



## Improving Care Coordination in Rural Communities

**February 13, 2014  
12 p.m. CT**

Kristine Sande, Moderator

## Presentation

- Q & A to follow – Submit questions using chat tab directly beneath slides
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# Presenters

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- **Alexa Brown**, NORC Walsh Center for Rural Health Analysis
- **Melissa Miles**, Bi-State Primary Care Association
- **Heidi Blossom**, MHA – An Association of Montana Health Care Providers

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## Improving Care Coordination in Rural Communities: The Rural Care Coordination Toolkit

February 13, 2014

Alexa Brown  
NORC Walsh Center for Rural Health Analysis

## Overview

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- Background
  - ORHP Rural Health Outreach Tracking and Evaluation Program
  - 330A Outreach Authority Grant Program
  - Evidence-Based Programs
- Rural Care Coordination Toolkit
- Findings and lessons learned
- Perspectives from the field

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## Rural Health Outreach Tracking and Evaluation Program

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- Funded by the Federal Office of Rural Health Policy
- NORC Walsh Center for Rural Health Analysis
  - Michael Meit, MA, MPH
  - Alana Knudson, PhD
- University of Minnesota Rural Health Research Center
  - Ira Moscovice, PhD
  - Walt Gregg, MPH
- National Organization of State Offices of Rural Health
- National Rural Health Association

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## Purpose of the Evaluation

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- The Rural Health Outreach and Tracking Evaluation is designed to monitor and evaluate the effectiveness of federal grant programs under the Outreach Authority of Section 330A of the Public Health Service Act
- The Outreach Authority program was created as part of the Public Health Service Act of 1991
- More than \$460 million has been invested in rural communities since program inception

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## Overview of 330A Outreach Authority Grant Programs

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- Nearly 900 consortia projects have participated and sought to expand:
  - Rural health care access
  - Coordinate resources
  - Improve rural health care service quality
- Eight grant programs operate under the authority of section 330A
  - Rural Health Care Services Outreach (Outreach)
  - Network Development Planning (Network Planning)
  - Rural Health Network Development (Network Development)
  - Small Health Care Provider Quality Improvement (Quality)
  - Delta States Rural Development Network (Delta)
  - Rural Health Workforce Network Development (Workforce)
  - Rural Health Information Technology Network Development (HIT)
  - Rural Health Information Technology (HIT) Workforce Program (HIT Workforce)

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## Focus on Improving Care Coordination

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- NORC develops evidence-based toolkits on rural health topics
- Why are HRSA and ORHP interested in care coordination?
  - Increase in care coordination programs, particularly in new models of care delivery and reimbursement
  - Improve quality of care, reduce costs, and improve health outcomes
- There is a need to identify and disseminate promising practices and resources on care coordination in rural communities

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## Why Evidence-Based Practices Are Important

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- Need to invest in programs that work and will have an impact
- Evidence informs decisions throughout the planning process
- Multiple forms of evidence are available to inform these decisions, at varying levels of rigor
- This toolkit includes evidence-based and promising practices and resources for rural communities



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## Rural Care Coordination Toolkit

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- Project Team

- Alycia Bayne, Alana Knudson, Alexa Brown, Naomi Hernandez, and Molly Jones



- Project Goals

- Identify evidence-based and promising models that may benefit grantees, future applicants, and rural communities
- Document the scope of their use in the field
- Build an Evidence-Based Model Toolkit around topic areas specific to rural care coordination

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## Project Activities

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- Reviewed ORHP grantees' applications and the literature to identify evidence-based and promising models to improve rural care coordination
- Conducted semi-structured telephone interviews with six ORHP grantees funded in 2012 and two non-grantees who were implementing care coordination programs
- Developed a toolkit of promising practices, offering resources and guidance about how to conceptualize, plan, implement, and evaluate care coordination programs
- Toolkit is available on the Rural Assistance Center (RAC) Community Health Gateway website:  
<http://www.raconline.org/communityhealth/>

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# RAC Rural Community Health Gateway

The screenshot shows the Rural Assistance Center (RAC) website. The header includes the RAC logo, navigation links for 'About' and 'Contact', and a search bar. A main navigation bar contains 'Online Library', 'Topics & States', 'Tools for Success', and 'RAC Publications & Updates'. The page title is 'Rural Care Coordination Toolkit'. A sidebar on the left lists the seven modules of the toolkit. The main content area provides an overview of the toolkit and lists the seven modules with brief descriptions of each.

