Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

The mission of the Center for Community Health Navigation at NewYork Presbyterian Hospital is to support the health and well-being of patients through the delivery of culturally-sensitive, peer-based support in the Emergency Department, inpatient, outpatient and community settings.
We aim to improve patient access to NewYork-Presbyterian and community health and social resources by deepening the connection between NYP and its surrounding communities. We seek to develop innovative patient-centered initiatives. Finally, we focus on the advancement of the Community Health Worker role and workforce and to enhance the Community Health Worker knowledge base and inform local practice.

Q3 Please indicate which category your organization falls under.

Health Care Provider,

Community Based Organization **,**

Other (please describe below: 150 character maximum):

Our Center for Community Health Navigation is based out of NewYork Presbyterian Hospital in partnership with 14 community-based organizations across New York City.

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants

of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

Early in the DSRIP grant planning process, the collaborators in the PPS recognized a significant and wide-spread interest to integrate community health worker models to support different clinical programs being proposed. In order to maximize resources, improve standardization, impact sustainability and optimize outcomes, the Center for Community Health Navigation was developed in 2015 as a foundational element supporting all aspects of CHW models in the PPS. The Center's goal was to support all direct patient-facing projects in the PPS spanning care models for HIV, Behavioral Health, Ambulatory ICU (Adult and Pediatric), Transitions of Care, Tobacco Cessation and ED Care Triage with community health workers.
The main innovation was to expand and to integrate community-based CHWs into the Center's hospital-community partnership model, a proven and well-established model at with more than a decade of success supporting adult and pediatric patients. This existing program had demonstrated decreased utilization in the ED and in-patient admissions for children with high-risk asthma, decreased HbA1c for diabetic adults as well as improved caregiver/patient confidence in self-management and offered linkage to primary care in the ED environment.

The community health worker model is at the core of the Center's and the PPS' mission to improve care for patients with Medicaid and to work collaboratively and in true partnership with our community based organizations. Within this mode community-based organizations (CBO) and NYP jointly recruit and supervise CHWs who are trained and supported by NYP staff and CBO staff to best integrate into clinical programs and work directly to support patients both in the clinical environment and in their community. They assess patients in a standardized manner for social determinants of health such as housing, food insecurity, insurance, access to medical homes, depression, transportation needs, domestic violence etc. The PPS recognized that in order to effectively improve the quality of care, improve outcomes and decrease costs the social determinants of the patients needed to be identified and addressed. Local experience demonstrated that employing CHWs was an effective "intervention' in working with families on the social determinants. They can effectively develop trusting relationships; connect families to local resources that are leveraged long-term, build capacity in communities and partner with clinical teams.

The Center provides expertise via a framework of managerial support for CHW program development as part of the PPS projects, IT infrastructure to ensure accessibility and integration, community partnership expansion, inclusion of cultural competency and peer-support, metric and data analytic support, and legal/privacy structure for sustainability.

- Expanding its pre-existing structure additional program managers were hired to develop and oversee the implementation of the new service lines needed to support the PPS projects at three campuses of NewYork Presbyterian providing care across the 5 boroughs of NYC. These managers lead CHW programs in HIV/Behavioral Health at NYP Columbia and Cornell, Ambulatory ICU (adult) at Columbia and Transitions of Care at Columbia, Cornell and Lower Manhattan Hospitals, Ambulatory ICU (pediatric) at Columbia and Cornell and ED Care Triage at Columbia, Cornell and Lower Manhattan and Tobacco Cessation at Columbia and Cornell.
- The Center led the development of IT infrastructure in the NYP application Allscripts Care Director© that enabled CHWs based out of CBOs and through the use of tablets, to document their patients' findings inclusive of social determinants. This enabled CBO partners to view the assessments as well as ensure that healthcare team members had access to this important information as well. This IT capability makes it feasible to identify and document the social determinants, address them locally and communicate efforts with community partners and healthcare teams.
- The Center expanded its network of partners from 4 to 14 through this DSRIP funding as it identified expertise in CBOs across NYC communities working alongside clinical counterparts at NYP to improve care for Medicaid patients. CBOs provided on-the-ground, community based perspectives to address social determinants and ensure long-term connections to services for patients in their local communities.
- Utilizing CHWs that come from their local communities, demonstrate expertise as "connectors", and serve as the bridge between the healthcare environment and patients results in an effective approach to address social determinants of health.
- The Center, through support from IT and with input from leadership at local CBOs developed a structure for tracking metrics and outcomes of patients in each CHW program. Examples of metrics across the programs include number of patients referred, enrolled, peer education sessions, social service referrals, confidence in self-management, identification of food insecurity, depression, housing insecurity, and insurance status. Other outcomes variable by program include 30 day re-admission rate and adherence to PCP appointments.
- The Center developed subcontract agreements with each CBO that describes the CHW role and expectations and enables NYP to pay the salary, fringe, and program-related expenses associated with each CHW.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	Yes (please specify when and the estimated number of people impacted): The Center was implemented in 2015 as our PPS was launched. To date we have serviced approximately 8,000 patients annually with DSRIP funding for ED navigation in this model and 5,000 patients supported annually in adult and pediatric disease management, transitions of care and tobacco cessation.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Social and Community Context** , **Health and Health Care**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**