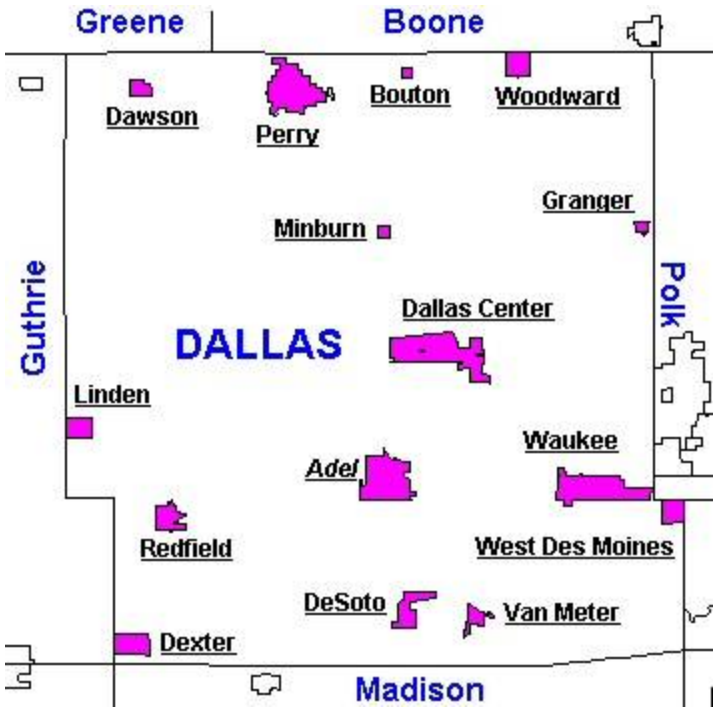
Health Navigation at the Local Level

Dallas County Public Health

February 2013

Dallas County

- Population approx. 69,000
- 14 towns + suburban corridor
- No central population base/medical facility



Issue

Community conversation with stakeholders and primary care providers:

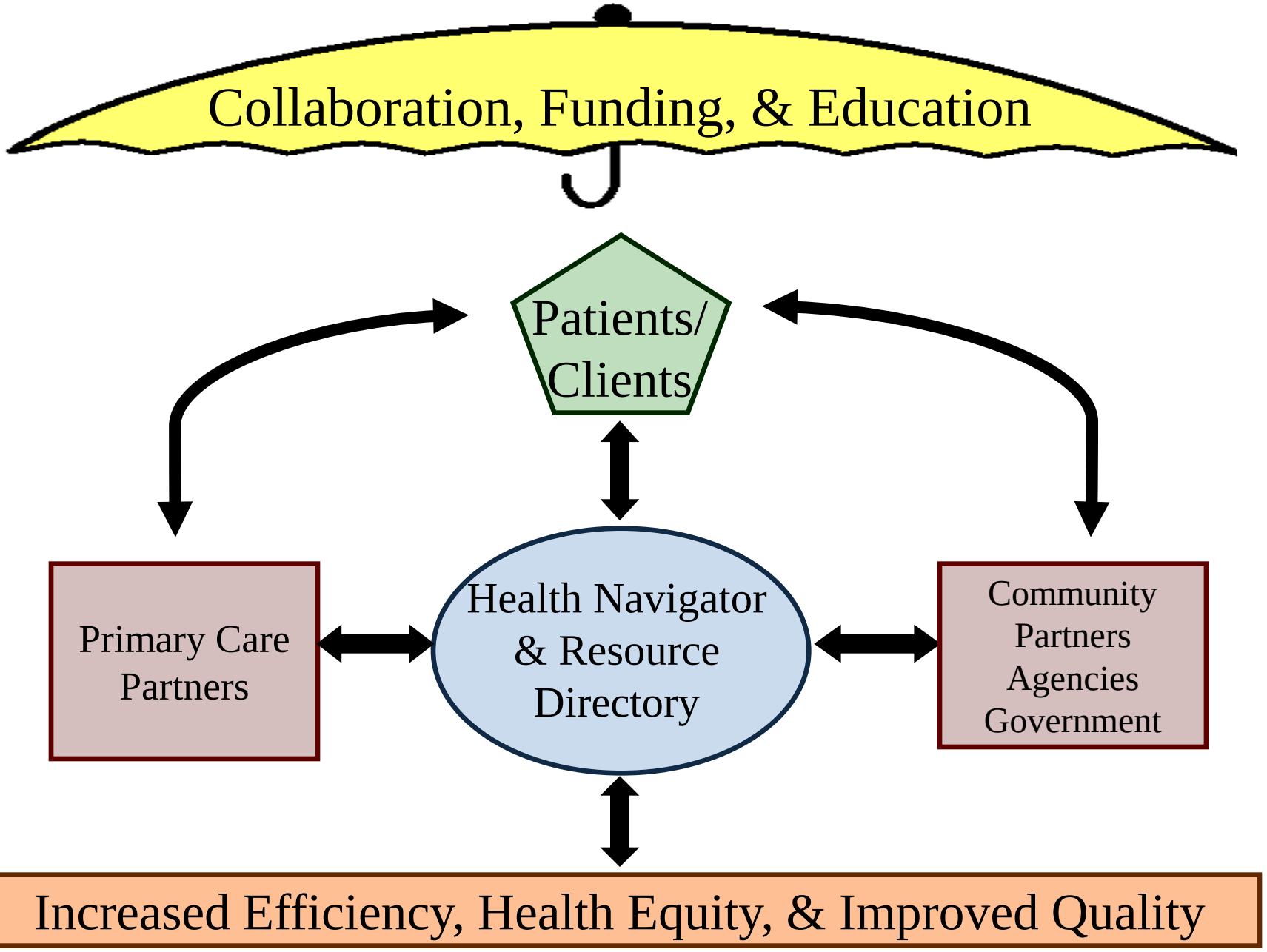
- Lack of access to care
- Confusion regarding community resources and programs including eligibility, benefits and application process

