Sinai Urban Health Institute (SUHI)
Chicago, IL

The Sinai Urban Health Institute (SUHI) is part of the Sinai Health System located in Chicago, Illinois. Community Health Workers (CHWs) have been central to SUHI’s work in eliminating health disparities in Chicago’s most vulnerable communities since its inception in 2000. A wealth of experience has been amassed in recruiting, training, supervising, and deploying the CHW workforce to deliver health education, assist clients in navigating the health care system, connecting clients with appropriate social service needs, and empowering the community to take control of their health and wellness. SUHI has implemented CHW projects in various health conditions, including: asthma, breast health, diabetes, HIV/STDs, and system navigation. SUHI has also conducted extensive research on the CHW model in general and in 2014, released a report entitled, Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings. Due to SUHI robust expertise, SUHI has been working with the Sinai Health System and consulting with other health care organizations and payers to teach them how to best implement the CHW model to better serve their patients and meet the dynamic needs of the changing health care environment.

Melissa Gutierrez Kapheim is a Program Director and Epidemiologist at the Sinai Urban Health Institute (SUHI). She has been with SUHI since 2006, where she specializes in Community Health Worker model implementation, conducting needs assessments, and implementation science.

Kim Artis was brought into the SUHI fold in March 2012 as a Community Health Educator for the extensive Helping Children Breathe and Thrive Program.

For more information, please contact Melissa Gutierrez Kapheim at Melissa.Gutierrez@sinai.org or 773-257-5258.
**Prevention and Access to Care and Treatment**

Boston, MA

PACT is a program for people living with HIV/AIDS who are struggling to take their medications and engage in healthcare. We are a team of community health workers who visit clients weekly in their homes (or wherever they’d like to meet) to give them support to achieve their goals. Services include weekly home visits to support clients, accompaniment to medical appointments, adherence and health promotion, education and counseling, and Directly Observed Therapy (DOT).

**Rachel Weidenfeld** is a public health social worker who has managed PACT for the past 5.5 years. She splits her time between program operations and leading training locally and nationally on the CHW model and supporting complex patients.

**Soridania Santana** has been with PACT for over 10 years. She recently transitioned to a full time position at the Codman Square Health Center and is using her expertise in the model to bridge the two programs in a new pilot.

For more information, please contact Rachel Weidenfeld at **Rweidenfeld@jri.org** or 857-399-1915 x2423 or Soridania Santana at **Soridania.Santana@codman.org** or 617-816-8512.
Overview of Programs and Presenters

**Care Connections Program (CCP)**  
Los Angeles, CA

The CCP aims to improve care for a subset of the sickest, highest-risk patients in the Los Angeles County Department of Health Services system by integrating Community Health Workers (CHWs) into the Patient-Centered Medical Home. CHWs work on multidisciplinary complex care teams to extend the reach of primary care into the community. They work with complex patients to reduce unnecessary utilization of services, and accompany patients toward better health outcomes by enhancing the patient’s ability to self-manage and navigate a fragmented delivery system, connecting patients to resources, and facilitating care coordination.

**Ami Shah** is a social epidemiologist and public health consultant for the Los Angeles County Department of Health Services. She has been working closely with a small group of innovators to integrate CHWs as part of the medical home model of care delivery.

**Brandi Sankey** is a CHW with a background in Public Health and Disease Prevention. As a member of the PCMH team, she helps deliver patient care that extends beyond the walls of the hospital or clinic.

For more information, please contact Ami Shah at ASah3@dhs.lacounty.gov or 213-250-8662.
Tumaini (Hope) for Health
Baltimore, MD

Tumaini (Hope) for Health is a collaborative effort between Johns Hopkins Medicine, Sisters Together and Reaching (STAR), and the Men and Families Center, Inc. (MFC). A multilevel community health worker program, Tumaini aims to reduce barriers to accessing health care and facilitates uptake of social and health services. The program is composed of two intersecting interventions: Neighborhood Navigators, who are volunteers trained and overseen by the Men and Families Center, and Community Health Workers, who are trained and employed by Sisters Together and Reaching.

Rev. Debra Hickman is Founder/President/CEO of Sisters Together And Reaching, Inc. (STAR), a non-profit, Faith/Community-based organization providing spiritual support, direct services and prevention education to the HIV/AIDS infected, affected and at-risk communities. Rev. Hickman has 42 years’ experience in community and health mobilization, assisting in the development of innovative programming for community health worker case managers, peer support groups and participants in numerous local and statewide community leadership forums.

Demetrius Frazier has over 15 years’ experience in public health. He began his career working in HIV/STI prevention, education, and providing counseling, testing and referral services. He is currently the Manager of Community Health Worker Case Managers in a new initiative in the STAR Innovations Department for the Tumaini CHWCM Program.

For more information, please contact Rev. Debra Hickman at dhickman@sisterstogetherandreaching.org or 410-276-8969.