CARE COORDINATION FOR MEDICAID BENEFICIARIES:

PAPER 3:
NEXT STEPS FOR COLORADO

Prepared for the:
Colorado Department of Health Care Policy and Financing

Shana Montrose
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Paper 3

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Request For Information Questions; Page 16
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Executive Summary

This is the third paper in the Care Coordination series. The first paper is a literature review and the second paper provides a landscape analysis of care coordination in Medicaid programs in Colorado. This paper identifies the next steps for Colorado based on the information in the previous two papers.

Literature review
The literature review provides insight on how the topic of care coordination has developed so far. The current body of literature contains many theories, but is void of agreement concerning best practices. This is in part because the concept of care coordination lacks a universal definition. Because care coordination means different things to different people, health care practitioners have found it difficult to agree on a single definition which provides the answer to the best care for all patients. As a consequence, there has been an array of pilot programs that test variations of the concept; however, the variations often result in diverse data and no useful way to compare the studies.

Pilot programs tend to target varying populations; these populations could be residents based in a particular geographic location, enrollees in a particular Medicaid program, or individuals with similar health statuses or with the same condition. Many of these projects were evaluated too soon and were prematurely judged to be unsuccessful in reducing the cost of health care; it is likely that these programs needed more time to evolve, as high start-up costs and lack of time to build community awareness probably led to skewed short-term results.

Results for measures of health impact are also mixed, in part because of the lack of standard measures and because it is difficult to adjust for risk across dissimilar pilots. Care coordination is particularly difficult to measure because it lacks a clear definition; additionally, many activities of care coordination are not separated from other clinical, administrative and patient support duties and are often not reimbursed by fee-for-service (which makes them difficult to track).

Landscape analysis
After studying the literature, we mapped the system of care coordination in Colorado. The landscape analysis compares program characteristics including legeal authority, payment systems, qualifications of care coordinators and target populations. We mapped which populations are served by which programs and the network interactions of the programs that deliver care coordination. Finally, we examined which care coordination activities are required by program and which of these were most successfully achieved. The result of the landscape analysis mirrored the confusion that surfaced in the literature review: there is little agreement on what care coordination is, who is responsible for what activities; and a patchwork web of programs, services and clients. The landscape analysis revealed the need to revisit care coordination in Medicaid programs to prevent against gaps in service delivery as well as to prevent against over utilizations. This paper makes recommendations for initiating such a process of review and reform.

This paper: population segmentation, coordinating the care coordinators, and next steps for Colorado

This paper focuses on three topics: population segmentation and coordinating the care coordinators, as well as next steps. There is increasingly a trend toward focusing on high-cost, complex chronic condition patients. This paper suggests maintaining this focus while incorporating high-cost complex patients into a broader system of care coordination, which provides the appropriate level of care for each patient based on the complexity of the case and the patient's willingness and ability to self-manage. A hybrid model is presented that combined the Bridges to Health model, which is rather holistic, and the Treo Solutions model, which is data driven.

The second section highlights the problem of lack of organization of care coordinators in the Medicaid system. We know that some clients who would benefit from care coordination do not receive these services while other patients are inundated with care coordinators who are not in communication with each other, thus defeating the purpose. An example of a patient with relatively minor chronic conditions is provided to show the complexity of the system , then a more manageable model is provided for contrast. This paper argues that by coordinating the care coordinators, patient safety will improve, business processes will be streamlined, the patient experience will improve, and over-utilization will be reduced.

This paper concludes by planning for next steps for Colorado Medicaid, based on the information collected in the landscape analysis of Paper 2. The experience of studying care coordination in Medicaid revealed how little understanding we have of what care coordination entails and whether it is working. The list of suggested next steps begins with further study of the problem, which will require extensive stakeholder engagement and would benefit from 1281 funding and the SIM proposal to incorporate care coordination into health reform initiatives in the state. The recommendation is to start with small pilots and to slowly build from there. This paper concludes with a list of questions to be issued as a request for information from the community stakeholders that can be used in the study and its stakeholder engagement phases.

The appendix includes two documents that support next steps for Colorado Medicaid. The first is a client survey that could be used to better understand care coordination from the Colorado Medicaid client perspective. The second is the AmeriCorps program developed by The Camden Coalition; which hires AmeriCorps volunteers as community health coaches. Colorado could replicate this model while planning next steps.

