



Community Care

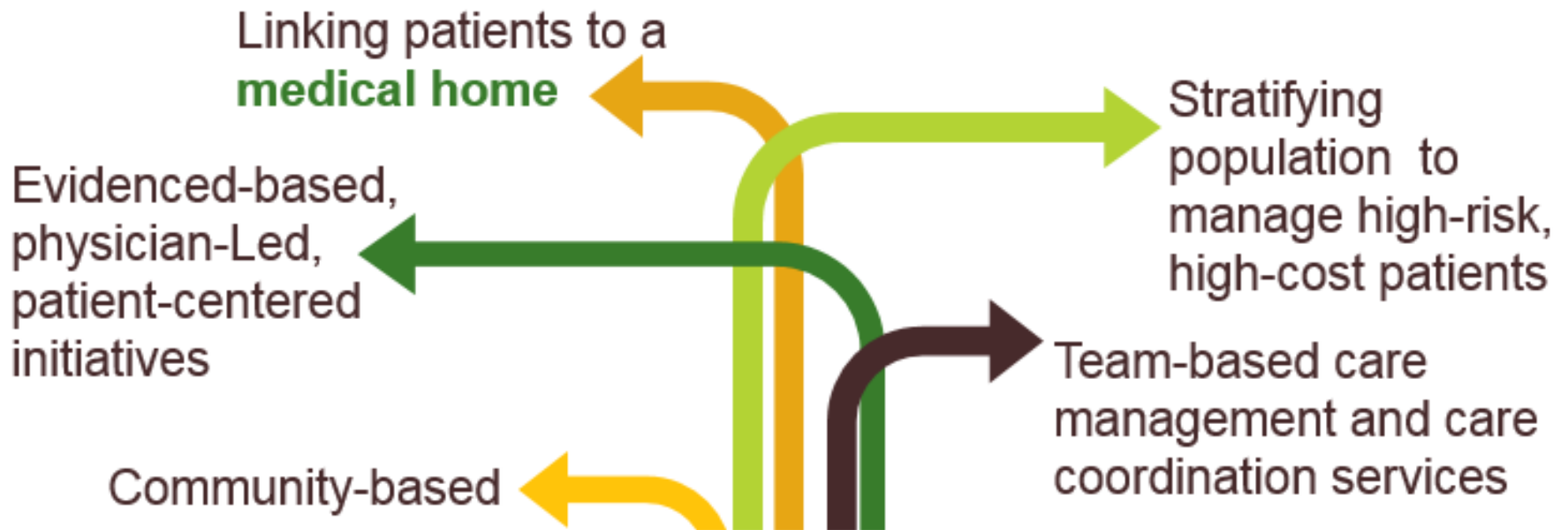
OF NORTH CAROLINA

*Community Care Partners of Greater Mecklenburg*

**Community Health Worker:  
André Logan**

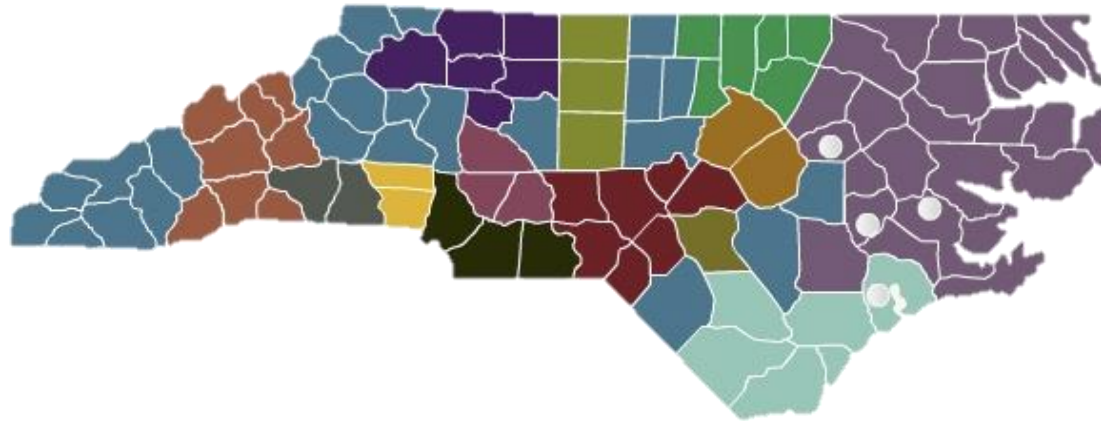
# Key Components CCNC's Health Care Model

