The Role of the Community Health Worker

NewYork-Presbyterian
Performing Provider System

- **Sergio Matos** is the Co-founder and Executive Director of the Community Health Worker Network of NYC
- **Patricia Peretz, MPH** is the Manager of Community Health and Evaluation and Co-leads the Center for Community Health Navigation at NewYork-Presbyterian Hospital
- **Dr. Adriana Matiz, MD** is an Associate Professor of Pediatrics at Columbia University Medical Center. She is also the Medical Director of NewYork-Presbyterian Hospital's Center for Community Health Navigation.

Community Health Worker Perspectives

Sergio Matos

Community Health Worker Network of NYC

April Hicks

Community Health Worker Consultants

Community Health Worker Network of NYC

The Community Health Worker Network of NYC is a professional association of CHWs that exists to advance the practice through education, advocacy, and research, while preserving the identity and character of CHWs.

CHW Definition

- Promotes health within a community by assisting individuals to adopt healthy behaviors.
- Serves as an advocate for the health needs of individuals by assisting community residents in effectively communicating with healthcare providers or social service agencies.
- Conducts outreach and implements programs in the community that promote, maintain, and improve individual and overall community health.
- May deliver health related preventative services such as blood pressure, glaucoma, and hearing screenings. May also collect data to help identify community health needs. Excludes “Health Educators” (#21-1091)

Published in the Federal Register July 21, 2016

CHW NETWORK NYC
Community Health Worker Network of New York City

What Do CHWs Do?

Outreach/Community Mobilizing

Preparation and dissemination of materials
Case-finding and recruitment
Community Strengths/Needs Assessment
Home visiting, Promoting health literacy
Community advocacy

System Navigation

Translation and interpretation
Preparation and dissemination of materials
Promoting health literacy, Patient navigation
Addressing basic needs – food, shelter, etc.
Coaching on problem solving
Coordination, referrals, and follow-ups
Documentation

Community/Cultural Liaison

Community organizing, Advocacy
Translation and interpretation

Participatory Research

Preparation and dissemination of materials
Engaging participatory research partners
Facilitating translational research
Interviewing
Documentation

Case Management/Care Coordination

Family engagement
Individual strengths/needs assessment
Addressing basic needs – food, shelter, etc.
Promoting health literacy
Goal setting, coaching and action planning
Supportive counseling
Coordination, referrals, and follow-ups
Feedback to medical providers
Treatment adherence promotion
Documentation

Home-based Support

Family engagement, Home visiting
Environmental assessment, Promoting health literacy
Supportive counseling,, Coaching on problem solving
Action plan implementation
Treatment adherence promotion, Documentation

