Racial Equity Rapid Response Outreach: Suggested Practices

April 30, 2020
Suggested Outreach Workflow

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

1. **Priority patient list**
2. **Outreach team performs patient outreach by phone**
3. **Did patient answer?**
   - Yes: **Outreach team completes screening**
   - No: **Outreach team documents outreach and returns patient to work queue**
4. **Did screening identify issues?**
   - Yes: **Patient is referred to community resources and/or provider care teams for follow-up**
   - No: **Patient continues to receive outreach on a regular cadence**
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

*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**

![Sample Comprehensive SDoH Screening](image-url)
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.

<table>
<thead>
<tr>
<th>As of MM/DD/YY</th>
<th>Total</th>
<th>By Race/Ethnicity</th>
<th>By Zip Code (Top 3-5 zip codes for priority patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Black</td>
<td>LatinX</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Zip Code #1</td>
<td>Zip Code #2</td>
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<tr>
<td></td>
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<td>Zip Code #3</td>
<td>Zip Code #4</td>
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<tr>
<td></td>
<td></td>
<td>Zip Code #5</td>
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</tr>
</tbody>
</table>

# 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.