

OneCity Health Innovation Fund Awardee

Strengthening Community-Clinical Linkages to Address Social Determinants of Health in Connection with Chronic Disease Self-Management



LEAD ORGANIZATION: Korean Community Services of Metropolitan NY

JOINT APPLICANTS: Mexican Coalition; Health People; New York City Department of Health & Mental Hygiene

NEIGHBORHOODS PROJECT INTENDS TO SERVE: Melrose, Morrisania, East Harlem, and Midtown

BUDGET: \$750,000

OVERVIEW

This project combines tailored, evidence-based chronic disease self-management interventions, delivered by community health workers (CHWs) from community-based organizations (CBOs), with connections to services that impact disease outcomes and health care utilization. Through this project, our goal is to enhance the Stanford Diabetes Self-Management Programming model (DSMP) by incorporating linkages to insurance, primary care, and resources to address social determinants of health for this population.

Our key activities include:

- CBO delivery of DSMP
- Utilization of NowPow to connect community members to resources that address social determinants of health
- Documentation and elevation of structural barriers impacting care
- Collaborative development of value-based payment billing model pilots to support sustainability of comprehensive chronic disease management programming in community settings

This project refines and tests the combination of evidence-based chronic disease self-management program delivery with connections to insurance, primary care, and services which address social determinants of health. Because this project will be based in sites that are less expensive than traditional health care sites, it could also demonstrate potential cost-savings for the health system, while also being proximal to, and in the spirit of, the community. Our partnerships and their impact could be replicated and scaled up by expanding the partner capacity and the network.

DSRIP METRICS THIS PROJECT WILL ADDRESS

This project will seek to reduce preventable admissions and preventable ER visits. In addition, this project will address comprehensive diabetes care A1c testing and lipid profile, and diabetes monitoring for people with schizophrenia. Finally, this project will also address premature deaths, preventable hospitalization ratios, insurance rates, connections to regular health care providers, obesity rates and diabetes complication hospitalizations.