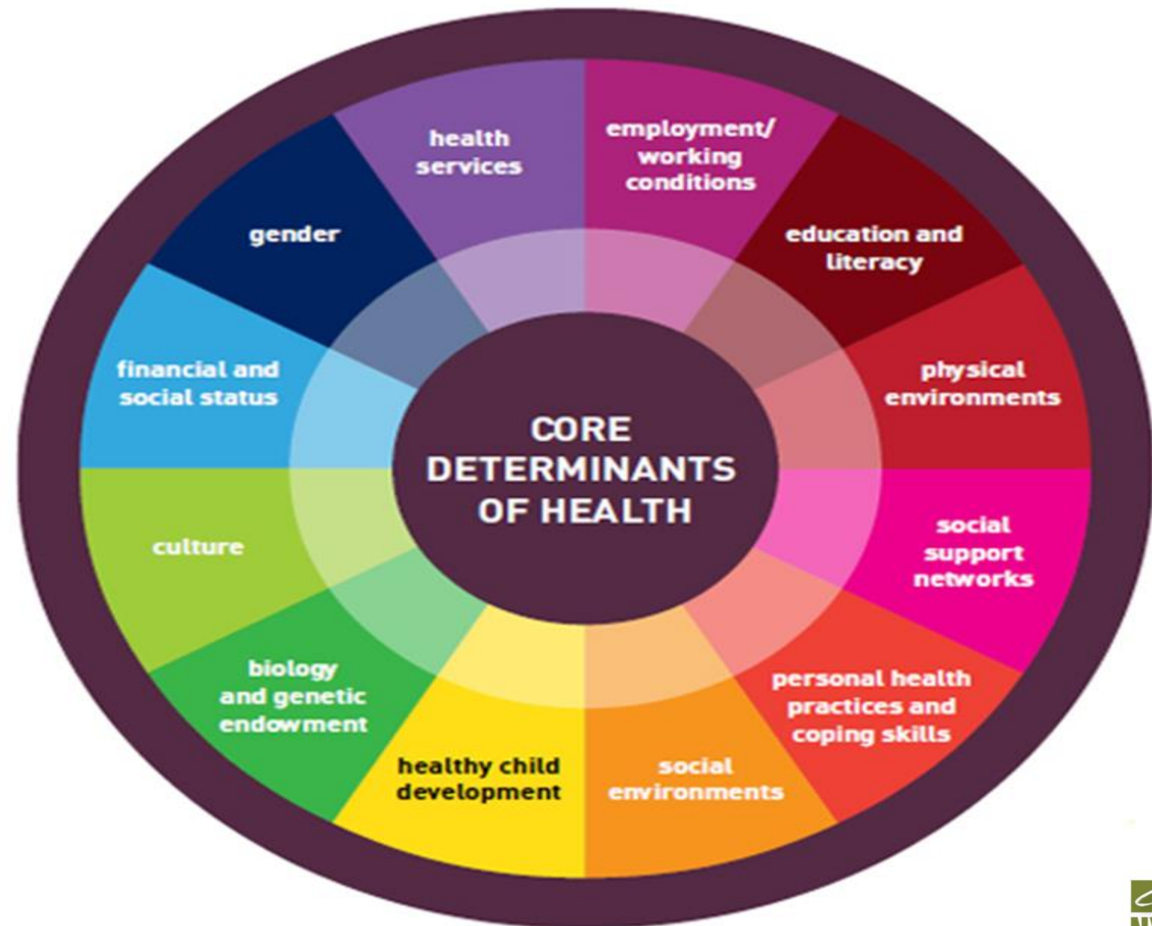
Health Promotion & Coaching

Translation and interpretation
Teaching health promotion and prevention
Treatment adherence promotion
Coaching on problem solving
Modeling behavior change
Promoting health literacy
Harm Reduction

Health and its Social Determinants

Health is the state of complete physical, mental and social wellbeing – and not merely the absence of disease.

This state of being is a fundamental human right…



CHW NETWORK NYC
Community Health Worker Network of New York City

Preferred CHW Attributes

Connected to Community

Resourceful, Creative

Mature, Prudent, Persistent, Courageous

Empathetic, Caring, and Compassionate

Open-minded, Non-judgmental, Relativistic

Respectful, Honest, Polite, Civil, Courteous

Friendly, Outgoing, Sociable, Charismatic

Dependable, Trustworthy, Responsible, Reliable

CHW NETWORK NYC
Community Health Worker Network of New York City

What CHW Employers Seek

- Shared life experiences
  - Socio-economic, educational, racial/ethnic
  - Most essential element considered by employers
  - Single largest contributor to success
- Personal Attributes
  - Essential to CHW work – relational experiences
  - Not just anyone can be a CHW
- Work Experience
  - Roles, Tasks, Skills
- CHW Training
  - Core competencies
  - Specialty topics
  - Least important

Study/site	CHW activities and outcomes	ROI (per year)	Sources for data
Homeless mentally ill	CHW home visits and behavioral change support reducing institutional care costs	1.15	Calculated from case-control data in Wolff et al. , 1997, reported in Viswanathan
Childhood asthma management, Seattle, WA	High intensity CHW intervention w. home visits, reducing urgent visit/hosp costs	1.21	Calculated from pre-post data in Krieger et al, 2005
Childhood asthma management, New York, NY	CHW provides education and care coordination reducing urgent visits/hosp.	4.01	Calculated from pre-post in Peretz et al., 2012 [1]with additional data from Nieto and Peretz
Theoretical savings for pediatric patients making clinic visits in Harrisonburg,VA	CHW will do primary care triage and manage limited protocol of conditions, reducing clinic visits	1.60	Calculated from comparison data in Garson et al 2012
Diabetes control along Texas border	Diabetes education and support in making lifestyle changes, reducing care costs through lower A1c	4.62	Calculated from comparative cost data in Culica et al., 2008
Employees of Langdale Mft in Lowndes County, Georgia	Case management support to workers with chronic disease, reducing acute care costs and work loss days	4.80	Calculated by Miller, 2011
Chronic illness patients in Denver Health Plan, Colorado	CHW intervention with care management, reduced urgent/hosp costs	2.28	Calculated by Whitley, Everhart & Wright, 2006
Arkansas Medicaid managed care program	CHW community connector program provided by state managed care program	2.92	Calculated by Felix et al, 2011
Molina Healthcare, Medicaid Managed Care, New Mexico	CHW with high-user, complex patients, providing navigation, health coaching, & chronic disease mgt	2.18	Calculated from pre-post data in Johnson 2011
Diabetes management for low-income patients in Baltimore, MD	Volunteer CHW educates & provides care coordination, reducing diabetes-related costs	6.10	Calculated from pre-post data in Fedder et al, 2003
Diabetes management for low-income patients, New York, NY	CHW provides education and care coordination, reducing urgent visit/hosp costs	2.32	Calculated from pre-post data supplied to the authors, reported in Findley, Matos & Reich 2012

