LEVERAGING OUTREACH TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME MODEL

INTRODUCTION

As more focus is given to transforming health care to enhance the patient experience, improve population health, and reduce health system costs, primary care providers need to adopt patient-centered practices and offer efficient, cost-effective health care services. The Patient-Centered Medical Home (PCMH) model emphasizes meeting the needs of the whole person through team-based coordinated care and continually improving quality and safety. A growing number of health centers are seeking formal PCMH recognition, accreditation, or certification as a way to demonstrate increased quality of services. Health centers are uniquely positioned to become medical homes because they have expertise and experience in providing culturally and linguistically appropriate comprehensive primary care services that take into consideration the unique needs of their patient populations and communities. Health centers provide a variety of enabling services that help increase access to health care by overcoming barriers like limited transportation options and lack of language services. Outreach programs, in particular, support health centers in building trusting, ongoing relationships with their patients, their patients' families, and the communities they serve.

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[1] and implementation. This resource provides a brief overview of PCMH principles and addresses the connections between outreach activities and these principles. It highlights steps actual health centers are taking to incorporate outreach staff into performance improvement planning, care management and self-care support, tracking and care coordination, ensuring continuity of care for mobile populations, and helping improve the patient experience. Finally, the resource ends with a discussion of the financial benefits of incorporating outreach workers into the PCMH care team.

PATIENT-CENTERED MEDICAL HOME MODEL OVERVIEW

What is PCMH?

The Patient-Centered Medical Home (PCMH) model promotes primary care delivery that uses care teams to ensure coordinated, patient-centered care. While the American Association of Pediatrics (AAP) has been using the concept of a medical home and team-based care since the 1960s, in 2007, the AAP teamed up with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) to form the Joint Principles of the Patient-Centered Medical Home.[2]

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1 For the purposes of this document, unless otherwise noted, "PCMH recognition" refers to Patient-Centered Medical Home recognition, accreditation, or certification as applicable by the relevant national and state agencies.
2 *Joint Principles of the Patient-Centered Medical Home.* Patient-Centered Primary Care Collaborative. Website Accessed on November 6, 2014: http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf.

The seven Joint Principles:[3]

◊ A personal provider develops a trusting relationship with the patient.
◊ A provider-directed care team collectively provides ongoing care for the patient.
◊ The care team focuses on the whole person, providing acute care, chronic care, preventive services, and end of life care.
◊ Care is coordinated and/or integrated across the different health care systems and the patient's community.
◊ The team provides care focused on quality and safety.
◊ Care is accessible for patients, who understand how to contact their team at any time of day through increased communication and by scheduling appointments.
◊ Payment reflects the value of the patient-centered medical home.

Patient-Centered Team-Based Coordinated Care

The care team can be comprised of many different health care professionals including doctors, nurses, community health workers, case managers, and pharmacists. The team works with the patient to provide patient-centered care.[4] Having a consistent set of professionals oversee patient care allows for the development of a close, trusting relationship with the team.

What is Patient-Centeredness?

"Patient centeredness refers to health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care."

-Institute of Medicine

By incorporating a variety of staff with a range of skills and expertise, the care team is able to manage the full spectrum of a patient's needs. This type of coordinated care improves a patient's experience by positioning each member of the team to work at the top of his/her license, ensuring easy exchange of information and limiting duplicated efforts.[5] By providing improved care coordination, the PCMH model has the potential to improve clinical quality, improve patient experience, and reduce health system costs.[6]

What is Coordinated Care?

Care coordination is "… 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 marshaling 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."

-The Agency for Healthcare Research and Quality

3 Ibid.
4 Masterson, K. August 2014. *A Team-Based Approach to Primary Care.* University of California San Francisco. Website Accessed on November 4, 2014: http://www.ucsf.edu/news/2014/08/116856/team-based-approach-primary-care.
5 *Open Access Statement.* Migrant Clinicians Network. Website Accessed November 6, 2014: http://www.migrantclinician.org/files/OpenAccessStatement_FINAL.pdf.
6 Stoimenoff, K. January 2013. *Care Coordination Models to Improve Clinical Quality and Performance: Expanding the Primary Care Team.* Health Outreach Partners. Website Accessed October 17, 2014: http://web.outreach-partners.org/resources/outreachconnection/162.

