Community Health Worker Roles
Within a Coordinated Care Model
Examples from Arizona

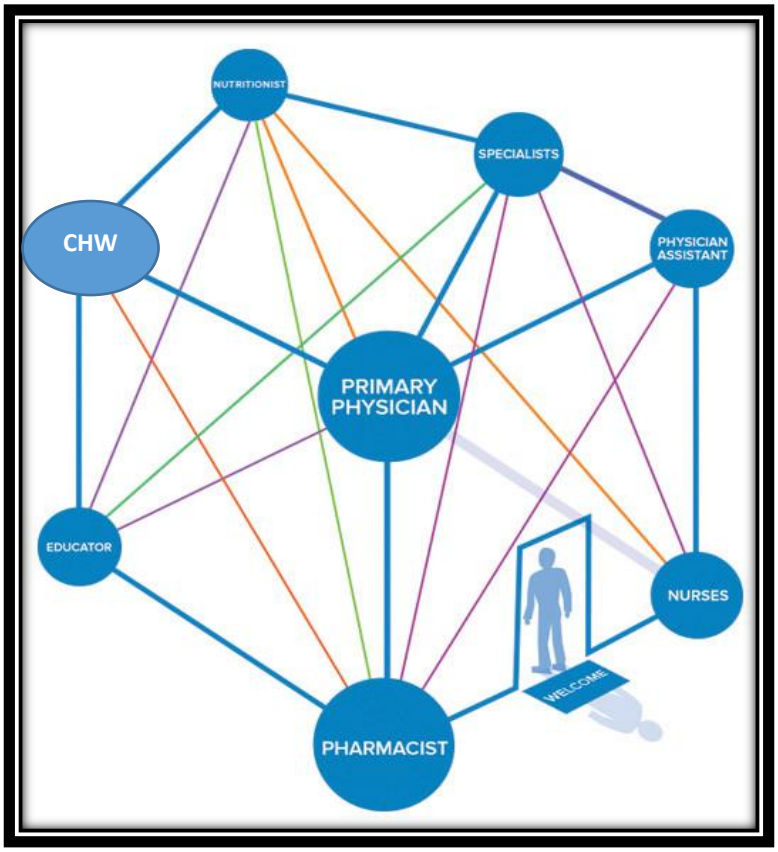
Patient Health Outcomes

- **20% reduction in hospital admissions.**
- **30% of high risk patients with diabetes (>8.0 HbA1c) under control.**
- **Average 1% reduction in HbA1c among high risk patients with diabetes.**
- **Average 20 point decrease cholesterol among high risk patients.**
- **Decrease in appointment no-shows.**
- **Increased patient engagement with provider recommendations in primary & specialty care.**

Adelante Healthcare
Phoenix, AZ

Health Coach

- patient education/counseling
- Glucometer/insulin teaching
- Assisting patient with identifying available community resources
- Transition of care calls-scheduling follow up, medication reconciliation
- Transfer to RN if patient has medication questions
- Health plan data; care opportunities Pre-visit planning-screening/preventive care



Banner University Medical Group
Tucson

Community Health Partners

- Home-based, interdisciplinary care management model
- Funded by University of Arizona Health Plans
- Focus on high utilizers of hospital services
- Chronic disease self-management support
- Transitions of care support
- Primary care visit preparation and accompany to visits
- Medication adherence support
- Community resource navigation
- Behavioral health care coordination

Mariposa Community Health Center
Nogales, AZ

Care Coordinators

- Home visiting
- Chronic disease self-management education and support
- Glucometer support
- Follow up with patients from hospital or emergency room visits
- Health promotion education
- Referral and follow up