Case Management for the Mobile Outreach Clinic

Amy Mosely

University of Florida

Abstract

Case management is an extremely important public health nursing intervention taken on behalf of the client in order to coordinate care and provision of services with the goal of improving health quality. The Mobile Outreach Clinic serving Alachua County, Florida and surrounding areas provides primary healthcare and preventative services to underserved and uninsured community members. Due to issues discussed, a system of case management is necessary for patient follow up, education, and healthcare planning. After a thorough assessment, a system of case management was put into place. This system takes in patients using the developed initial referral form, and then tracks patient's progress using the narrative progress notes form. Evaluation of the project has not yet occurred, however outcomes will hopefully reflect a positive improvement in the health of patients seen on the Mobile Outreach Clinic.

Keywords: case management, Mobile Outreach Clinic

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Introduction

With the uninsured rate in America reaching an all time high of 17.1% in 2011 (Mendes, 2012), it is becoming increasingly important to turn attention to this growing population. This underserved population requires increased assistance in navigating the complex healthcare system America is faced with today. Finding providers, free or low cost services, and/or timely treatment can all prove a difficult task for those lacking insurance. It is of extreme importance to coordinate the care of these at risk individuals in order to prevent treatment delays, health deterioration and disease, further barriers to healthcare, and ultimately to empower such persons to be in control of their own healthcare. Many non-traditional clinics are taking hold in the community, targeting these underserved populations (Howe, Buck, & Withers, 2009). Serving Alachua County, Florida and the surrounding areas is the Mobile Outreach Clinic. This Bluebird bus brings primary healthcare to underserved and uninsured community residents. With the rates of uninsured rising to approximately 20% in Alachua County (United States Census Bureau, 2009), this mobile clinic bridges the gap in finding healthcare for these individuals. However, there is a lack of a functioning system of case management for these individuals receiving primary healthcare treatment on the Mobile Outreach Clinic. This paper discusses the importance of case management in the underserved and uninsured population, explores the difficulties that the Mobile Outreach Clinic faces in developing an efficient system for case management, and describes in detail the project at hand which focused on creating a working system for case management of the individuals seen on the Mobile Outreach Clinic.

Background

As defined by the Minnesota Department of Health, “case management optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services” (2001, p.93). Case management is the assessment, planning, and coordinating of services provided to the client, while taking into account the effectiveness of those services and the client’s individual capabilities (Stanhope & Lancaster, 2008). Case management should increase the quality of a client’s life by decreasing the fragmentation of services provided. The process of case management meets the client where they are, plans and coordinates the services the client needs, and continually evaluates and reassesses the client’s health status.

Case management is one of sixteen public health interventions that are defined by the Minnesota Department of Health (2001). Public health interventions are “actions that PHNs [public health nurses] take on behalf of individuals, families, systems, and communities to improve or protect health status” (p. 1). All public health interventions work together for the good of the health status of the focus of the intervention, whether that is an individual, a family, or a system. However, case management is not an intervention that functions alone. This public health intervention correlates well with other interventions such as referral and follow up. Case management cannot take place if there is no contacting of the client after services are provided. Improvements in a client’s quality of life cannot take place when there are no referrals for necessary services. Case management is also connected with other public health interventions such as health teaching, counseling, consultation, advocacy, and collaboration. Without these concurrent interventions, case management would fail as a system.

Current literature findings suggest that case management along with education is effective in improving functional status of women enrolled in Florida’s Welfare Transition

Program (Kneipp et al,. 2011). Since case management is obviously an important part of improving the health of patients, the following discusses the history of the Mobile Outreach Clinic, issues faced in regards to developing a working case management system, and project assessment findings.

History of Mobile Outreach Clinic

The Mobile Outreach Clinic, hereafter referred to as *the bus*, was first employed to deliver prenatal care to women in rural areas who had difficulty receiving care in the traditional medical system. The bus was grant funded and provided outreach to women in rural communities surrounding Alachua County, Florida. The bus was successful in increasing prenatal care, while also decreasing infant mortality in this underserved population. Soon after, the bus was used by the pediatrics department at a local tertiary care teaching hospital for a research project. This follow up project screened for and evaluated the effects of drug and alcohol exposure in children. After sitting idle for approximately two years, the bus got back on the road through funding from CHOICES, a program designed to improve healthcare access for Alachua County residents who are working but uninsured. After a community assessment of Alachua County and surrounding areas was conducted, it was discovered that multiple populations were at risk for health disparities. This community assessment led to over 2,324 patients since January 2010 receiving primary care on the bus, which includes “four rooms for counseling, education, taking patient vital signs and lab work” (Hardt & Comstock, 2011, p. 16).

