Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

THE ROLE OF OUTREACH IN CARE COORDINATION

OUTREACH REFERENCE MANUAL

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INTRODUCTION

Between 2000 and 2030, the number of Americans with one or more chronic conditions will rise 37 percent, an increase of 46 million people.[1] Since 2010, the Affordable Care Act has expanded health coverage to millions of Americans, including those with chronic health issues. Health centers must be prepared to meet the increasing demand of the newly insured as well as the complex needs of their changing patient populations. This is especially true for health centers that serve chronically ill and medically underserved populations. These individuals have unique barriers to care such as cultural and linguistic needs, low socioeconomic status, unreliable transportation, lack of insurance, unfamiliarity with the healthcare system, and limited health literacy skills. In order to effectively and sustainably address the health needs of these populations, health centers must enhance their current service delivery models.

The Triple Aim framework is widely recognized as a comprehensive approach to improving the current U.S. health care system. The goals of the Triple Aim framework include (1) improving patient experience, (2) improving the health of populations, and (3) reducing the cost of health care. The framework encourages health care organizations to explore new health care delivery system models that include care providers beyond primary care physicians. Key models include:

- **Patient-Centered Medical Home (PCMH)** functions by bringing together a team of health care professionals with various skills and areas of expertise to provide comprehensive services and manage patient needs.
- **Patient-Centered Health Home (PCHH)** functions similarly to a PCMH, but provides additional services and support to meet the needs of high-risk and high cost patients, typically those with multiple chronic illnesses.
- **Accountable Care Organization (ACO)** is a group of health care providers who voluntarily share responsibility for the care delivered and health outcomes of a defined patient population.

Underlying all of these models is the concept of care coordination, which emphasizes collaboration between providers to increase quality of care and ultimately improve patient outcomes. Care coordination can also help reduce the cost of health care. It was estimated that inadequate care coordination contributed to $25-45 billion in wasteful spending in 2011.[2] Health centers engaging in care coordination can reduce the overall cost of care by reducing medication errors, repetitive tests, and preventable hospital admissions.

HOP Tip: HOP's *Leveraging Outreach to Support the Patient-Centered Medical Home Model* resource provides an overview of the PCMH principles and discusses how outreach staff may best be integrated within this model of care. HOP reviewed existing sources and conducted interviews with key staff from health centers, health departments, Primary Care Associations, and other technical assistance providers to identify concrete strategies for using outreach teams to enhance PCMH recognition and implementation.

For more information visit : outreach-partners.org/resources

ABOUT THE CHAPTER

The purpose of this chapter is to support health centers with improving or expanding their care coordination efforts. This chapter makes the case for integrating outreach workers into care coordination teams and shares examples of how health centers can accomplish this. The first section defines care coordination. The next section presents the value of including outreach workers on a care coordination team. The final section includes

1 Robert Wood Johnson Foundation. (2010). Chronic care: Making the case for ongoing care. Available at http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf545

2 Burton, R. (2012). Health policy brief: Improving care transitions. Health Affairs. Available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76

outreach role functions and examples of how outreach workers can contribute to care coordination efforts in key areas. Scattered throughout the chapter are case studies and patient vignettes from health centers that highlight care coordination models employed around the country.

HOW CAN HOP ASSIST YOU FURTHER?

If you would like further assistance with incorporating outreach workers into care coordination at your health center, please visit www.outreach-partners.org and click on "Contact Us." Specifically, HOP can help you:

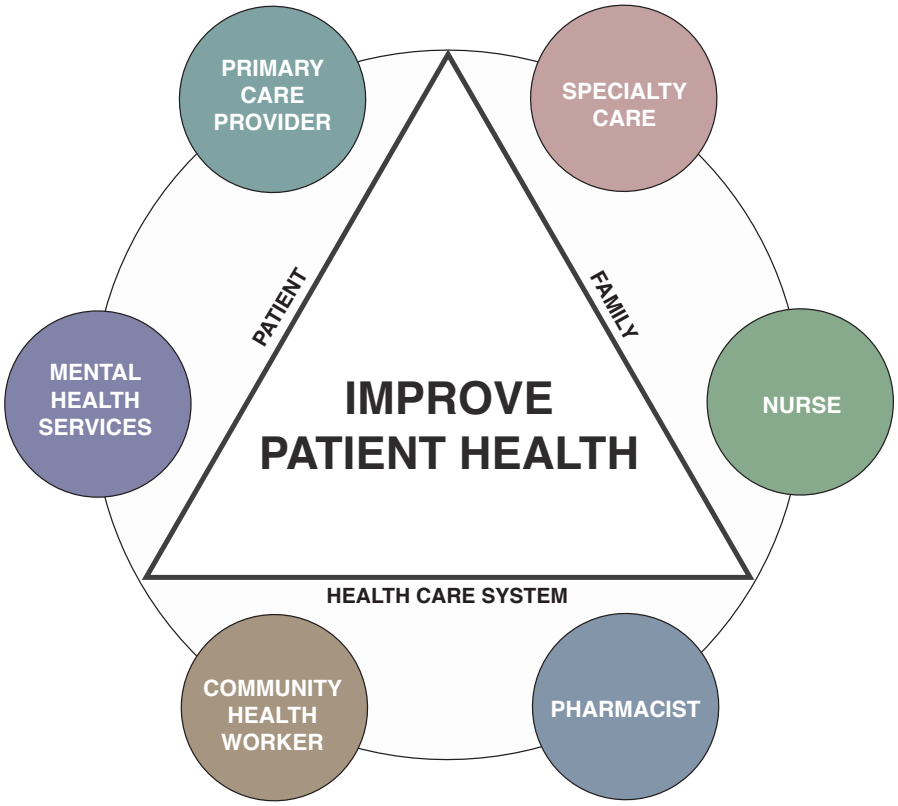
- Understand the role of outreach
- Develop goals and objectives for care coordination
- Create a work plan for your care coordination activities
- Develop strategies to work with community partners
- Provide effective health education
- Calculate the cost savings of integrating outreach workers in care coordination efforts