Developing a Care Coordination Model for Colorado Medicaid

Population Segmentation

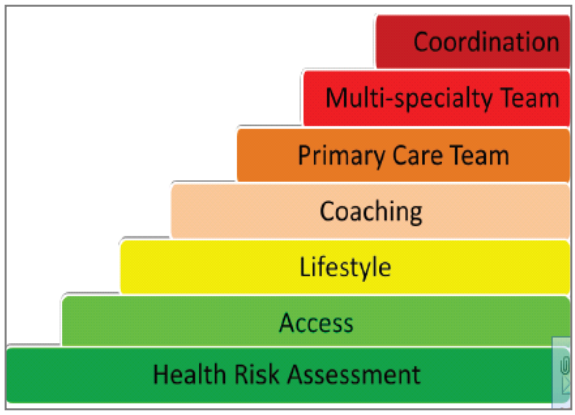
Paper 1 reviews models in the literature for patient segmentation and identifies a trend toward targeting high-cost patients with multiple chronic conditions. Various models are distinguished by the way high-cost patients are described and subcategorized and by the extent to which non-high cost patients or patients without multiple chronic conditions are included in the model. The Bridges to Health model is the most comprehensive, offering a life cycle approach that takes patients from birth to death and from health to illness.

Bridges to Health and Treo Solutions

Treo Solutions has developed a similar model. The primary difference is the Bridges to Health model is more descriptive and more subjective, while the Treo Model is somewhat less descriptive, but much more precise in its ability to use claims data to categorize patients. Terms such as "normal function" and "likely return to health" used in the Bridges to Health model may require the opinion of a medical practitioner whereas pregnancy could be determined through claims data alone.

Treo's intervention pyramid

Treo Solutions has recently developed a pyramid-shaped model that provides basic care coordination services to the entire population, while building in additional services as patients' needs increase. Colorado should consider such a model so that all patients are connected to care coordination at the level appropriate to their needs. Resources should be directed to patients with multiple and serious chronic conditions, but be available to other clients in the Medicaid system.



Care coordination for "healthy" clients

It is not clear whether care coordination for low-cost patients offers a sufficient return on investment and therefore should be offered conservatively; however, there may be some value in identifying a care coordinator for patients before they take ill and in developing relationships and a culture of care coordination so "healthy" patients understand and feel comfortable with this system early in their experience of Medicaid. Care coordination, especially when engaged with healthy clients, must be seen as increasing client convenience and support rather than creating another layer of bureaucracy.

Local models

Rocky Mountain Health Plan, of Region 1, developed the following model for Durango. Other RCCOs have similar models of levels of care coordination. This model focuses not on the diagnosis, but rather on the patient's ability to manage the condition and the extent to which the "disease process" is controlled. Local models such as this one should be viewed as essential sources of knowledge and experience as the Department develops a more comprehensive care coordination program.

RCCO 1: Care coordination levels

Level 1 – Preventative Care, Wellness Care
The Member receives a call to help establish a primary care physician (PCP) or practice. The Member will receive reminders for annual and preventative care screenings.

Level 2 – Well-controlled disease process; Member with good self-management skills
The Member has a single, well-managed chronic disease and support is provided for the Member to continue his or her disease process. The Member is triaged based upon his/her chronic disease; the Disease Manager provides disease-specific materials and helps the Member to obtain his/her health and wellness goals.

Level 3a – Moderately well-managed Disease Process (controlled and uncontrolled periods and referrals to specialists required)
This level includes more robust support for the Member to self-manage his or her disease process. This may include community classes, Care Coordinator phone calls, or consults with ancillary professionals (e.g., nutritionists) in practice settings.

Level 4 – Complex Outpatient Care Coordination – Poorly controlled disease process
Typically, the Member at this level will have multiple morbidities and multiple barriers to accessing the appropriate care. Locally based Care Coordinators will build trust-based patient-centered relationships to facilitate the Member's ability to effectively navigate the health care system; they will also facilitate the numerous providers and Care Coordinators in contact with the Member to effectively care for the Member. Care Coordinators focus on the immediate needs of the Member. Activities may include home visits, accompanying the Member to appointments, helping the Member access financial and social programs, and supporting other activities as needed. The Nurse Navigators, based out of the San Juan Basin Health Department, provide complex case management for any Member who is classified at this level.