Currently, the Mobile Outreach Clinic focuses on helping people in Alachua County and surrounding communities gain access to healthcare by going out into their neighborhoods to offer such care. The services provided far exceed the prenatal care offered during the earliest history of the bus. Nowadays, services include routine health screenings and comprehensive

primary care. Practitioners on the bus not only provide care to pregnant women in rural areas, but see community members of all ages, from infants to older adults. Specifically, services provided on the bus include routine physicals and health screenings, well-woman and well-child checks, family planning and medical services, check ups for minor illnesses and ailments, and care for chronic illnesses, including diabetes, hypertension, chronic obstructive pulmonary disease, depression, back pain, etc. The bus also deals heavily in referrals to other community resources, such as social work, psychological consultations, WE CARE, a network that provides people access to volunteer medical and dental providers, and to the University of Florida [UF] dental clinics, seeing as how the bus does not provide direct dental care. Prescriptions and over the counter medications, excluding narcotics, are prescribed. Blood pressure and blood sugar are monitored for those in need of assistance due to chronic health conditions. In addition, confidential human-immunodeficiency [HIV] and other sexually transmitted disease testing and counseling are offered. Services provided generally mirror those of an urgent care center. There are no specialized services such as radiology or electrocardiography provided on the bus. However, free laboratory work can be done on a limited basis through a donation made from the teaching hospital. Services on the bus are provided free of charge, thus benefitting the uninsured population that the bus targets.

The Mobile Outreach Clinic is partnered with nine other organizations in the Alachua County community. These partnerships allow for the bus to provide free care for the underserved and uninsured population in Alachua County and surrounding areas.

The mission of the bus is simple, “to make health promotion, disease prevention, health screening and program enrollment accessible to currently underserved populations of Alachua County, embodying a model that could be adopted in any teaching hospital community” (UF &

Shands, 2012, "Mission Statement," para. 1). The goal is not only to benefit underserved Alachua County residents through these stated interventions, but to extend this model for use in other teaching hospital communities.

The Mobile Outreach Clinic employs a single registered nurse who works on the bus five days a week. This nurse started as the first coordinator on the bus, providing prenatal care for women in rural areas. Her role is to screen, refer, educate, and provide case management, time permitting, for patients receiving healthcare on the bus. However, with all of the nurse's overwhelming responsibilities and commitments, an organized system for case management was difficult to sustain.

Many other factors contribute to the difficulty of providing case management. Problems the bus faces have been divided into three categories: problems with the patient population, problems with the provider population, and problems with resources and funding. Alone, each individual problem could be enough to make case management a daunting task. Combined, these problems contribute heavily to the lack of a functioning and organized case management system.

In regards to the patient population, most individuals seen on the bus have some sort of trouble with access to healthcare. Whether it is due to the lack of a job, home, insurance, money, education, or transportation, these individuals are at risk for being unable to obtain necessary healthcare. When levels of education, presence of health insurance, and income were made statistically equal, inequities in mortality risk were reduced and even disappeared between rural whites, blacks, and Hispanics and their urban counterparts (Probst, Bellinger, Waselmann, Hardin, & Glover, 2011). The patient population that the bus targets is already at risk for higher rates of health disparities and disease, by empowering this population through case management

to take control of their healthcare within their capabilities, reductions in health disparities and disease will hopefully occur.

To further complicate achieving access to healthcare and case management in this population, continual address and phone number changes only decrease the ability to contact these patients. Sometimes these patients have to choose between a phone bill and a grocery bill, thus physiological needs take precedence and cell phones run out of minutes or become inactivated. This creates a very difficult problem in contacting these patients for follow up in regards to case management purposes.

In addition to the problems encountered with the patient population, the provider population on the bus poses its own hindrances. The bus is staffed by a single registered nurse and different providers from local free and low-cost healthcare clinics. Each day of the week, a different physician or nurse practitioner from these various organizations provides healthcare on the bus. However, each provider also comes with his or her own documentation system, all of which are electronic now. Therefore, it could be that, theoretically, a patient could be seen on a Monday under one clinic provider and come back Tuesday under another clinic provider, yet neither provider would know about the other visit were it not for the registered nurse. In addition to multiple providers and documentation systems, each day the bus is in a different location, sometimes two a day. This can lead to problems in case management just by sheer confusion of where each patient is located. The Health Insurance Portability and Accountability Act of 1996 [HIPAA] is another consideration in the struggle for case management. This affects the viewing of electronic health records kept by each clinic on different days, as well as patient education and follow up on such a crowded bus filled with patients, health science students, and providers.

As if these problems weren't enough, funding for the bus is not guaranteed. The Mobile Outreach Clinic is funded by national grants and private and public donors. Even the providers staffed on the bus are a donation from their respective organizations. Therefore, the issue arises of how to develop a sustainable, cost and time efficient case management system for patients seen on the bus requiring extensive coordination of healthcare in the face of these aforementioned problems.

Project Objectives

The objectives of this project included assessing case management needs on the Mobile Outreach Clinic, in collaboration with the nurse, to establish a case management system to address the assessed needs, and developing an evaluation plan in collaboration with the nurse in order to evaluate the effectiveness of the case management system. The goal was to design a sustainable system of case management in which patients who visited the Mobile Outreach Clinic with chronic, complex, or new onset health conditions would be followed up, educated, and referred appropriately. This idea of case management leads to a more coordinated provision of care. Yet, before any intervention could take place, extensive assessment of the current state of the bus, the difficulties it faces, and the need for case management had to occur. Assessment findings have already been presented in the history section of this paper, which discussed the history of the bus, the problems it faces, the services it provides, the population it serves, the providers it employs, and the role of the sole nurse on the bus. These assessment findings helped to direct how a system of case management could appropriately fit into the workings of the bus. It is important to note that a system cannot be fully sustainable and optimally functioning if the entity that system was designed for is not part of the design process (Milio, 1970). This is a basic principle in community nursing. The intervention designed took shape as two forms designed to

organize referral for case management, as well as to document the education, follow up and planning of care that was done. After developing the case management system, the hope was to be able to evaluate if the system was actually functioning efficiently and helping patients lead healthier and more coordinated lives.

Intervention Design

As stated previously, contacting the patients for follow up is extremely important. If a patient cannot be reached, it is impossible to coordinate care and efficiently work to improve health outcomes. A large part of the assessment went to understanding why these patients are so difficult to reach. A lot of the patients seen on the bus are low income individuals who might not have a cellular phone, home phone, or even a permanent residence. For this reason, not only was the patient's basic contact information, such as personal address and phone number, included on the form for referral for case management, but extended contact information, such as an alternate contact name, phone number, and additional phone number, was included on the form. This way another close friend or family member of the patient may be able to be reached and could direct the search for contacting the patient. It is important to note here that the alternate contact would not be given information about the patient's medical history and/or reason for case management, lest privacy violations occur (U.S. Department of Health and Human Services, 2002). This extended contact is only used as a means to reach the patient when traditional forms of contact have failed.

A continuation of the assessment of the issues that the Mobile Outreach Clinic faces found common health conditions that were frequently encountered. These issues included family planning and sexually transmitted disease testing and diagnosing, chronic health conditions such as diabetes and hypertension, acute health conditions such as common colds, aches and pains,

dental concerns, rashes, sore throats, and adult and children physicals for school, sports, and work. The patients with chronic health conditions and newly diagnosed illnesses are the targeted populations for this project. The form developed for initial referral for case management includes the most common chronic health conditions and newly diagnosed illnesses that are seen on the bus. When a patient is initially referred for case management, the nurse being able to circle a category allows the process to be organized and expedited, which is especially important when more patients are waiting to be seen on the bus. This was chosen over leaving just a blank space to write in the issue regarding referral for case management because the design was more time efficient.

Notably, it was necessary to include a blanket privacy statement on the form so that the patient knows exactly why they are being referred for case management. This was also important so that the patient would know which members on their healthcare team might be privy to their medical information, on a need to know basis only (U.S. Department of Health and Human Services, 2002).

In addition to the initial referral form, a progress form was also developed in which narrative notes can be taken to provide a comprehensive picture of that patient and how their healthcare is being managed. Since there is only one nurse working on the bus and it is impossible to physically follow up and coordinate the care of every patient that would require case management, it was suggested to expand the duties of case management to the junior nursing students in the Baccalaureate nursing program at UF during their community health experience. This is another reason why the privacy statement previously mentioned was so important. The patient needs to understand that it may be a student following up, educating, and

helping with their care in order for informed consent for case management to occur (see Appendices A and B for complete initial referral form and progress notes form, respectively).

At the time of writing this paper, evaluation of the proposed system of case management on the Mobile Outreach Clinic has not yet taken place. Due to scheduling difficulties with junior nursing students, the bus, and the registered nurse, the forms have yet to be used to their full potential. Upon evaluation however, there is hope that patients who are referred for case management are appropriately followed up within a timely manner. Follow up may include coordinating care, education, encouragement, empowerment, advocacy, scheduling appointments, etc. By documenting a patient's progress on the progress notes form, improvements in health and coordination of services and care provided will likely be seen. Overall general improvement of health is a pertinent goal in the future evaluation of this project.

Role in the Project

From the beginning of the project, I assessed the whole situation contributing to the lack of much needed case management on the Mobile Outreach Clinic. This took the longest part of the project and at some times even seemed to be going nowhere. Once one problem in regards to case management was understood, another would spring up. After a lengthy and ongoing assessment, I developed the forms and organizational folder system that is going to be used as a gateway to case management on the bus. This also took a while because each version of both the initial referral form and the progress notes form had to be screened and fixed in order to develop the best working form possible. My future role in the project will to be to implement the use of the forms and actually begin educating, following up, and coordinating the healthcare of the patients referred for case management. After the form has been used for a while, I hope to evaluate the effectiveness and make necessary changes where appropriate.

