The Benefits of Social Support From Community Health Workers: A Qualitative Study of a Local CHW Program for People Experiencing Homelessness

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Scholarly Report submitted in partial fulfillment of the MD Degree at Harvard Medical School

Date: 20 February 2020
Student Name: Sophia Meyerson Herts, BA

Scholarly Report Title: The benefits of social support: A qualitative study of a Community Health Worker program for people experiencing homelessness

Mentor Name(s) and Affiliations: Barbara Gottlieb, MD, MPH, Department of Medicine, Brigham and Women’s Hospital; Singumbe Muyeba, PhD, Josef Korbel School of International Studies, University of Denver

Collaborators, with Affiliations: The Massachusetts Housing & Shelter Alliance
Abstract

Title: The benefits of social support from Community Health Workers: A qualitative study of a local CHW program for people experiencing homelessness

Authors: Sophia Meyerson Herts, Singumbe Muyeba and Barbara Gottlieb

Purpose: This report describes findings from a qualitative evaluation of a Community Health Worker (CHW) program: Hospital to Housing, a grant-funded program run by the Massachusetts Housing and Shelter Alliance and the Massachusetts Behavioral Health Partnership/Beacon Health Options. Beyond evaluating the role of CHWs in this specific program, this project aims to contribute to a broader understanding of how CHWs can address the needs of marginalized, medically and socially complex populations.

Methods: This program evaluation was a qualitative, descriptive study with the purpose of program evaluation. Twenty-six semi-structured interviews were conducted with the CHWs (n = 4), a selection of their clients (n = 15), and both current and prior program leaders (n = 7) to explore stakeholder perspectives on the CHW role. Clients were sampled until a point of saturation was reached – when no new concepts emerged from additional interviews. To analyze the interview transcripts, a grounded theory approach was used to inductively develop and assign codes.

Results: Five key CHW roles were identified: relationship-building, social support, system navigation for housing, system navigation for health care and community engagement. Program strengths included therapeutic relationships between the CHWs and their clients, the program’s outreach-based approach, and the flexibility of the CHW role. Program challenges included variability among the CHWs, inadequate supervision and support, and a lack of affordable housing options.

Conclusions: The findings from this evaluation demonstrate the potential for CHW programs to incrementally yet meaningfully impact well-being and engagement with services among chronically homeless populations. These findings also suggest that the effectiveness of CHW programs depends on both individual CHW efficacy as well as program design. Lessons learned include that social support is a crucial component of the CHW role and that hands-on, client-centered supervision is essential in order to balance CHW flexibility and consistency.
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Glossary of Abbreviations

ACO: Accountable Care Organization

CHW: Community Health Worker

MBHP: Massachusetts Behavioral Health Partnership

MCO: Managed Care Organization

MHSA: Massachusetts Housing and Shelter Alliance
Section 1: Introduction

Community Health Workers (CHWs) are increasingly being recognized as an important component to achieving the quality, cost and outcome goals of health care reform. Although CHW programs have formally existed in the United States since the 1960s, these programs have typically been small, short-term and grant-funded. However, in 2010, the passage of the Affordable Care Act started to change this landscape. The Affordable Care Act generated new funding mechanisms and highlighted “the key role of Community Health Workers in achieving important goals of health care reform.” Since then, the formation of Accountable Care Organizations (ACOs) and the ongoing shift from fee-for-service to value-based payment models have sparked further interest in funding and implementing CHW programs.

A CHW is defined as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.” As this definition suggests, CHWs take a client-centered approach, adapting their role to suit each client’s needs. Depending on the program design and individual client needs, CHWs perform a variety of roles including education, cultural mediation, outreach, advocacy, care coordination, system navigation, and social support.

As more and more health care entities implement CHW programs, it is important to understand what makes CHW programs effective. While quantitative evidence on the effectiveness of CHWs demonstrates mixed results, the variation among CHW programs makes it difficult to draw conclusions from these studies. As Dr. Shreya Kangovi, director of the Penn Center for CHWs, wrote, “Saying that ‘Community Health Workers are effective’ is like saying ‘movies are good.’ Some are; others aren’t. The key question is not whether Community Health Workers are effective, but how we can make them as effective as possible.”

In order to understand how to make CHWs as effective as possible, it is necessary to define and describe the key elements of their work. However, the very nature of CHWs’ work – flexible, adaptable and client-driven – makes it challenging to capture exactly what CHWs do. Because of this challenge, research and program evaluation should be done in close collaboration with the people who best understand this work – CHWs and their clients.