Level 5 – Transitions of Care
In the course of an acute exacerbation of an illness, the Member might receive care from a PCMP or specialist in an outpatient setting, then transition to a hospital admission before moving on to yet another care team at a skilled nursing facility. Finally, the Member might return home, where he/she would receive care from a Home Health nurse. Each of these shifts from care providers and settings is defined as a care transition and local Care Coordinators will work with the Member to manage these transitions. Members in acute facilities are automatically enrolled for Care Coordination services. The Nurse Navigators coordinate with all of the Member's providers and help with the transition to the Member's home or the next level of care.

Status check: Colorado

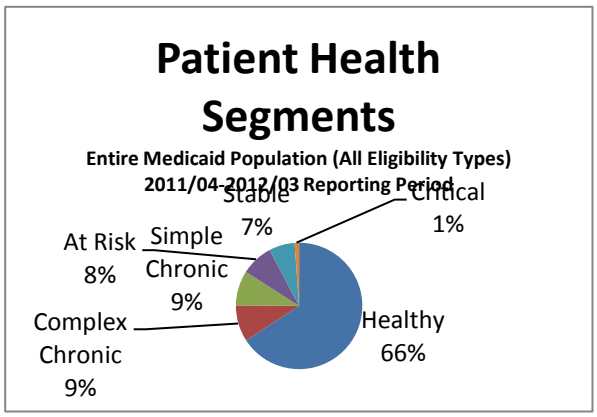
Landscape analysis reveals lack of uniformity in method and service delivery
In the landscape analysis (Paper 2) we see that most Medicaid programs offer care coordination to clients in need of these services rather than uniformly to all clients. The exceptions are specialized programs in which eligible clients are, by definition, in need of care coordination; these programs coordinate care for 100% of their members. "Need," however, remains undefined at the program level and is not standardized at the department level. Need should be determined by the Department with input from both providers and clients, and based on flexible guidelines rather than inflexible definitions within reason of resource capacity. The landscape analysis shows that programs offer varying combinations of care coordination activities – some of which are required and others which are not required, but offered. These programs show varying degrees of success.

Directions for the Department
The Department might consider designing a comprehensive system of care coordination by accomplishing the following:

1. Define major health condition levels with attention to levels of self-management capacity (see text box above: RCCO 1 Levels of care coordination)
2. Define health status indicator taxonomy within major health condition levels
3. Define level of care coordination
4. Determine which program can best provide appropriate level of care coordination
5. Define funding mechanisms and guidelines for reimbursement

Applicants for 1281 funding should be encouraged to submit proposals that address and test these requirements. The State Improvement Model application to CMS should also consider new approaches to a comprehensive system of care coordination.

The pie chart below shows the breakdown of all Medicaid patients by health segments as defined by Treo Solutions. (A caution: these are estimates and may be slightly skewed by the inclusion of CHIP and managed care segments.)



Treo Solutions

A hybrid model

The diagram below borrows and combines concepts from the Bridges to Health model and the Treo Solutions model. In this model, all clients start at "healthy," with the exception of babies and children who are born with health concerns and enter programs designed to meet specific pediatric needs. The pediatric program will need to be further developed in consultation with pediatric experts at the Department, as well as with stakeholders.

Life cycle

The hybrid model follows a life cycle flow in which there are many routes toward eventual decline. The first stage is maternity, in which many women will enter the healthcare system and where a new patient's life begins. The majority of pregnancies will be low-risk and can be managed at the primary care level. A few pregnancies that are high-risk may lead to more acute and potentially critical levels, as shown with arrows in the diagram.

Flexibility of the model

All adults will eventually move from healthy to either acute or chronic condition health status. Each of these statuses can move directly to critical and decline, but most often there will be intermediary stages of "normal function" or "significant but stable" (there is mobility between these as well). The level of independent functioning, self-management and illness severity should impact the level of care coordination required. Eventually these patients will move into the critical phase and into decline, which is further divided into short-term and long-term decline.

Determining levels of care

The status indicator (second column) helps a care coordinator make decisions about the level of care for each client (third column). Arrows in the third column represent mobility between levels of care. Primary care will cover the majority of the population from healthy to pregnant and acute and chronic. Managed care is somewhat parallel to primary care and depends more on financing differences than client health status. These settings are represented in Colorado by the ACC and MCO programs, which could remain separate or become integrated.

Transitions

The focal point of future discussions should be the transition of patients with chronic conditions from primary and managed care to levels of care that offer more intensive care coordination. The options shown in the diagram are: home and community options, nursing facility options, hospice, as well as the option of remaining in the current level of care if the patient's needs are met.

