
# Community Health Workers as Health Care Home Care Coordinators

**Presenter: Molly Jacques, MPH**

**Program Manager, Health Care Homes**

# HCMC Overview

- A safety net hospital providing care for low-income, the uninsured and vulnerable populations,

- Minnesota's premier Level 1 Trauma Center with many nationally recognized programs and specialties and

- The major teaching hospital for physicians in Minnesota.

health reform MINNESOTA
HCH | Health Care Homes

# What is a Health Care Home?

A Health Care Home (HCH) or a medical home is an approach to primary care that involves a fundamental partnership between primary care providers, families and patients w/ the goal of improving health outcomes and quality of life for all individuals, especially those with chronic or complex health conditions.

# Enrolled Patients – Who are they?

Demographic Summary:

1. Approximately 800+ patients receiving care coordination

2. All have at least one chronic and complex condition (medical or social).

3. Supplemental Factors
   - Approximately 37% have a language barrier
   - Approximately 28% have a Serious and Persistent Mental Illness diagnosis (as defined by MDH)

4. Payer Information
   - Vast Majority of enrolled patients have public insurance

# Why Hire Community Health Workers?

- Liaisons / relationship builders – staff typically come from the communities they serve.
- Lower health disparities - provide access to services, improve the quality and cultural competence of care.
- Awareness - Increase our general understanding of diverse populations.