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1 Kangovi, 2015.
2 Rosenthal, et. al., 2010.
3 American Public Health Association. “Community Health Workers.”
4 CHW Core Consensus (C3) Project, 2016.
5 Individual studies show that CHW interventions improve chronic disease outcomes, and reduce utilization of emergency and inpatient health care services. But recent systematic reviews demonstrate that while many CHW interventions lead to improved outcomes, not all of them do. For instance, Kim’s systematic review found that 62% of RCTs examining cardiovascular risk (n = 26) demonstrated that the CHW intervention led to a statistically significant decrease in cardiovascular risk factors. And in Jack’s systematic review of the impact of CHWs on the use of healthcare services, they found that 42% of RCTs measuring ED visits, hospitalizations or urgent care visits (n = 16) demonstrated that the CHW intervention led to a statistically significant decrease in use of at least one of these services. Kim et. al., 2016. Jack et. al., 2017.
6 Kangovi, 2018.
This study aims to provide a nuanced and detailed understanding of the work that CHWs do within the Hospital to Housing program, a grant-funded program that employs CHWs to assist chronically homeless individuals in obtaining housing and engaging with primary care services. Through exploring stakeholder perspectives, this evaluation aims to describe the key components of the CHW role and the factors that influence CHWs’ effectiveness. By doing so, this evaluation addresses several knowledge gaps. First, there are few qualitative studies examining the CHW role in the United States. Second, to the best of our knowledge, there are few public records of similar CHW programs specifically targeting chronically homeless and high utilizer populations. Thus, assessment of the Hospital to Housing program presents an opportunity to understand the role of CHWs in a new context while also identifying best practices that are transferable to other programs.

Section 2: Methods

**Study Design:** This is a qualitative, descriptive study for the purpose of program evaluation. This evaluation was submitted to the Institutional Review Board of the Harvard Faculty of Medicine, and was deemed IRB exempt as program evaluation rather than human subjects research.

**Study Setting:** The Hospital to Housing program is a three-year grant-funded program run by a partnership between a homeless advocacy organization, the Massachusetts Housing & Shelter Alliance (MHSA), and the Massachusetts Behavioral Health Partnership/Beacon Health Options (MBHP/Beacon), a behavioral health managed care organization. The program consists of five CHWs located across Massachusetts (Boston, Pittsfield, and Lowell). The CHWs work with chronically homeless individuals with serious mental health conditions who frequently utilize emergency and inpatient behavioral health services. The CHWs help these individuals obtain permanent supportive housing and engage with community-based behavioral health and primary care services. The goals of the program are to place individuals into housing and improve their health through reducing avoidable utilization of acute health care services and increasing utilization of outpatient services.

All CHWs are hired and employed by MBHP/Beacon. Their caseloads range from 15-20 clients. They work with clients for a variable amount of time, from six months to at least three years. At the time of this study, the CHWs received supervision from the program director at MHSA and administrative support from program leaders at MBHP/Beacon. During the study, one CHW was promoted to Senior CHW, and began supervising the other CHWs.

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1. A literature search revealed only a few qualitative studies on CHW programs, including: Heisler 2009, Ingram 2005, the C3 Project 2016, Purales 2018. According to Glenton, only 17% of trials involving CHWs also conducted qualitative research, but the descriptions of methods and results were sparse. In the conclusion, Glenton argues for the need for more qualitative research examining CHW programs. Glenton et. al., 2011.
2. The only public record found was a 3-year pilot project through the National Health Care for the Homeless Council, funded by the Center for Medicare & Medicaid Innovation through a Health Care Innovation Award. National Health Care for the Homeless, 2016.
**Participant Sampling:** All current program leaders were interviewed, as well as the three prior leaders. All but one of the CHWs were interviewed. A purposive sampling method referred to as maximum variation sampling was used to select clients. This is a technique commonly used in qualitative studies to identify how a phenomenon (in this case, the impact of program participation) is understood among different people, and to identify common themes that cut across this variation. For this evaluation, clients were selected so that the sample displayed diversity across domains of interest, including the specific CHW with whom clients worked, geography (Boston, Lowell, Pittsfield), and housing status (recently housed or homeless). Exclusion criteria included any clients who had been working with their CHW for less than three months, any clients that the CHWs believed might not feel emotionally safe during the interview, and any clients with a cognitive impairment that would prevent them from consenting, as determined by the CHWs. Interviews with clients were conducted until reaching theoretical saturation (when no new themes emerged from additional interviews).

**Data Collection:** Semi-structured, in-depth interviews were conducted with all participants. The interview guides (Appendix B) were developed with assistance from a panel of content experts. A single interviewer (S.M.H.) who was trained in qualitative interviewing conducted and audio-recorded all interviews. Interviews lasted between 60 to 120 minutes. The interviews took place at a location of each participant’s choice. Clients were given a $10 gift card for their participation in the program evaluation. Written consent from all participants was obtained before the interviews.

**Data Analysis:** An inductive, grounded theory approach was employed. Grounded theory methods allow for the construction of theories that emerge from the data. All interviews were transcribed. Two coders (S.M.H. and S.M.) separately developed and assigned inductive codes for 20% of the transcripts. After comparing codes and resolving inconsistencies, one coder (S.M.H.) continued to develop and assign codes for the remaining transcripts. The codes were used to identify common themes, which were further analyzed into broader themes and then linked to establish theoretical statements.