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HRSA and Patient-Centered Medical Homes

The Health Resources and Services Administration (HRSA) supports the adoption of the PCMH model by Health Center Program grantees through two different initiatives, providing technical assistance and covering fees and survey costs.[7] The "Patient Centered Medical/Health Home (PCMHH) Initiative" assists health centers in gaining PCMH recognition through the National Committee for Quality Assurance (NCQA).[8] The "Accreditation Initiative" assists health centers in becoming accredited ambulatory care, laboratory services, or behavioral health care organizations through The Accreditation Association of Ambulatory Health Care (AAAHC) or The Joint Commission (TJC), both of which offer PCMH status in addition to their general accreditation.[9] HRSA's FY 2015 goal was to have 55% of health centers achieve PCMH recognition[10] and by October 2014, 57% had already achieved PCMH status.[11] Five entities are accepted under the Bureau of Primary Health Care's definition of health centers with PCMH recognition: NCQA, AAAHC, TJC, and state agencies in Oregon[12] and Minnesota.

HRSA'S INITIATIVES[13]			
	Agency	Recognition/Accreditation/Certification	Eligibility
Patient-Centered Medical Health Homes Initiative	NCQA	Patient-Centered Medical Home Recognition	Health Center Program Grantee and FQHC Look-Alikes
Accreditation Initiative	AAAHC	Patient-Centered Medical Home Accreditation[14]	Health Center Program Grantees
	TJC	Primary Care Medical Home Certification[15]	Health Center Program Grantees

7 *HRSA Patient-Centered Medical/Health Home Initiative*. Health Resources and Services Administration. Website Accessed November 6, 2014: http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html.
8 *HRSA Patient Centered Medical Home Resources: Comparison Chart*. Health Resources and Services Administration. Accessed January 28, 2014: http://bphc.hrsa.gov/policiesregulations/policies/pcmhrecognition.pdf.
9 *Accreditation Initiative Update*. Health Resources and Services Administration. Website Accessed on November 6, 2014: http://bphc.hrsa.gov/policiesregulations/policies/pal200912.html.
10 *Patient Centered Medical Home (PCMH) Initiative Update*. Health Resources and Services Administration. Website Accessed on November 6, 2014: http://bphc.hrsa.gov/policiesregulations/policies/pcmhtranscript.pdf.
11 Macrae, J. October 2014. *Bureau of Primary Health Care Update.* Bureau of Primary Health Care. Webinar Accessed on November 10, 2014: http://78449.choruscall.com/dataconf/productusers/hrsa/mediaframe/9991/indexr.html#.
12 Note that Oregon's accreditation is "Patient-Centered Primary Care Home" (PCPCH).
13 *HRSA National Quality Recognition Initiatives Resources: Comparison Chart. Accreditation Association for Ambulatory Care, Inc.* Website Accessed on November 6, 2014: https://www.aaahc.org/Global/pdfs/PCMH_Comp_Chart.pdf.
14 Through the AAAHC's accreditation program, health centers can opt to be evaluated on their integration of PCMH standards into their overall operations, giving them PCMH status. Additionally, the AAAHC provides a less rigorous PCMH certification that evaluates an organization only through the PCMH tenets and not the greater accreditation standards. This certification does not make health centers eligible under HRSA's Accreditation Initiative, though HRSA will recognize the health center's PCMH status.
Accreditation Update. Health Resources and Services Administration. Website Accessed November 6, 2014: http://bphc.hrsa.gov/policiesregulations/policies/transcriptstandardsandaccredidation.PDF.
15 HRSA recognizes TJC's optional add-on PCMH Certification, which is given to organizations that already have achieved TJC Ambulatory Care Accreditation and fulfill the additional PCMH standards.
Accreditation Update. Health Resources and Services Administration. Website Accessed November 6, 2014: http://bphc.hrsa.gov/policiesregulations/policies/transcriptstandardsandaccredidation.PDF.

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PCMH Standards

The three HRSA-recognized national agencies provide PCMH recognition, accreditation, and/or certification in three-year cycles: NCQA provides PCMH recognition, AAAHC provides both accreditation and a less rigorous certification, and TJC provides a PCMH certification as an addition to their ambulatory care accreditation.