Professions Are Communities of Practice and Each Has Different Cultures

Technical professions – medical, dental, nursing, allied health

Values - academic achievement, credentials, accreditations, titles, status, position

Purpose - service delivery

Character - prescriptive relationships - dualistic

Skilled Professions – plumbers, carpenters, actors, iron workers, athletes

Values - ability, creativity, performance, talent, efficiency

Purpose – product

Character - cooperative relationships

Social Professions – clergy, civic leaders, community organizers, CHWs

Values - trustworthiness, integrity, ethic, understanding, compassion, dedication, honesty, resourcefulness, empowerment, self-efficacy

Purpose – empowerment, building community and social capital

Character - peer relationships – relativistic, humanistic

Thank you

Sergio Matos, CHW and Executive Director
Community Health Worker Network of NYC

April Hicks
Chief Operations Officer
CHW Consultants

sergio@chwnetwork.org
april@chwnetwork.org
www.chwnetwork.org

CHW NETWORK NYC
Community Health Worker Network of New York City

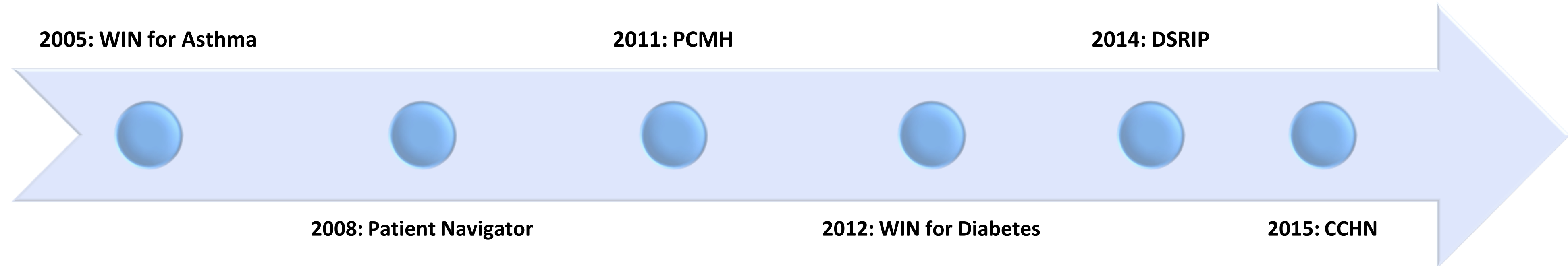
AMAZING
THINGS
ARE
HAPPENING
HERE

Center for Community Health Navigation at NewYork-Presbyterian Hospital

Patricia Peretz, MPH
Adriana Matiz, MD

NewYork-Presbyterian

CENTER MILESTONES



AMAZING THINGS ARE HAPPENING HERE

CENTER MISSION

- **Mission:**
  - To support the health and wellbeing of patients through the delivery of culturally-sensitive, peer-based support in the Emergency Department, inpatient, outpatient and community settings
- **Goals:**
  - Improve patient access to NewYork-Presbyterian
  - Deepen connection between Hospital and community resources
  - Develop innovative patient-centered initiatives
  - Advance the Community Health Worker role and workforce
  - Enhance the Community Health Worker knowledge-base and inform local practice

AMAZING THINGS ARE HAPPENING HERE

CHW MODEL

- Hospital-Community Partnership
- Community Health Workers
    - Bilingual
    - Community-based
    - Peer support & education reinforcement
    - Members of health care teams

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

AMAZING
THINGS
ARE
HAPPENING
HERE

PROGRAM STAGES: PEDIATRIC ASTHMA

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 Visit/Home Environmental Assessment	Home Visit	Home Visit
Goal Setting & Service Referrals	Goals Check-in	Service Referrals
Provider-Led Workshops	Service Referrals	12 Month Follow-up
Intake Survey	6 Month Follow-up	Graduation

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

AMAZING
THINGS
ARE
HAPPENING
HERE

CORE TRAINING CURRICULUM

NYP Credentialing	Shadowing Senior Workers
CHW Core Competencies	Asthma 101
Home Visiting	Nutrition 101
Case Management	Diabetes 101
Goal Setting	Behavioral Health 101
Motivational Interviewing	Health Literacy
Cultural Competency	Home Remedies
Integrated Pest Management	HIPAA
Time Management/Case Management	Mental Health/Wellness

AMAZING THINGS ARE HAPPENING HERE

CHW HIGHLIGHTS

- **ASTHMA**
  - 1319 patients enrolled in year-long program
  - 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**
  - 531 patients enrolled in year-long program
  - Nearly 60% of graduates improved their A1C levels
  - Nearly 100% of graduates stated that they are able to cope and reduce their risk

PCMH-BASED SUPPORT AND EDUCATION

- **Community Health Workers:**
  - Work as members of the team and participate in multidisciplinary meetings and rounding
  - Apply non-clinical, peer-based approach to reinforce key health messages
  - Help patients understand diagnoses and uncover disease management obstacles

Impact: 6004 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.

AMAZING THINGS ARE HAPPENING HERE

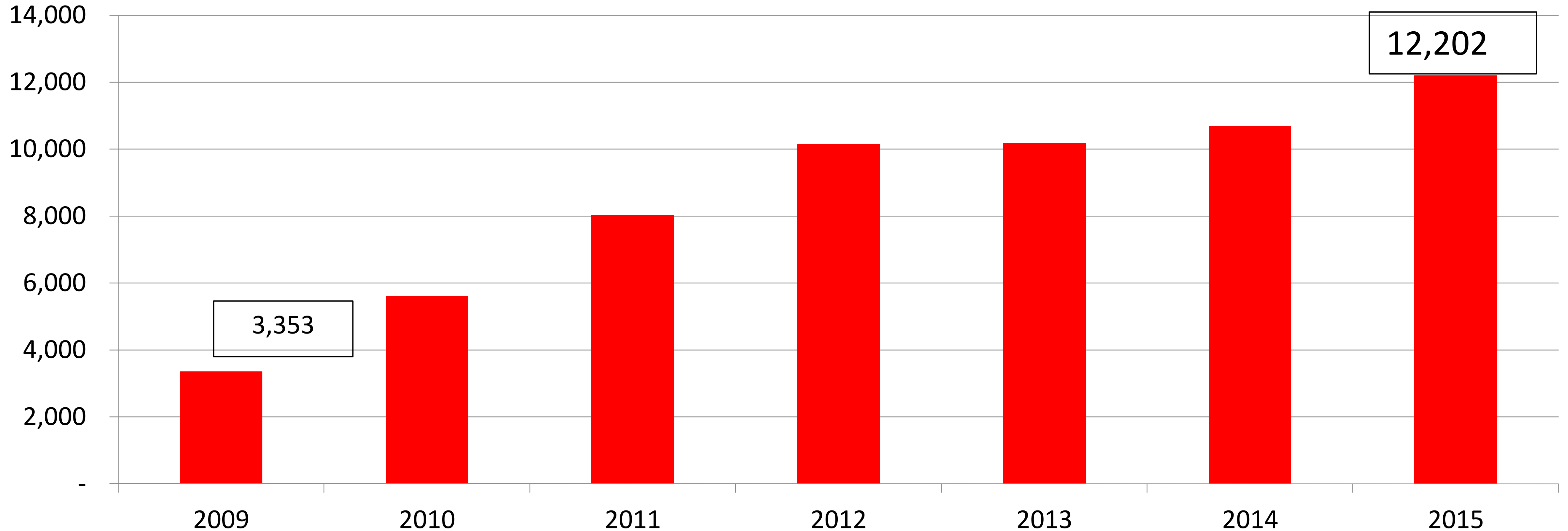
PATIENT NAVIGATOR

- Bilingual and community focused
- Non-clinical, peer supporters who deliver following Key Messages:
  - Importance of Primary Care Provider (PCP)
  - Importance of having insurance and maintaining it active; knowing their financial resources
  - Importance of medical appointment adherence
- Schedule appointments for patients requiring one or more of the following:
  - A primary care physician / specialty care appointment
- Post discharge follow-up