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9 Palinkas, et. al., 2015.
11 Charmaz, Chapter 1: An Invitation to Grounded Theory, 2006.
12 Ibid.
Section 3: Results

1. Participant Characteristics

26 interviews were conducted including 15 clients, 4 CHWs, and 7 current and prior program leaders. All participating clients met inclusion criteria for the Hospital to Housing program. These criteria included chronic homelessness (being homeless for at least one year or on at least four occasions in the last three years), having at least one mental health diagnosis, and meeting program criteria for high utilization of acute health care services (three inpatient behavioral health hospitalizations in the last year)\(^1\) In addition to homelessness, other significant challenges that clients described were trauma histories, social isolation and mistrust of the health care system. Client demographics are displayed in Table 1. Program leader characteristics are displayed in Table 2. Because of the small number of CHWs, their characteristics are not displayed in order to protect anonymity.

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<thead>
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<td>Male</td>
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<tr>
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<td>Current vs. prior leader</td>
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<td>4 Prior:</td>
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2. The CHW Role

The interviews suggest that the Hospital to Housing CHWs perform five key roles: 1) Relationship-building: getting to know clients through consistently reaching out, engaging in unstructured conversations, and utilizing appropriate self-disclosure; 2) Social support: spending time with clients without a specific agenda, accompanying clients to appointments and to complete tasks, frequently checking in with clients, providing encouragement, and supporting clients unconditionally; 3) System navigation for housing: referring clients to housing organizations, searching for housing options, addressing barriers to housing, and assisting with the application process; 4) System navigation for health care: referring clients to health care resources, assisting with scheduling and remembering appointments, problem-solving to help clients manage their medical issues, and coordinating with health care providers and managed care organization staff; and 5) Community engagement: referring clients to community resources and doing community activities together with clients.

\(^1\) Chronic homelessness as defined by the Housing and Urban Development definition; acute utilization as defined by Hospital to Housing program guidelines.
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<th>Subthemes</th>
<th>Quotations</th>
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| Relationship-building        | - Client: “When I met [my CHW], I was very distant from her. I used to hide from her when we had appointments, but she always found me. No matter where I was, I’d turn around and there was her face. …She kept coming and coming. When I went to the psych hospital or the emergency room, she came to visit me. When I was inpatient, she came to visit me.”  
- CHW: “To form the initial relationship, I visit my clients [in the hospital]. I go every day or multiple times a day. Pop in, here I am again. Getting to know them there has been really helpful. …I think it’s been the showing up with no agenda. Just going and sitting. I don’t delve too deep. Details certainly come out, but it’s really just sitting there.”  
- Client: “[My CHW] shared pieces of her life. I found out she’s in recovery. Then I found out she liked chocolate. Then one day she mentioned something about her kids. …She’s helping me get on track, but why does she need to share who she is? It’s just, trust. Made me connect with her. Then I was more inclined to feel comfortable with her. Because here she is willing to tell me something about her personal life. It made me feel she cared.”  |
| Social support                | - Client: “We’ll meet just to talk. And that’s what I find helpful. I’ve been really on guard with people. And so just being with somebody and laughing some and feeling at ease again, I like.”  
- Client: “[When my CHW comes to appointments], it helps me with my anxiety. She does a lot of the talking. With my anxiety, I have a very hard time with people. She’ll come with me whenever I ask her to, if she has the time.”  
- Client: “[My CHW] talks to me every day. She makes sure I’m okay. Makes sure I’m mentally okay.”  
- Client: “I’ve been having a lot of problems with my ears. …And that’s the biggest fear I have – losing my hearing. I told [my CHW], if I lost my hearing, I couldn’t survive. She’s the one that encouraged me to go to the ear doctor. And she’s been going with me. We’ve been going back and forth, back and forth, trying figure out what the hell is going on. So [my CHW] has been a great support for me. Nobody else ever did all that for me before.”  |
| System navigation for housing | - CHW: “I don’t know anything about housing. It’s a huge complicated system and I don’t have the in. People that work for housing organizations will hear like, oh there’s vouchers coming up in some place, or there’s units becoming available. So the key is to make an inroad with one or two housing people and send your clients that way. Then I monitor what’s happening. I will email, make phone calls, follow through, but the actual applications – that nitty gritty type of stuff – I don’t do.”  
- CHW: “When someone qualifies for housing, it’s like a puzzle that I need to put together so they can even apply. I help people with the issues that they need to fix before they can do the application.”  
- CHW: “I don’t want [my clients] to think that I’m going to give them a home because I don’t have that power. I don’t have anything in my hands that I can offer them, more than anyone else. But the difference is that I can do it one-on-one with them. I’m always available. I’m always with them. I support them.”  |
| System navigation for health care | - CHW: “Setting them up very quickly with primary care and psychiatry, and getting medications regulated is right at the very top of my list. I try to set them up with daily meds from a vising nurse or [health care organization]. Take it out of their hands. And getting their meds in a lock up. Cause at shelters there’s no place to keep your meds. They get stolen and then, it’s such a bad cycle.”  
- Client: “The lady said, ‘I don’t know what to tell you. I can’t help you.’ And she hung up the fucking phone on me. After that I said, ‘I’m done with this.’ I could not even try to deal with making another [primary care] appointment. My mind was just like, you sons of bitches, treating me that way. That’s wrong. So I called [my CHW] and let her know. She was like, ‘You just need to go up there in person.’ So I went up there.”  
- Client: “[My CHW] would come over. She would ask, ‘Have you been taking your meds? How’re things going?’ And the medication stabilized me. It’s been a great help. I tried going without my meds, forget it. Because when I don’t take my medication, my bipolar gets crazy.”  
- CHW: “It’s really beneficial to form teams with outside providers. And to work with the clinical social workers [at the MCO] and with the teams that are already established. Like there’s a project called the Readmission Project within [the MCO]. At my urging we’re trying to embed ourselves within these care teams. A lot of the success that I’ve had is because I work with them.”  |
| Community engagement          | - Client: “[My CHW is] trying to help me get back to work cause it’s not a good thing for me to be idle. …But I need to help people. I need to be able to see a change in something. So [my CHW] looks at it that way. She’ll tell me, ‘Oh did you check in at [non-profit serving youth]? Or [shelter] again?’”  
- CHW: “We’re trying to get [clients] involved in community and other resources. Like with [client name]. She has food delivery. She has a therapist. She has somebody distributing her meds every day. My next move is trying to get her to go to the YMCA next door to her house. Maybe she’ll make a friend.”  |
3. Strengths of the Hospital to Housing Program