Though the three HRSA-recognized national agencies' PCMH standards vary slightly due to scope and priority, they all uphold the PCMH Joint Principles. The standards are not organized to correlate directly with each of the Joint Principles, but instead are interrelated sets of principles that reflect the values of the Joint Principles throughout. The standards are reviewed through different processes: NCQA requires documentation submission while AAAHC and TJC verify adherence through on-site surveys.

FOR MORE INFORMATION

If you are interested in learning more about the different PCMH standards and recognition processes, visit the websites of the agencies. Note that while HRSA's initiatives only include NCQA, AAAHC, and The Joint Commission, there are additional national and state agencies that provide PCMH recognition.

NCQA: http://www.ncqa.org/
AAAHC: http://www.aaahc.org/
The Joint Commission: http://www.jointcommission.org/
URAC: https://www.urac.org/
State of Oregon: http://www.oregon.gov/oha/pcpch/Pages/index.aspx
State of Minnesota*: http://www.health.state.mn.us/healthreform/homes/
State of Massachusetts: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/

Benefits of PCMH Recognition

Having PCMH recognition, accreditation, or certification is valuable for health centers for a number of reasons including: 1) it provides an objective assessment of the quality of care provided; 2) it positions health centers competitively in a changing health care landscape; and 3) it moves them toward better health care, healthier people and communities, and more affordable care.[16]

Standards outlined by each of the agencies are intended to ensure that care is accessible, accountable, comprehensive, integrated, patient-centered, safe, and affordable.[17] While many health centers are already utilizing PCMH-standard systems to achieve these goals, by working towards PCMH recognition, health centers demonstrate and strengthen their commitment to quality care and create the opportunity for enhanced reimbursement rates and structures.[18] Additionally, service quality improvement to meet PCMH standards moves health centers to meet and even exceed Healthy People 2020 objectives around clinical outcomes.[19] Further, providing health services that focus on the whole person helps address the social determinants of health. By connecting with communities; identifying patients' social, economic, and clinical needs; reducing barriers to care; and facilitating access to health and social services, health centers are able to provide referrals to meet social and economic needs that impact health and are beyond the scope of clinical care.[20]

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16 Stoimenoff, K. January 2013. *Care Coordination Models to Improve Clinical Quality and Performance: Expanding the Primary Care Team*. Health Outreach Partners. Website Accessed October 17, 2014: http://web.outreach-partners.org/resources/outreachconnection/162.
17 Ibid.
18 Ibid.
19 *Accreditation Update*. Health Resources and Services Administration. Website Accessed November 6, 2014: http://bphc.hrsa.gov/policiesregulations/policies/transcriptstandardsandaccredidation.PDF.
20 Lee, S. May 2013. *Social Determinants of Health: Addressing Access to Affordable and Nutritious Food for Underserved Populations*. Health Outreach Partners. Website Accessed on November 21, 2014: http://web.outreach-partners.org/resources/outreachconnection/190.

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What are the Social Determinants of Health?

The social determinants of health are "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

-The World Health Organization

THE CONNECTION BETWEEN OUTREACH AND PCMH

Health Outreach Partners defines outreach as "…the process of improving people's quality of life by facilitating access to quality health care and social services, providing health education, bringing linguistically and culturally responsive health care directly to the community, helping people to become equal partners in their health care, and increasing the community's awareness of the presence of underserved populations."[21] While outreach is often included in the definition of enabling services, for the purposes of this resource it is defined broadly and includes but is not limited to many enabling services that are provided outside of the health center walls.

There is a natural alignment between the principles of the PCMH model and outreach program activities. While individual health centers may define outreach differently, the common goal of all outreach efforts is to foster access to health care services. Both the PCMH model and outreach activities work towards increased access to care and improved health outcomes by building strong relationships with patients.

Outreach teams can be comprised of a variety of employees and volunteers including clinical staff, patient navigators, case managers, community health workers, promotoras, or health educators. Staff can have varying levels of trainings, certifications, and licensures based on desired activities. No matter how an outreach team is structured, many outreach program activities can be leveraged to meet PCMH standards. Examples of these activities include the following:

- Delivering culturally and linguistically appropriate services and referrals,
- Assisting with connecting patients to both health and social services,
- Supporting transitions between providers and other phases of care,
- Helping filling out applications and forms,
- Facilitating and providing transportation services,
- Aiding with interpretation,
- Meeting patients where they are comfortable,
- Participating on care teams, and
- Providing health education and self-care support.