“ ***. . . patchwork of programs/resources with no central point of information or coordination”***

Vision

Dallas County Partnership for Health determined the need for an online Resource Directory and a Health Navigator.

"***Residents of Dallas County will have access to available resources in the county through one point of contact, with emphasis on timely referrals, fewer steps to receipt of care, efficiency, increased options and improved outcomes.***"


Collaboration, Funding, & Education
Patients/ Clients
Primary Care Partners
Health Navigator & Resource Directory
Community Partners Agencies Government
Increased Efficiency, Health Equity, & Improved Quality

Health Navigation Can Assist With:

- Screening for needs and refer/assist client in obtaining needed services & resources
- A medical payment source
- Access to medications
- Other “non-medical” services (housing, heat assistance, childcare, food, etc.)

How it Works

- Healthcare provider, agency or individual may refer to health navigation (healthcare providers are given priority)
- Providers complete a SHORT form and fax referral
- Navigator
  - Contacts client within 3 days
  - Screens for additional information/needs
  - Refers/assists client in obtaining resources
  - If referred by a healthcare provider, follows up with client on progress and completes information loop back to provider

Health Navigation is Not:

- Emergency Service
- Case Manager/Care Coordinator/Health Coach
- Discharge Planner

However, the Health Navigator CAN Assist ALL of these

Client Focused Health Navigation

- Mode and location of contact
- Primary presenting issue and additional issues from client's perspective
- Screening tool; client guides level of information & assistance
- Can provide hands on assist – applications, paperwork, translation, interpretation
- Level of involvement, # contacts & timeframe vary widely

Health Navigation Skills/Knowledge

- Local, State, Federal Resources
- Children/Families
- DHS/Medicaid
- Aging/Medicare
- Bilingual
- Health/Medical

Utilize a team approach – Registered Nurse, Social Worker, Community Health Worker

Needed by Healthcare Providers

- Providers trained to focus on clinical status; not underlying issues/causes or quality of life
- Discomfort with “non-medical” issues
- *4 in 5 Surveyed Physicians:*
  - *Say unmet social needs are directly leading to worse health (everyone, not just low-income)*
  - *Are not confident in their capacity to address their patient’s social needs (RWJF Survey; Health Care’s Blind Side December 2011)*

Health Navigation Benefits

To Patients, Providers & Community:

- Access to payment source/meds
- Help address underlying social issues
- Can impact ER visits, hospital admissions & readmissions
- Maximizes resources

FY 2013 Data (Jul – Jan)

- Averaging 52 clients per month
- Averaging 3.7 Contacts per Client
- Referral Sources
  - 21% Healthcare Providers
  - 25% Community Partners
  - 54% Self/Family
- Primary Presenting Issue
  - 70% Access to Care
- Barriers
  - 48% Income

Contact Information

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