Age + Action

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Improving the Health of Vulnerable Older Adults through Peer-led Programs:

JASA's Community Health Navigators

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Agenda

- Overview of JASA Services
- Introduction to JASA's Community Health Navigation Program
- Community Health Navigation Services
- Keys to Success
- Summary

JASA Overview

- Founded in 1968 – 51 years of service to New Yorkers
- Deep knowledge of neighborhoods and key stakeholders
- 50+ locations
- 1,900+ staff members
- 10+ languages spoken by staff
- Reaches 43,000 older adults

JASA Services

Three primary service areas to support aging in place:

- Quality housing for 2,400 low-to-moderate income older New Yorkers
- Homecare to nearly 900, tailored to individual needs
- Comprehensive home and community-based services:
  - 22 senior centers provide nearly 400,000 meals
  - Deliver over 500,000 meals to homes
  - 5,100 clients receive case management
  - Over 2,800 receive protective services or guardianship
  - NORCs reach 5,300 clients
  - Nearly 1,800 receive elder abuse prevention and legal representation

JASA's Community Health Navigation Program: Project Description

- JASA's Community Health Navigators (CHNs) are a team of 40 older adults in Brooklyn and the Bronx with diabetes, hypertension, and other chronic conditions who have learned to manage their health and receive training to help their peers in the community to do the same.

- They volunteer to deliver a wide-range of self-management programs to improve community health and there is mutual benefit to both the volunteers and program participants

- The program enables seniors to benefit from the support of individuals like themselves, who have similar health issues and share life experiences. It also enhances JASA's programming.

JASA CHN 1 Story

JASA CHN 2 Story

Community Need

Older adults in North Brooklyn face more health risks and life challenges than the average older adult in NYC

Health Outcomes:

- Avoidable diabetes hospitalization rates are 75% higher
- Diabetes deaths are 59% higher
- Hypertension and renal disease deaths are 38% higher
- Obesity rates are 20% higher

Demographics/Social Determinants of Health:

- 60% of adults hold high school diplomas, the third-lowest rate in the city
- 57.9% of residents speak Spanish at home; the NYC average is 25.5%
- 34.4% speak English less than well; the NYC average is 22.7%

Health Behaviors:

- 37% more reported usually drinking one or more sugary drinks daily
- 7% more reported having eaten no fruits and vegetables yesterday
- 13% more reported no exercise in the past 30 days

Program Objectives

To stimulate peer-to-peer interaction for people with shared life experiences to:

- Adopt healthy lifestyle practices that reduce health risks, prevent health decline, avoid preventable hospitalizations, and enable better quality of life
- Develop skills and confidence to self-manage chronic disease and make informed decisions about health

- To build local capacity and culturally competent approaches that increase access to information, services and resources, and improved community health

- To deliver self-management programs that help people who have ongoing health conditions learn how to live life to the fullest -- lives with less stress, more energy, and a greater ability to do the things they want to do.

- To coordinate and connect with medical providers to improve health, healthcare and contribute to JASA's sustainability

Community Health Navigation Services

- CHNs support their peers in two primary program areas:

Chronic Disease Management

Stanford Model - Evidence-Based Group Programs:
Diabetes Self-Management Program in English/Spanish

- Chronic Disease Self-Management Program in English/Spanish
- Chronic Pain Self-Management Program

Community Blood Pressure Control Programs:

- *"Keep on Track" Blood Pressure Monitoring Program*
- *Walk with Ease (Walking Club)*
- *Matter of Balance (Stretch/Fitness Class)*
- *Nutrition Classes*

Bronx Health Corps – Health Education Workshops:

- *Healthy Living (Nutrition, Physical Activity, Stress Management, Older Adult Sexuality)*
- *Alzheimer's and Dementia Related Diseases*
- *Managing Asthma and COPD*

Care Transitions

to Prevent Avoidable Hospital (Re)admissions

One-on-One Coaching:

- Healthy Eating
- Blood Glucose Monitoring
- Blood Pressure Control
- Falls Prevention
- Social Visits to Prevent Isolation/Connect to Community Resources

Chronic Disease Management: Stanford Self-Management Programs

CHNs facilitate evidence-based Chronic Disease Self-Management Programs (CDSMP) developed at Stanford University. The programs meet weekly for 2.5 hours over a six-week period and are highly interactive, focusing on building skills, sharing experiences, and social support.