These activities are based on the trusting relationships that outreach staff members develop with community members. Such relationships allow increased communication between patients and the health center, inviting patients to become more active participants in their health care. Outreach considers the whole-person and understands how a person's experiences outside a health center can affect his/her ability to access care and follow through with referrals or recommendations.

Due to the natural connection between PCMH principles and outreach activities, health centers have the opportunity to leverage the knowledge and expertise of outreach workers to support the PCMH recognition process and upkeep PCMH standards. Outreach staff can be incorporated into performance improvement planning, participate on care teams, help manage patient care, promote patient self-care, support tracking and coordinating care, and assist mobile populations in staying connected to health care services.

21 *National Outreach Guidelines for Underserved Population.* Health Outreach Partners. 2012. Website Accessed on January 28, 2015: http://web.outreach-partners.org/resources/nationaloutreachguidelines.

Sample Crosswalk of Outreach Activities and PCMH Standards*

Outreach Activity Addressed in Resource	Focus Area	Example Standards Supported by Outreach		
		NCQA	AAAHC	TJC
#1 - Maximizing Outreach in PCMH Planning and Performance Improvement	Performance Improvement	Involve care team in performance improvement.	Ensure an active and peer-based improvement program.	Implement ongoing performance improvement.
#2 - Incorporating Outreach Workers Into Care Teams	Increasing Patient-Centeredness	Care team provides range of patient services.	Care team provides services.	Care team provides care, treatment, and services based on patients' needs.
#3 - Managing Populations Through Outreach	Population Management	Collect and use data to identify patient groups and remind them of needed care.	Coordinate consultations, referrals, and transfers of care.	Identify patient groups through collected data.
#4 - Using Outreach to Help Manage Patient Care and Promote Self-Care	Plan and Manage Care	Support patient in managing own care.	Utilize patient self-management tools.	Provide self-management tools and techniques.
#5 - Supporting Tracking and Coordinating Care Through Outreach	Plan and Manage Care	Track tests and coordinate care across multiple providers.	Coordinate consultations, referrals, and transfers of care.	Provide coordinated care through making and tracking referrals.
#6 - The Role of Outreach in Supporting Care Coordination for Mobile Populations	Population Management	Assess and manage health needs of specific patient population.	Plan for transfers of care.	Provide population-based care.
#7 - Tapping Into Outreach to Help Improve Patient Experience	Increasing Patient-Centeredness/ Access	Provide patients with information about Medical Home and care team services and processes.	Provide patients with information on care team and Medical Home.	Provide patients with information about Medical Home functions and services.

*This crosswalk was adapted from the Primary Care Development Corporation's "Crosswalk of Medical Home Standards/Certifications." Accessed on January 23, 2015: http://www.pcdc.org/assets/pdf/09-09-11-crosswalk-of-medical-home-stds.pdf.

LEVERAGING OUTREACH TO SUPPORT PCMH

This section describes many ways that outreach workers can support health centers both in becoming and functioning as Patient Centered Medical Homes. Outreach workers are bridges between the community and the health center: their experiences outside of the health center and connection to the community make them valuable partners in establishing true patient-centeredness.

#1 - Maximizing Outreach in PCMH Planning and Performance Improvement

Health centers can leverage the knowledge of outreach staff to meet PCMH standards by involving them in the planning process for PCMH recognition and continued quality improvement. Outreach staff members provide a unique perspective that is beneficial to planning teams. They have an understanding of the community and a patient's experience outside of the health center, which affect how a patient approaches his/her care. When outreach representatives are invited into PCMH recognition and performance improvement planning conversations, they can provide input about how to best communicate with patients and what types of services and materials will work well with the patient population to fulfill standards of enhanced patient access. This input allows health centers to plan for tailored interventions that increase access for even the most vulnerable health center patients. Outreach staff members are already involved in activities that support PCMH standards and the planning team can leverage their knowledge to create stronger processes.

PRACTICE EXAMPLE: OUTREACH SUPPORTS PLANNING

Blue Ridge Community Health Services (BRCHS) has eleven health center locations in North Carolina, all of which are PCMH-accredited through The Joint Commission. To ensure staff involvement in decision-making and continued quality improvement, BRCHS implemented Performance Improvement (PI) teams, including a PI team on PCMH accreditation planning. The PCMH PI team, tasked with preparing for the accreditation process and continually reviewing the center's operations to strengthen PCMH practices, includes an outreach staff member. A representative with expertise in outreach is essential to this team because he can offer a different perspective on patient-centeredness. By offering insight into the patient experience beyond the health center, the outreach representative helps the PCMH planning team implement practices that best serve patients and engage patients in their own care. For example, BRCHS serves many migratory and seasonal agricultural workers who can only come to the health center in the evening. BRCHS examined how they could best alter not only their center hours but also build an organizational culture that ensures all those walking in the door prior to closing receive the same quality health care. Having someone on the team that speaks articulately about the patient context, including barriers to care, allows for systems to be implemented that result in a better patient experience.

#2 - Incorporating Outreach Workers into Care Teams

As outlined in the Joint Principles, a provider-directed team of professionals should be used to provide and manage continuous patient care. The composition of the care team differs across health centers and a variety of staff may participate. Including outreach workers on the care team can prove beneficial: they can inform the team of what is occurring with individual patients in the community and provide a unique perspective on the patient's context.[22] For example, outreach workers conducting home visits or providing outreach services at places of employment may have information that is critical to patient care and may impact recommendations. Outreach workers often have an understanding of how the social determinants of health specifically impact patients and their families and can share this information with the team.

22 Gardner, H. June 2011. *Highlights from HOP's National Peer-to-Peer Event on Outreach and The Patient-Centered Medical Home.* Health Outreach Partners. Website Accessed October 17, 2014: http://web.outreach-partners.org/resources/outreachconnection/33.

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PRACTICE EXAMPLE: EMBEDDING CHWS ON CARE TEAMS

Mosaic Medical is a Federally Qualified Health Center in Oregon with five clinic sites, all with Tier 3 Patient Centered Primary Care Home (PCPCH) accreditation through the state. After many years of incorporating Community Health Workers (CHWs) into general patient support roles, Mosaic worked to embed CHWs into clinical care teams. In order to fully integrate CHWs, Mosaic transitioned the supervision of the CHWs from the clinic managers to RN Care Coordinators. Each CHW works closely with the team's RN Care Coordinator to best address the needs of patients with the most complex medical and social service needs. All CHWs focus not only on case management activities and outreach events but also on providing individual health education. Each CHW is trained as an instructor for Stanford's Living Well with Chronic Disease program and receives additional training on topics like tobacco cessation and obesity prevention. Because CHWs have full access to the Electronic Health Record (EHR) system, all their activities are recorded in the patient record, which allows for ongoing conversations among the care team. In addition, all members of each care team regularly meet to discuss complex issues and work together to solve challenges.

Because Mosaic Medical receives Per Member Per Month (PMPM) payments as part of an alternative payment methodology, more emphasis can be given to non-clinic visits. One of the ways Mosaic maximizes PMPM payments is by using CHWs to conduct home visits. For example, one health center in particular has a sizeable aging Medicare population. CHWs at this location conduct home safety visits with these patients to help assess mobility and safety. In addition, CHWs can assist patients in learning how to navigate the public transportation system in order to decrease no-show rates and support access to health services.

#3 - Managing Populations Through Outreach

Health centers implementing PCMH should take steps to proactively improve the overall health of the patient population by utilizing patient data that the center collects. Instead of solely thinking about patients as individuals, health centers will need to think about caring for an entire population.[23] Care should anticipate needs and improve health outcomes, especially for high-risk patients.[24] This includes an emphasis on preventative care and helping patients stay healthy and manage their conditions as effectively as possible. Health centers must be prepared to generate lists of patients in order to provide reminders and help them stay on top of their health care needs. Outreach workers who are integrated into the care team can be used to help the health center accomplish this task, as they are familiar with the priority population.

PRACTICE EXAMPLE: OUTREACH AND POPULATION MANAGEMENT

Clínica Family Health Services, located in Colorado, serves 42,000 patients annually and has five sites with Level 3 NCQA PCMH recognition. Clínica uses pods, or care teams, at each of their health center sites. Each pod has a variety of staff members who participate including providers, behavioral health specialists, nurses, and case managers. Case managers are responsible for connecting patients to community resources, providing services such as diabetes education and tobacco cessation support, conducting home visits as needed, and proactively reaching out to patients regarding upcoming care needs. Clínica uses internal tools such as chronic disease registries to help support population management and guide outreach efforts. Anyone in the pod can generate the reports based on a specific condition like diabetes. All patient information and any associated alerts are included in the report. For

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23 *Population Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare.* 2012. Institute for Health Technology Transformation. Website Accessed on November 21, 2014: http://ihealthtran.com/pdf/PHMReport.pdf.
24 *From Intervention to Prevention: Demystifying Population Health Management.* October-November 2012. University of Rochester Medical Center. Website Accessed on November 21, 2014: http://www.urmc.rochester.edu/news/publications/pulse/oct-nov-2012/story1.cfm.

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example, a diabetic patient who may be due for a foot exam may also need to make an appointment for an eye exam. When the case manager contacts the patient, all of the needs identified in the alerts can be addressed at one time. This comprehensive approach allows Clínica to actively monitor the health of their patient population and provide much needed support in staying connected to the full spectrum of health care services.

#4 - Using Outreach to Help Manage Patient Care and Promote Self-Care

Outreach workers not only serve as liaisons to a patient's care team, but can also be integral to the team. A key component of the PCMH model is to engage patients in their own health care. In order to accomplish this, providers develop individualized care plans with self-management goals that are shared with the patients. Health centers implementing the use of care plans can have lower cost personnel, like outreach workers, communicate with the patient regarding self-management goals and barriers to achieving these goals.[25] Outreach workers can be effective liaisons between the patients and providers, as they may be perceived as more approachable for patients who feel insecure about asking questions. Outreach workers can communicate in a culturally and linguistically appropriate manner to ensure that patients understand treatment goals. Further, with proper training and supervision, outreach workers can provide health education to support building skills to practice healthy behaviors and follow through on treatment recommendations. For example, with appropriate training, licensure, or certification, outreach workers can assist with nutrition counseling, address diet and exercise needs, support stress management, and help patients understand medication management.

PRACTICE EXAMPLE: PATIENT NAVIGATORS SUPPORT PATIENT SELF-CARE

Benton County Health Services (BCHS) consists of four clinic sites in the Willamette Valley area of Oregon. All four sites have Tier 3 Patient Centered Primary Care Home (PCPCH) accreditation through the state. Over the last six years, BCHS's outreach program has grown from one part-time Community Health Worker (CHW) to 14 full-time CHWs who serve in the role of patient navigators. The CHWs, or patient navigators, were brought into the clinic so that they would have one foot firmly in the clinic and one foot grounded in the community. BCHS's navigation team includes several clinical navigators who have received extensive training in topics including health literacy, Medicaid, diabetes management, motivational interviewing, popular education, and tobacco cessation. With proper training, close supervision, and consistent access to clinical staff, the clinical navigators have become integral members of primary care teams. These clinical navigators see patients, participate in morning huddles, talk with providers and pharmacists, and work closely with nurses. They regularly provide self-management support and health education based on individual patient needs. In addition to the work done inside the health center, all navigators participate in outreach events and spend time in the community doing activities like home visits.

BCHS's navigators are trained to chart interactions as interim notes in the Electronic Health Records (EHR) system. Much of the work navigators complete with patients is coded as "PCPCH" in the EHR under care coordination, comprehensive care management, or community and social support. Recording how many and what type of client interactions, or "touches," that navigators provide supports BCHS's understanding of the navigators' role in both contributing to the provision of PCPCH services and addressing the social determinants of health. This information is shared with BCHS administrators and board members to reinforce the value of the navigators and highlight how navigators support organizational initiatives such as BCHS's alternative payment methodology pilot project and the work conducted with a Coordinated Care Organization.

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25 *Business Value of Health Outreach Programs Strategic Framework*. 2013. Health Outreach Partners.

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#5 - Supporting Tracking and Coordinating Care with Outreach

Referral relationships can improve quality of care for patients and ensure that care is coordinated across the health care system. Some health centers include building relationships with specialty providers and helping patients to navigate referrals to other providers in outreach staff job responsibilities.[26] In truly comprehensive community health outreach programs, outreach workers participate in care coordination by connecting patients 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 patients, and advocating for patients both within the health center setting and in the broader health and social service arena.[27] Using outreach workers to reach out and help patients navigate care across the spectrum of health care services supports the health center in holistically addressing the needs of each individual.

PRACTICE EXAMPLE: OUTREACH HELPS WITH FOLLOW-UP AND REFERRALS

Beaufort Jasper Hampton Comprehensive Health Services, Inc. (BJHCHS) has eight sites in South Carolina, including the Ruth P. Field Medical Center, a site with NCQA PCMH Recognition. BJHCHS's outreach staff engage with the patient by providing referrals and appropriate follow-through. Providers give specific instructions to outreach workers, who then contact the patient to provide information such as test results or schedule follow-up appointments. If required, the outreach worker assists in scheduling transportation for medical appointments, making connections to additional resources, and helping secure needed medications. The outreach worker then provides updates to the nurse assigned to the patient and completes written documentation of the interaction. The nurse updates the Electronic Health Record (EHR) as appropriate and the outreach worker scans and attaches any relevant notes to the patient's EHR. This system works particularly well at BJHCHS because the outreach staff has an excellent working relationship with the providers. The providers appreciate the unique, trusting relationship outreach workers have with patients and leverage that to ensure patients remain connected to the health center and actively follow up on care recommendations.

#6 - The Role of Outreach in Supporting Care Coordination for Mobile Populations

Achieving PCMH recognition includes ensuring continuity of care. This aspect of providing services is particularly challenging for health centers serving mobile populations like migratory agricultural workers and persons experiencing homelessness.[28] It is important for health centers serving large transient populations to identify and implement adaptations for mobile patients.[29] One such adaptation includes "integrating outreach and other enabling services with clinical care as part of care coordination." Outreach and community health workers can assist the team in staying connected to the patient and facilitate care transitions as a way to help overcome the challenge of successfully working with mobile populations in a PCMH.[30] Specifically, by being a consistent presence in the community, outreach workers can help the health center stay linked to these patients by seeking them out where they live, work, and spend time to ensure that they do not fall through the cracks. Further, outreach workers can work with a patient with high mobility to help make sure the patient travels with an adequate supply of medication, maintains access

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26 Gardner, H. June 2011. *Highlights from HOP's National Peer-to-Peer Event on Outreach and The Patient-Centered Medical Home.* Health Outreach Partners. Website Accessed October 17, 2014: http://web.outreach-partners.org/resources/outreachconnection/33.
27 Stoimenoff, K. January 2013. *Care Coordination Models to Improve Clinical Quality and Performance: Expanding the Primary Care Team.* Health Outreach Partners. Website Accessed October 17, 2014: http://web.outreach-partners.org/resources/outreachconnection/162.
28 *Outreach Across Populations.* Health Outreach Partners. Website Accessed November 17, 2014: http://web.outreach-partners.org/images/2013nna/2014_NNASummary_FINAL.pdf.
29 Ibid.
30 *Migrant Adaptations PCMH Crosswalk.* Migrant Clinicians Network. Website Accessed January 8, 2014: http://www.migrantclinician.org/toolsource/tool-box/migrant-adaptions-patient-centered-medical-home-crosswalk-tool.html.

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to complete medical records, and takes steps to connect to the next source of health care when he/she leaves the health center's service area.

BRIDGE CASE MANAGEMENT RESOURCE FOR MOBILE POPULATIONS

Health Network, a free service provided by Migrant Clinicians Network, provides mobile patients with continuity of care through global patient navigation and bridge case management, both in the US and around the world. Health Network offers virtual case management to schedule appointments, set up transportation services, and advocate for patients wherever they go. Enrollment into Health Network can be a valuable tool for health centers to help ensure continuity of care and establish a patient-centered medical home for their patients. In anticipation of a patient's departure from the health center's coverage area, staff can use Health Network to connect patients to their next source of health care. A health center can check in on an enrolled patient's status at any time until a closure report has been sent to the health center that completed the initial enrollment. For more information on Health Network, please visit: http://www.migrantclinician.org/services/network/enrollment-in-health-network.html.

#7 - Tapping into Outreach to Help Improve Patient Experience

The PCMH model requires processes for improving the patient experience for both the individual and the family unit. Outreach staff members can bridge a patient's daily experience with his/her experience in the clinical setting to make care more relevant and manageable, engaging patients to become active participants in their own care. One strategy for accomplishing patient engagement is to assist patients in understanding how to use the system in order to receive care. Facing the complicated health care system can be overwhelming. An outreach worker can use his/her understanding of a patient's experiences to provide clear information regarding the purpose of the care team, how to make an appointment, what to bring to an appointment, and who to call to get assistance during the day and after hours. For example, if an outreach worker knows that a patient cannot easily access the Internet, he/she might spend more time explaining how to get assistance via phone. Further, if the patient is not familiar with the purpose of primary care, the outreach worker can provide information about when and how to access primary care versus urgent care services. This more targeted assistance empowers the patient to better navigate the health delivery system.

PRACTICE EXAMPLE: PROVIDING PCMH ORIENTATION TO PATIENTS

Community Health Partners (CHP) has four health center sites across two counties in Montana. CHP's Bozeman and Livingston sites received Level 3 NCQA PCMH recognition in October 2014. One of the NCQA PCMH standards addresses ensuring enhanced access and continuity of care including patient access to services and advice both during and after office hours. Not only does CHP provide enhanced access and continuity, CHP invests time and resources to support their patients in understanding what a patient-centered medical home is and what that recognition means to them. In order to make sure patients know when and how to access care and work with their care team, CHP has outreach and enrollment workers and resource coordinators meet with new patients during their first visit to the center for a comprehensive insurance eligibility screening and a thorough introduction to the PCMH model. These meetings empower patients to become more active partners in their health care by reviewing how to communicate with providers during and after hours, explaining what to expect regarding patient care, and providing information about community resources such as transportation services or the local food pantry.

POTENTIAL FINANCIAL BENEFITS OF INCORPORATING OUTREACH

While the PCMH Standards for NCQA, AAAHC, and TJC do not require a reformed payment model, the Joint Principles of PCMH address the need for alternative payment systems. The Joint Principles encourage financing systems beyond the traditional system that rewards utilization instead of outcomes, prevention, or alternative methods of care.[31] Payment systems that align with PCMH principles reward continuous, patient-centered care and values care provided by both physicians and non-physicians.[32] Examples of such include shared savings and pay-for-performance incentives. Under such payment models, an outreach worker can contribute by reaching patients who do not need a clinical intervention to track alternative "touches" that can be counted toward requirements for "per-member-per-month" models and by utilizing their relationships with the community to encourage patients to take part in preventative care.[33] Care provided by outreach workers allows the health center to benefit financially by having physicians operate at the top of their license while still meeting payment requirements. Allocating appropriate tasks to outreach workers that might otherwise be conducted by a clinician lowers costs of care for the health center. Furthermore, outreach workers can help reduce the total cost of care to a health system by encouraging appropriate utilization of primary care versus urgent care services.

PRACTICE EXAMPLE: RECORDING OUTREACH "TOUCHES"

Benton County Health Services' patient navigators record in the EMR how many and what type of navigator touches are provided. This information contributes to BCHS's alternative payment methodology pilot project and the work conducted with a Coordinated Care Organization by helping meet requirements for client-provider interactions, allowing the health center to take part in shared savings. *See page 9 for more detail about Benton County Health Services' work*.

CONCLUSION

Health centers have an opportunity to use outreach to support achieving PCMH recognition and effectively provide a medical home to patients. In order to improve clinical quality, enhance patient experience, and reduce health system costs, the skills of all staff should be fully utilized. Health centers should leverage the skills and strengths of outreach workers to offer patient-centered, culturally and linguistically responsive health care. Outreach workers can support a wide range of PCMH activities as demonstrated above. Health centers should not overlook the value of outreach to the PCMH model.

31 *The Patient Centered Medical Home*. Robert Graham Center. Website Accessed January 21, 2015: http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2007/rgcmo-medical-home.Par.0001.File.tmp/rgcmo-medical-home.pdf.
32 Ibid.
33 *Business Value of Health Outreach Programs Strategic Framework*. 2013. Health Outreach Partners.

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