HOP Tip: "HOP Tips" are a key feature of the Outreach Reference Manual. They are indicated by a light bulb and are brief implementation tips that point out additional resources or provide suggestions.

1. WHAT IS CARE COORDINATION?

According to the Agency for Healthcare and Quality Research, care coordination involves **"deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."**[1] Ultimately, care coordination facilitates the communication and collaboration between care teams, patients, and their families to keep patients engaged in their care. It approaches care from a "whole-person" standpoint by addressing various components of health such as physical, mental, environmental, and social needs.

The graphic[2] below is a visual description of care coordination. As depicted in the middle of the graphic, the primary goal of care coordination is to improve patient health. The triangle surrounding this goal represents the communication and collaboration that occurs between the patient, family, and health care system. Though not exhaustive, the outermost layer represents the variety of care providers that work together to coordinate health and social services in order to optimize health outcomes.



Organizations typically engage in care coordination in ways that meet the unique needs of their patient population(s). For example, some organizations might practice care coordination by using an electronic health record system to facilitate communication between specialty and primary care providers. Other health centers might find that the

1 Agency for Healthcare Research and Quality. (2015). Care coordination. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

2 Adapted from: Agency for Healthcare Research and Quality. (2014). Care coordination measures atlas update. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html

CARE COORDINATION SPOTLIGHT

A Statewide Approach to Care Coordination

Missouri Primary Care Association

In 2012, Missouri was the first state in the country to gain approval from the Center for Medicare and Medicaid Services to add Primary Care Health Home (PCHH) services to the state Medicaid plan[1]. The primary goal of the PCHH is to improve patient care and reduce costs to the Medicaid system by addressing unnecessary emergency room (ER) admissions. The Missouri Primary Care Association (MPCA), an organization representing many of Missouri's community health centers, was heavily involved in the planning of this initiative. An advocate for policies and programs that ensure the delivery of high quality, accessible, and personalized health care services, the MPCA worked closely with its members to meet PCHH requirements. Care coordination is a central component of the PCHH. Participating health centers must maintain specific staffing roles, including a nurse care manager, behavioral health consultants, health home director, and a care coordinator. Collectively these individuals work to support patients in accessing appropriate and necessary care services.

An estimated 18,000 Medicaid patients are enrolled in PCHH. To facilitate the coordination between health centers and hospitals, the MPCA and the Missouri Medicaid Agency worked together to establish an information-sharing platform. Prior to the PCHH initiative, a patient's ER admission information was only collected by the Missouri State Health Department. Primary care providers were left unaware of their patients' ER use. Now, ER admission information is shared via secure e-mail with providers due to an intergovernmental agreement between the State Health Department and State Medicaid Agency to allow use of the information for population health management and care coordination. The e-mail includes the patient name, Medicaid agency number, primary reason for ER visit, and which ER was visited. Using this information, health centers are able to target high ER utilizing patients to refer and enroll in the PCHH program.

The MPCA actively participates in monthly meetings hosted by the Missouri Medicaid Agency. These meetings bring together other PCHH members as well as mental health and primary care providers to discuss community barriers to health. MPCA then uses the information shared to inform new approaches to care. In 2015 the Missouri Medicaid agency began the Community Health Worker Pilot for Primary Care Health Home. The MPCA supports this pilot project at 3 health centers where community health workers (CHWs) offer support to high utilizers of the hospital inpatient and ER services. In this pilot, patients are provided in-home and community-based support services by CHW's in partnership with the care team at the PCHH. Those services include advancing patient health literacy, assisting with coordination of medication management, facilitating appointments, and assistance in obtaining social services. The impact of this program has already demonstrated positive results. Participating health centers report stronger ties to the community and credit the CHWs for fostering this connection.

The state of Missouri was the first state in the country to have a PCHH plan approved. Its success has made it a model for many other states looking to adopt PCHH programs. MPCA was significantly involved in writing, developing, and implementing the plan. For states looking to adopt a PCHH model, MPCA underscores the role of interagency and community collaboration. According to the MPCA, building a platform to strengthen communication and coordination between state agencies and community partners is key to a successful PCHH program.

1 Missouri Department of Social Service. (2015). Missouri Health Homes. Available at http://dmh.mo.gov/mentalillness/mohealthhomes.html

most effective way to address the needs of patients with chronic diseases, such as diabetes, is to have nurses, primary care providers, and pharmacists work together to provide medication management services. The individual roles and responsibilities involved in care coordination can differ, but the underlying principle is ultimately the same: increase collaboration and communication between patients, clinicians, and institutions to ensure an appropriate exchange of information and adequate delivery of health care and social services.

Outreach workers have a close connection with the health center and the broader community, as well as an extensive knowledge of patient needs. They can facilitate the building and strengthening of relationships across health and social service providers, which in turn supports patient access to culturally and linguistically appropriate care, improves health status, and advances quality of life for the individual and their community. The role of outreach in care coordination will be addressed in subsequent sections of this chapter.

CARE COORDINATION QUICK OVERVIEW [3, 4]

What is Care Coordination?	Who Provides Care Coordination?	Who is a Part of the Care Team?	What are examples of Care Coordination?
Deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.	Clinical or non-clinical healthcare workers, such as a public health nurse or outreach worker. Care coordination can be provided by a small team or by an individual care coordinator.	The care coordinator(s) works closely with the care team, which can be composed of doctors, physician assistants, behavioral/mental health providers, pharmacists, etc. A care coordination director or manager, PCMH administrator, or other leadership/ administrator role often oversees care coordination and is involved in long-term planning for care coordination efforts.	• Patient navigation • Health education • Creation of a plan of care • Individualized health coaching • Engaging and motivating patients • Identifying and supporting patient self-management goals • Benefits coordination

CASE MANAGEMENT VS. CARE COORDINATION

In writing this chapter, HOP sought the guidance of several health centers practicing successful care coordination. Through interviews with key staff, HOP collected insightful information that helped define and establish parameters for describing care coordination. Findings from those interviews indicate that for most health centers it is important to make the distinction between case management and care coordination. Though the terms are often used interchangeably, health center staff engaged in care coordination emphasize that their roles and responsibilities extend beyond those of case management staff.

3 Rural Health Information Hub. (2014). Rural care coordination toolkit. Available at https://www.ruralhealthinfo.org/community-health/care-coordination

4 Center of Excellence in Care Coordination (CoECC). (2014). Nurses, social workers, promotoras: who does what? Available at http://carecoordination.swcahec.org/job-description/

CARE COORDINATION PATIENT EXPERIENCE

Patient Profile: Mr. Jones

Mr. Jones is a patient at Sunnyvale Health Center. He has diabetes and hypertension, and recently visited Sunnyvale after experiencing chest pains and extreme fatigue. Two months after his appointment, Mr. Jones receives a call from a Nurse Case Manager (NCM) at the health center. The NCM sees in the Electronic Health Record that Mr. Jones was referred to a Sunnyvale nutritionist but has not made an appointment. Mr. Jones explains that he has not been able to find a time that he can take off work since the trip to the health center is very far, and he does not have a car. He also reveals that he is at risk of losing his housing if he does not work extra hours to pay rent that he owes.

The NCM tells Mr. Jones that he is eligible to receive additional case management support for his health-related needs. She explains that if he consents to enrolling, she will follow-up with him on a monthly basis, and they will identify and work towards his health goals together. For his current situation, she can help him make an appointment that works for him and coordinate his transportation with the Medicaid Ride Program. She can also work with the referral coordinator to assist him in getting the help he needs for his other barriers, such as affordable housing. Mr. Jones agrees to enrolling in the case management program. As a result, he is now getting the full scope of support he needs – inside and outside of the health center – to effectively manage his diabetes and hypertension.

The NCM is a part of a care coordination team that supports Medicaid patients with chronic diseases. The NCM works with providers to identify new patients that would be good candidates for case management from their existing patient list. NCMs follow-up with patients about each appointment, their care plan, medication management, and referrals to behavioral health providers and specialists. They also participate in morning huddles to ensure that providers have all of the information they need about a patient.

This fictional vignette is based on the Affinia Healthcare's care coordination model.

- **Case management:** Case management services are typically provided in a "package" by a health plan or managed care plan. These services tend to focus solely on a patient's medical needs. For example, case management services may be offered only for high-risk patients diagnosed with a chronic disease or condition, such as diabetes or cardiovascular disease.

- **Care coordination:** Care coordination services, on the other hand, are not limited to only high-risk patients, but could be used to address the preventative needs of all patients, whether they have a high- or low-risk level for a specific chronic disease. Care coordination employs a much broader social service model than is typically used in case management. Specifically, care coordination services take into account patients' full psychosocial context—such as housing needs, income, and social supports—as it pertains to health. Representatives across the health centers interviewed agree that the ultimate goal of care coordination is to improve patient outcomes by addressing the biological, environmental, and social factors that affect their health.

2. OUTREACH WORKERS AND CARE COORDINATION

The scope of care coordination services provided to a patient may vary significantly depending on the particular needs of the individual. Some patients receiving care coordination services may only need a low level of assistance. However, patients with complex needs may require care coordination across many different health and social services, such as: medical services, specialist visits, and social supports, including transportation support or health insurance navigation. To ensure that the unique medical and psychosocial needs of each individual patient are met, care coordination must be appropriately staffed with individuals that understand the complexity and variance of the patient population needs.

WHY INCLUDE OUTREACH IN CARE COORDINATION

Health centers serve communities that face many barriers to accessing health care, in particular, vulnerable and medically underserved populations. Outreach services are a critical function of many community health centers. Strong outreach initiatives often offer the best opportunity for many patients to connect to care, engage with medical homes, and improve their health. Outreach workers often provide services that support care coordination such as prevention education, benefits assistance, and coordination of services. As the fields of outreach and care coordination become more formalized, there is an opportunity to define the role of outreach workers in care coordination.

