Initiative	Team Structure	Care Navigator Role(s)	Evaluation Measures/Results
Primary Care-Based Models			
LACDHS Care Connections Program Five outpatient clinics Los Angeles County, CA • LAC+USC outpatient clinic • El Monte Comp Health Center • Roybal Comp Health Center • MLK Outpatient Center • Humphrey Comp Health Center • WERC	Implements complex care management for high risk, high cost patients. Integrates 24 Community Health Worker (CHWs) recruited and trained by WERC into selected PCMH teams at participating outpatient clinics. A physician or RN care coordinator supervises/mentors the CHW within the PCMH team structure.	• Patient engagement and activation • Health system navigation • Comprehensive assessment and care planning • Care transitions support • Chronic disease support and health coaching • Social support • Advanced illness management support	Pending. TCE-funded evaluation led by UCLA Clinical and Translational Science Institute and Anansi Health using quantitative and qualitative data that includes selected measures in: • Access to care • Utilization • Cost • Patient and provider experience
Medicaid Managed Care Plan New Mexico[i] • Molina Healthcare of New Mexico • University of New Mexico Department of Family Medicine (UNM) • Hildago Family Medical Services (FQHC)	Specialized care team apart from PCMH consisting of: • Molina Healthcare medical director • RN health services director • Care coordinator • UNM coordinator • CHWs deployed at three sites in New Mexico and employed by either UNM or FQHC	• System navigation • Access to care • Chronic disease management • Health literacy	• Significant reductions in claims and payments in emergency department (ED), inpatient, non-narcotic and narcotic prescriptions, primary care, and specialty care • Yielded return on investment of $4 for every dollar spent • Based on results, Molina Healthcare replicated program in CA and other states
Health Care Safety Net ACO Hennepin Health[ii] Minneapolis, MN • Hennepin County Human Services and Public Health Department • Hennepin County Medical Center • NorthPoint Health and Wellness Center (FQHC) • Metropolitan Health Plan (Medicare and Medicaid enrollees)	ACO created for people newly eligible for Medicaid due to ACA, many of whom face physical, behavioral, and social challenges. The ACO stratifies patients into risk tiers, which allows Hennepin Health to direct finite care coordination resources and interventions to high risk, high cost members. Interdisciplinary care coordination teams, located in primary care clinics and targeting high risk patients, consist of: • RN care coordinator • Social worker • CHW The team also includes Physician, NP or PA, and psychologist, with support provided by a pharmacist, chemical dependency counselor, and addiction psychiatrist.	CHWs reach out to and establish relationships with members to help them: • Understand their care plans • Provide follow up on missed appointments and referrals • Resolve barriers to treatment • Facilitate social support	After first year of operation: • Decrease in ED visits of 9.1 percent • Increase in outpatient visits of 3.3 percent • No change in hospitalizations • Increase in patients receiving optimal diabetes care from 8.6 percent to 10 percent • Increase in optimal vascular care from 25.0 percent to 36.1 percent • Increase in optimal asthma care from 10.6 percent to 13.8 percent • Expansion of CHW workforce

Initiative	Team Structure	CHW Role(s)	Evaluation Measures/Results
Nonprofit Safety Net Hospital • Bronx-Lebanon Hospital Department of Family Medicine (DFM)[iii]	CHWs were integrated into DFM's PCMH to provide care management, because the the nurse case-manager model was too costly and peer support appeared preferable for the patient population. CHWs were supervised by a physician and a CHW administrator.	• Home visits • Coaching on self-management activities • Phone outreach and follow up • Shared group visits with physician • Linking to services • Accompany on medical visits	Among patients with diabetes and other chronic health conditions: • ED visits declined by 5.0 percent • Hospitalizations declined by 12.6% • Yielded return on investment of $2.30 for every dollar spent • CHW position was made permanent
