Benefits Realization Case Study: Outreach workers in Rural Wellington are the bridge for individuals to overcome barriers and access appropriate resources

Background

Overall, the health status of people living in rural communities is poorer than those living in urban communities [1]. Access to healthcare in rural regions can be difficult due to distance between the patient's home and care facilities, low population densities, and lack of availability of certain care providers [2]. Patients living in rural British Columbia indicated their top challenges to receiving healthcare were having to travel to receive care, lack of continuity of care, and lack of communication between care providers [3]. Health and access to healthcare are also influenced by social determinants of health (SDOH) such as socioeconomic status, housing, food security, and psychosocial factors [1]. One strategy to improve health in rural areas is to develop community-based solutions to meet health challenges of residents [1]. The Rural Wellington Community Team (RWCT) is one such solution.

The Rural Wellington Community Team (RWCT) is composed of outreach workers who are assigned to each Family Health Team (FHT) in the Rural Wellington area. They work in the community and with each FHT to connect individuals with complex challenges to community agencies, help them to navigate social programs, and support them when family or friends cannot help. The team is also composed of Care Coordinators with the Canadian Mental Health Association and Community Care Access Centre. They recognize that health is influenced by a variety of factors and work to address the SDOH in a way that recognizes the unique challenges of those living in rural areas. Research suggests that providers who know how to ask their patients or clients about their social challenges were more likely to successfully help patients to overcome those challenges [4].

Value Proposition

Rurality is a social determinant of health that has a significant impact on residents living with complex conditions, as residing in a non-urban location impacts their ability to access appropriate care. The team outreach approach bridges the gap between patients and community resources, empowering patients to overcome their barriers.

Feedback from RWCT Clients

"I was given many options of who could help."

"I had no idea these [services] existed."

"It's nice to have people say they are here for you…made a huge difference in my life."

"It really, really helped…I didn't feel alone."

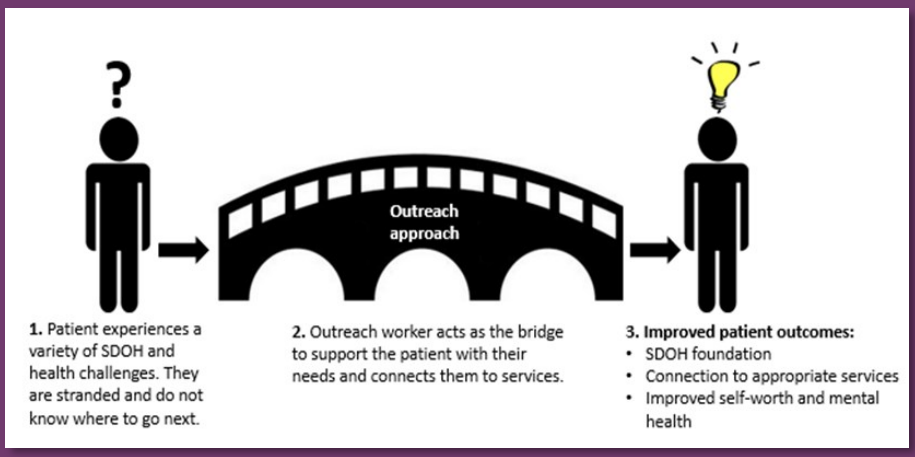
"If I don't know, [the outreach worker] makes it clear to me."

"If it wasn't for [the outreach worker], we'd be lost."

"[The outreach worker] will listen to me and I'll calm down again."

What were the Benefits?

Individuals that are connected to the RWCT experience complex health problems and face a variety of barriers related to the SDOH, including challenges related to finances, housing, employment, food, transportation, and their psychosocial environment. Overall, they simply do not know where to go next. Patients' primary care physicians often are not aware of all the community services that exist to support their complex patients and feel stranded. The outreach worker acts as the bridge and walks with the resident to address their barriers.



Outreach workers help to build a foundation for their clients that is grounded in addressing the SDOH. When residents have their basic needs met, they are more able to focus on managing their health problems and accessing services. For example, outreach workers address barriers to transportation by visiting patients in accessible locations and arranging transportation to health care appointments and other services. Tangible improvements have also been seen in outreach patients' mental health and feelings of isolation. Many patients have low self-worth before being connected with an outreach worker; the outreach worker provides a form of social support, which has a positive impact on the patients' feelings of validation and overall self-worth.

Outreach clients* feel their outreach worker has:

- **Helped them with their challenges (100%)**
- **Made them more aware of health and community services that exist in the area (100%)**
- **Listened to them (88%)**
- **Helped them to manage their health problems (63%)**
- **Improved their health (50%)**

Results from interviews with 16 outreach clients

Program Details

Healthcare spending is highly concentrated: the top 1% and top 5% of health services users accounted for 34% and 66% respectively of health cost in Ontario in 2007/8 [5]. These high health care users are likely to be patients with complex care needs and/or multiple chronic conditions. The Ontario Ministry of Health and Long-Term Care recognized the need to better coordinate care for these most complex patients within the community in order to improve health outcomes and drive health system efficiencies, and thus initiated the Health Links approach to care in 2012.

The Waterloo Wellington Local Health Integration Network (WWLHIN) is in the process of conducting an evaluation of the Health Links approach to care within the region. The eHealth Centre of Excellence (eCE) has supported this evaluation by conducting a Benefits Realization (BR) study in each of the four sub-LHIN geographies within the WWLHIN. The eCE's work focused on the impact of the Health Links approach to care by conducting a pre-post Coordinated Care Plan (CCP) comparison of acute care use and developing clinical narratives to highlight the clinical value enabled through the Health Links approach. This BR case study is one of the outcomes of the eCE work.

Works Cited

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If you are interested in participating in a future BR case, please contact eCE BR Practice Lead Lori-Anne Huebner at: Lori-Anne.Huebner@eHealthCE.ca

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