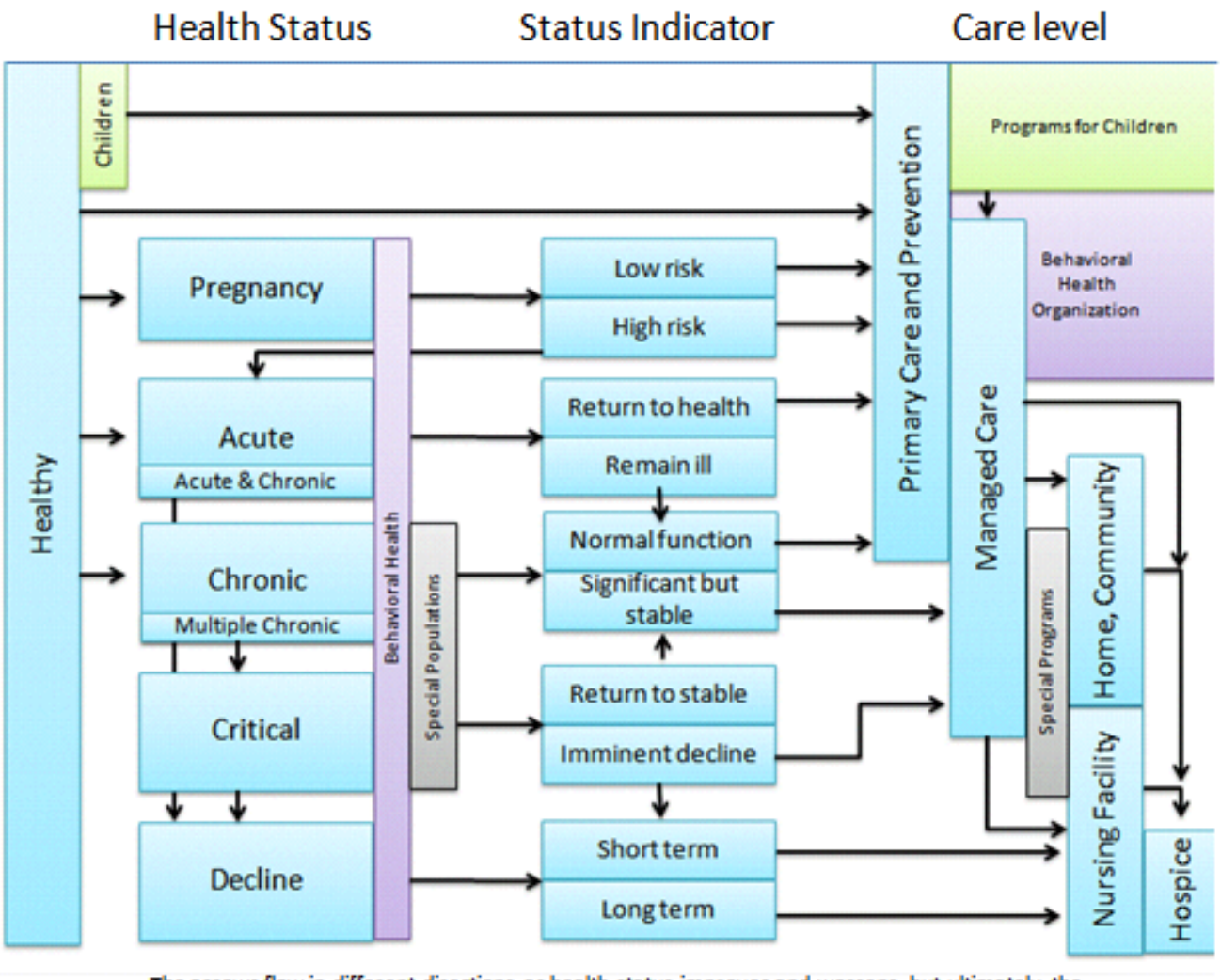
Eventually many patients will choose hospice as a final option. Transitions from each level of care program or setting must be carefully planned and ideally will rely on advanced technological systems that facilitate seamless transitions.

Children with health concerns are served in special programs. Healthy children become healthy adults.

Healthy individuals receive primary care and prevention; they will eventually have acute problems or chronic conditions.

Acute problems may be resolved or become more serious. Chronic conditions will stabilize or become more serious.

Serious problems become critical and either resolve or lead to decline.



The arrows flow in different directions as health status improves and worsens, but ultimately the arrows flow through the life cycle, indicating different levels of care for different life stages.

