NACCHO
National Association of County & City Health Officials

1100 17th Street, NW, Seventh Floor
Washington, DC 20036
Phone: 202-783-5550
www.naccho.org

2017 Model Practices

Applicant Information

Full Name: Jennifer Walters

Company:

Title:

Email: jennifer.walters@dallascountyiowa.gov

Phone: (515)993-3750

City: Adel

State: IA

Zip: 50003-4420

Model Practice Title

Please provide the name or title of your practice: *

Dallas County Public Health - Health Navigation Program

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- [x] Access to Care
- [ ] Advocacy and Policy Making
- [ ] Animal Control
- [x] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [ ] Community Involvement
- [ ] Cultural Competence
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [x] Health Equity
- [ ] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [ ] Organizational Practices
- [ ] Other Infrastructure and Systems
- [ ] Organizational Practices
- [ ] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce
- [ ] Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Social Determinants of Health

Is this practice evidence based, if so please explain. :

The Health Navigation Program is consistent with evidence-based practices, such as the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers.

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☑ Nutrition, Physical Activity, and Obesity
- ☐ Tobacco
- ☐ Healthcare-associated Infections
- ☐ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☐ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

Dallas County, Iowa has a population of approximately 80,133 residents and is among the fastest growing counties in the United States. Dallas County's population has increased by 62.3% in the last ten years, and the growth has outpaced the services and infrastructure available to support health in our communities. As a result, residents have to travel farther distances to access services and employment. Furthermore, Dallas County is becoming increasingly diverse, with immigrants and refugees settling in both our urban and rural communities. These populations face significant barriers to accessing health and social services including lack of health insurance, confusion on how to use existing health insurance, limited health literacy, transportation, cost, and language. Geographic isolation, cultural barriers, and access to healthy food outlets are added complications that negatively impact health and wellbeing. The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. It is the goal of Dallas County's Health Navigation Program that residents will have access to available health resources in the county through one point of contact, with increased options, and improved health outcomes. Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers, and Ann Cochran, a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care and social services. Beth Frailey,, a Master's level public health professional supervises the Health Navigators, and uses program data to plan, implement and evaluate system level changes within our communities. Once our Health Navigation staff receives a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if the need(s) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop. Specific objectives for the Health Navigation Program include: reaching 300 unique clients per year, tracking and increasing number of referrals from partners, and documenting systems changes through success stories. For the year 2016, each of these objectives has been met. Over 400 unique clients have been served, referral sources have been tracked to identify where outreach would be beneficial, and client success stories provide examples of systems change. Furthermore, community coalitions to address transportation and healthy food barriers have been created as a result of tracking clients' primary presenting issue and primary barriers. The benefits of Health Navigation reach patients, providers, and the community by providing one-on-one assistance to residents in overcoming barriers and helping them navigate systems, while also identifying and implementing changes to the system itself to make it easier for residents to be physically, mentally, emotionally, and financially healthy. As the innovator of the Health Navigation Program, it is essential that Dallas County Public Health continues to improve and expand the program to better serve residents in Dallas County while also providing an evidence-based model for other Central Iowa communities. More information for Dallas County Public Health can be found at the website: http://www.co.dallas.ia.us/department-services/public-health-home-health.

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)
- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF

Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

With increased coverage options, we expect more patients seeking care, often with complex social needs, such as food insecurity, unemployment, or no money to pay for gas or electricity. Not surprisingly, these challenges impact the health of patients and their families. Extensive research documents that these non-medical factors account for as much as 40% of health outcomes. For instance, asthma is linked to living conditions, diabetes-related hospital admissions to food insecurity, and greater use of the emergency room to homelessness; however, physicians do not always have the time, resources, or expertise to address these non-medical needs. A national survey of physicians in the American Medical Association reveals that 85% of providers believe addressing patients' social needs is as critical as addressing their medical needs, yet only one in five physicians are confident in their capacity to address them. These physicians also said that if they had the power to write prescriptions to address social needs, they would represent approximately 1 out of every 7 prescriptions written – or an average of 26 additional prescriptions per week. The Health Navigation Program is able to fill this gap by working in partnership with primary care providers to assess and coordinate patients' and families' medical and social needs, and facilitate access to community-based resources. The U.S. health care system is in the process of transformational change, which includes incentivizing collaboration among healthcare, human service, and community partners to address social determinants of health. The Health Navigation Program at Dallas County Public Health is helping residents address social determinants of health, overcome barriers, and access resources to live long, healthy lives, regardless of income, education, or ethnicity. Health Navigators do this by connecting residents to local resources, including but not limited to: health insurance, food, rent, housing, employment, education, transportation, parenting/child care, mental and behavioral health services, and other wellness options. Dallas County, Iowa has a population of approximately 80,133 residents and is among the fastest growing counties in the U.S. Between 1990 and 2010, Dallas County experienced a 122% increase in population; people of color and/or Hispanic heritage grew from representing 1% of the population to over 11%. Within Dallas County, the City of Perry is characterized by even greater diversity, with 35% of residents of Hispanic/Latino origin, and 32% speaking a language other than English in their home. Dallas County's growth represents a shift from an agricultural to suburban commuter community. The change brings opportunities and access to services for many, but also exacerbates inequities between the affluent eastern side of the county and the rural and ethnically diverse communities to the north and west. While the Health Navigation Program is available to all residents of Dallas County who need assistance accessing health or social services, the program specifically targets low-income, vulnerable populations, including: uninsured patients (5.72% of Dallas County residents according to the 2013 American Community Survey); individuals eligible for Iowa Health and Wellness Plan and/or Marketplace Insurance (1,599 residents enrolled as of September 30, 2015); patients with multiple chronic health conditions; persons living in our rural communities (Adel, Dallas Center, De Soto, Van Meter, Minburn, Dawson, Bouton, Linden, Redfield, Woodward, and Dexter); persons of Hispanic or Latino/a origin and immigrants and refugees; persons with transportation barriers; residents with no high school education and/or limited health literacy; patients with a recent visit to the Emergency Department (one visit within last 45 days); and patients with multiple emergency department visits (six or more visits in past 24 months). Annually, the program serves more than 500 individuals. The number and duration of contacts vary based on the client's needs. Before the Health Navigation program, there was no program that went into client's homes to help them meet their basic social and health needs, and there was no centralized location for partners to access local resources. The program goes beyond only helping with direct access to care, and also addresses the root causes of poor health by facilitating system-level changes in our communities. In 2015, Dallas County Public Health Completed a community health needs assessment, including a survey of community partners and the general public, focus groups, key informant interviews, and extensive review of quantitative and qualitative data. The priorities identified by the community include: 1). social connection and participation/willingness to act for the common good. 2). Safe, reliable, and accessible ways to move around. 3). Cultural competence and understanding of diversity/disparities. 4). Physical activity and 5). Access to and consumption of healthy food. These priorities are included in a 5-year health improvement plan. This plan serves as the roadmap for addressing health concerns, and will guide the development and focus of Health Navigation's system-level strategies moving forward. The Health Navigation Program is consistent with evidence-based practices, such as the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Community Health Workers are members of the communities they serve, and thus better equipped to build trusting, one-on-one relationships with clients and providers. While patient-centered medical homes and community health worker models have been used in clinical settings, the Health Navigation Program is unique in that it is managed and administered by a Local Health Department. Furthermore, the Health Navigation Program is innovative in the partnerships that it has created with clinics, community partners, and residents. Clients are referred to the Health Navigation program by clinical partners, community partners like local food pantries and nonprofit organizations, friends, family, or self-referrals. These partnerships allow Health Navigators to reach residents that might otherwise not hear about the program and creates avenues for referrals to resources to address each client's unique barriers. In addition, partnerships help to create systems changes in transportation, food, and access to care that benefit all of Dallas County.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