3.1. Therapeutic relationships

The CHWs established strong therapeutic relationships with their clients. Despite longstanding social isolation, most clients expressed a feeling of connection with their CHW. Clients emphasized the importance of this connection and described many benefits including feeling comfortable reaching out for help, feeling less lonely, having more hope and greater self-esteem, and experiencing incremental improvements in their mood.

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<tr>
<th>Subthemes</th>
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<td>The importance of connection</td>
<td>- CHW: “Our work is defined as bridging and connecting clients to services, but the real work for me has been forming connections with our clients where they come to me and count on me. Any success I’ve had has come from these relationships.”</td>
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<tr>
<td>Reaching out for help</td>
<td>- Client: “I don’t know how it’s happened, but [my CHW has] just made me comfortable enough where I can text her and say, ‘Hey, just checking in.’ I can do that with my sisters. I don’t do that with anyone else.”</td>
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<td>- Client: “I know I can always reach out to [my CHW]. If I were to text her now and say, ‘I have a problem’, she’s going to tell me what she’s doing and when she’ll contact me back. Like [with my rent], I told her I was having a problem, she contacted [the housing authority], and then they finally got back to me. That works out for me. But at the shelter, it was different. They don’t pay people attention. So I never asked them, like, look into that or call over there or find out about that.”</td>
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<tr>
<td>Decreased loneliness</td>
<td>- Client: “It feels like I’m not so alone. Like I’m not doing this all by myself. When I feel alone, I get in a space where it’s like, oh my god, nobody likes me. Nobody really cares. I can’t do this. This is just too hard. But when someone’s helping me, that gets better.”</td>
</tr>
<tr>
<td>Increased hope and self-esteem</td>
<td>- Client: “[My CHW] was there to say I’m here for you, no matter through the right or wrong, good or bad. I’m not going to let you give up. I’m going to care about you whether you like it or not. I’m not going to say, do it on your own. I’m going to be there as your worker to make sure you do this and this and this, instead of me giving up on myself. That’s the attitude that she gave me. Keep fighting, we’ll make it.”</td>
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<td></td>
<td>- Client: “And she’s sharing personal things with me about her, so she believes I’m a good person. She believes in me. It kind of gave me that extra security. That I am something, that I am important, that I can do this.”</td>
</tr>
<tr>
<td>Improved mood</td>
<td>- Client: “Sometimes I can get discouraged. I’ll be like, I’m not filling out another [job] application, which means that I’m slipping and that depression and stuff is kicking in. But it’s almost like [my CHW] just knows. Because then I’ll get a text message. …When I need her without asking for it, she’ll call me or text me. It makes me feel a little better because I know that she’s on my side. Like she’s not gonna let me drown. She’s gonna help me.”</td>
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<td></td>
<td>- Client: “[Working with my CHW] actually makes me not so stressed out. Like not so panicky. Because I know there is somebody that I could call anytime I needed to, to help me. And before her, I had nobody to call. I literally had nobody. So, having [my CHW] has like, literally, tremendously, just makes me happy.”</td>
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3.2. Being outreach and community-based