**Rural Care Coordination Toolkit**

**Modules**

- 1: [Introduction to Care Coordination](#)
- 2: [Program Models](#)
- 3: [Implementation](#)
- 4: [Sustainability](#)
- 5: [Evaluation](#)
- 6: [Dissemination of Best Practices](#)
- 7: [Program Clearinghouse](#)

Home > Community Health Gateway > Care Coordination

**Rural Care Coordination Toolkit**

Welcome to the Rural Care Coordination Toolkit. The Toolkit is designed to help you identify and implement a care coordination program. It also provides you with resources and best practices.

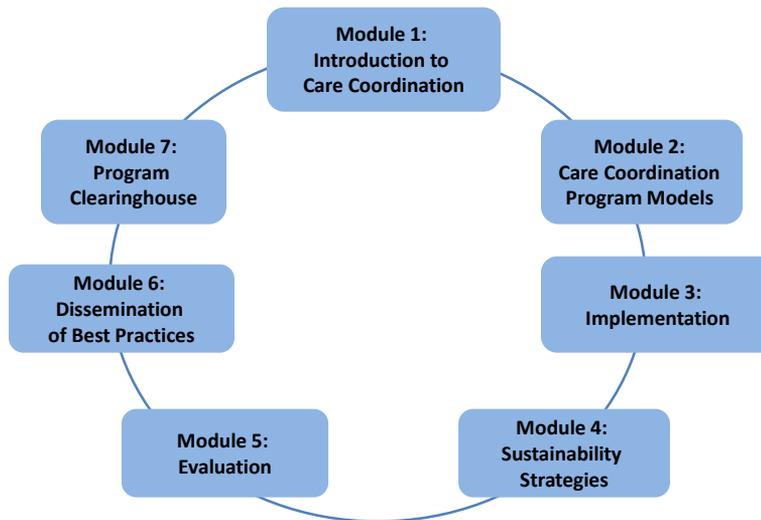
The toolkit is made up of several modules. Each concentrates on different aspects of care coordination programs. Modules also include resources for you to use in developing a program for your area.

- **Module 1: Introduction to Care Coordination**  
An overview of care coordination and issues specific to rural care coordination.
- **Module 2: Program Models**  
Six care coordination program models and their characteristics.
- **Module 3: Implementation**  
Implementation considerations for each care coordination program model.
- **Module 4: Sustainability**  
Strategies to ensure the sustainability of your care coordination program.
- **Module 5: Evaluation**  
Evaluation frameworks, data sources, objectives and measures for care coordination programs.
- **Module 6: Dissemination of Best Practices**  
Methods for sharing results from your rural care coordination program.
- **Module 7: Program Clearinghouse**  
Examples of care coordination programs that have been implemented in rural communities.

This toolkit is also available as a [printable PDF](#).

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## Organization of the Toolkit



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## Findings: Promising Rural Care Coordination Models

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- **Care coordinator model:** clinical or non-clinical health care workers (“care coordinators”) deliver services to patients and help patients overcome barriers to care and treatment
  - Types of care coordinators: health educators, patient navigators, care managers, and community health workers.
- **Health information technology (HIT) model:** strategy that uses electronic health records (EHRs) and other HIT to facilitate the coordination of care between patients, care coordinators, and health care providers
- **Partnerships model:** health care organizations form partnerships with hospitals, clinics, and community partners in order to achieve care coordination goals
  - Many rural programs establish consortia to manage programs

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## Findings: Promising Rural Care Coordination Models (cont’d)

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- **Patient-centered medical home (PCMH)\* model:** a model for providing patient care that is comprehensive, patient-centered, coordinated, accessible, and high quality
  - Characteristics include a strong relationship between patient and primary care physician; coordination between PCP and medical care team; coordination of care across settings; and use of HIT
- **Health Homes model:** a comprehensive person-centered system established by Section 2703 of the Affordable Care Act, which coordinates care and services for Medicare-Medicaid dual eligible enrollees who have:
  - Two or more chronic conditions, one chronic condition and are at risk for a second, or one serious and persistent mental health condition

\*Defined by HHS Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Primary Care Collaborative

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## Findings: Promising Rural Care Coordination Models (cont'd)

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- **Accountable care organization (ACO) model:** a system of care that integrates people, information, and resources for patient care activities and creates financial incentives for care coordination.
  - Rural providers may form a legal entity with other Medicare providers. Improving care coordination through ACOs may help rural providers to lower costs, reduce fragmentation, and improve quality of care.
  - ACO model is supported by HIT, and some have established a role for care coordinators to help monitor high-risk patients.

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## Lessons Learned

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- **Facilitator of success:** Partnerships are critical to success
  - Care coordination programs should adopt a “whole person” mindset to focus on diverse patient needs (e.g., transportation, home safety, nutrition, and literacy)
  - Programs should involve staff from diverse disciplines
  - Inform health professionals to gain buy-in and familiarize them with care coordination goals
- **Challenges:** Common challenges are related to funding and workforce (e.g., recruitment, retention, and training of appropriate, qualified staff)
- **Evaluation:** Communities are engaged in evaluation activities to document the success of their programs, but measuring impact is difficult

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## Contact Information

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The Walsh Center for Rural Health Analysis  
NORC AT THE UNIVERSITY OF CHICAGO

A photograph of a rural Vermont farm scene. In the foreground, there is a large, modern, light-colored barn with a curved roof. To the right, there are two tall, cylindrical silos. The farm is situated in a valley with rolling hills and mountains in the background under a clear sky.

## **Bridges to Health:** A Care Coordination Model for Migrant Dairy Workers in Rural Vermont

Melissa Miles, MPH, Project Manager  
Office of Rural Health Policy Outreach grantee

## What will be covered today?

- Goals
- Partners
- Population
- Model and tools
- Outputs and outcomes
- Lessons Learned



## Who's involved?

### **Consortium:**

- UVM VT Migrant Education Program (VMEP)
- Open Door Clinic

### **Partners and Collaborators:**

- Health centers and hospitals
- University of VT Medical School
- Two liberal arts colleges
- Volunteers and coalitions at the local level
- State Office of Rural Health and Primary Care

## **What are the Bridges to Health goals?**

- Train staff and increase knowledge to provide health care outreach and enrollment
- Raise awareness of local health services and provide care coordination when needed
- Assist health centers to improve linguistic and cultural capacity
- Train volunteers at colleges, universities, and communities

## **Who's our population?**

### **Migrant Dairy Workers and their Families**

- 93% from Mexico; 7% Guatemala
- 11% speak an indigenous language
- 99% uninsured
- 87% male
- 36% have high school degree
- Work avg. 70 hours/week
- No work visa program
- 61% have worked in dairy less than 2 years



## Why focus on migrant workers?

### Extreme Health Care Access Barriers

- Knowledge of where and when to go for care
- Fear
- Transportation
- Cost
- Language
- Dangerous occupation



## What is our care model?

Build upon and leverage existing staff who have knowledge and comfort with the population to:

- Assess
- Refer
- Arrange transportation & interpretation
- Follow-up
- Provide direct nursing and medical services on the farms



## What tools do we use?

Some are included in the Rural Care Coordination Toolkit (*Module 2 - Program Models* and *Module 5 - Evaluation*):

- Health Access Guides
- Bilingual Emergency Contact Cards
- Handouts on common conditions
- Farmworker and Farmer surveys
- Accessibility Assessment Tool
- Trainings and protocols for care coordinators

## What is an Accessibility Tool?

A self-assessment that a practice can use to score themselves in five key areas:

- Language
- Hours
- Transportation
- Registration and cost
- Cultural competency

## **How did we do our first year?**

(5/1/12 – 4/30/13)

- Outreach to 1,220 individuals on 75 of 97 targeted farms
- 331 unduplicated encounters
- 369 medical visits (all for uninsured)
- Met with health systems in 8 counties on access
- Over 150 students, volunteers, and providers trained in cultural competency for migrant workers; 6 interns this summer working for the project

## **How do we know our impact?**

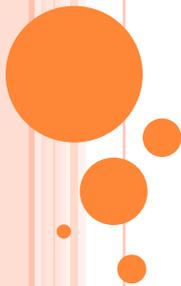
(5/1/12 – 4/30/13)

- 95% of those referred had completed health visits
- 90% of health centers made at least 1 change in their practices to improve access
- Survey results still show access barriers and fear in accessing services:
  - 50% still report access barriers
  - 0% would feel comfortable calling to make a doctors appointment
  - 24% would call 911 if they needed to

## What have we learned?

- Dedicated staff with local influence is a powerful tool to reach the underserved
- More outreach generates more outreach!
- Lack of control even with increased care coordination
- Encouragement of farmworkers and training for health centers does not equal access





## MONTANA FRONTIER COMMUNITY HEALTH CARE COORDINATION DEMONSTRATION GRANT

Heidi Blossom MSN, RN  
MHA/MHREF

### BACKGROUND

- Montana Frontier Community Health Care Coordination Demonstration Grant was awarded in 2012.
- The purpose of this grant is to improve the health status of clients with multiple chronic conditions who are Medicare and Medicaid beneficiaries living in frontier areas



## WHAT IS A FRONTIER AREA?

- To participate in this grant each facility has a population density of less than 6 people per square mile
- There are 11 facilities that participate in the Community Health Worker (CHW) demonstration
- Of the 11 facilities, six have less than 4,000 people in the county. Four of the facilities have less than 6,000 people in the county and only one has 10,000 people.



## COMMUNITY HEALTH WORKERS

CHWs are paraprofessionals who work directly with members of the community who have chronic conditions. The clients of CHWs are preferably Medicare or Medicaid beneficiaries, and the CHWs support them in improving their health, reducing avoidable hospitalizations, and reducing readmissions. CHWs also link their clients with health and social services needed to achieve wellness.

## WHAT DO THE CHWs DO?

- Perform face-to-face and phone contact with their clients on a scheduled basis and as needed.
- Support and educate clients in medication management and adherence; exercise; nutrition; health care system navigation; health promotion and management of chronic illnesses.
- Provide support and notify clinical team and program manager regarding changes in: behavior, medication compliance, and other issues related to the established care plans.
- Help coordinate client transportation and accompaniment as needed to scheduled appointments.

## WHAT DO THE CHWS DO? CON'T.

- Assure clients get appropriate and timely services by making referrals and motivating/teaching people to seek care.
- Participate in regularly scheduled staff development training to improve self-knowledge of chronic illness.
- Communicate all concerns to the Care Transition Coordinator.
- Communicate with clients, families, and providers to keep them informed and help bridge barriers to clients' health care goals.
- Create a non-judgmental atmosphere in interactions with individuals and their identified families.

## COMMUNITY OUTREACH

- Red Hat Ladies
- Pot-Luck Dinners
- Transportation Coordination
- “Stepping on Program”
- City Planning

## WHO PROVIDES REFERRALS

- Providers
  - Senior Centers
  - Low Income Housing directors
  - Sheriff
  - Communities of Faith
  - Families and Friends
- 

## SUCCESSSES

- Prevented elder abuse
  - Prevented disaster
  - Lowered ER visits and EMS calls
  - Assisted clients to receive needed care
  - Helped clients understand their disease and treatment
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## BARRIERS

- Clients
  - Content with current situation
  - Will not participate because this is a grant
- Facilities
  - Motivation to participate unclear
  - Concerned that success of this program will impact the bottom line
  - No space for the CHWs to work
  - Limited communication between the CEO and the providers
  - Champion for the program has left the facility

## BARRIERS, CON'T.

- Providers
  - Believe that anyone dealing with “patients” should be nurses
  - Concern about government intervention
  - Lack of control
  - Concerned that the success of this program will impact the bottom line (e.g., reduce revenue)

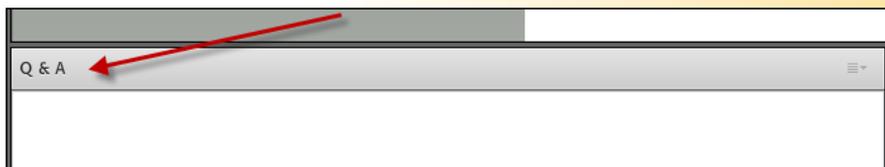
## LESSONS LEARNED

- Need a champion in each facility
- Community Health Workers should be from the community they serve
- Turn-over is an issue that needs to be addressed
  - Revisit number of CHW hours
- Resourceful people make the best Community Health Workers



## Q & A

- Submit questions using Q & A tab directly beneath slides.



# Thank you!

- Contact us at [www.raconline.org](http://www.raconline.org) with any questions
- Please complete webinar survey
- Recording and transcript will be available on RAC website



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