Esperanza

Expanded Care Teams

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Chicago, IL

Urban; 5 sites

Founded 2004

~50,000 Patients

Over 300 Employees

WHY
Our health center created expanded care teams

Mission: *to deliver **health** and **hope** for Chicago's underserved communities.*

Values:

- **Caring**: Bringing compassion, respect and understanding to all those we serve
- **Quality**: Striving for excellence and innovation in every aspect of our work
- **Family**: Building a shared sense of community where every person feels welcome and at home

NATIONAL ASSOCIATION OF Community Health Centers®

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Expanded Care Teams

WHAT?

WHY?

HOW?

Step 1:
Define Care Standards
Started with COVID-19…expanded to more

- **Care Coordination**
- **Care Management**
- **Contract Tracing Overview**
- **Population Health COVID Recovery**

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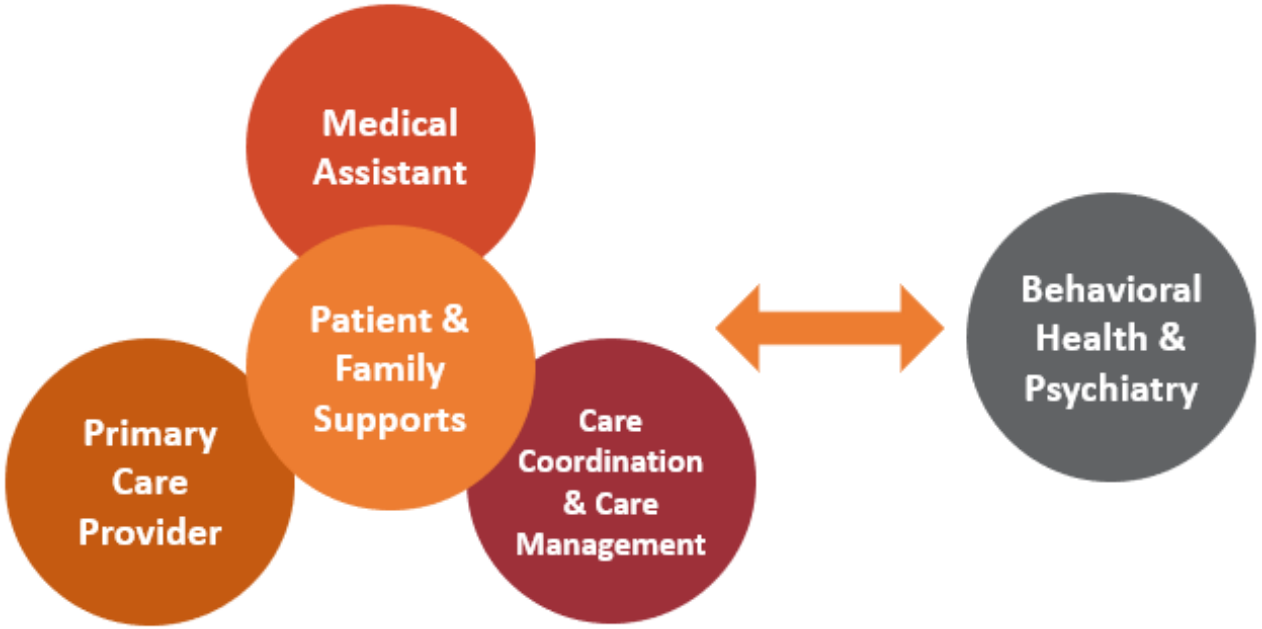
Step 1:
Define Care Standards
Started with COVID-19…expanded to more

Aligning with Esperanza's overall mission, our view of Population Health Recovery looks to continue improving the overall health of our patients while, also, looking to bring back those who have fallen out of care due to the COVID-19 pandemic. This means expanding outreach and creating awareness about chronic and seasonal diseases along with issues that encompass the goal of treating the individual holistically.

- Colorectal cancer screening outreach
- Diabetes control outreach
- OB C-19 vaccine outreach
- VeggieRx Program

Step 2:
Distribute Tasks to Meet Care Standards & Document Workflow



Reassigned Care Coordinators and Care Managers to support other departments during the pandemic

Call Center & Nurse Line

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Step 3:
Leveraged current positions
Added new position

Care Coordination
Connect patients to community resources
Population health outreach
Patient Education
Internal Programs

Contract Tracing Team
Outreach to patients to connect to COVID testing and care
Population health approach allowed focus on other conditions

Care Management
High risk complex patients
Primarily payer specific
Create care plans in partnership with provider and care teams and support patients towards achieving those goals

Quality
Coach care teams around team dynamics and support teams to meet quality goals through QI methodology
Data and dashboards
Patient safety

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Step 4:
Train staff

Virtual and in-person team training

- **Care Coordination Team**
  - Refresher trainings on breast, cervical, and colorectal cancer screening, hypertension control, diabetes control, well child visits.
- **Contract Tracing Team**
  - How to outreach to patients for specific population health measures (breast, cervical, and colorectal cancer screening, hypertension control, diabetes control, well child visits).