Subjects taught include:

- Techniques to deal with problems such as frustration, fatigue, pain, and isolation
- Appropriate exercise for maintaining and improving strength, flexibility, and endurance
- Appropriate use of medications
- Communicating effectively with family, friends, and health professionals
- Nutrition
- Decision-making and how to evaluate new treatments
- Making weekly action plans

Program impact:

- CDSMP has been shown to help participants improve their health behaviors, health outcomes, and reduce healthcare utilization.
- Findings from analyses showed significant reductions in ER visits (5%) at both the 6-month and 12-month assessments as well as hospitalizations (3%) at 6-months among national CDSMP participants. This equates to potential net savings of $364 per participant and a national savings of $3.3 billion if 5% of adults with one or more chronic conditions were reached.*

*Source: BMC Public Health. 2013 Dec 6;13:1141. doi: 10.1186/1471-2458-13-1141. The impact of chronic disease self-management programs Lorig K,

Chronic Disease Management: Stanford Self-Management Programs at JASA

	CDSMP	DSMP	CPSMP	CTS
Program Participants	People with Chronic Conditions/Caregivers	People with Diabetes/Caregivers	People with Chronic Pain/Caregivers	People with Cancer/Caregivers
Shared Topics	• Healthy Eating • Action Plan • Feedback/Problem Solving • Making Decisions • Dealing with Difficult Emotions • Positive Thinking • Communication Skills • Working with Health Care Professionals	• Healthy Eating • Action Plan • Feedback/Problem Solving • Making Decisions • Dealing with Difficult Emotions • Positive Thinking • Communication Skills • Working with Health Care Professionals	• Healthy Eating • Action Plan • Feedback/Problem Solving • Making Decisions • Dealing with Difficult Emotions • Positive Thinking • Communication Skills • Working with Health Care Professionals	• Healthy Eating • Action Plan • Feedback/Problem Solving • Making Decisions • Dealing with Difficult Emotions • Positive Thinking • Communication Skills • Working with Health Care Professionals
Unique Topics	• Preventing Falls and Improving Balance • Pain and Fatigue Management • Better Breathing • Endurance Exercise • Making Healthy Food Choices • Medication Usage	• What is Diabetes • Monitoring • Dealing with Stress • Preventing Hypoglycemia • Focusing on Fat • Preventing or Delaying Complications • Strategies for Sick Days • Foot Care	• What is Pain • Moving Easy Program • Pacing and Planning • Stress & Relaxation-Guided Imagery	• Fatigue Management and Getting Help • Managing Pain • Living with Uncertainty • Future Plans for Health Care • Cancer & Body Changes • Cancer & Relationships • Guided Imagery
Outcomes	• Improved self-efficacy demonstrated, reductions in hospital use	• Reduced A1C demonstrated, reductions in hospital use	• Improvements in pain, life satisfaction and self-efficacy	• Decreased depression, pain, problems related to stress and sleep

Chronic Disease Management: Program Participation

274 Clients Participated in Self-Management Programs with an 80% Completion Rate Over an 18-Month Period

Program	Workshops	Participants	Completers*	% Completers
Diabetes Self-Management Program (DSMP)	6	88	72	82%
DSMP in Spanish	2	30	24	80%
Chronic Disease Self-Management Program (CDSMP)	6	97	79	81%
CDSMP in Spanish	3	43	30	70%
Chronic Pain Self-Management Program	1	16	13	81%
Total	18	274	218	80%

* **Completer =** attended at least four of the six workshops.

