Community Health Workers Advancing Telehealth Equity: Patient Navigation

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AIR nyc

Mission

AIRnyc Community Health Workers meet people where they live to connect families to care and build health equity at the individual, family and community levels.

History and Partnerships

Established in 2001 as a Community Based Participatory Research (CBPR) project among Harlem Hospital Center, Mailman School of Public Health, Department of Biostatistics and the Harlem Children's Zone

Launched as an independent Community Based Organization in 2011

healthfirst
FIDELIS CARE
GREATER NEW YORK HOSPITAL ASSOCIATION GNYHA
NY HEALTH FOUNDATION
VILLAGECARE
Sun River Health
NEW YORK STATE Department of Health
Affinity Health Plan
NYC HEALTH+ HOSPITALS
NYC Health
Montefiore HEALTH SYSTEM, INC.
Mount Sinai

Health Equity in Action

Virtual and/or in person engagement by phone, SMS or video

Build trust, practice empathy, cultural humility, and resourcefulness

Mitigate barriers to care, motivate, improve treatment adherence

Facilitate connections to essential medical and social care

Track performance, close loops and measure impact

Sun River Health FQHC Program

- **Objectives:**
  - Reducing barriers to health and social care through enhanced access to and facility with telehealth and virtual care
  - Center patients' health and social needs from their perspective
- **Patients Served:** Sun River Health FQHC patients in The Bronx with asthma, COPD, and/or hypertension (some with high history of no show)
- **Navigation Support Provided:** connections to care, prescription navigation, telehealth navigation, health coaching for chronic conditions, social needs navigation

Sun River Health

Program Highlights

- **Strong relationship** with Sun River Health
- **CHWs embedded in Sun River Health EMR***
  - Enabling patients for patient portal (Healow) - 24.2%
  - Set up appointment - 35.5%
    - Access to Luma for appointment scheduling
- Referrals to Health Homes when applicable, allows AIRnyc to focus on providing **care coordination to those not eligible**

*percentage of patients out of total patients screened

Patient Story

- **36-year-old Bronx woman** experiencing **increased asthma symptoms** without a full supply of medicine and **not getting care for over 6 months**.
- The patient is **depressed,** due housing situation in a cramped NYCHA apartment and facing **rental arrears**.
- CHW **helped the patient schedule a PCP appointment** at Sun River Health and get all her medications. Now her **asthma is more controlled** and having her medications on hand has been helpful.
- CHW also **connected the patient with mental health assistance**. CHW started an **ERAP application for rent arrears**. The CHW is working on the patient's housing situation, including a transfer request through NYCHA.