The CHWs spend most of their time out in the community. Rather than meeting clients in their offices, the CHWs meet with clients at locations they choose, such as hospital cafeterias, coffee shops, parks, public libraries, homeless shelters, and their homes (once they obtain housing). The CHWs also do community activities with clients, such as going for walks, visiting an animal shelter, or volunteering at a community garden. The interviews revealed that meeting clients in locations of their choice rather than in the CHWs’ offices fosters trust and companionship.
<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Quotations</th>
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<tbody>
<tr>
<td>Meeting with clients in the community</td>
<td>- Program leader: “The key piece with this program is that the CHWs are out in the community. They go wherever the client is. The client is inpatient, they’re going there. The client is at the shelter, they’re going there. The client is in detox, they’re going there. That the CHWs are independent agents functioning in the community is huge.”</td>
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<td></td>
<td>- CHW: “[My clients] see me like a friendly person. I see them on the street, at the library. I see my clients everywhere. …And sometimes I know that they tell me things they wouldn’t tell anyone else because I’m there with them in the city, in the community. It’s not a set-up place. It’s a place where they feel safe and comfortable.”</td>
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<tr>
<td></td>
<td>- Client: “[My caseworker] went into his office, and then he saw whoever came to the door. [My CHW] is just more hands on. Like she’s making visits to see me and whatnot. And she’s always there. So it’s not like I be alone dealing with certain things when it comes to [my CHW].”</td>
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<tr>
<td>Doing community activities</td>
<td>- CHW: “One time [my client and I] went to the animal shelter, she wanted to do that. And then for like two or three weeks we went to this weekly movie group. You had to watch the movie between. Then she lost interest in that, so I’m like, okay. But she hasn’t been in the hospital. And she’s actually becoming more positive.”</td>
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### 3.3. Flexibility

The CHWs take a client-centered and situation-specific approach. The CHWs do not have a specific checklist of tasks that they must complete with each client. Rather, they modify their approach to suit each client’s individual goals. And while the CHWs see some clients daily, they see other clients weekly or monthly. The interviews revealed that the CHWs can be so flexible because there are few restrictions on how they spend their time.

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Quotations</th>
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<tbody>
<tr>
<td>Tailored approach</td>
<td>- CHW: “The first time that [my clients and I] sit down and talk, I tell them, ‘I do a variety of things, it’s so different for everybody. So with you, what do you think your needs are? Tell me about why you think this program might help you.’ And usually we come up with a list of things. Like, ‘I don’t have a doctor. I want to quit smoking. I don’t have a place to live.’ And so, we start from there.”</td>
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<td></td>
<td>- CHW: “My experience has been that when working with clients, we all have preconceived ideas about what their problem is, what they should do. And I have always felt that you have to sit and listen to the client, and look at what they need.”</td>
</tr>
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<td></td>
<td>- Program leader: “I don’t think you can prescribe it [what the CHW-client relationship looks like]. It’s responding to whatever clients’ needs are at the time. It’s not like within four weeks you should’ve done this.”</td>
</tr>
<tr>
<td>Few restrictions</td>
<td>- CHW: “[My role is different because of] the flexibility. Like I can work all day with one client with no restrictions.”</td>
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<td>- Program leader: “Because [the CHWs are] not reimbursed, they’re not limited to only spending fifteen minutes with a client. Part of what makes them successful is that flexibility. Maybe I can spend fifteen minutes with John today. He’s fantastic until next week. But Sarah is in the middle of a crisis, so I might have to spend a couple hours with her. The CHWs have that flexibility that many other workers don’t have.”</td>
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### 4. Challenges of the Hospital to Housing Program

#### 4.1. Variability among the CHWs

Although consistent themes emerged to describe the CHWs’ roles, the interviews also revealed variability in how the CHWs perform these roles. Regarding social support, the interviews suggest that some CHWs spend more time with their clients, form closer relationships with them, and place greater value on the importance of connection. As for system navigation for housing, some of the CHWs provide hands-on support to search for and apply to housing, but other CHWs refer clients to housing organizations, staying involved to monitor their progress
but not managing the day-to-day work. And when it comes to system navigation for health care, some CHWs predominantly focus on helping clients initially access primary care and behavioral health services, while other CHWs continuously try to help clients stay engaged in these services.

4.2. Inadequate supervision and support
A lack of adequate supervision and support was highlighted as one of the greatest challenges and limitations of the program. Supervision did not occur consistently, there was high turnover among supervisors, and there was not enough clinical support for the CHWs’ personal challenges. Program leaders were aware of these challenges, and were already thinking about how to address them. Midway through this program evaluation, a new supervision model was developed. One of the CHWs was promoted to senior CHW and began supervising the others.

<table>
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<th>Subthemes</th>
<th>Quotations</th>
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| Supervision | - CHW: “[Supervision] just wasn’t consistent. It was supposed to be once a week, but it was maybe once a month.”   
- Program leader: “One of the biggest challenges we’ve struggled with is how to get consistent support for the CHWs. When the grant was written and submitted, supervision was not planned for appropriately. This has had long-lasting ramifications, with us trying to piece together a supervisory structure that is consistent and gets the CHWs what they need. We’re still working on it.”   
- Program leader: “Leadership for this program is a two-person job. I think the intention was that it would be two people, but that didn’t happen. It was one person who had programmatic, administrative and supervision responsibilities. I don’t think you could do all that effectively with one person.”   
- CHW: “When you think about the program, we’ve had so many changes. I’m not sure how it’s gonna be now, so it’s been frustrating. …I’m pretty discouraged. I’m not all excited like I used to be and whatever.” |

| Support     | - CHW: “[Our work] can be really triggering if you’re not in a good place yourself. One day of being really tired and not getting enough sleep, and who knows. It’s tough. I really think we need to have someone clinical on staff for ourselves. And I definitely think we’re lacking that – those supports.”   
- Program leader: “I think having a clinical person on staff, or somebody that can be brought in periodically, or somebody that the organization has a contract with – something like that should be in place. I do think it’s best if it’s someone who’s not necessarily employed by the program, who’s not a regular staff member. Because the CHWs need a safe space. They need somebody who’s removed from whoever is signing their paycheck.” |

