AMAZING THINGS ARE HAPPENING HERE

Center for Community Health Navigation

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COMMUNITY HEALTH WORKER MODEL

- Implemented in 2005
- Hospital-Academic-Community Partnership
- Community Health Workers
  - Community-based
  - Bilingual
  - Peer support & education reinforcement
  - Members of health care team

Peretz P, Matiz LA, et al. Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative. American Journal of Public Health: August 2012, Vol. 102, No. 8, pp. 1443-1446

PROGRAM STAGES

Stage 1 Months 1 - 3	**Stage 2** Months 4 - 6	**Stages 3** Months 7 - 12
Comprehensive Education	Monthly Check-In	Bi-Monthly Check-In
Home Environmental Assessment	Home Visit	Home Visit
Goal Setting & Service Referrals	Goals Check-in	Service Referrals
Provider-Led Asthma/Diabetes Workshops	Service Referrals	12 Month Follow-up
Baseline Survey	6 Month Follow-up	Graduation

*Frequency of check-ins and intensity of services determined by participant needs

PCMH SUPPORT AND EDUCATION

Implemented: February 2011

CHWs:

- Apply non-clinical, peer-based approach to reinforce key health messages
- Help patients understand diagnoses and uncover disease management obstacles
- Participate in multidisciplinary meetings and rounding

Impact: 5421 patients have received practice-based support & education since February 2011.

Matiz LA. et al. The Impact of Integrating Community Health Workers into the Patient Centered Medical Home. *J Prim Care Community Health*. 2014 Oct;5(4):271-4.

PROGRAM OUTCOMES

Asthma:

- 1104 patients enrolled in year-long program
- Retention at 6 months: 77%, at 12 months: 65%
- ED visits and hospitalizations decreased by more than 65% among graduates
- Nearly 100% of graduates stated that they feel in control of child's asthma

Diabetes:

- 343 patients enrolled in year-long program
- Retention at 6 months: 90%, at 12 months: 81%
- Nearly 60% of graduates improved their A1C levels
- Nearly 100% of graduates stated that they are able to cope and reduce their risk

PATIENT NAVIGATOR MODEL

- Implemented in 2008
- ACN-ED Partnership
- Based in 5 NYP EDs
- Patient Navigators
  - Bilingual
  - ED-Based
  - Peer support & education reinforcement
  - Members of health care team

ED-BASED SUPPORT AND EDUCATION

Patient Navigators:

- Provide culturally sensitive education and support related to the importance of primary care and how best to navigate the health care system
- Help patients overcome health care access and insurance challenges
- Schedule appointments for patients requiring one or more of the following:
  - A primary care appointment
  - A specialty care appointment
- Follow-up with patient to ensure that patient attends scheduled medical appointment(s)
- Support patients and their families to achieve the most successful plan for continuity of care

PROGRAM OUTCOMES

Cumulative to date:

- 52,000 patients served since 2009
- 91% of patients without PCP had new PCP appointment upon discharge
- 77% of patients with a scheduled follow-up appointment attended the appointment

Sub-sample:

- Emergency departments visits decreased by 36% among high utilizers post-navigation
- ACN Primary care visits increased by 80% for adults and 35% for children post-navigation

LESSONS LEARNED

- CHWs from the local community are uniquely positioned to build trusting partnerships
- CHWs can move fluidly between community and health care settings
- CHWs can be the “voice” of the community in clinical settings and bridge gaps in care
- Community partner involvement in all aspects of the program development and evaluation is critical to program success
- Theses models are transferable to other disease areas and other populations
- It is important to develop a sustainability plan early and to revisit it often

NEXT STEPS (DSRIP)

1. Expand models to Cornell & Lower Manhattan
2. Expand support to new populations
3. Expand and enhance training curriculum

CONTACT INFORMATION

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