Who are Outreach Workers?

Outreach workers act as liaisons between the health center and the community. They are often responsible for providing basic health and social services. The majority of outreach services are performed outside of the health center or organization. Individuals performing key outreach functions may be called any number of titles, including: outreach worker, community health worker, lay health worker, promotora/promotor de salud, health educator, or patient navigator, among others.

There is an evidence base for including outreach workers in care coordination teams, particularly for patients with acute health needs or chronic conditions. In a 2011 policy brief, the Centers for Disease Control found that integrating outreach workers into the care coordination team helped to effectively control hypertension among high-risk populations, leading to a positive impact on individual health outcomes. They also found that patients served by an integrated care team consisting of an outreach worker and nurse case manager fared better than those served by teams that were led solely by outreach workers or by nurse case managers.[1] Many outreach workers are trusted members of the communities served by health centers, and therefore bring a unique perspective and important knowledge of the community to a care coordination team. They can leverage this knowledge to provide effective care coordination that addresses the psychosocial, cultural, and linguistic needs of the community.

COST SAVINGS OF INTEGRATING OUTREACH INTO CARE COORDINATION

There are many ways in which outreach workers can support with care coordination to help health centers achieve cost savings or enhanced reimbursement. Beyond the considerable community expertise and skills that outreach workers bring to a care coordination team, outreach workers can help health centers realize financial benefits by contributing to clinical efficiency and Triple Aim outcomes.

1 Brownstein, J.N., Andrews, T., Wall, H., Mukhtar, Q. (2011). Addressing chronic disease through community health workers: A policy and systems-level approach.. Available at http://www.cdc.gov/dhdsp/docs/chw_brief.pdf.

CARE COORDINATION SPOTLIGHT

Engaging Community Health Workers for Successful Care Coordination
Benton County Health Services

Benton County Health Services (BCHS) provides health care to residents in the Willamette Valley area of Oregon. With a patient population including migratory and seasonal agricultural workers, people experiencing homelessness, and undocumented individuals, BCHS has adopted care coordination as a means to effectively meet the complex health needs of its community.

Community Health Workers (CHWs) are an integral part of BCHS's delivery of quality care. Currently there are 22 CHWs serving as health navigators who are heavily involved in the care coordination program. Their roles and responsibilities range from outreach and enrollment, clinic support, connecting students and families to social services, and policy and advocacy work. For BCHS, effective care coordination occurs when all patient needs are met. Through this multi-functional network of CHWs, BCHS ensures its patients' needs are addressed both in the clinic as well as in the community.

Within the clinics, BCHS permanently organizes care teams into the same workspace. Having care teams not only working together but also sitting together, improves the communication necessary to develop appropriate care plans for each of their patients. Care teams are composed of physicians, registered nurses, medical assistants, pharmacists, behaviorists, and CHWs. CHWs discuss with the care team the cultural beliefs or social barriers that prevent patients from taking medication or accessing care. The care team is then able to provide alternative treatment plans or work closely with CHWs to provide patients with health education services. Having all care team members work in close proximity to each other increases sharing of critical information and results in better quality care for the patient.

A critical factor in the success of BCHS's care coordination program is the organizational understanding and support of CHWs' roles and knowledge of the community. BCHS advises other programs to invest in staff training and encourage constant communication between CHWs and other staff in order to achieve buy-in at all levels. Gaining organizational support, establishing staff roles and responsibilities, and developing a clear communication plan are key strategies for implementing a successful care coordination program.

Clinical Efficiency
Including outreach workers in clinic-based care coordination can improve clinical efficiency by expanding provider reach and the entire team's capacity to optimally care for patients. For example, health center physicians often provide services such as medication management, nutrition education and referrals. Having well-trained outreach workers deliver these services when appropriate allows providers to spend more time with complex cases or to serve more patients. Additionally, these services are often best provided by someone familiar with the patient's context and specific needs. By supporting patients and keeping them engaged in their care, outreach workers can contribute to effective care coordination. Ultimately, these care services can result in more appropriate patient use of health services, decreased no-show rates, and better management of chronic conditions, which improve clinical efficiency and can result in cost savings for the health center.

Triple Aim
Outreach workers may also be able to support health centers that receive PCMH/PCHH supplemental payments or pay-for-performance incentives in meeting their goals. In some instances, in order to receive supplemental payments, health centers need to follow up with patients between appointments. An outreach worker is often an optimal way to reach those patients who do not need a clinical intervention. For example, an outreach worker's care coordination services can sometimes be counted as a part of meeting requirements to sustain a supplemental PCMH/PCHH per-member-per-month payment from Medicaid. Outreach may also play a role in achieving specific

quality measures that are included in pay-for-performance arrangements. For example, if outreach workers are able to convince women to be screened for cervical cancer through care coordination, a health center may receive the financial benefit tied to achieving higher screening rates. Given their close ties to the community served, outreach workers are ideal support staff for these initiatives.

HOP Tip: HOP created the OBV toolkit to support health centers in making the business case for investing in outreach services. The toolkit provides health center decision makers a framework for understanding the value of outreach and tools to calculate the return on investment for including outreach workers in clinical processes and alternative payment initiatives based on their own data. Learn more about and gain access to the OBV toolkit at: outreach-partners.org/obv-toolkit.