Safety Net System Southeast Health Center Transitions Clinic[iv] San Francisco, CA • San Francisco DPH clinic • UCSF • City College of San Francisco	CHW paired with a physician to conduct outreach to released prisoners at various locations (i.e., weekly parole meetings) and connect them with a medical home. No further information on team structure.	CHW provides case management services: • Assistance with housing, employment, legal aid, and substance use counseling • Home visits • Accompaniment • System navigation • Chronic disease self-management support	• 36% increase in average number of new patients seen each month • 55% of patients attended initial appointment and 77% attended 6-month follow up appointment • 50% reduction in ED use • High levels of patient satisfaction
Harbor-UCLA Medical Center, Department of Family Medicine[v] Harbor City, CA • Lomita Family Clinic	Hospital-based, university-affiliated family health center within DHS system that implemented grant-funded CHW program combining nutrition education with behavior-change goal setting to address high rates of obesity/diabetes and broader social determinants of health. A physician started the program, shared in training, and supervised the CHWs.	• Health education at clinic, schools, and housing project sites • Coordinated patient visits • Assisted with physician instructions • Helped physicians understand patient population • Practice improvement with medical team	One of 15 best practice case studies on building primary care teams featured in a 2007 California HealthCare Foundation report by UCSF's Dr. Tom Bodenheimer
Health Care Safety Net Project Dulce[vi] San Diego County, CA • County of San Diego • Community Clinics Health Network • San Diego State University • Scripps Whittier Diabetes Institute	Trained diabetes RNs from the Scripps Whittier Diabetes Institute lead multidisciplinary care team that provide clinical care and management for FQHC patients. The team includes: • CHWs • Registered dieticians • Medical Assistants as health coaches	CHWs are peer health educators providing diabetes self-management education	Have been several studies documenting the effectiveness of clinical, behavioral, and economic outcomes. A randomized trial of only CHW peer education demonstrated: • Greater improvements across time in A1C and diastolic blood pressure in intervention group vs. usual care group • Significant improvements in A1C and secondary indicators (total cholesterol, HDL and LDL cholesterol) in the intervention group
Hospital-Based Models			
Medicaid Fee-for-Service Patient Centered Transition (PaCT)[vii] Philadelphia, PA • Hospital of University of Pennsylvania • Penn Presbyterian Med Center • Spectrum Health Services (FQHC)	Specialized care team based at two academic medical centers consisting of: • Physician • LCSW • CHWs	Facilitated discharge plans and care transitions • Patient education/activation • Social support • System navigation • Advocacy	Intervention patients were more likely to: • Obtain post-hospital primary care • Report high-quality discharge communication • Show greater improvements in mental health and patient activation Intervention patients were less likely to: • Have multiple 30-day readmissions

Initiative	Team Structure	CHW Role(s)	Evaluation Measures/Results
Medicaid Fee-for-Service Hospital 2 Home Project[viii] New York, NY • Health and Hospitals Corporation (HHC), Bellevue Hospital	Specialized care team based at a public hospital consisting of: • Physician • Social worker • Care manager • Housing coordinator	Facilitated discharge plans and care transitions • Systems navigation (i.e., access to appointments and mental health/SUD treatment) • Home visits • Supportive housing placements	• 37.5% decrease in inpatient admission • 10% decrease in ED visits • Increase in outpatient visits • Medicaid spending decreased by $16,383 per patient • Based on pilot results, program was expanded to two other HHC hospitals
Medicaid Managed Care Plan Community Care of North Carolina, Northern Piedmont Community Care[ix] Durham, NC • Duke University Durham Community Health Network • Community Care Partners	CHWs work with various combinations of nurses, social workers, and health educators to serve specific populations: • High-risk/high-cost patients: CHWs conduct patient follow up post-discharge as part of treatment team • Medicaid managed care support: 7 full-time CHWs are employed and work as part of care coordination teams • A parallel program targets uninsured patients with 2 full-time CHWs and volunteer community organizers	• Follow up with high-risk/high-cost hospital discharges, home visits, and outreach to homebound elders • Support for Medicaid managed care, and community health education • Identify social/economic needs that might interfere with effective recovery • Assists in the treatment plan • Mobilizes community services/resources	Decrease in ED and hospitalization costs
