS EVALUATION MEASURES AND STANDARDIZED TOOLS USED IN OKLAHOMA

## Oklahoma State Department of Health (OSDH)

OSDH asks each district to send in a monthly CHW highlight to be shared. Information requested includes: CHW name, community served, why they like being a CHW, and a story of a client or group that they helped successfully. The OSDH has several CHW success stories available here: https://vimeo.com/showcase/communityhealthworkers. OSDH develops quarterly reports for each district. The following measures are documented: # of client contact; # of referrals; # of media stories, and success stories.

OSDH CHWs use the PRAPARE™ tool translated into a survey for baseline and 3-months follow-up. Measures documented include: # of COVID-19 cases; meetings attended; messages developed; # of clients; specific health conditions; vaccine and testing events; # screened; # Medicaid applications; referral needed; connecting to health department services; ER & primary care questions; follow-up questions to ER questions, e.g. reason for ER visit; self-reporting; if referral met need or if clients needed follow-up (if referral was completed).

## Tulsa Health Department (THD)

THD evaluates three CHW programs: ER Utilizers, COVID-19, and New Mothers. Evaluations are described below:

1. **ER Utilizers**
   Process: To determine the patient's referral plan, questions were taken from: American Academy of Family Physicians Social Needs Screening Tool; The EveryONE Project; and WellRX Tool.
   Outcome (30-day program): 90-day pre/post program, ER utilization, inpatient visits, outpatient visits, urgent care visits, follow up visits, ROI.

2. **COVID-19 Outreach**
   Process: THD Community Outreach Specialists and Supervisor will develop professional relationships with local pharmacies, schools, businesses, community health clinics, homeless shelters, subsidized housing organizations, and other community partner organizations to provide public health information, including vaccine information, at-home Covid tests and STI prevention information; and create opportunities for vaccination sites, focusing on disproportionally affected populations.
   Outcomes: Outreach activities and clinics including organizations, businesses and individuals reached; public health education provided; and vaccines provided will be reported monthly to supervisor and manager.

3. **New Mothers**
   The MCH outreach team primarily serves families with children, including pregnant moms, and provides enrollment into SoonerCare as well as other referrals as needed. Since Adult Medicaid expansion, the team is also able to enroll ages 19-64 without a minor child in the home.
   Process: Outreach workers (CHWs) in the MCH outreach program provide services which often include SoonerCare agency new enrollment assistance for walk-in clients to THD and via phone whenever possible. They can verify income and other documentation requested by OHCA and upload it to their case. CHWs complete a database entry on each contact via a Qualtrics link to capture demographic data, what was provided to the client in terms of education, materials and referrals. NOTE: The outreach process is episodic in that we see the client through to enrollment completion and referrals provided. The client is encouraged to contact the team for renewal annually and when any changes need to be made to the application. The MCH outreach team will launch a customer service satisfaction link beginning in July of 2023 to get feedback on client experiences with the team.
   Outcomes: MCH outreach captures data regarding the number of individuals enrolled, information and referrals provided and demographics on clients served. This data is assembled into a quarterly report which includes information on numbers served by zip code, where referrals were referred from, and services provided. MCH will add the results of the customer service link beginning with the fall 2023 Quarterly report.

## MyHealth Access Network

MyHealth Access Network (https://myhealthaccess.net/ ) uses a mobile screening system in partnership with its Oklahoma health care partners. Screening for Social Determinants of Health (SDOH) using the Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool (HRSN) includes:

- Housing instability and quality
- Food insecurity
- Utility needs
- Interpersonal violence
- Transportation needs beyond medical transportation

More information on the MyHealth process is available here: https://myhealthaccess.net/sdoh/

The AHC HRSN Screening Tool is available here: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf