CHICAGO

Racial Equity Rapid Response Outreach: Suggested Practices

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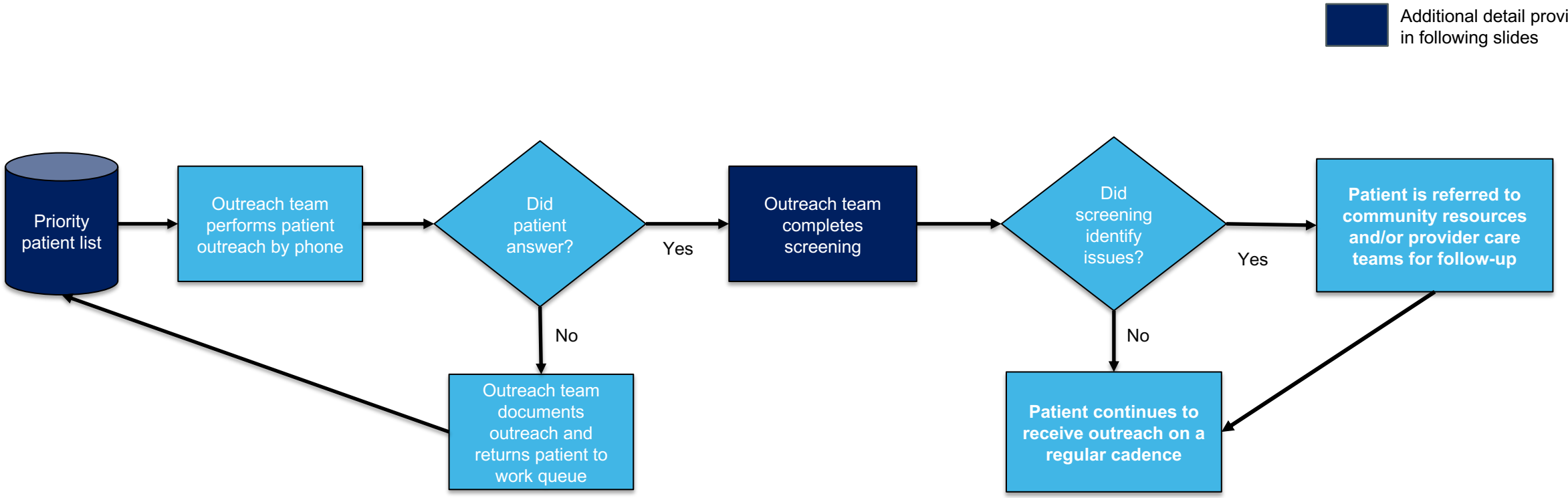
Suggested Outreach Workflow

The workflow illustrated below can be customized to align with a provider's specific operating model



Priority Patient List: Suggested Criteria

A prioritized list of patients for outreach can be developed by filtering each provider's patient population by specific criteria

Filter for all patients with priority profile:

- **Race/Ethnicity**
  - **Black**
  - **LatinX**
- **Age**
  - **65+**
- **Chronic underlying conditions***

Select patients in top 3-5 zip codes (with highest number of priority patients):**

- **Zip code #1**
- **Zip code #2**
- **Zip code #3**
- **Zip code #4**
- **Zip code #5**

PRIORITY PATIENT LIST FOR OUTREACH

*Underlying conditions include diabetes, hypertension, chronic lung disease, asthma, heart disease, kidney disease, liver disease, obesity, and immunosuppression

**Once outreach in those top zip codes has been completed, providers move on to patients in other Chicago zip codes and zip codes outside Chicago.

Note: Sources for patient list may include EMR, Medicare lists, ER visits, etc.

Suggested Components of Screening

Wellness and chronic medical condition checks are most critical; SDoH screening should be included, but may be limited

Components of Screening

- COVID-19 symptom check
- COVID-19 education
  - How to reduce risk of infection
  - Recognizing symptoms
  - Appropriate response to symptoms, including when/how to contact their PCP
- Medication check
  - Refilling chronic medications, including behavioral health medications
- Home management of chronic conditions, e.g.,
  - Supplies: Home BP monitor; glucometer
  - Follow-up: Internet; phone
- Screening for depression, anxiety, and domestic violence
- SDoH screening (may be limited)

Sample Comprehensive SDoH Screening

Social Determinants of Health Screening

RUSH

Every patient faces different stressors that can affect their health. We ask everyone who comes to Rush about these issues because we may be able to help. Any answers you provide are considered protected health information and are **not shared** with external agencies without your permission, unless you or your family members are in immediate danger.

Patient Name:_____ **DOB:**_____ **Date:**_____

Section	Please check a response
Primary Care	Do you have a doctor (primary care physician) or nurse that you see regularly? ☐Yes ☐No ☐Decline to answer
Insurance	Do you have health insurance or a medical card? ☐Yes ☐No ☐Decline to answer
Food Insecurity	Are you worried that your food will run out before you have money to buy more? ☐Yes ☐No ☐Decline to answer In the last twelve months, have you run out of food that you bought and didn't have money to get more? ☐Yes ☐No ☐Decline to answer
Utilities	In the last two months, have you had difficulty paying your electric, gas or water bill? ☐Yes ☐No ☐Decline to answer
Transportation	Do you have a hard time finding transportation to and from your medical appointments? ☐Yes ☐No ☐Decline to answer
Housing Instability	Do you currently have a place to stay/live? ☐Yes ☐No ☐Decline to answer In the next two months, will you have a place to stay/live? ☐Yes ☐No ☐Decline to answer

Suggested Roles and Responsibilities

Successful implementation of targeted outreach will require collaboration across multiple care teams, with different roles and responsibilities

Outreach Lead

Outreach lead is main RERR point of contact and coordinates outreach efforts across teams. As POC, outreach lead provides regular reporting on agreed-upon metrics, as well as key trends and concerns identified during outreach.

Outreach Team

Outreach team – comprised of MAs, care managers, CHWs, care coordinators, etc. – conducts preliminary outreach to priority patients; once contact has been made, outreach team conducts screening. Based on screening, outreach team provides patients with referrals to other care team members and connects patients to community resources.

Nursing Team

Nursing team receives referrals for medication refills and for patients with symptoms who are in need of telehealth or face-to-face appointments. Nursing team may refer patients to primary care providers and others, particularly for patients who have hypertension, diabetes, asthma, COPD, and heart disease.

Social Work Team

Social work team receives referrals for patients who score high for depression or anxiety, or who have very complex needs that can't be addressed by the initial caller. Social work team may refer patients to behavioral health providers and others.

Metrics and Reporting

Outreach leads provide weekly progress reports* using metrics included in the chart below, in addition to providing qualitative feedback on key trends and concerns identified during outreach efforts

As of MM/DD/YY	Total	By Race/Ethnicity		By Zip Code (Top 3-5 zip codes for priority patients)				
		Black	LatinX	Zip Code #1	Zip Code #2	Zip Code #3	Zip Code #4	Zip Code #5
# of Patients on Priority List								
# of Patients Reached (Cumulative)								

*Initial response to confirm participation in program is requested by May 8th. Weekly progress reports are requested every Friday, starting on May 15th.