4.3. Lack of affordable housing options
All of the CHWs and program leaders identified the lack of affordable housing options as a major challenge for the program. As one program leader said, “It’s challenging to have a project where the end result is permanent housing, but there’s not anything magical that the CHWs have in their toolkits. They don’t have specific vouchers – it’s the same limited number.”
Section 4: Discussion, Limitations and Conclusion

1. Discussion

This study explored CHW, client, and program leader perspectives on the role of the CHWs and the factors that influence the CHWs’ efficacy. Although this project was designed as program evaluation, it did, in fact, generate generalizable knowledge that may help other entities implement similar CHW programs. Two key lessons were: (1) social support is a crucial component of the CHW role; and (2) close supervision is essential in order to balance CHW flexibility and consistency.

Social support as a crucial component of the CHWs’ work

Social support refers to the perception of being cared for, having assistance available from other people, and belonging to a supportive social network. Although the Hospital to Housing program objectives focus on system navigation (obtaining housing and engaging with outpatient health care services), our study suggests that the CHW role of social support was crucial to both accomplishing these objectives and improving clients’ well-being. While the CHWs provide multiple types of social support in the Hospital to Housing program, our study especially emphasizes the benefits of emotional support: behavior that leads people to feel loved, cared for, and respected by others. Many clients described how their CHWs’ emotional support helped them feel less lonely, more hopeful, and more motivated to engage in services. It was also noted that the positive emotional connections between clients and their CHWs may become a model that helps clients form additional positive relationships with others.

The importance of the emotional support provided within the Hospital to Housing program suggests that future programs may benefit from emphasizing the CHW role of emotional support. However, providing emotional support is a nebulous concept that may be difficult to effectively operationalize. Our findings suggest that CHWs’ ability to provide emotional support depends on both program design as well as individual CHW efficacy. Regarding program design, our study suggests that programs can create an environment that promotes social support by encouraging community outreach, limiting restrictions on how CHWs spend their time, maintaining low caseloads, and discussing client-CHW relationships during supervision and group discussion. Regarding individual CHW efficacy, our study offers potential best practices for how to provide emotional support. These practices include getting to know clients on a personal level, engaging in unstructured conversations, spending time with clients without a specific agenda, spending time with clients in the community doing activities together and accompanying them to appointments, and frequently checking in with clients. Study participants emphasized

that relationship-building and connection are key. As one client said, “I have to feel something inside of me to go further with [my workers]. I have to feel connected with them. Otherwise they’re not getting my time. Because I just won’t believe that they’re serious about my best interest.”

**Balancing flexibility with consistency**

Our study reveals that a key challenge for the implementation of effective CHW programs is balancing flexibility with consistency. While CHW flexibility stood out as an important strength of the Hospital to Housing program, variability among the CHWs also stood out as a limitation on overall program efficacy.

In order to maintain CHW flexibility while also promoting specific guidelines and best practices, our study suggests that close, hands-on and client-centered supervision is essential. Because CHWs take different approaches with different clients, we suggest that the program supervisor should have detailed knowledge of the clients, including their individual circumstances and goals. The supervisor should frequently discuss individual cases with the CHWs in order to offer advice, promote best practices, and stay up-to-date with each case. It also may be beneficial for supervisors to spend time doing outreach in the community with the CHWs in order to get to know their clients and to model skills for relationship-building and social support. And it may be beneficial for supervisors to facilitate regular group discussions of client cases among all the CHWs. Overall, these suggestions are consistent with prior recommendations in the literature. However, we further emphasize the importance of supervisors discussing individual cases, conducting outreach with the CHWs, and modeling interpersonal skills.

**2. Limitations and Strengths**

This program evaluation has several limitations. First, some of the specific findings may not be generalizable to other CHW programs. This evaluation was conducted within a single CHW program that targets chronically homeless populations with serious mental health conditions and patterns of high utilization of emergency and inpatient behavioral health services. Second, this program evaluation is limited by selection bias. While aiming for maximum variability, the method of sampling was also a convenience sample; ease of access played a role in the selection of respondents. Furthermore, the program evaluation only included clients who trusted their CHWs and who had a reasonably good relationship with them – good enough to agree to meet the interviewer. Although interviews were conducted until reaching theoretical saturation, this selection bias means that it is possible that the experiences and views of the interviewees do not represent the typical client. Another limitation is that each participant was only interviewed at one point in time. Clients experience many ups and downs, and the CHW-client relationships are constantly evolving, but the findings only represent participants’ views from one moment of time. Thus, there is a need for further studies that include longitudinal follow-up to explore how CHW-client

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relationships change over time. Finally, one CHW did not participate in the program evaluation. Only one of her clients was interviewed, but this interview was not included in the evaluation because of the need for triangulation. Therefore, we are unable to account for any variation and divergence that this CHW might have presented to the evaluation if she had participated.

