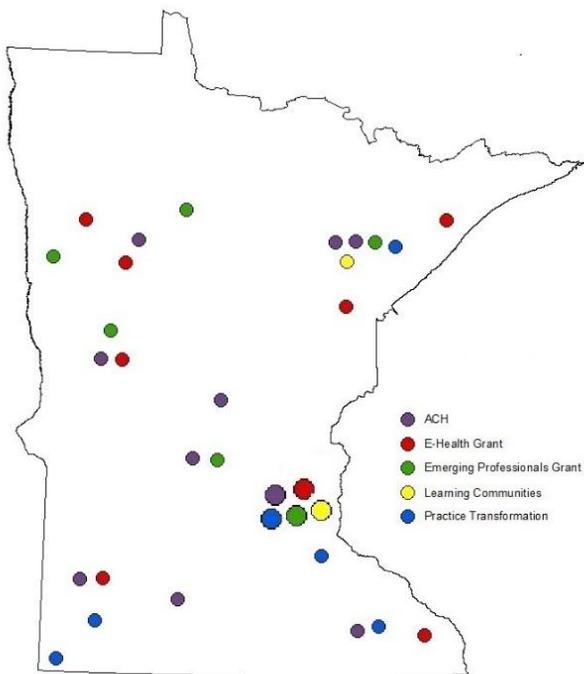


**MINNESOTA ACCOUNTABLE
HEALTH MODEL
SIM MINNESOTA**

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In February 2013 the Center for Medicare and Medicaid Innovation (CMMI) awarded Minnesota a State Innovation Model (SIM) testing grant of over \$45 million to use across a three-year period. The goal is to help its providers and communities work together to create healthier futures for Minnesotans. Minnesota's SIM initiative is a joint effort between the Department of Human Services (DHS) and the Department of Health (MDH) with support from Governor Mark Dayton's office.

Minnesota is using the grant money to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. Thanks to SIM funding, dedicated programs are now in place to improve health in Minnesota communities, provide better care to our state's residents, and lower health care costs by expanding patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services.

Emerging Professions

Community health workers help patients with complex care needs

JULY 2015

When Gabriel's Community Health Worker (CHW) from MVNA, a nonprofit public health organization, visited him for the first time, she learned that Gabriel had not been picking up his prescriptions because his Medicare Part D and health insurances had lapsed.

It turned out that Gabriel, a native of the Philippines with complex health conditions including renal failure, had received notices but he doesn't understand written English well and did not understand how or if he should even be responding to them. Gabriel's insurances and details of recent and past activity (paperwork submissions and actions administered by his plans) were in total disarray.

MVNA serves many individuals with complex care needs, including those living with chronic conditions and those with both behavioral and physical health needs. Through a State Innovation Model (SIM) grant, MVNA has hired a community health worker and increased the number of patients served by team-based integrated/coordinated care. By integrating the community health worker into a home visiting health care team, MVNA can better ensure clients will follow through on post hospital discharge clinic visits and be better equipped to meet their plan of care goals, with the hope of decreasing hospital re-admissions.

The community health worker who assisted Gabriel was able to get his coverage back on track through a series of visits, and many hours of phone calls to Medicare, Hennepin County, and the Senior Linkage Line. Most importantly, she was able to help him understand why his coverage continued to lapse. Finding out why he couldn't get his prescriptions paid for, and that they were finally ready for pick-up was a big relief to Gabriel. He continuously thanked his community health worker for all the time with him and for help resolving the issues.

MVNA Goals

MVNA has incorporated a new philosophy of care called Relationship-Based Care (RBC) that states the patient and family experience is their core business focus, and that relationships are core to caring. RBC is the implementation of a care delivery system that supports viewing the patient as a person, working with clinicians, and providing smooth transitions between caregivers.

The addition of a community health worker, a new profession on the care team, supports the RBC model and is

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seen by both the Medical Social Worker (MSW) and the Registered Nurse (RN) case managers as an integral part of the interdisciplinary care team. The community health worker provides a critical level of support to those professionals and has enhanced their ability to work at the top of their license.

After the first nine months, the MVNA community health worker provided services to 109 clients and 71% of post-hospital clients seen by the community health worker reported attending their first post-discharge clinic visit.

MVNA continues to look for opportunities to reduce readmissions and is working with Hennepin County Medical Center (HCMC) flag high at-risk clients so the community health worker can make contact within 48 hours of hospital discharge.

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"Maria" is high risk for hospital re-admissions due to chronic obstructive pulmonary disease exacerbation and has a history of visiting the Emergency Department as often as four times a week. The MVNA community health worker has found Maria difficult to track down and establish a connection with because of her frequent readmissions to the hospital and lack of a working phone. Unable to reach her by phone, the community health worker dropped by her apartment and left materials. Maria called back and the health worker and Maria met the next day.

Shortly into the visit the community health worker learned that Maria was anxious because she thought she was out of oxygen in her portable tanks. One tank was in fact empty, the other was full. Maria reported that she didn't know how to change from the empty tank to the full one, that she forgets to turn her portable tank off when she uses the oxygenator, and that she was currently waiting for the oxygen supply company to come and help fill the portable tanks.

The community health worker assisted with follow-up by calling the supplier and leaving a message asking when they could be expected to arrive. While waiting for a return call, the community health worker connected Maria's portable tubing to a full portable tank and instructed her on how to use them, as well as when to call 911 if she felt short of breath.

At one of the care coordination visits it was discovered that without a landline phone, Maria's Life Alert system was not functional and had not been working or tested since April 2015. MVNA is now helping Maria explore potential programs to help to pay her past due phone bill so that the Life Alert system can be reactivated, as well as check her eligibility to receive a free cell phone.

Maria now receives skilled nursing services and community health worker services. Thanks to care coordination, Maria has attended her follow-up primary care provider appointments, been connected to a long awaited dental appointment, and has been assessed for assisted living services, which will include meals and personal care attendant services. She is also now using a different model of oxygen equipment that is easier for her to manage and hasn't been admitted to the hospital since the community health worker and skilled nursing services were put into place.