Problems Faced

As with any group project, scheduling is always a difficulty that is encountered. It was hard to find a good time where school, work, and the nurse's schedule on the bus all correlated. However, once a day was found that schedules worked out, it was important to stick with that day weekly in order to work on the project. In addition to the stress of scheduling, the hassle of HIPAA presented when trying to think of a way to get in contact with patients through other family members or friends, and when trying to figure out just exactly how to keep a patient's information private among students potentially helping out with the project, as well as other patients present on a crowded bus. Therefore, the privacy statement was included and a secure way to keep the medical information in a locked bag was developed. I think most difficult to deal with at first though was the vast idea of case management, which involves and incorporates so many other public health nursing interventions that it's hard to differentiate among them. It was also hard to even come up with just a working definition for case management, as it is such a broad concept. I found that my idea of what case management was and entails changed over the course of this project. Where I came into this project thinking that the forms developed were what case management was, I now see those forms as only a means to the bigger picture of managing a patient's care. However, I think I learned the most valuable lesson in public health, which is that once one problem is solved, the solution leads to the discovery of another problem. It's easy to get overwhelmed in something as big as public health, but I've learned how important it is to focus on one problem at a time and not try to solve everything at once. If I've learned anything throughout this project, it is to be accepting of the uncertainty of public health.

Learning Experiences

In addition to what's previously been stated as lessons learned, I definitely learned how important it is to be assertive in public health nursing. If the patient is the nurse's top priority (Fowler, 2008), and the public health field focuses on improving health and preventing disparities, the public health nurse's priority is to design interventions that facilitate reaching this goal. However, one must be assertive to do so because the public health nurse is typically autonomous and independent. Along those same lines, I learned how interconnected all aspects of public health and community life really are. If a patient has a low income, that not only affects their housing, nutrition status, and general overall health, it also affects their communication capabilities as evidenced by transient phone numbers and addresses. Throughout this project I have also learned the ongoing nature of all public health interventions. They do not just start and stop precisely, they can wax and wane, but are always developing. Lastly, because of participating in an honors seminar and project, I fully understand now that the way to advance the nursing profession is to get involved and contribute to the growing body of research. The only way nurses can make safer and better practices for patients is to get involved.

Summary

Overall, the purpose of this paper was to discuss the importance of case management in the underserved and uninsured population, explore the difficulties that the Mobile Outreach Clinic faces in developing an efficient system for case management, and describe in detail the project at hand which focused on creating a working system for case management of the individuals seen on the Mobile Outreach Clinic. A lengthy assessment of the current Mobile Outreach Clinic, problems it faces, the population it serves, and the lack of a working system of case management was performed. Assessment findings led to the development of two forms, an initial referral form and progress notes form, which allowed for an organized case management

system to arise. At the writing of this paper, evaluation of the case management system has not occurred, however expectations include the outcome of improvements in the health of the underserved and uninsured population that the Mobile Outreach Clinic reaches by optimizing the coordination and provision of services through the use of follow up, education, and healthcare planning.

Current literature has shown the importance of case management in an underserved and uninsured population at risk for increased health disparities. By empowering these patients through the appropriate coordination of services provided and planning of healthcare, the hope is for a healthier community. Steps have been taken to better provide Mobile Outreach Clinic patients requiring case management a way to improve their health.

Conclusively, working on this honors project has exemplified one of the most effective ways that nurses can positively change the outcomes for their patients, by getting involved. This was an extremely important lesson to learn and one that will not be soon forgotten. Only through immersion in this project could the lessons of public health nursing and meaning of the broad concept of case management be taught and experienced. By personally contributing to the assessment, formation, and future evaluation of the project, scholastic achievement has been accrued. Only by this push towards excellence will the nursing profession better the outcomes for present and future patients.

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Appendix A

Initial Referral Form Example

Name: _____ Date of Birth: _____

Address: _____ Alternate Contact: _____

_____ Alternate Phone #: _____

Phone #: _____ Additional Phone #: _____

Needs Follow Up and/or Education On:

Diabetes	New Pregnancy	Family Planning	Smoking Cessation
Heart Disease	New Diagnosis	Test/Procedure	Obesity
Wound Care	Lab Work	STD Counseling	

Other:

_____
_____
_____
_____
_____

I, _____, give the Mobile Outreach Clinic and those working for its purposes permission to _____.

Printed Name _____ Signature _____ Date _____

Appendix B

Progress Notes Form Example

Page _____

Name: _____ Date of Birth: _____

Case Management Progress Notes

Date	Health Issue/Concern