Chronic Disease Management: Self-Management Program Impact

Survey data was collected to evaluate program impact

- 160 of the 218 program completers responded, and feedback was extremely positive

Post-Survey Question	Strongly Agree	Agree	Disagree	Strongly Disagree
I have been able to maintain the lifestyle changes for my health that I have made.	50%	47.5%	2.5%	0%
I now have a better understanding of how to manage my health.	60%	40%	0%	0%
Taking an active role in my own health care is the most important factor in determining my health and ability to function.	69.4%	30.6%	0%	0%
I would recommend this workshop to a friend.	73.1%	26.9%	0%	0%

Chronic Disease Management: "Keep on Track" Blood Pressure Control

- 20 CHNs were trained in "Keep on Track" by the Department for the Aging to deliver weekly blood pressure monitoring programs
- CHNs have monitored blood pressure for 300 community members in the community:
  - 39% of community members have had high blood pressure at least one time
  - To address hypertension in the community, CHNs have delivered Fit Club programs
    - Fit Club includes weekly blood pressure monitoring programs, evidence-based physical activity programs such as Walk with Ease and Matter of Balance, and nutrition classes
    - 165 community members have attended a Fit Club program
  - JASA's new Electronic Health Record (EHR) system will enable CHN programs to track blood pressure over time and to demonstrate program impact

Chronic Disease Management: The Bronx Health Corps (BHC)

- The BHC's mission is to empower older adults to manage their health through volunteer training, health literacy, education and community engagement
- Initial funding for the Bronx Health Corps came from the Geriatric Workforce Enhancement Program (GWEP), a Health Resources and Services Administration grant to the Hartford Institute for Geriatric Nursing (HIGN) at NYU Meyers College of Nursing – the creators of the content and the program
- Since then, other funders have provided support including the New York Community Trust to expand the Bronx Health Corps
- The program is implemented by several community-based organizations, including JASA, and an extensive network of Senior Centers in the Bronx

Chronic Disease Management: Bronx Health Corps

To date, 269 workshops have been held in the following areas:

- Healthy Living Series
- Alzheimer's Disease and Related Dementia
- Asthma
- Healthy Heart
- Opioids

Chronic Disease Management: Bronx Health Corps – JASA

- Nearly 5000 seniors were trained in Bronx Health Corps content through JASA's Community Health Navigators
- 68% reported positive health behavior changes at follow-up
- 79% of **Healthy Living** attendees reported positive changes
  - 55% were eating more fruits and vegetables
  - 54% exercised more
- 72% of **Alzheimer's Disease and Related Dementia** attendees reported positive changes
  - 48% shared information with family and friends
  - 31% spoke with a healthcare provider about ADRD

Care Transitions: Project Description

JASA's home-based care transitions (CT) intervention aims to prevent avoidable readmissions and other adverse events post-discharge, as well as address the social determinants of health.

JASA's CT intervention:

- Utilizes evidence-based models (i.e., the Coleman Model) as a foundation, and leverages JASA's extensive experience working in the community with CT and related interventions
- Addresses physical, mental and social health needs
- Delivers services both in the hospital and at home to provide continuity across settings
- Connects older adults and their caregivers to community resources that enable stable home-based functioning