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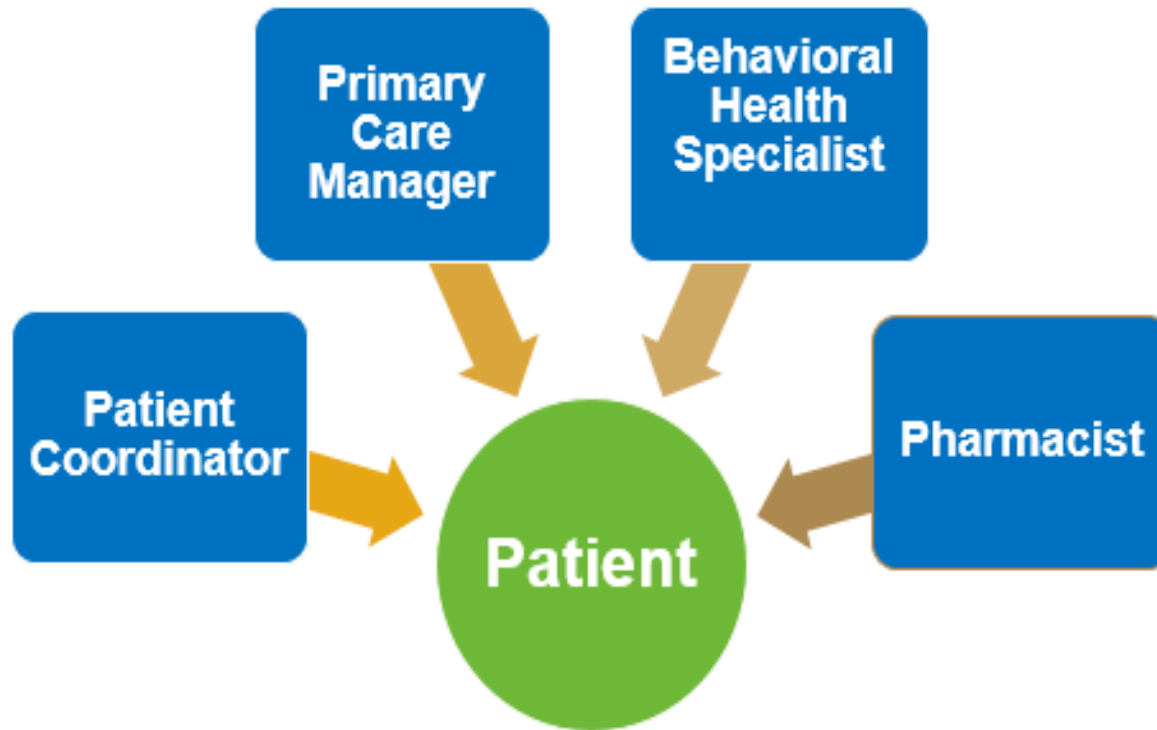
# Community Care Partners of Greater Mecklenburg

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Serving Anson, Mecklenburg and Union Counties

## Team-Based Care



To ensure the best care possible we partner with...



- **186 Medical Providers**  
Atrium Novant Independent
- **Behavioral Health**  
Management Entities (LME/MCOs)
- **Health Departments**
- **Hospitals**
- **Department of Social Services**
- **School Health**
- **Local Community Resources**
- **Crisis Providers**

# Health Community Worker

Assistant  
Peer  
Resource  
Educator  
CHOW  
Trusted  
Advocate  
Specialist  
Counselor  
Support  
Family  
Outreach  
Promotora  
Navigator  
Patient  
Public  
CHR  
Facilitator  
Case  
Coordinator  
Cultural  
Adherer  
Asthma  
Workshop  
HIV  
Nurturer

CHWs serve as an advocate for community members by providing information and education to help them improve their lifestyle by encouraging self-management and linking them to their proper healthcare options.

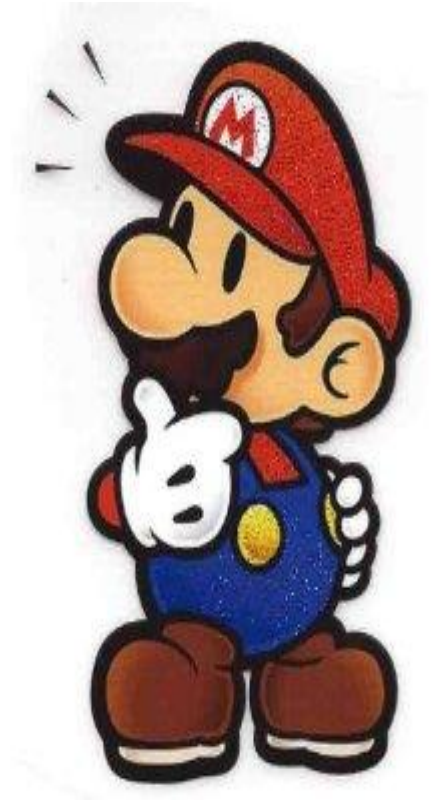




# “So...what do you do?”

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- Population health/Outreach
- Engage vulnerable populations
- Patient advocacy
- Health promotion, prevention and patient self-management education



# “So...what do you do?” (cont.)

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- Work to reduce cultural and socio-economic barriers
- Facilitate access to community resources
- Accompany patients to medical appointments and home visits





# How we accomplish this?

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- Build case loads by pulling daily ED list, customer care line referrals, and monthly inactive priority list
- Outreach calls to assess patients needs to link them with proper resources



# How we accomplish this? (cont.)

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- Establish goals and care manage patients in “Light” status
- Facilitate self-management classes for healthy lifestyles
- Partner with outside healthcare facilities (i.e. Charlotte One Van initiative) to provide healthcare services within the community



# Goals

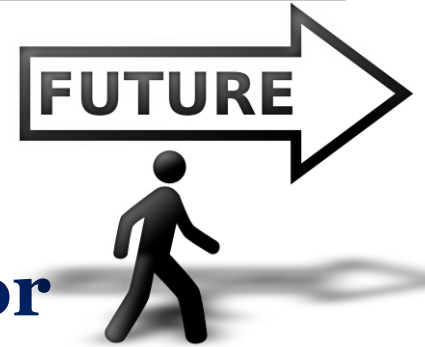
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- Empower patients to become self-sufficient
- Reduce ED utilization
- Link patients to PCP and have them maintain an ongoing relationship with provider
- Accomplish goals collaborated with patients
- Improve patients health and quality of life.
- Have patients use copings skills, such as heart math and 4x4 breathing skills



# We've only just begun...

## Future endeavors include...



- ❖ **Outreach to assisted living and senior housing communities**
- ❖ **Healthy lifestyle presentations and tips for CCPGM staff**
- ❖ **...and much more as we explore and expand to improve population health!**