Nonprofit Hospital Healthy Breathing Pediatric Asthma Project[x] • Esperanza Community Housing Corporation • California Hospital Medical Center (CHMC) • FQHCs	UniHealth Foundation-funded project based on successful partnership with St. John's Well Child and Family Health Center and other community-based organizations. Esperanza CHWs receive referrals from CMHC ED and Pediatrics. CHWs perform in-home visits to address environmental home health hazards as a result of poor housing conditions over 6-month period. Although not a part of a medical team, CHWs have provided training to CHMC physicians.	• Home visits • Connect to FQHC medical home • Patient education • Medication adherence • Asthma action plan	In cases with 6-month follow up visits completed: • 64% of families are more knowledgeable about asthma • 85% of multiple-admission patients did not return to CHMC ED • 100% of single-admission patients did not return to CHMC ED • 58% of Pediatric admissions did not return to CHMC
Medicaid Fee-for-Service Baltimore, MD[xi] • University of Maryland School of Pharmacy (UMDP) • University of Maryland Medical System • MD Medicaid Diabetes Program • Other patients/providers	University based-CHW intervention that included: • Clinical supervisor • Volunteer CHW	• Provide home visits and phone contacts • Teach patients with diabetes and/or hypertension to manage their illness(es), follow therapy and behavioral regimens • Maintain visits with a PCP	• 40% decrease in ED visits and 33% decrease in hospital admissions • 27% decrease in hospital admissions and Medicaid reimbursement • $2,245 average savings per patient and $262,080 total savings • Improved quality of life
Non-Profit Hospital System Contracted to Provide Nueces County's Indigent Health Care Program[xii] Corpus Christi, TX • Christus Spohn Health System	Goal was to link frequent ED users with a medical home and reduce costs • 4 CHWs deployed in hospital (inpatient/ED) • 3 CHWs deployed in primary care clinics	• Assisting patients with language needs • Addressing concerns with a physician, RN, or social worker • Providing system navigation tools	• Increased return on investment ranging from $2.70 to $16.56 per patient • Increased patient satisfaction

Initiative	Team Structure	Care Navigator (CHW) Role(s)	Evaluation Measures/Results
Nonprofit System with 9 Hospital EDs Community Outreach Personal Empowerment (COPE) Program[xiii, xiv] Houston, TX • Memorial Hermann Health Care	Certified CHWs and social workers with training and cultural/linguistic capacity help frequent users post-discharge. Patients must agree to use a physician office for non-emergency care and to follow up with scheduled appointments	• Navigate the health system • Obtain a medical home • Schedule appointments • Secure social services	• Savings on ED visits and inpatient costs of $5,556 per patient, with 1,022 patients from 2008 to 2011 • Will compare savings pre/post-navigation intervention under state's DSRIP plan
Other Models			
L.A. Care Health Plan Funding Spinal Cord Injury Peer Project Los Angeles County, CA • Rancho Los Amigos National Rehab Center • WERC	Trains Peer Educators to work with medical team and newly injured patients as they are discharged from the hospital. Goal is to reduce severe depression and prevent pressure ulcers.	• Patient engagement and activation • Mental health support and health coaching • Social support	• Reduction of severe depression • Avoidance of pressure ulcers • PCMH participation • USC team providing evaluation
National Institute of Neurological Disorders and Stroke Grant Stroke Medical Home - SUCCEED[xv] Los Angeles County, CA • Four LACDHS Hospitals • UCLA Dept. of Neurology • WERC • Esperanza Community Health Corp	Implements an outpatient clinic with a specialized PCMH team headed by a neurologist that uses CHWs trained by WERC to improve control of risk factors among stroke patients discharged from LACDHS hospitals to prevent future strokes. Expanded to Cedars-Sinai Medical Center with California Community Foundation funding.	• Conducts home visits with stroke patients using mobile technology • Coaches on self-management skills • Serves as a liaison between patient and care team • Assesses for social isolation and depression • Mobilizes resources.	Pending. Some evaluation measures include: • Reducing systolic blood pressure • Controlling other stroke risk factors and improving lifestyle habits • Cost analysis of the medical home team and other study components

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