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Step 5:
Monitor Task Performance in Dashboards

COVID				Other Vaccines	Cancer Screening	Nutrition	Other…
Vaccination		Testing	Rapid Tests	Flu vaccines	Screening	VeggieRx	
~24k vaccinations	OB rate increased from 39% to 61%	~2,300 pts tested	22k distributed	~900 vaccinations	increased from 28% to 70% (2021)	2,600 boxes distributed	

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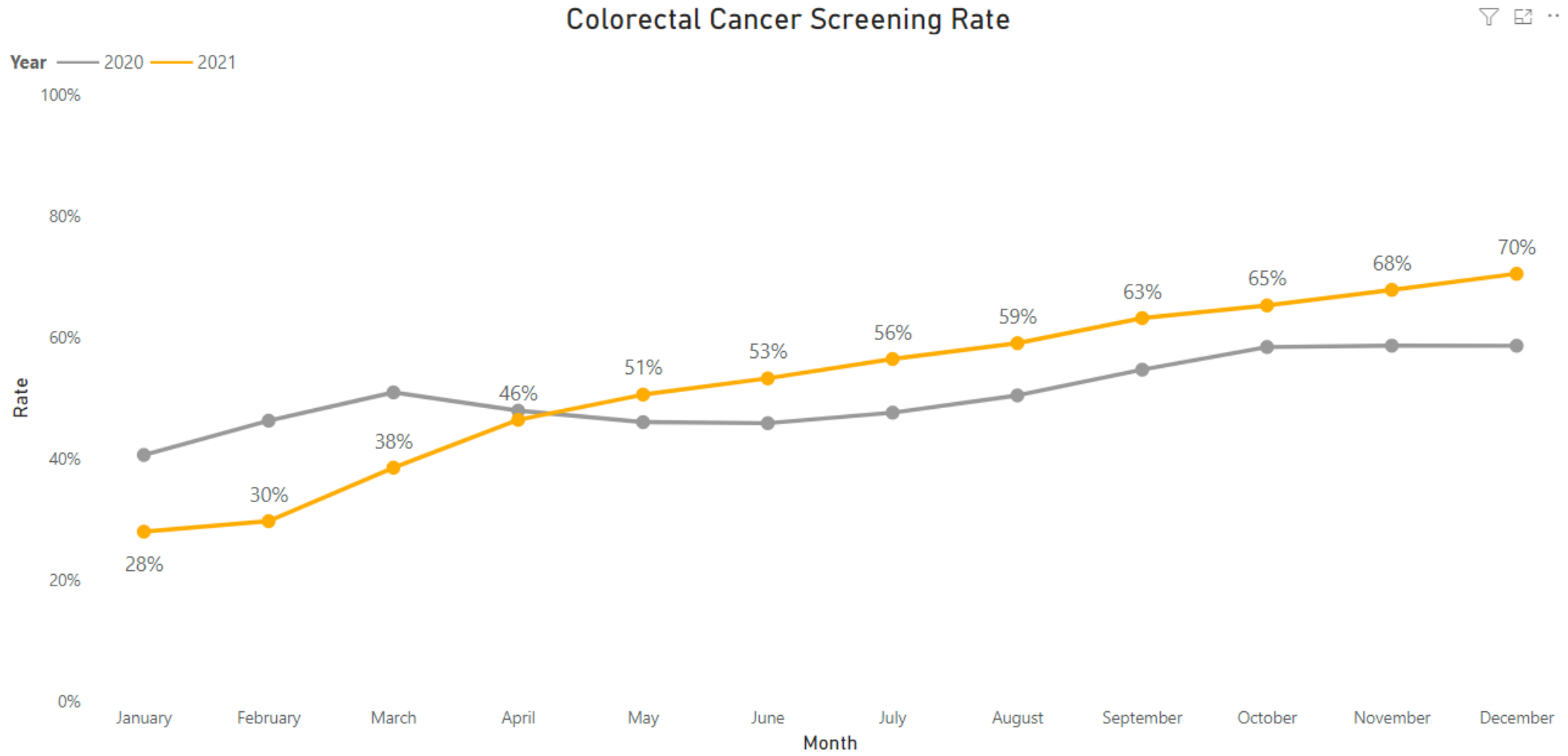
Step 5:
Monitor Task Performance in Dashboards



Step 6:
Hardwire Accountability into Personnel Systems and Performance Reviews

Having discussions across teams and departments to coordinate efforts and avoid duplication - more uniformity across the health center

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Step 7:
Educate Patients on Redesigned Care Team

Contract Tracing Team:

- *Patient Script* used for well-being checks
- Addressed any issues or barriers patient shared
- Connected patients with primary care, behavioral health services, community resources, etc.

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