In 2010, Dallas County Public Health conducted a community health needs assessment. Through interviews, focus groups, and community conversations, “access to care” was a consistent issue identified as a top priority. In response, an “Access to Care” workgroup was formed. The workgroup created an online resource directory (http://www.co.dallas.ia.us/department-services/resource-directory) and developed the Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents will have access to available health resources in the county through one point of contact, with increased options, and improved health outcomes. Specifically, the program aims to serve over 300 unique clients per year, identify and increase referral sources, track the barriers identified by clients in order to initiate community-level projects, and document systems change through client success stories. Due to the need for comprehensive, coordination, and continuity of care for Dallas County residents, the Health Navigation program was implemented in 2011. In order to implement the program, it was first necessary to secure funding to support Health Navigation staff. Once Dallas County Public Health (DCPH) recruited and trained staff for the Health Navigation program, they focused on building a resource database and promoting the program to clinical and community partners. The Health Navigation program is open to all Dallas County residents, free of charge. Therefore, the program popularity and need has increased over time as Dallas County has grown. In order to meet the growing need, Dallas County Public Health applied for and secured funding from the United Way of Central Iowa, allowing the program to dedicate more staff time to meet clients’ needs and facilitate the access to healthy food and transportation initiatives. Partnerships are critical to the success of the Health Navigation Program and the systems-level changes it seeks to implement. The Health Navigation Program has established partnerships with nearly every organization that provides health resources and/or social services in our area. Our Health Navigation Steering Committee has representation from all primary care practices in Dallas County, including: Mercy, Unity Point, The Iowa Clinic, Dallas Center Medical Associates, Redfield Clinic, and Dallas County Hospital. Members of the steering committee are clinical champions who are committed to collaborating with community resources to enhance their clinical capacity and help patients and families coordinate services. These champions have a well-established history of referring patients to the Health Navigation program, and continue to advocate for care that is coordinated to ensure patients are connected to medical and social resources in the community. In addition to the previously identified primary care clinics, organizations that provide referrals to Health Navigation and accept referrals from Health Navigation include: Aging Resources of Central Iowa, Boone/Dallas Decat & CPPC, Coalition of Human Service Providers, Crisis Intervention and Advocacy, Dallas County Community Services, First Christian Church, Iowa State University Extension and Outreach New Opportunities Family Development/Head Start/WIC, Partners in Family Development, Sumpter Pharmacy, Tyson Foods – Perry, and numerous faith-based organizations. In addition, the Health Navigation program has established partnerships with the following agencies, in which we refer our Health Navigation clients to their organization for additional services, or their organization refers participants to Health Navigation for care coordination and access to community resources: Adel DeSoto Minburn School District, Catholic Charities, Childserve, Dallas Center Grimes School District, Easter Seals, HIRTA Public Transportation, Heartland Area Agency on Aging, Iowa Childcare Resource and Referral, Iowa Legal Aid, Lifeline Resources, Lutheran Services of Iowa, Mid-Iowa Family Therapy, Proteus, Swanson Dental, USDA Rural Development Housing, Veteran’s Affairs, Waukee Area Christian Services Food Bank, and Waukee Area Christian Services Free Clinic. In addition to partnerships, securing funding was a critical step to the success of the Health Navigation Program. In FY2016, DCPH applied for and was awarded an $88,784 grant from the Iowa Primary Care Association's Community Care Coordination initiative. Funded activities included: convening a multi-disciplinary advisory council and steering committee with representation from all primary care clinics in Dallas County; upgrading our current Health Navigation Database; conducting a needs assessment of providers; and developing an action plan to help providers better meet the social needs of their patients. DCPH also applied for and was awarded a $69,000 annual grant, starting in FY2016 from the United Way of Central Iowa (UWCI). Funded activities include piloting a clinic screening tool, recruiting non-traditional partners, collaborating and cross-referring to existing public health programs, and collaborating with WIC to allow post-partum follow-up to assess families’ insurance, health and social needs, and enroll in Health Navigation services when appropriate. To continue to advance the system-level changes identified in the 2016 Community Health Needs Assessment, DCPH applied for and was awarded the State Innovation Model (SIM) grant from the Iowa Department of Public Health. Included in this request is $26,000 that will be used specifically to support system-level projects related to transportation and food security. The program is funded through SIM ($236,780), UWCI ($69,000), and DCPH (in-kind support for supervision, rent, accounting, IT, and HR).

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice.

Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)
    - List any secondary data sources used (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.
    - Describe how results were analyzed
    - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

The goal of the Health Navigation Program is to connect residents with available health resources to improve health outcomes. All clients who are referred to the Health Navigation Program are screened for health, social, and economic needs and connected with appropriate resources to support total health and well-being. In addition, Dallas County Public Health gathers stories from Health Navigation clients and evaluates program and community-level data to identify and implement system-level interventions. In order to evaluate the Health Navigation Program, specific reporting measures have been captured quarterly. These include: number of individuals served (unduplicated), number of participant encounters, primary presenting issue, outgoing referrals, and barriers that clients face. After each participant encounter, the Health Navigators log details into the client's chart in the Health Navigation Database, powered by Salesforce. Utilizing Salesforce to capture data facilitates easier use of data to determine successful outgoing referrals, which partners are actively referring clients, and what are the primary barriers that Dallas County residents face. To supplement the quantitative data that is recorded by client data, the program compares County Census data, BRFSS data, and Community Commons data to justify that the program is meeting the needs of the County. When reporting number of unique individuals served and number of participant encounters, it was discovered that a small proportion of clients require multiple visits to meet complex social needs. At the same time, many clients just needed information about a resource or how to use the resource. Utilizing this data, DCPH is in the process of planning and implementing a process with clinical partners that would incorporate clinical health coaches to triage patients who need quick and easy information to address their social needs. Clients with complex social needs will be referred to Health Navigation so that Health Navigator can visit the clients on a long-term basis. It is hoped that this will help increase efficiency and capacity of the Health Navigation program so that we can meet the needs of more Dallas County residents. Utilizing the data to modify future practices is necessary for the success of public health programs. In addition to quantitative data captured by the Health Navigation Database, qualitative data is also utilized in the form of client success stories that demonstrate systems level changes as a result to community interventions. For example, Health Navigation clients cited transportation and access to healthy foods as common barriers in 2015, which led to the development of community coalitions to address food and transportation in 2016. As a result of this data, DCPH was able to implement a transportation voucher program which provided free rides to clients who did not have transportation to clinical appointments, and farmer's markets. Similarly, client barriers in 2016 will inform community interventions and program planning for the following year. It is desired that the Health Navigation Program not only meets the needs of individual clients, but also uses lessons learned to create a healthier community for all Dallas County residents.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.*)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