CARE COORDINATION PATIENT EXPERIENCE

Patient Profile: Mrs. Davis

Mrs. Davis is a patient at Sunnyvale Health Services. She is diabetic and has been previously referred to a diabetes self-management class offered by the health center. Mrs. Davis has missed the last two classes as well as her last diabetic follow-up appointment. Recently, she made an appointment to visit the clinic after beginning to experience frequent episodes of faintness and dizziness.

Prior to her visit, a CHW named Carmen calls Mrs. Davis to see how she is doing. Carmen is part of a care coordination team composed of a Registered Nurse and Community Health Workers (CHWs) serving as case managers. Mrs. Davis explains to Carmen that she has reduced her medication intake from the prescribed twice-daily dose to once daily in effort to make it last until her next appointment, and that she was unable to attend the classes and appointment due to childcare issues. She also informs Carmen that she is experiencing extreme financial hardship due to a large hospital bill, leaving her unable to purchase nutritious food for herself and family.

Carmen communicates Mrs. Davis's case to the rest of the care coordination team, including her primary care provider, Dr. Brown. Dr. Brown takes this information into consideration to appropriately treat Mrs. Davis. The Registered Nurse on Mrs. Davis's care coordination team follows up to explain the importance of proper medication management. The CHWs work closely with Mrs. Davis and help her acquire financial assistance as well as affordable childcare. Over the next few months, CHWs regularly follow up with Mrs. Davis and assess her need for additional support services.

As a result of successful care coordination, Mrs. Davis begins to take all of her medications as prescribed and starts to regularly attend the diabetes self-management class, where she learns to cook nutritious food that she can now afford. After two months, Mrs. Davis no longer reports any episodes of faintness or dizziness.

This fictional vignette is based on Benton County Health Services' care coordination model.

3. THE ROLE OF OUTREACH & KEY CONSIDERATIONS

THE ROLE OF OUTREACH IN CARE COORDINATION

Care coordination requires redefining how staff interact with each other and re-envisioning care team roles. Outreach workers can be integrated into care coordination teams in a variety of capacities based on identified community needs and the care coordination model that the health center uses. Outreach workers may provide care coordination services by working closely with a clinically trained provider, such as a registered nurse or licensed clinical social worker, or other care coordination staff. They may perform care coordination as the primary function of their role or in combination with other outreach responsibilities.

The table below shows examples of potential role functions and tasks an outreach worker could perform as a member of the care coordination team. Many of the care coordination tasks overlap between role functions. Most outreach workers will not take on every work role function or task on this list, and some tasks may be assigned to another member of the care coordination team. On the following page is a sample job description for an outreach worker who is a member of a care coordination team.

THE ROLE OF OUTREACH IN CARE COORDINATION[1]

Role Functions	Who Provides Care Coordination?
Community Outreach	• Work in communities, neighborhoods, or client homes • Serve as liaison between clinical and community settings • Translate across linguistic and cultural boundaries • Identify potential barriers to information or physical care
Resource Navigation	• Inform and enable access to available community services and support groups • Refer and provide warm handoff to appropriate health care and social services providers
Health Literacy Support	• Inform client about health promotion and illness prevention • Identify knowledge gaps and inaccurate information about the health system, eligibility, or benefits • Fill knowledge gaps or assist client in correcting inaccurate assumptions
Client Engagement	• Assess the client's readiness through motivational interviewing techniques • Support client in goal setting, prioritization, and attainment • Encourage and support healthful behavior change • Facilitate client self-management according to a shared plan of care
Logistic Support	• Manage multiple appointments • Provide transportation assistance • Accompany clients to appointments for cultural and linguistic translation if appropriate • Assist client in ensuring continual supply of medications, equipment and supplies, as well as meals

1 Prepared by Nora Flucke, The Center of Excellence in Care Coordination, from Nurses, social workers, promotoras.(2014). Available at http://carecoordination.swcahec.org/job-description/

SAMPLE JOB DESCRIPTION: OUTREACH WORKER CARE COORDINATOR

Position Reports to:
Nurse Care Management Coordinator

Job Summary:
The Outreach Worker Care Coordinator (OWCC) will be responsible for addressing the health and social service needs of patients and their families by helping them to navigate and access community services and resources, and to adopt healthy behaviors. The OWCC supports providers and the Nurse Care Management Coordinator though an integrated approach to care coordination and community outreach. Specifically, the OWCC will promote, maintain, and improve the health of patients and their families; provide social support; advocate for health needs; and provide basic medical services such as first aid and limited health screenings. A portion of the duties will be performed in locations outside the clinic where patients are present, including home visits.

Responsibilities Include:
- Develop a means for on-going follow up with patients.
- Conduct intake interviews with patients, including enrollment and/or referring patients to enrollment specialists.
- Assist patients with completing application and registration forms.
- Use basic motivational interviewing to help patients set personal goals and attend appointments.
- Create culturally sensitive and competent health education materials to promote preventative health and support chronic disease management.
- Provide referrals for services to community agencies based on identified goals.
- Work closely with medical providers assigned to the same patient to ensure that patients have comprehensive and coordinated care based on needs and pertinent information identified from outreach.
- Communicate consistently with Nurse Care Management Coordinator to evaluate patient status.
- Record patient care coordination information in EMR and other software within 1 day of contact.
- Manage assigned caseload of patients.
- Perform other duties as assigned