Care Transitions: Target Population

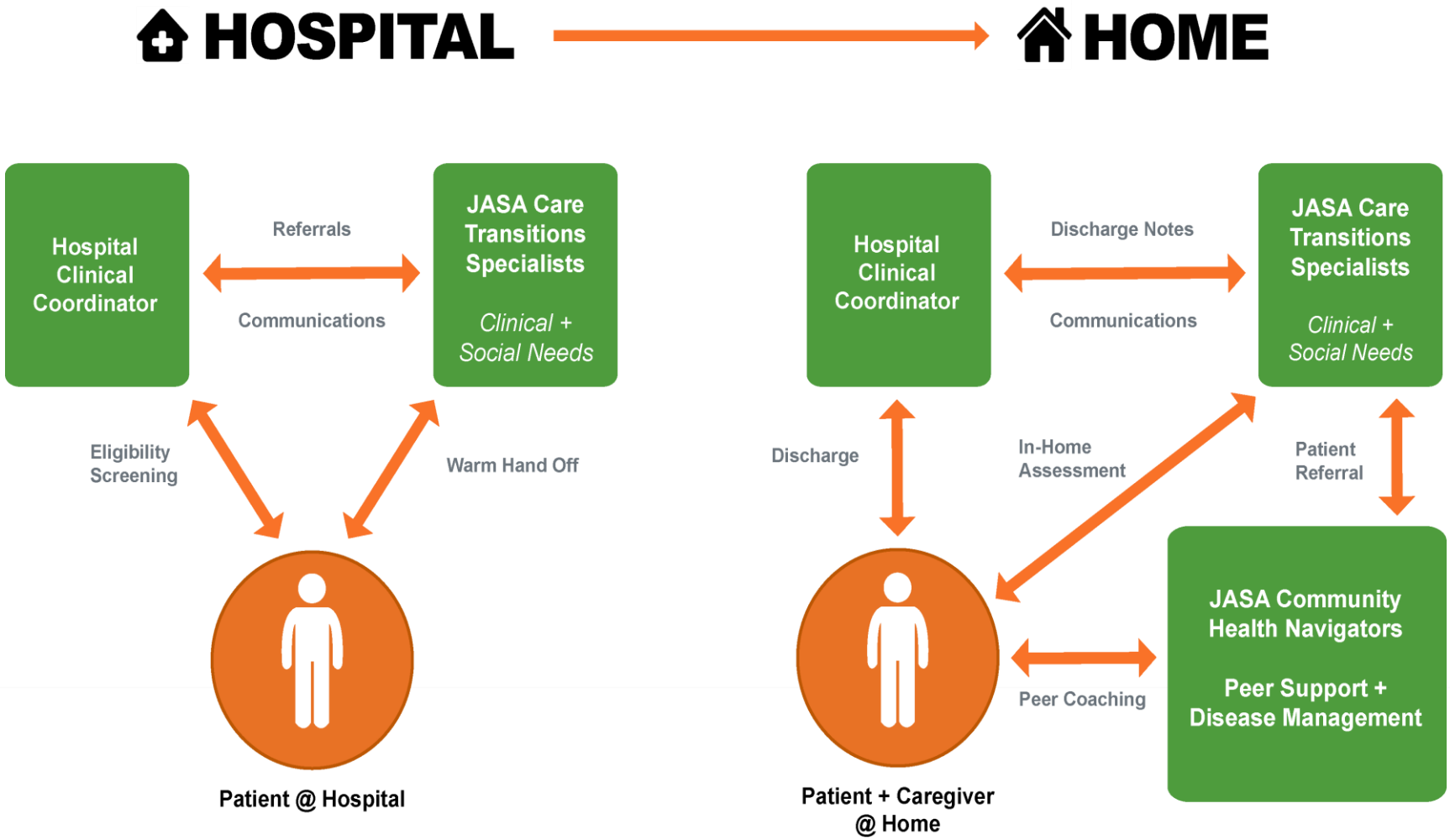
- Inpatient admissions at Wyckoff Hospital who reside in Bushwick, Ridgewood, Bed-Stuy, East New York, Cypress Hill and Williamsburg
- 55 years or older
- Medicaid, Medicare, Dual Eligibles and the Uninsured
- Speaks English or Spanish
- Have comorbidities or complex medical conditions, focusing on CVD, DM, and COPD
- May be affected by factors such as food insecurity, language barriers, or lack of social supports

Care Transitions: Staffing Model

Care Transitions Specialist: International Medical Graduate	Care Transitions Specialist: Social Worker	Community Health Navigator: Peer Coach

• Discharge Instructions Review & Translation
• Medication Support
• Physician Follow-Up
• Patient Education & Disease Management
• Primary Care & Community-Based Services Linkages
	• Social Needs Assessment and Referrals (e.g., Nutrition, Transportation, Medicaid, Home Care, Caregiver Support)
	• Mental Health Support and Referrals
		• Health Coaching & Chronic Disease Self-Management Support
		  • Blood Pressure Control
		  • Blood Glucose Monitoring
		  • Healthy Eating
		  • Social Visits/Connect to Community Services
		  • Falls Prevention
		• Ongoing Social Support and Companionship

Care Transitions:
Care Transitions Model



Care Transitions: CHN Services

- JASA's CHNs live in the same community and have many of the same health conditions as the patients they are helping who are being discharged from the hospital
- They extend JASA's clinical staff services and provide peer support in English and Spanish:
  - Blood Pressure Control
  - Blood Glucose Monitoring
  - Healthy Eating
  - Falls Prevention
  - Social Visits/Connect to Community Services
- JASA is partially reimbursed through a contract with the hospital for CHN services which contributes to program sustainability.