On the other hand, this program evaluation has important strengths that might suggest that the lessons learned can be applied elsewhere. Several characteristics make the evaluation credible. First, the interviews generated rich and detailed data. Participants appeared to be comfortable, and they freely shared information with the interviewer about many personal experiences and beliefs. Second, there was convergence of key themes. While interviewees described a range of experiences, these descriptions could often be grouped into overarching themes. The triangulation method – using multiple different data sources (in this case, interviews with the clients, CHWs, and program leaders) – was employed to assess consistency of the data, and we found that there was consistency across the various perspectives. Many of the insights and ideas were confirmed independently by others involved in the program. The achievement of theoretical saturation (similar themes emerged during the later interviews) also supports our conclusion that there was convergence of key themes. Finally, the use of the member-checking method adds to this evaluation’s credibility. The findings were presented to all of the CHWs, all of the program leaders, and one client. These participants had the opportunity to share their thoughts on the findings and verify the key themes that emerged. By doing so, we confirmed that the themes identified resonated with the stakeholders that were queried.

Because of its credibility, this study contributes to knowledge that may be applied more broadly, including our understanding of the attributes and defining features of the work that CHWs do. Since this study is one of few studies that explore client perspectives on working with CHWs, it provides new insights into the ways that CHWs form relationships and provide social support to highly vulnerable clients. Further, this study highlights programmatic factors that strengthen or limit the effectiveness of CHWs’ work. These factors may provide a framework to evaluate the quality and effectiveness of other CHW programs, and they may provide guidelines for improving the effectiveness of the CHW role through understanding and supporting best practices.

3. Conclusion

The clients of the Hospital to Housing program experience chronic homelessness as well as a variety of chronic mental and physical illnesses. This study demonstrates the potential for CHW programs to incrementally yet meaningfully impact social isolation, well-being and engagement in services for marginalized and vulnerable adults. We found that clients especially valued forming close relationships with their CHWs and receiving

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emotional support from them. Our study also identified important program characteristics, including community outreach; minimal restrictions on how CHWs spend their time; low case-loads; and close, client-centered and hands-on supervision. While our study depicts some of the benefits from working with CHWs, it is also important to emphasize that there are many structural problems outside of CHWs’ control. As Lisa Renee Holderby-Fox, one of the prior Hospital to Housing program directors, said, “We [CHWs] can enhance services. We can enhance the organization that we’re working for and it’s reach in the community. We can do all of these things, but we’re not the only answer…But I do think everybody should have a CHW, or at least have access to a CHW.” Efforts to implement CHW programs should be in concert with efforts to improve system effectiveness and structural inequities. As CHWs support their clients and help them engage in services, effort should also be made to enhance the quality of health care delivered to highly vulnerable populations, to increase the availability of affordable housing options, and to strengthen the emotional support that clients receive from other workers when transitioning from homelessness to permanent housing.
Section 5: Acknowledgements

Thank you to my mentors and co-authors, Singumbe Muyeba and Barbara Gottlieb for your advice, guidance, and wisdom. You have both taught me so much throughout this multi-year project.

Thank you to the Community Health Workers in the Hospital to Housing program. I could not have completed this project without you. Thank you for welcoming me and teaching me about the work that you do. Thank you for all of your hard work in helping me connect with your clients, and for making time out of your busy schedules to participate in this program evaluation.

Thank you to Lisa Renee Holderby-Fox for generating the idea for this project and for trusting me to complete it. Thank you to Kara Bray for being a source of inspiration, for your guidance on the project design, and for helping me interpret the data. Our many conversations contributed enormously to this project. Thank you to Linda Wood-Boyle, Josh Cuddy, Erin Donohue, and Nancy Norman for embracing this project and for going above and beyond to help me complete it. Thank you to Joyce Tavon for your thoughtful comments and edits to this report. Thank you to Joe Finn for giving me independence to conduct this project, while also providing support. And thank you to all of the staff at MHSA for welcoming me into your office, sharing about your work, and teaching me about housing programs and policies.

Finally, thank you to the many program clients for participating in this project. I feel so lucky to have had the opportunity to get to know you. Thank you for being open to meeting with me, and for sharing so much about yourselves and your life experiences. I hope that your intelligence and thoughtfulness shines through in this report.
References


Appendix A

Names and roles of the program leaders that were interviewed:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Employer</th>
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<tbody>
<tr>
<td>Kara Bray</td>
<td>Current H2H senior CHW (supervisor of the other CHWs)</td>
<td>MBHP/Beacon</td>
</tr>
<tr>
<td>Josh Cuddy</td>
<td>Current H2H program manager</td>
<td>MHSA</td>
</tr>
<tr>
<td>Erin Donohue</td>
<td>H2H administrative program leader</td>
<td>MBHP/Beacon</td>
</tr>
<tr>
<td>Joe Finn</td>
<td>Executive director, author of the grant for H2H</td>
<td>MHSA</td>
</tr>
<tr>
<td>Lisa Renee Holderby-Fox</td>
<td>Prior H2H program director and CHW supervisor</td>
<td>MHSA</td>
</tr>
<tr>
<td>Nancy Norman</td>
<td>H2H administrative program leader</td>
<td>MBHP/Beacon</td>
</tr>
<tr>
<td>Linda Wood-Boyle</td>
<td>Prior H2H program director and CHW supervisor</td>
<td>MHSA</td>
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Appendix B

Semi-Structured Interview Guide, Clients:

I’d like to start out by getting to know you. Could you tell me about yourself?