Qualifications and Experience:
- High school diploma or high school equivalency exam
- Bachelor's degree in health sciences or social service fields preferred
- At least two years experience within community service, health, or social service sector
- Basic computer skills
- Relevant work with underserved populations a plus

Skills:
- Strong writing and communication abilities
- Exceptional interpersonal skills

Other Requirements:
- Car, valid driver's license, and proper insurance
- Flexible schedule—may be asked to work some nights and weekends

KEY CONSIDERATIONS FOR INVOLVING OUTREACH IN CARE COORDINATION

Changing the scope and function of care coordination to include outreach workers can be an effective way to improve patient outcomes, particularly for patients with multiple barriers to care and acute health needs. HOP's research and interviews highlighted four key considerations for implementing more robust and sustainable care coordination efforts:

- Strong organizational policies and structures
- Coordinated social services
- Focus on patient/provider relationships
- The use of supporting information technology systems

This section will provide the rationale and examples of how health centers may approach addressing each consideration.

Organizational Policies and Structures

Successful implementation of care coordination strategies often requires a complete shift in culture at the health center. It can take time and may be challenging for staff, community partners, and patients themselves to adjust to changing roles, new communication methods, and new processes. When establishing a new care coordination team, or incorporating outreach into an existing team, it is important to ensure that there is support from the health center's leadership.

From the beginning, health centers should establish clear organizational structures, develop policies and protocols, and engage in strategic planning for implementing care coordination. These efforts are vital to driving a fundamental change in how staff work together and approach care delivery to provide true patient-centered, team-based care. Health centers using outreach workers to carry out care coordination services can support their staff by clearly defining the role of outreach in care coordination efforts when making strategic decisions.

Examples:

- **Organizational Chart:** Create a new organizational chart that illustrates the role of the outreach worker as part of the care coordination team.
- **Outreach Sustainability:** Having a consistent care coordination team can be very important for continuity of care. Ensure the sustainability of outreach workers on your care coordination team by allocating appropriate funding for their involvement.
- **Care Coordination Planning:** When engaging in long-term planning of care coordination efforts or building infrastructure to support care coordination, seek out outreach worker input about emerging trends, community needs, and effective care coordination processes.

Patient-Provider Relationships

An objective of care coordination is to improve patient-provider relationships and communication regarding health issues. Patients with multiple chronic conditions may regularly see many different providers and require extensive systems navigation. Medication errors, unnecessary or repetitive test, and preventable emergency room use and hospital admissions are costly consequences of patients' inability to navigate the system and the lack of care coordination between patients and providers.[2] Appropriate care coordination can support providers in delivering more effective care that targets patient health goals and addresses the underlying issues impacting health and wellbeing.

2 Traver, A. (2013). The promise of care coordination: Transforming health care delivery. Available at http://familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf

Outreach workers in care coordination teams can play an important role in supporting patient-provider relationships in a culturally and linguistically responsive way. Outreach workers can also leverage their personal experience and knowledge of the community to address the most challenging cases.

Examples:

- **Medication Management:** Outreach staff can work with the physicians to identify patients with poor medication adherence in order to understand and address barriers to taking medication, such as a patient's health literacy level. Outreach staff can use motivational interviewing strategies to encourage patients to adhere to their medication plans. In addition, they can partner with pharmacist to develop a responsive care plan and implement interventions to resolve non-adherence.

- **Referral Follow-up:** To ensure a positive health care experience, outreach workers can call patients to confirm appointment times, remind patients of what they will need to bring to the appointment, and coordinate enabling services such as interpretation or transportation. They can also prompt patients to follow up on applicable health goals with providers.

- **Working with Caretakers:** Partnering with caretakers, such as family members or friends of patients, can lead to improvements in a patient's quality of care and safety, enhanced patient experience and satisfaction, and ultimately, better health outcomes. For patients who want to involve caretakers in their care, outreach staff can educate, prepare, and empower caretakers to engage with the patient's health care; ensure that confidentiality issues are addressed; and support effective communication between the patient, caretakers, and providers.

Coordinated Social Services

Many health center patients have complex needs that require both medical and social service coordination, such as transportation, housing assistance, health insurance enrollment, and applying for financial assistance to cover the cost of care. Coordinating with social service providers to respond to the non-medical needs of patients ensures that care coordination is truly patient-centered and addresses all barriers to care.

Many outreach programs already provide resource navigation, and spend most of their time in the community reaching patients and building relationships with outside agencies. Outreach workers can leverage these existing relationships to support their care coordination work.

Examples:

- **Identify and Align Needs with Resources:** Outreach workers can help identify and align patient needs with existing or readily available community resources. They can also periodically assess referral resources and forge new partnerships as needs arise.

- **Facilitate Access to Resources:** Some patients may need support with accessing resources. Outreach workers can support patients by scheduling appointments, accompanying patients to social service agencies, and helping with any other issues that come up while accessing services.

- **Consider Community Needs Collaboratively and Holistically with Partners:** For communities that experience many barriers to care or have multiple social service needs, outreach staff can work with community partners to address community approaches to care. For example, they can work with community partners to create a strong referral network and referral process.

HOP Tip: Learn more about taking collective action to ensure health access with HOP's collaboration toolkit. Request the resource at: outreach-partners.org/resources/resource-request-form

CARE COORDINATION SPOTLIGHT

Using Multiple Strategies to Approach Care Coordination

Gulf Coast Health Center, Inc.