Care Transitions: Program Snapshot

	Year 1	Year 2	Year 3
WHMC patients referred to JASA	245	375	353
Readmission rate	8%	11%	11%
JASA Care Transitions Services			
% of patients visited in the hospital	86%	86%	92%
% of patients visited at home	60%	60%	68%
% of phone call follow-ups (no home visit)	21%	18%	`18%
CHN service referrals	20%	40%	46%

Care Transitions:
Key Services Provided

JASA Care Transitions Direct Services	Year 3
Wyckoff Hospital Patients Referred to JASA	353
% of patients who needed/received help understanding their discharge instructions	66%
% of patients who needed/received help with their medication	67%
% of patients who needed/received patient education (e.g., disease management, red flags, medication)	82%
% of patients who needed/received help with physician follow-up visits	45%

Closed Loop Service Referrals

	Year 3
Wyckoff Hospital Patients Referred to JASA	353
Health Coaching/Peer Support (Healthy Eating, Blood Glucose Monitoring, Blood Pressure Control, Falls Prevention, Social Visits)	39%
Nutrition Services (MOW, SNAP, Food Pantry, Congregate Meals)	25%
Transportation	16%
Mental Health Services (Psychotherapy, PEARLS)	12%
DME/DMS	12%
Medicaid	10%
Home Care	10%
Skilled Services (PT, OT, CHF/COPD Services)	6%
Housing Services (Legal, Help Center)	4%
Urgent Care/Physician Housecalls	4%
Caregiver Support	1%
Adult Protective Services/LEAP	1%

Summary of Results:
Patient Satisfaction Survey

Patient Satisfaction	Yes		No		Not Sure		No Answer		Total	
The Care Transitions Team helped me to understand my health conditions and how to manage them.	76	95%	2	3%	1	1%	1	1%	80	100%
The Care Transitions Team helped to understand red flags and health risks, and how to prevent future hospitalizations.	72	90%	2	3%	5	6%	1	1%	80	100%
The Care Transitions Team improved my understanding of my discharge intructions and how to mange my health at home post-hospitalization.	75	94%	3	4%	1	1%	1	1%	80	100%
The Care Transitions Team made me aware of services in the community that can help to maintain or improve my health, and prevent future hospitalizations.	72	90%	1	1%	6	8%	1	1%	80	100%
Were you satisfied with JASA's Care Transitions Team?	75	94%	0	0%	4	5%	1	1%	80	100%
Would you recommend JASA's Care Transitions Program to a family member or a friend if they were hospitalized?	72	90%	3	4%	4	5%	1	1%	80	100%

= # of patients = % of patients

Keys to Success

- Effective recruiting and retention strategies are critical -- with a focus on identifying and engaging seniors with desirable Community Health Navigator characteristics
- Active and ongoing support for the Community Health Navigators, and effective oversight of their day-to-day activities
- Meaningful incentives -- educational opportunities, individual recognition and financial rewards (when possible)
- Strong team-building efforts that make Community Health Navigators feel part of a group and community
- Thoughtful approaches to program evaluation that take into account varying comfort levels with technology and data collection

Summary

- Community Health Navigators are a highly effective means to deliver chronic disease self-management programs, support care transitions and provide social support to their peers in the community – they support a diverse set of programs
- Community Health Navigation programs provide mutual benefit to volunteers and the peers they are supporting
- Self-management programs not only provide vital health information, but also provide social support which is invaluable for people living with chronic conditions
- Community Health Navigators provide a vital resource for patients between doctor's visits – these programs can improve health outcomes and quality of life

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