OVERVIEW:-----

As key elements of the Affordable Care Act fall into place with the approach of 2014, Community Health Centers and other Health Center Program grantees will be required to balance significant opportunities with considerable challenges. Expanded health coverage will increase demand for services among the newly insured. Continued funding for health center expansion will increase capacity, but health centers will need to improve efficiencies, maximize staffing resources, and demonstrate quality in order to compete in a new health care marketplace. The Patient Centered Medical Homes model, with its emphasis on meeting the needs of the whole person, is one for which health centers are uniquely qualified. Health centers achieving PCMH recognition demonstrate quality of care and have access to enhanced reimbursement rates and structures.

Care coordination is a key tenet of the Patient Centered Medical Home and a promising practice in achieving the triple aim of better health care experience, better population health, and lower cost across the health care system. Care coordination helps to reduce the dangers of fragmented care by ensuring that all involved in a patient's care share important information and understand their roles. Care coordination also involves working closely with individuals and families to keep them informed and engaged in their care. In this Technical Assistance Brief, we hone in on the issue of care coordination and discuss how health centers can leverage the strengths and resources inherent in their outreach teams to enhance these efforts.

BACKGROUND AND CONTEXT

Affordable Care Act:
Starting in 2014, qualified Americans with incomes up to four times the federal poverty level will have access to health coverage through Medicaid or through tax credits subsidizing the cost of private insurance. Expanded health insurance coverage for low-income families offer health centers the opportunity to maximize their federal grant dollars to serve the most vulnerable members of their communities. However, health centers will need to rise to this opportunity by proactively identifying and assisting eligible but uninsured members of their communities in getting health coverage; expanding staff capacity to meet the increased demand for services in their communities; and positioning themselves to compete in a marketplace where the patient population they serve has increased access to health care choices.

Quality and the Triple Aim
There is ample evidence for the need to improve the quality of how health care is delivered. The 2001 Institute of Medicine report ?Crossing the Quality Chasm: A New Health System for the 21st Century? asserted that the system of health care delivery in the United States had failed to keep pace with rapid advances in medical technologies and science. The report highlighted the inconsistency of care being provided across the population. It also recognized the changing needs of Americans with respect to health care. With chronic diseases like diabetes, heart disease, and asthma on the rise, new systems of care are called for that engage people over time with a full complement of services. Such systems require simplification, coordination, and effective collaboration among health care professionals.

In their 2008 Health Affairs article ?The Triple Aim: Care, Health, And Cost,? authors Donald M. Berwick, Thomas W. Nolan, and John Whittington argued that improving the system of healthcare in the United States would require improvements in three key -- and interconnected -- areas: improving the experience of care, improving the health of populations, and reducing per capita cost of health care. They referred to this system of linked goals as the ?Triple Aim? and stressed that it addresses improvements to the health care system as a whole, not just improvements at individual health provider sites. In any given community, this system may include community health centers, private providers, hospital systems, public health departments, community based agencies and other institutions.
An important aspect of the Triple Aim is a willingness to reconsider the way primary care services are structured and delivered. This includes increased involvement of individuals and families. It also includes expanding the definition of who provides primary care services. The authors described medical home teams that establish long-term relationships with patients, work with those patients to develop shared care plans, coordinate care with other providers, and offer new and expanded ways of accessing health services.

**Patient Centered-Medical Homes**

As a part of the Affordable Care Act, the Secretary of Health and Human Services created a National Quality Strategy, which pursues the three broad aims of better care, healthy people/healthy communities, and affordable care. The Health Resources and Services Administration (HRSA) has established Patient Centered Medical Homes (PCMH) recognition as a key quality target for the coming years. By September 30, 2013, HRSA aims to have 25% of Health Center Program grantees recognized as a Patient Centered Medical Home (PCMH). HRSA is supporting health centers in these efforts by covering costs and fees for various PCMH recognition programs and partnering with the CMS Primary Care Demonstration. PCMH recognition is valuable for health centers for a number of reasons: 1) it is an objective assessment of the quality of care they provide; 2) it positions them competitively in a changing health care landscape; and 3) it moves them toward the three-part aim of better health care, healthier people and communities, and more affordable care. \[iv\]

Several national organizations offer PCMH recognition programs for individual health centers, while regional and national demonstration programs across the country are testing the effectiveness of various PCMH models. Each of these models has certain tenets at its core, including care that is accessible, accountable, comprehensive, integrated, patient-centered, and safe. Coordination of care, both within and across health delivery systems, is a key principle of Patient Centered Medical Homes.

**CARE COORDINATION**

**Care Coordination Defined.** The Institute of Medicine Committee on the Quality of Health Care in America underscored the importance of care coordination in its recommendations for how to redesign the health system. Specifically, the Committee recommended that "Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care." \[iv\] In response to this IOM priority, the Agency for Healthcare Research and Quality (AHRQ) sought to define and develop frameworks and measures for implementing and evaluating the effectiveness of care coordination models. AHRQ defines care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care." \[v\]

Care Coordination in Practice. The Safety Net Medical Home Initiative (SNMHI), a national PCMH demonstration project, established Care Coordination as one of its key change concepts? for transforming health center programs into Patient Centered Medical Homes that improve health outcomes and reduce health care costs. \[vii\] The initiative houses a comprehensive collection of online resources and tools to assist health centers in implementing PCMH models including an implementation guide entitled "Care Coordination: Reducing Fragmentation in Primary Care." \[viii\] Care coordination is seen as integral to reducing barriers to care and involves making the primary care setting the center of patient-related activity. The health center not only coordinates its own activities, but also those of other providers, including labs, specialists, hospitals, and other community organizations. The SNMHI suggests strategies to support care coordination that include co-locating services and developing clear protocols and standardized referrals. The Reducing Care Fragmentation toolkit includes case studies, resources, and tools to support the development of a care coordination model.
Components and Staffing: The specific components of care coordination vary across models, but most involve tracking and following up on tests, referrals, and other transitions such as emergency room visits or hospital discharges. More expansive models may include linking patients with community resources and providing intensive care management for those patients at especially high risk. Accountability for this coordination and relationships and agreements with other providers are key elements of an effective system of coordinated care.

Staffing models vary based on the resources available in the health center and the needs of its unique patient population. Some may establish a full-time referral coordinator that is charged with care coordination. Others may use staff and/or volunteer "patient navigators" to walk patients through the entire health care experience. Still others may assign care coordination responsibilities to staff possessing different skill sets based on the needs of individual patients or patient subpopulations. Any health center planning to build or improve its care coordination efforts will need to organize its team in a way that supports the change. Delegating and/or hiring staff with specific care coordination responsibilities and then training them to carry out these responsibilities in ways that best support the patients is critical. Training may include skill-building around cultural competency, motivational interviewing, problem solving or care planning.

Activities: Specific responsibilities of Care Coordinators may include highly regulated activities around maintaining tracking systems and updates to electronic medical records and coordinating with other providers and/or insurance companies. Activities that are more patient-focused and potentially less prescriptive may include some or all of the following:

- helping patients understand what to expect with referrals;
- helping patients address barriers such as insurance or financial issues, transportation, or interpretation needs;
- Acting as the navigator or point of contact for the patient, and advocating on the patient’s behalf;
- Identifying, maintaining relationships with, and using cultural and community resources that may benefit the patient;
- Reminding patients about scheduled appointments and providing assistance in keeping appointments as needed. [ix]

Care Coordination for Special Populations. The work of care coordination for special populations can be especially challenging when dealing with lack of insurance and a multitude of other barriers to care. Migrant and seasonal farmworkers face barriers such as lack of transportation, lack of knowledge about available services, lack of health insurance, cost of health care, poor living and working conditions, language differences, cultural differences, social and physical isolation, discrimination, and fear.[x] In addition, continuity of care is a major challenge for migrant farmworkers who routinely move in order to stay employed in agriculture. Many individuals experiencing homelessness also experience lack of knowledge about available services, lack of transportation, lack of insurance and the cost of health care as barriers to getting the care they need. Other factors including embarrassment, nervousness about filling out forms and answering questions, and ? for people living on the streets -- self-consciousness about appearance and hygiene can also present significant barriers.[xi] Often, as a result of living and social conditions, vulnerable populations including farmworkers and individuals experiencing homelessness experience multiple complex health and social service needs. These are populations for whom coordination of care, while potentially the most challenging, may also be most needed. This is where outreach can play a major role.

THE ROLE OF OUTREACH IN CARE COORDINATION

Outreach for Underserved Populations: Outreach is a critical function of health centers serving people who are low-income, uninsured, and/or members of underserved populations such as migrant and seasonal farmworkers, people experiencing homelessness, racial and ethnic minorities, the elderly, and people living with HIV/AIDS. A strong outreach program offers the best opportunity for the most vulnerable populations to be connected to and engaged with true medical homes.

Health centers use individuals in a variety of capacities and roles to promote health care access and reduce health disparities.
Individuals performing key outreach functions may go by any number of titles, including outreach worker, community health worker, promotor/a de salud, lay health advisor, or patient navigator, among others. They are generally well-connected to the community, often with language and cultural ties that help them to develop trusting relationships with vulnerable community members. They also develop and maintain valuable connections with other health and social service agencies in the community.

In a truly comprehensive community health outreach model, outreach teams participate in care coordination by connecting underserved populations to the local health and social service delivery system, providing outreach-centered case management services, coordinating access to behavioral health support, assisting underserved populations to enroll and maintain enrollment in health and social safety net programs, collaborating with other community-based agencies on behalf of underserved individuals, and by advocating for these individuals both within the health center setting and in the broader health and social service arena. [xii]

IHI Care Coordination Model: The Institute for Healthcare Improvement (IHI) developed a care coordination model for people with multiple, complex medical and social needs aimed at achieving the triple aim of better health outcomes, better experience of care, and lower health care costs. [xiii] This model looks not only at the specific needs of each patient, but at the resources that each brings to the table—things like personal strengths and assets, community connections, and social support. It builds on research showing that the most effective care coordination programs have in common personal, trusting relationships between the care coordinator and patient. Through this model, the most high-cost patients are targeted for care coordination—primarily those who visit the emergency room frequently and often unnecessarily. The care coordinator is responsible for helping these patients identify individual goals and then assists in coordinating services to meet these goals. The care coordinator may be a nurse, case manager, community health worker or some other role, depending on the specific needs of the patient. A community health worker skill set is seen as especially appropriate for patients with social instability or lack of social support. Individuals experiencing homelessness frequently fall into this category, as do migrant and seasonal farmworkers.

Expanding the Primary Care Team: Benton County Health Services (BCHS) in Oregon uses Community Health Workers (CHWs) as an integral part of their primary care team. [xiv] Their CHWs routinely provide health education, linkages to the health center and other community providers, and care coordination services. One CHW has the expanded role of Clinical Health Navigator. This position is tied closely to that of a Registered Nurse Care Coordinator. Both of their activities are documented in patient charts, for ready access by the entire health care team. CHWs also share critical social and cultural information impacting patients' care with the rest of the care team. BCHS has found that by building a trusting relationship with the patient, a CHW can increase meaningful communication between the care team and the patient, recognize and address barriers to care that may not be visible to the care team, improve coordination of care, and improve the likelihood that your patients will understand, engage in, and adhere to their care plan.

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 system-level health care costs. Health centers have access to enhanced reimbursement rates and structures through PCMH recognition programs, all of which emphasize the role of care coordination. Health center outreach teams can play an effective role as part of a primary care team through the provision of culturally competent, responsive care coordination that responds to the complex health and social service needs of vulnerable populations.
In this document, unless otherwise noted, the term "health center" is used to refer to organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended. It does not refer to FQHC Look-Alike organizations or clinics that are sponsored by tribal or Urban Indian Health Organizations, except for those that receive Health Center Program grants.


The Triple Aim: Care, Health, And Cost. Health Affairs, 27, no.3 (2008):759-769
Donald M. Berwick, Thomas W. Nolan and John Whittington.


Reducing Care Fragmentation: A Toolkit for Coordinating Care.  

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National Outreach Guidelines for Underserved Populations.  
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Community Health Workers as Patient Navigators. Northwest Regional Primary Care Association Health Center News. 