Integrating CHWs into the Primary Care Setting

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PRESENTATION OUTLINE

1. Background
2. Program Model
3. CHWs and the Patient Centered Medical Home
4. Key Findings
5. DSRIP Opportunity
6. Next Steps

BACKGROUND

WASHINGTON HEIGHTS AND INWOOD

COMMUNITY CHARACTERISTICS

- 270,700 residents
- 51% foreign-born
- 75% Latino (55% Dominican, many recent immigrants)
- 70% speak Spanish at home
- 43% of children live below poverty line

Schwarz et al. Asthma in New York City. *NYC Vital Signs.* 2008;7(1):1–4.
Olson et al. Take Care Inwood and Washington Heights *NYC Community Health Profiles.* 2006;19(42):1–16

PROGRAM MODEL

COMMUNITY HEALTH WORKER MODEL

- ❑ Regional Health Collaborative
- ❑ Hospital-Academic-Community Partnership
- ❑ Community Health Workers
  - Bilingual
  - Community-based (4 CBOs)
  - Peer support & education reinforcement
  - Care Coordination and PCMH-based support
  - Members of health care team

Peretz 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 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

CHWS AND THE PATIENT CENTERED MEDICAL HOME

PCMH SUPPORT AND EDUCATION

Implemented: February 2011

CHWs:

- Use 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
- Accept on-site referrals for year-long care coordination program

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.

PCMH SUPPORT AND EDUCATION

Referral and Feedback:

- Any member of the care team may refer to CHW
- CHW delivers feedback to care team during session
- Referrals for care coordination are made via EMR
- Enrollment and program status documented in patient EMR

Impact: 5421 patients have received practice-based support & education to date

KEY FINDINGS

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- CHWs based in 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 the PCMH and “bridge gaps” in care
- Successful integration requires on-going support and continuing education related to the role of the CHW
- Community partner involvement in all aspects of the program development and evaluation is critical to program success

DSRIP OPPORTUNITY

DSRIP REQUIREMENTS

- The DSRIP program will promote "community-level" collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years.
- Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
- Employ qualified candidates for community health workers who meet criteria such as cultural competence, communication, and appropriate experience and training.
- Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education, healthcare service utilization, and enhance social support to high-risk pregnant women.

NYP PPS PROJECTS

Project	Key Features
Integrated Delivery System	• Integrated governance structure • Standardized clinical protocols and referral mechanisms • Integrated IT and reporting infrastructure • Level III PCMH
ED Care Triage	• Enhanced Patient Navigators embedded in ED (WC, CU, LM) • Connections to PCPs for <30 day follow-up visits • Warm handoffs to CBOs
Ambulatory ICU (ped and adult)	• Enhanced care coordination for high-risk patients (WC, CU) • Multi-disciplinary care teams, including specialists • CHW home visits
Care Transitions to Reduce 30-Day Readmissions	• Targeted RN care coordinators for most at-risk(WC, CU, LM) • Warm handoffs to post-acute providers and PCPs • Embedded pharmacy support • Follow-up phone calls • CHW home visits

PPS PROJECTS

Project	Key Features
Behavioral Health and Primary Care Integration	• Integrated primary care teams into NYSPI and NYP clinics • Additional NPs for expanded capacity (CU)
Behavioral Health Crisis Stabilization	• Embedded care teams in CPEP, mobile crisis (CU) • CHW home visits
HIV Center of Excellence	• Enhanced care coordination for high-risk patients (WC, CU) • Enhanced relationships with pharmacies and CBOs • CHW home visits
Integration of Palliative Care into PCMHs	• Palliative care teams integrated into PCMH (CU) • Additional palliative care training for ACN and community PCPs • CHW home visits
Promote Tobacco Use Cessation	• Outreach through CBO with CHWs to reconnect (WC, CU, LM) individuals with primary care and smoking cessation treatment

NEXT STEPS

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1. Launch the Center for Community Health Navigation
2. Expand models to Cornell & Lower Manhattan
3. Expand support to new populations
4. Expand and enhance training curriculum

CONTACT INFORMATION

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