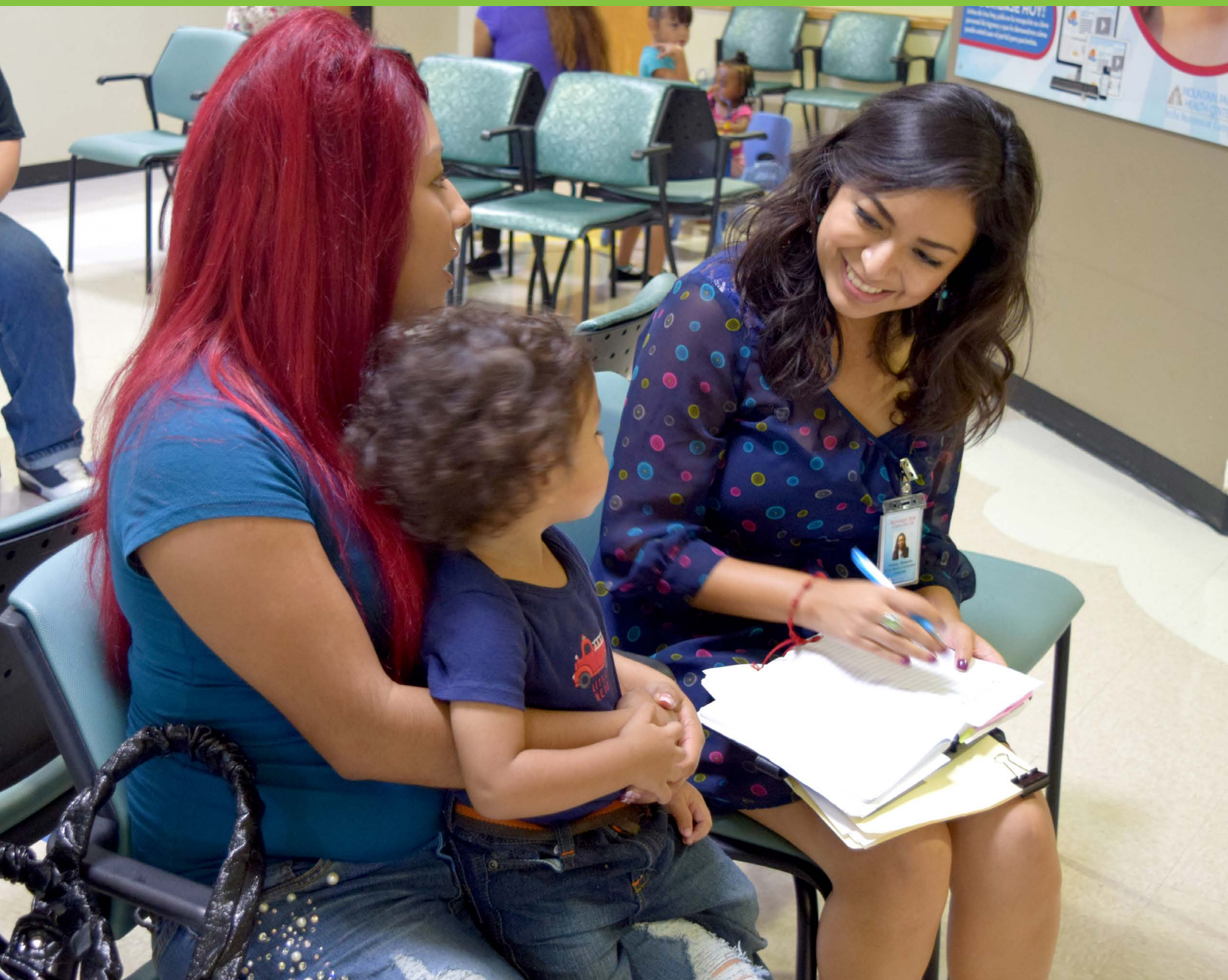
Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

THE ROLE OF OUTREACH IN CARE COORDINATION

OUTREACH REFERENCE MANUAL



ACKNOWLEDGEMENTS

Health Outreach Partners (HOP) would like to extend its appreciation to the staff that contributed to the development of this chapter.

Chapter Contributions
Edith Hernandez, MPH, MSW
Diana Lieu
Alexis Wielunski, MPH

HOP Editorial Contributions
Kristen Stoimenoff, MPH
Caitlin Ruppel

HOP also wishes to thank the following people and organizations for their contributions to the development of this chapter.

External Reviewer
Nora Flucke RN, MSN, Center of Excellence in Care Coordination

Interviews
Karen Funk, MD, MPP, Clinica Family Health Services
Irma Dowden, Gulf Coast Health Center, Inc.
Carl Dahlquist, Gulf Coast Health Center, Inc.
Angela Herman-Nestor, MPA, Missouri Primary Care Association
Veronica Padilla, AMPLA Health
Sonia Shanklin, RN, MSN, Affinia Healthcare
Kelly Volkmann, MPH, Benton County Health Services

Cover Photograph
Compliments of Mountain Park Health Center

TABLE OF CONTENTS

List of Care Coordination Spotlights & Patient Experiences

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.