AMAZING THINGS ARE HAPPENING HERE

Garbers S, Peretz P, Greca E, Steel P, Foster J, et al (2016) Urban Patient Navigator Program Associated with Decreased Emergency Department Use, and Increased Primary Care Use, among Vulnerable Patients. J Community Med Health Educ 6: 440. doi: 10.4172/2161-0711.1000440

PATIENTS SUPPORTED BY YEAR 2009-2015

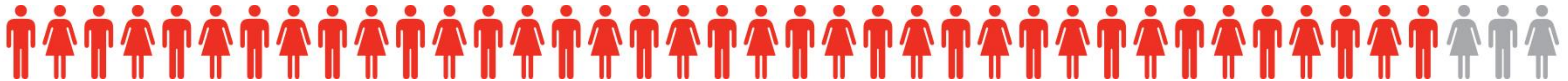


Note: Patient Navigators supported a total of 58,961 patients at NewYork-Presbyterian/The Allen Hospital, NewYork-Presbyterian/Columbia University Medical Center and NewYork-Presbyterian/Morgan Stanley Children's Hospital over this period.

AMAZING THINGS ARE HAPPENING HERE

CONNECTION TO PRIMARY CARE: 2009-2015

- 92% of patients presenting without a primary care provider had a primary care appointment upon discharge.*

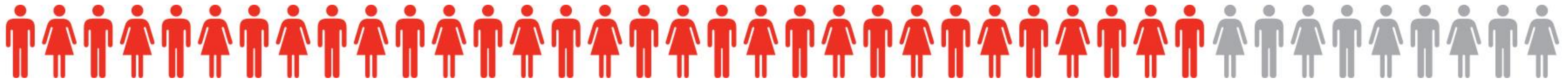


* Since the Patient Navigator Program was implemented at NewYork-Presbyterian/Weill Cornell in late 2015, we have not included NewYork-Presbyterian/Weill Cornell data in our full year 2009-2015 analyses.

AMAZING THINGS ARE HAPPENING HERE

ADHERENCE TO FOLLOW UP CARE: 2009-2015

- 77% of patients for whom a follow-up appointment was scheduled attended that appointment.*



* Since the Patient Navigator Program was implemented at NewYork-Presbyterian/Weill Cornell in late 2015, we have not included NewYork-Presbyterian/Weill Cornell data in our full year 2009-2015 analyses.

AMAZING THINGS ARE HAPPENING HERE

PATIENT NAVIGATOR HIGHLIGHTS

- Nearly 60,000 people have been supported by Patient Navigators in NewYork-Presbyterian's Emergency Departments on three of our campuses.

- Over 40,000 men, women and children have been seen by primary care physicians and specialists – at appointments set up by these Emergency Department Patient Navigators.

- We have changed and enriched our model of post-Emergency Department visit follow-up care to include both Patient Navigators and Community Health Workers.

- The Patient Navigator Program has proven so successful that we have implemented this model of care within the NewYork-Presbyterian/Weill Cornell Medical Center Emergency Department and will be bringing it to NewYork-Presbyterian/Lower Manhattan.

- NewYork-Presbyterian has become a nationally recognized thought leader in Patient Navigation and Community Health.