Gulf Coast Health Center has been serving Southeast Texas residents for over 26 years. Committed to serving the community and providing high quality comprehensive care, Gulf Coast practices various care coordination strategies to accomplish its organizational mission.

1. Comprehensive care: The Port Arthur center operates a comprehensive care model, where patients have access to pediatrics, ob/gyn, family medicine, internal medicine, mental health, dentistry, vision, dietetic services, and pharmacy all in one central location. This increases patient access to care by addressing potential barriers such as transportation or unfamiliarity with navigating the health care system. Additionally, a centralized location of care services improves the quality of care delivered by facilitating multi-provider communication.

2. Patient Navigators: All patients of Gulf Coast have free access to patient navigators to assist with various health care needs including:

- Obtaining enrollment assistance to health care though state, federal, or private programs
- Obtaining referrals to specialists
- Obtaining free medications

Patient navigators also coordinate with external agencies and service providers to connect patients to available community resources.

3. Care Coordination for ACO: As a member of an Accountable Care Organization (ACO)[1], Gulf Coast participates in a care coordination program to reduce emergency room admissions of high-risk/high-need Medicare patients. Working closely with other ACO members, Gulf Coast identifies a list of Medicare patients to enroll in the care coordination program. Once a patient is enrolled, a Registered Nurse Case Manager (RN) and community health worker (CHW) work closely with the provider to support patient adherence to their treatment plan. Together, the RN and CHW assist patients with:

- Scheduling primary care appointments
- Referral follow-up
- Updating patient chart with medical history
- Medication management
- If needed, connecting patients to social services (i.e. housing, food)

CHWs facilitate the communication between the provider and the patient by assessing for patient barriers to care, connecting them with social service needs, and also providing language translation. Thus increasing patient access to care, engagement in their care, and improving health status outcomes.

1 Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. Learn more at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/

CARE COORDINATION SPOTLIGHT

Leveraging Eligibility Enrollment Workers for Care Coordination
AMPLA Health

AMPLA Health in Northern California serves six counties with a diverse community, including many agricultural workers and their families. Care coordination significantly benefits those patients who face barriers to accessing health care and social services. In response to opportunities brought about by the Affordable Care Act (ACA), AMPLA has utilized their Eligibility and Enrollment program to expand care coordination efforts.

Prior to the ACA, AMPLA offered care coordination solely through Referral Nurses, who primarily coordinated patient referrals to specialists. To address additional needs, the Patient Navigator/Patient Services Coordinator created an Enabling Services Coordination Program to provide combined health insurance enrollment and social services. The program utilizes Eligibility Enrollment Workers as a support system throughout the Ampla Health facilities. Patients are routed to Eligibility Enrollment Workers before or after their doctor appointments; the Eligibility Enrollment Workers provide the following services:

- Health insurance and managed care enrollment
- Basic preventative health education on topics such as proper hydration, preventing heat illness, medication adherence, nutrition and fitness, oral health, and the importance of following up on appointments
- Referrals to social services, such as food assistance, WIC, housing assistance, and other charity programs
- Working with primary care providers to navigate patients to internal nutritionists, behavioral health services, and dental services

AMPLA's program leverages eligibility and outreach staff to take on basic care coordination tasks to help ensure that patients are connected to needed supports. Providing these additional care coordination services at AMPLA has resulted in more preventative visits, increased knowledge about services available, and more patients feeling empowered to ask health-related questions.

Information Technology Systems[3]

There is an increasingly important role for technology in healthcare. Effective use of electronic health record (EHR) systems can decrease the fragmentation of care, enhance communication across care providers and care coordinators, and ultimately improve population health. EHRs, coupled with robust internal processes around how and what to communicate, greatly benefit populations seeing multiple providers, such as the chronically ill, and individuals transitioning between care settings, such as from an emergency room to a health center. The electronic transfer of patient records is important when information is needed quickly and can reduce the possibility of errors. Providers will have a better chance of knowing about relevant conditions being managed by another provider or social service provider, and outreach workers will be able to make informed decisions about care coordination services based on a fuller understanding of patient and population health.

Examples:

- **Create Electronic Workflows:** EHRs can support care coordination, improve time management, and may reduce errors by replacing paper and manual care coordination processes with electronic workflows. For example, with adequate technology and planning, outreach workers can document notes from the field directly into the EHR instead of writing on paper and taking the second step of transcribing notes in the EHR.

3 Vincent, W. (2014). Using technology to optimize population health care coordination outcomes. Healthcare Informatics. Available at http://www.healthcare-informatics.com/article/using-technology-optimize-population-health-care-coordination-outcomes.

- **Monitor Patient Status:** Using an EHR, outreach workers can ensure patients' continuity of care. They can track whether or not a referral was completed or work with patients to complete referrals. They can also use it to routinely check-in with patients to assess needs for follow up appointments and services.

- **Prioritize Care Coordination Issues with a Dashboard:** Outreach workers can report and organize EHR data into a dashboard[4] to identify current and emerging needs of the patient population. Dashboards can show certain health behaviors across a population, which can highlight the need for additional outreach or health education.

When using the EHR to support or integrate care coordination efforts, it is important to ensure confidentiality and only disclose patient information to providers who are directly involved in the care of the patient. It will require more than just IT infrastructure implementation to improve care coordination. Health centers will need to develop comprehensive, standardized workflow processes and procedures, and identify and address challenges involved with the adoption of technology in order to truly create effective communication systems.