Housing:
- Could you tell me about your experience trying to get housing?
- Who is helping you with this process?
- What challenges have you faced?
- [If housed] Tell me about your experience now that you have housing. What’s it like for you?
  - How was the transition to living on your own?
  - What challenges do you face? Who helps you with these issues?

Health:
- How do you view your health?
- What goals do you have for trying to stay healthy?
- I’d like to learn more about your experiences with the health care system. How many times did you go to the emergency room in the past year? Hospital? Psychiatric hospital? Detox?
  - What issues lead you to go to the emergency room, etc.?
  - Who helps you decide where to go to get help?
  - Who do you talk to when you feel sick?
- Think back to the last time you were in the hospital. Tell me what it was like for you to be discharged from the hospital and go back to your daily life.
- Tell me about the doctors that you work with.
- What kinds of things make it hard for you to stay healthy?
  - Some people have trouble remembering their doctor’s advice. How’s that for you?
  - How about scheduling and getting to appointments?
  - How about getting enough food or preparing food?
  - Some people say that it’s hard to remember to take their medications. How’s that for you?
- So we’ve talked about some challenges for staying healthy. What helps you deal with these issues?

Working with your CHW:
- I’d like to learn more about what it’s like working with [CHW]. Tell me about your relationship.
- Tell me about how you started working with [CHW].
  - What made you decide to work with [CHW]?
  - What made you trust [CHW]?
- Do you feel like [CHW] has gotten to know you?
  - [If yes] What did [CHW] do to get to know you?
- Do you feel like you trust [CHW]?
  - [If yes] What makes you trust [CHW]?
  - [If no] Tell me about why not.
- How would describe [CHW’s] role?
  - What have you and [CHW] done together?
  - How does [CHW] help you with housing?
  - How does [CHW] help you with your health?
- Do you and [CHW] share any characteristics or life experiences?
  - How does sharing this experience impact your relationship?
- How is working with [CHW] different than working with [x]?
**Semi-Structured Interview Guide, CHWs:**

**Working with clients:**
- Could you tell me about your role in the Hospital to Housing program?
- How do you describe the program when you’re meeting with clients?
- How would you describe your clients?
- Tell me about your relationships with your clients.
  - What’s your approach to engaging clients and forming these relationships?
  - What do you think makes clients trust you?
- In what ways do you think you help your clients?
  - Could you tell me some examples?
- Tell me about times when you have not felt helpful. What were the challenges?

**Program goals:**
- As you know, data is getting collected on housing retention and health care utilization. What do you think of these ways of looking at the success of this program?
- What do you think leads your clients to frequently use the emergency room and hospital?
- How do you think your work impacts clients’ health care utilization, like hospital and emergency room visits?
- How do you help your clients obtain housing?
- What challenges do your clients face once they’ve obtained housing?

**Teamwork:**
- Who else does each client work with? How do you fit into your client’s care team?
- How is your role different than these other providers?
- What gaps in the housing and health care system do you think that community health workers can address? What do you think is the need for this role?

**Characteristics of CHWs:**
- To you, what does it mean to be a community health worker?
- As you probably know, Community Health Workers are defined as “frontline public health workers who are trusted community members and/or have an unusually close understanding of the community they serve.” What do you think of this definition? How do you think it applies to yourself?
- How do you believe that having this close understanding of the community affects your work with clients?
  - How has it benefitted your work?
  - How has it made your work more challenging?

**Program design:**
- This job can be very challenging. What support do you have? What other support do you wish you had?
- What does supervision look like?
- What job requirements make your work challenging?
- What changes would you make to the design of this program?
Semi-Structured Interview Guide, program leadership:

About the program:
• I’d like to start by hearing about your role in the Hospital to Housing program (H2H).
• What was your interactions with the CHWs like, and what was your involvement in their work?
• Tell me about the goals of H2H.
• What is the definition of H2H success for you?
• How would you describe the role of the Community Health Workers?
• How do CHWs select and find clients?
• In what ways do you believe the CHWs help their clients?
  o How are the CHWs involved in addressing utilization of health care services?
  o How do the CHWs help their clients obtain housing?
• What challenges do you believe the CHWs face?

Development of the program:
• Why did you decide to get involved in this program?
• How was the idea for H2H developed?
• What was the original intention of H2H and how has this changed?
• What is the need for a program like H2H?
• What do you believe were the missing gaps that H2H seeks to address?
• What are the broader policy implications of the H2H program?

Program details:
• What does supervision look like for the CHWs?
• What other support do the CHWs have?
• Could you tell me about the hiring process for the CHWs?
• What changes would you make to the design of this program?