AMAZING THINGS ARE HAPPENING HERE

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

AMAZING THINGS ARE HAPPENING HERE

NYP 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) • CHW
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 • **Patient Navigator**
Promote Tobacco Use Cessation	• Outreach through CBO with **CHWs** to reconnect (WC, CU, LM) individuals with primary care and smoking cessation treatment

AMAZING THINGS ARE HAPPENING HERE

CCHN OUTCOMES

- Developed 8 new Community Health Worker initiatives across four NewYork-Presbyterian campuses and surrounding communities
- Implemented Patient Navigator and Community Health Worker initiatives at NewYork-Presbyterian/Weill Cornell Medical Center
- Formalized agreements with 14 community based organizations across Manhattan
- Developed comprehensive Community Health Worker, Patient Navigator, Peer Training curriculum
- Enabled Community Health Worker documentation in Allscripts Care Director

AMAZING THINGS ARE HAPPENING HERE

PROGRAM LESSONS LEARNED

- CHWs from the local community are uniquely positioned to build trusting partnerships with patients and colleagues
- 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
- CHW models can be transferable to other areas and populations

AMAZING
THINGS
ARE
HAPPENING
HERE

STRATEGIC LESSONS LEARNED

- Align with hospital and community strategic initiatives
- Implement sustainability plan early and revisit often
- Develop and implement reliable evaluation plan
- Involve collaborators in development, implementation and evaluation
- Educate and continuously reinforce key messages with health care team
- Maintain balanced approach will all stakeholders

CONTACT INFORMATION

Patricia Peretz MPH
Manager, Community Health and Evaluation
Center Lead – Center for Community Health Navigation
pap9046@nyp.org
212 305-4065

Adriana Matiz MD
Associate Professor at Columbia University Medical Center
Medical Director – Center for Community Health Navigation
lam2048@columbia.edu
212 342-1917

Presenter Biographies

NewYork-Presbyterian
Performing Provider System

Sergio Matos

Sergio Matos has been a community health worker for over 30 years and has worked to help communities organize around issues of environmental and social justice, hunger, chronic disease management and social and economic issues that affect their health. Sergio is the co-founder and executive director of the Community Health Worker Network of NYC – an independent professional association of CHWs that works to advance the CHW workforce while preserving the integrity of the work. Under his leadership, the CHW Network of NYC has matured into a recognized and respected policy and training institute that conducts research, training and advocacy. The Network has trained over 1000 CHWs throughout the US and the Caribbean. Sergio is a past chair of the Community Health Worker Section of the American Public Health Association – the largest association of public health professionals in the world – where he worked as a policy leader and futurist to build a national platform that developed a national CHW definition and succeeded in getting the US Department of Labor to issue a unique standard occupational classification (SOC # 21-1094). Sergio recently co-authored a book titled, *Bridging the Gap – How CHWs Improve the Health of Immigrants*, published by Oxford University Press.

Patricia Peretz, MPH

Patricia Peretz is the Manager of Community Health and Evaluation at NewYork-Presbyterian Hospital where, for the last 9 years, she has worked alongside health care providers, program staff, and community partners to design, implement, and evaluate community health initiatives aimed at reducing the burden of illness in local communities. In this capacity, Patricia co-leads the Center for Community Health Navigation at NewYork-Presbyterian Hospital that encompasses the peer-based Community Health Worker and emergency department-based patient navigator programs based on 5 sites of NewYork-Presbyterian Hospital and in the surrounding communities. Prior to this role, Patricia worked at the New York City Department of Health and Mental Hygiene where she refined and evaluated strategies to improve the delivery of care for children with special needs and where she conducted research on the prevalence of overweight and obesity amongst low-income, pre-school aged children in New York City. Patricia is a graduate of the Mailman School of Public Health at Columbia University.

Dr. Adriana Matiz, MD

Dr. Adriana Matiz is an Associate Professor of Pediatrics at Columbia University Medical Center. She is also the medical director of NewYork-Presbyterian Hospital's Center for Community Health Navigation where she oversees the clinical integration and model development of the Patient Navigator and Community Health Worker programs across the healthcare system. Dr. Matiz has served as the medical director of WIN for Asthma, a nationally recognized program to strengthen community-wide asthma management for children in Northern Manhattan which later expanded the Community Health Worker model to include adult patients with diabetes. She has created an asthma medical home model for children, pediatric care management model and is currently developing a model of care for children with special health care needs in primary care practices to improve care and reduce preventable healthcare utilization. Her passion is to decrease health disparities and to expand the delivery of culturally competent care. Dr Matiz is a native of Colombia, raised in NYC and a graduate of NYU College of Arts and Science and the School of Medicine. She completed her pediatric training and subsequent Chief Residency at Montefiore Medical Center/Albert Einstein College of Medicine and resides with her family in the Bronx.

Thank you for attending!!!

NewYork-Presbyterian
Performing Provider System