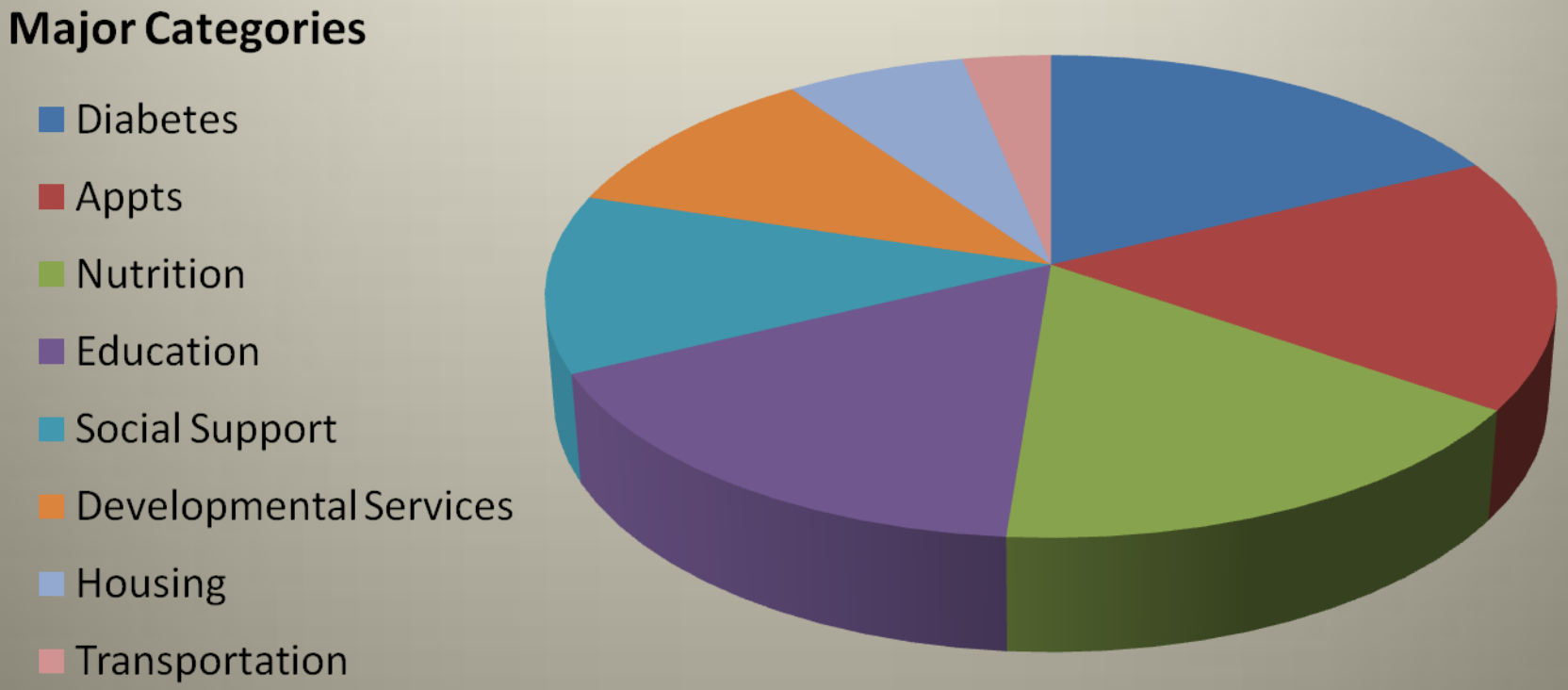
# Community Health Workers

# Care Coordinator – Key Responsibilities

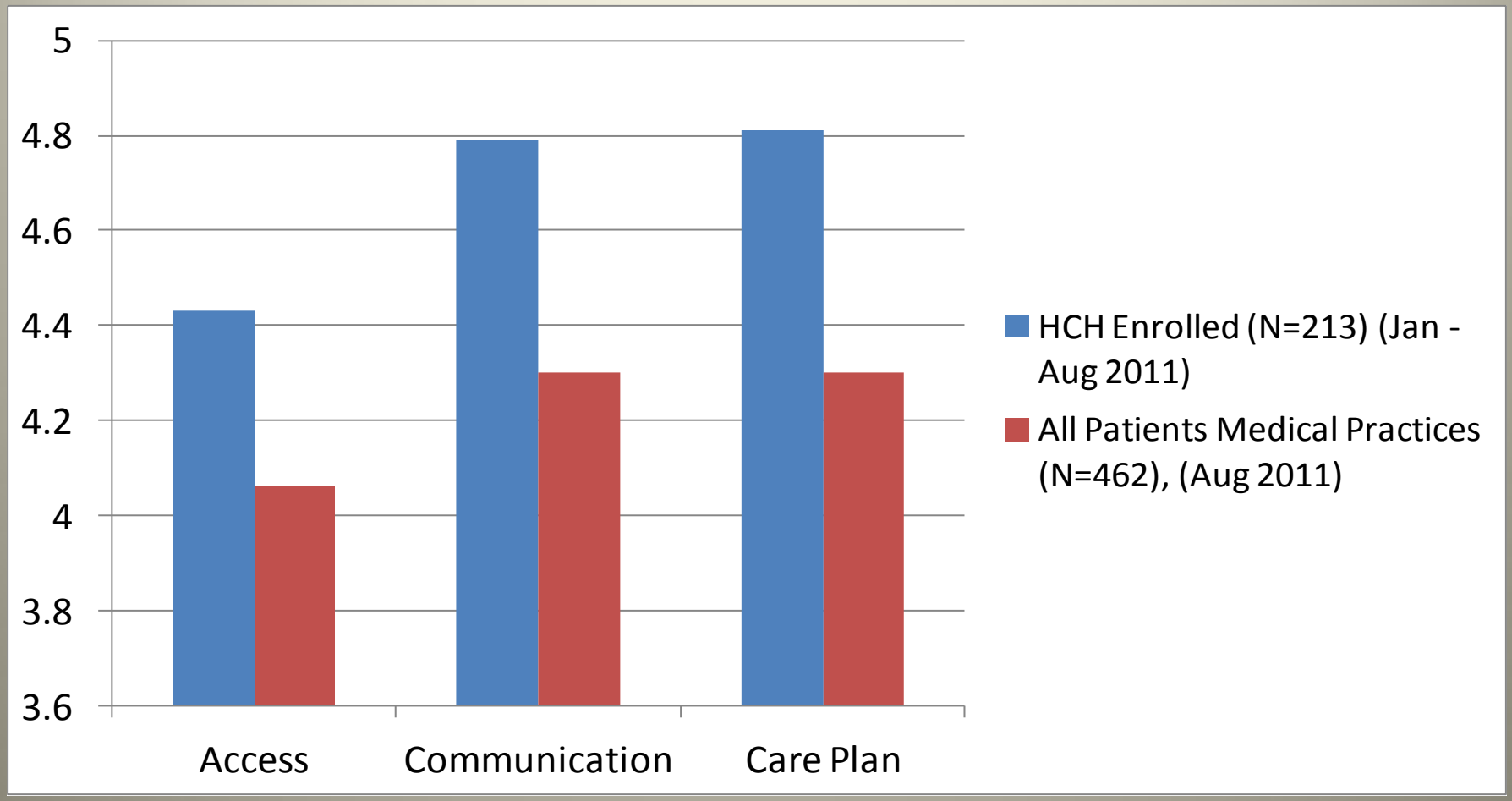
| Category | Tasks |
|---|---|
| Care Planning / Enrollment | Participate in initial care planning meeting with provider and patient/family to establish a care plan and set patient-centered goals. |
| Encouragement Support / Barriers | Contact patient to address 1) goal progress, 2) barriers to care including changes in housing, insurance, ability to fill medications, etc. |
| Admission Transitions | Contact patient post discharge to assist with scheduling appointments and transfer medical questions to care team. |
| Pre-Visit Planning (Gaps in Care) | Alert provider of critical information (e.g.: Health Maintenance Due) prior to clinic visits |
| Appointment Compliance / Referrals | Follow-up with patients if they miss appointments, try to help reschedule, coordinate transportation if necessary |

# Goal Setting

**Care Coordinators helped Patients set over 3,000 goals!**



# Improved Patient Satisfaction of HCH Patients




*Note: Survey results may have been influenced by varying survey methodologies*.

# Quality Improvement in Pediatrics – (MNCM Optimal Asthma)