HOP Tip: Healthcare hotspotting is a data-driven process that identifies patterns in certain regions of the healthcare system. It can be used to target interventions and better address patient needs, improve quality of care, and reduce costs. The Healthcare Hotspotting Data Toolkit guides healthcare organization through the process of hotspotting for their own populations. Learn more about or access the resource at: http://healthcarehotspotting.com/wp/data-and-documentation/

4 A dashboard is an interface to organize and present aggregated data that is easy to read and analyze.

CONCLUSION

Care coordination has been identified as an integral component of health delivery models that improve patients' health care experience, improve health outcomes, and reduce health care costs. Outreach workers' community ties, cultural competency, and language capabilities can be leveraged to enhance care coordination efforts. Integrating outreach staff into the primary care team fosters care coordination that directly responds to the complex health and social service needs of vulnerable populations.

ADDITIONAL APPROACHES

This chapter has highlighted a variety of approaches to care coordination. The table below highlights three additional resources that include effective approaches. We encourage you to explore these resources as you develop care coordination strategies that best fit the needs of your community.

Rural Health Information Hub	The Rural Health Information Hub's Care Coordination Toolkit helps care providers identify and implement a care coordination program. The toolkit specifically identifies six program models for care coordination, including: Care Coordinator Model, Health Information Technology Model, Partnerships Model, Patient-Centered Medical Homes, Model Health Homes Model, and the Accountable Care Organizations Model. For more information visit: ruralhealthinfo.org/community-health/care-coordination
Institute for Healthcare Improvement	The Institute for Healthcare Improvement offers a resource that outlines methods and opportunities to better coordinate care for people with multiple health and social needs. There is a special emphasis on the experience of providing care coordination for people experiencing homelessness, and the paper reviews ways that organizations have allocated resources to better meet the range of needs of this population. For more information visit: asmdc.org/speaker/images/IHICareCoordinationModelWhitePaper2011.pdf
AHRQ	The Agency for Healthcare Research and Quality provides a definition for care coordination and why it is important. Included in this resource are examples of care coordination models, as well as specific activities that work in these models. For more information visit: ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

CARE COORDINATION SPOTLIGHT

Leveraging the Entire Care Team for Care Coordination

Clinica Family Health

Clinica Family Health (Clinica) is a community health center providing comprehensive primary care services to the underserved residents of south Boulder, Broomfield, and west Adams counties of Colorado. Clinica has a long history of providing care coordination services, which they are constantly improving based on the experience of their patients.

Clinica is a member of two regional Accountable Care Organizations[1] through their state Medicaid program, and receives a per member, per month payment to provide care coordination services through their case management program to patients of the ACOs. Clinica works closely with their ACOs to identify appropriate Medicaid patients for care coordination by looking at level of risk and utilization of emergency room services.

Clinica's comprehensive care coordination care team includes primary care providers (a doctor, nurse, and physician assistant), medical assistants, a case manager, a behavioral health professional, office technicians, referral case managers, and medical records staff. Once a patient is enrolled, they meet with their care team at Clinica to create a care plan that addresses their unique health needs. The care plan prioritizes health issues patients identify as the most important. Each patient also receives a shared care plan (see template on the next page) that shows a patient's care coordination across all services and providers. It outlines their care team members, medications, goals, and how to access support.

Once a care plan is in place, each member of the care team establishes his or her own plan to support the care coordination of the patient. Based on identified needs, different members of the care team will provide a wide variety of follow-up to support patients in achieving health goals. For example, the care team nurse may conduct a home visit to ensure that a patient discharged from the hospital understands how to manage their medication, the case manager may support the patient with obtaining stable housing and accessing food stamps, and the behavioral health professional may work with the patient to address domestic violence concerns.

An important factor in the success of Clinica's program is the patient voice. Clinica believes that as long as you listen and create a welcoming environment, patients will tell you what they need and the barriers they face. Clinica has Patient Voice Committees and takes every opportunity to get feedback from patients receiving care coordination. Based on Clinica's ACO fee-for-service indicators, care coordination greatly decreases the cost of care for patients over a 12-month period. However, Clinica knows they are successful when they see patients using the emergency room less and come to appointments doing better in all areas of their health.

1 Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. Learn more at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/

YOUR CLINICA SHARED CARE PLAN

A Care Plan is a road map to better health that is created by you and your care team.

Patient Name:	Address:	Phone Number:

Care Team Members

Care team members are people who help you manage your health. Anyone who you feel has a role in your health care can be a part of your team.

You may contact members of your Clinica Family Health care team at (###) ###-####.

Team Member	Name	Comments

Diagnosis

This is a list of your current health needs

Problem	Additional Information

Medications

Below is a list of prescription, over-the-counter medications, vitamins, and supplements that health care professionals have advised you to take. We have printed this list from your medical record.

Medication	Dose	Sig Description	Start Date	Last Refill

Goals

By setting goals, you can take on active role in helping yourself feel better. Your personal goals are listed below.

Goals	Internal Comments

Support

This is the additional support that will help you reach your goal.

Order Date	Order	Diagnosis	Description

Red Flags

These are signs or symptoms that indicate that your health is worsening and that you should reach out for help.

Symptom	Action

Comments:

Disclaimer

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