With more than five years of experience planning, implementing, and evaluating the Health Navigation Program, the following best practices have proven to be effective: Strategic Planning/Benchmarking: All program staff (management, IT, Health Planners and Health Navigators) come together monthly to review the program's current processes, identify gaps, and brainstorm solutions for improving service delivery and addressing social determinants of health. . Addressing the social determinants of health: Social determinants of health are conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants of health include: access to educational, economic, and job opportunities, access to health services, transportation options, social support, access to healthy food, language/literacy, and the built environment. All of the Health Navigation strategies are aimed at addressing social determinants through connections to resources and social supports, as well as changes to systems and the built environment to make healthy choices easier, especially for vulnerable populations. Appropriate staffing/resources: The Health Navigation Program is implemented by a bi-lingual Community Health Worker. There is extensive evidence that Community Health Workers improve patient knowledge, access to health care, increased use of preventive services and healthy behaviors (County Health Rankings & Roadmaps, 2014). As a true Community Health Worker, Vivian serves a variety of functions for the Health Navigation Program, including providing outreach, education, referral and follow-up, and home-visiting services for both English and Spanish-speaking clients. In 2014, the Health Navigation Program added a Master's level Social Worker, Ann Cochran, to help grow the service. Ann brings a person-centered, interdisciplinary approach to integrating health care and support services that are tailored to individuals' needs and goals. Through an increase funding support, the Health Navigation program was able to dedicate staff time to facilitating access to healthy food and transportation activities. Partnerships: Community partnerships are vital to achieving benchmarks, maximizing efficiency, and avoiding duplication of services. A unique barrier to Dallas County is that there are three major health systems (Mercy, Unity Point, and the Iowa Clinic), two independent practices (Dallas Center Medical Associates and Redfield Clinic), and two hospitals that provide emergency and specialty care (Dallas County Hospital and Methodist West Hospital). Data sharing is difficult among health providers because the health systems utilize different electronic health systems, collect data to varying degrees of completeness, and operate under different philosophies. In addition, implementing referral systems to the Health Navigation program has been challenging due to organizational barriers and the need for trust among providers that patients will be provided for. In order to build partnerships, the Health Navigation program created promotional materials, allowed clinic Health Coaches to shadow the Health Navigation program, and hosted monthly in-person meetings to find alignment between organizations. Dallas County Public Health continues to expand the list of partners with ongoing engagement to ensure referral, feedback, and communication loops are embedded as standard practice. Through regular communication, partners have opportunities to review the benefits of the project, address opportunities for improvement, and identify strategies for growth. This structure allows us to build a platform for strategic planning. In addition, collaboration with clinical partners provides the unique opportunity to collect data and run a cost-benefit analysis to determine cost savings for preventing hospital and clinic readmissions for clients who have been referred to the Health Navigation program. The Health Navigation program is unique in that it is run by a local health department. In order for the program to be sustainable, Dallas County Public Health will need to secure future funding. We hope to do this by partnering with local clinics and capturing the data that demonstrates the success of Health Navigation. As healthcare transformation is implemented, the quality of care, rather than the quantity, will determine reimbursement. Hospitals and clinics will be seeking partners who can help prevent hospital readmissions and improve health outcomes of their patients. Years of experience serving clients, extensive knowledge of local resources, and data demonstrating improved health outcomes for patients will position the DCPH Health Navigation Program to be a partner for large health systems. In order to obtain data demonstrating improved health outcomes for Health Navigation clients, DCPH Health Navigation will be partnering with one of the local health systems in 2017 to implement a screening toolkit for patients, a streamlined referral process, and sharing client data to capture health outcomes. As a local public health department, we believe that we must be at the forefront of innovative prevention strategies so that we can continue to be a key player in healthcare transformation.

Additional Information

How did you hear about the Model Practices Program:: *

- [ ] I am a previous Model Practices applicant
- [x] At a Conference
- [x] NACCHO Website
- [ ] Public Health Dispatch
- [ ] Colleague in my LHD
- [ ] Model Practices brochure
- [ ] NACCHO Exhibit Booth
- [ ] NACCHO Connect
- [ ] Colleague from another public health agency
- [ ] E-Mail from NACCHO
- [ ] NACCHO Exchange