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

Patricia Peretz, MPH
Adriana Matiz, MD
CENTER MILESTONES

- 2005: WIN for Asthma
- 2008: Patient Navigator
- 2011: PCMH
- 2012: WIN for Diabetes
- 2014: DSRIP
- 2015: CCHN
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
CHW MODEL

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

# PROGRAM STAGES: PEDIATRIC ASTHMA

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stages 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months 1 - 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Education</td>
<td>Monthly Check-In</td>
<td>Bi-Monthly Check-In</td>
</tr>
<tr>
<td>Home Visit/Home Environmental Assessment</td>
<td>Home Visit</td>
<td>Home Visit</td>
</tr>
<tr>
<td>Goal Setting &amp; Service Referrals</td>
<td>Goals Check-in</td>
<td>Service Referrals</td>
</tr>
<tr>
<td>Provider-Led Workshops</td>
<td>Service Referrals</td>
<td>12 Month Follow-up</td>
</tr>
<tr>
<td>Intake Survey</td>
<td>6 Month Follow-up</td>
<td>Graduation</td>
</tr>
</tbody>
</table>

*Frequency of check-ins and intensity of services determined by participant needs
### CORE TRAINING CURRICULUM

<table>
<thead>
<tr>
<th>NYP Credentialing</th>
<th>Shadowing Senior Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW Core Competencies</td>
<td>Asthma 101</td>
</tr>
<tr>
<td>Home Visiting</td>
<td>Nutrition 101</td>
</tr>
<tr>
<td>Case Management</td>
<td>Diabetes 101</td>
</tr>
<tr>
<td>Goal Setting</td>
<td>Behavioral Health 101</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>Health Literacy</td>
</tr>
<tr>
<td>Cultural Competency</td>
<td>Home Remedies</td>
</tr>
<tr>
<td>Integrated Pest Management</td>
<td>HIPAA</td>
</tr>
<tr>
<td>Time Management/Case Management</td>
<td>Mental Health/Wellness</td>
</tr>
</tbody>
</table>
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.

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

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

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

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!!!