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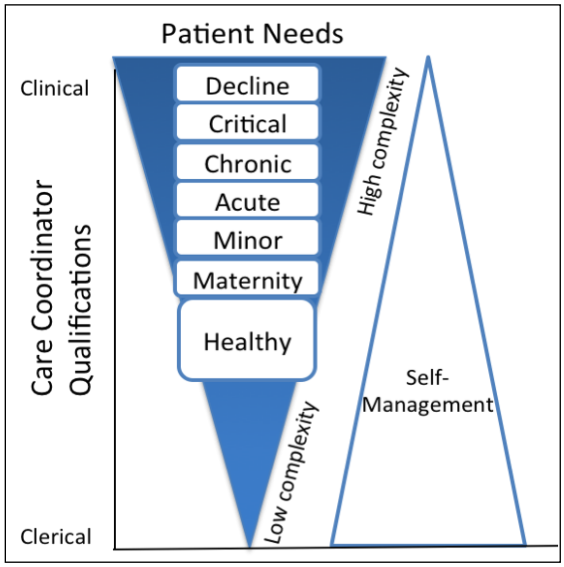
More on the hybrid model
The model below shows that as patients' cases become increasingly complex, their needs increase. As patients' needs increase, the ability of these patients to self-manage decreases, and the responsibilities of the care coordinators increase.

Patient Needs
Lower complexity clients are associated with greater ability to self-manage; they should be encouraged and supported to do so. Health status levels are associated with care coordination levels. **Supportive care** coordination should be available to healthy clients, pregnant women and infants, and clients with minor conditions that are well managed. **Active care** coordination should focus on clients who require additional assistance managing stable acute and chronic conditions with some exacerbations. **Intensive care coordination** is needed for clients in critical condition and/or in declining health, whether the decline is short- or long-term. The settings for clients at these levels will differ as they progress from health to decline.



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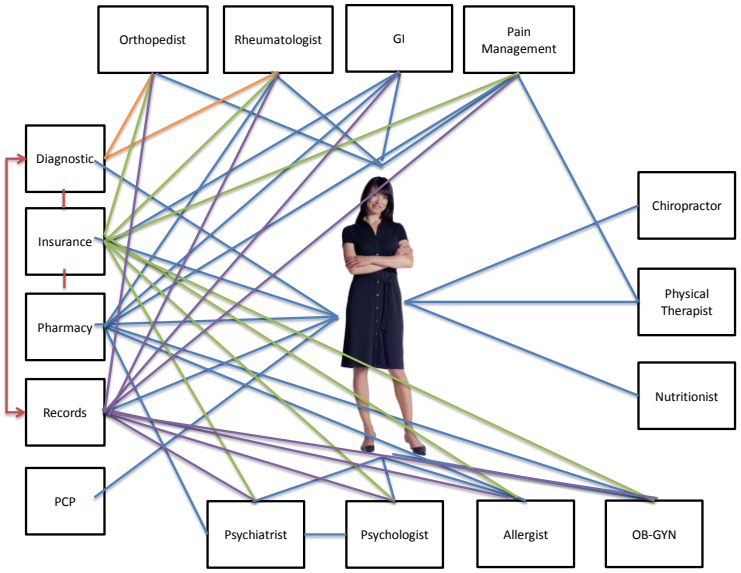
Care Coordinators
As complexity of clients' cases increase, so too should the qualification requirements to work with these clients. Some models focus on the medical group practice, holding PCPs responsible for care coordination; other approaches explore alternatives, such as health coaches. The RCCOs are testing care coordination at different levels; the existing Medicaid programs employ care coordinators at different levels of certification and experience. These models should be compared in order to determine what level of employee is best suited for each level of care coordination and cost effectiveness. The Camden Coalition AmeriCorps health coach model is especially interesting because it employs low-cost pre-medical students with links to the community to support more advanced nurse practitioners. The Department should explore models that pair up care coordinators, with each coordinator at a different career level or representing different expertise (such as an RN with an MSW).

Coordinating the Care Coordinators

Another important next step for the Department is to interview or survey clients and care coordinators, in order to understand what works best on the ground. As an example, the figure below shows a client experience prior to enrollment in the ACC. This sample demonstrates the complexity of managing a minor chronic condition, fibromyalgia, without the assistance of a care coordinator.

Life without a care coordinator

Prior to receiving care coordination services, the patient managed her own care. This patient has fibromyalgia and asthma; she moves between Medicaid and employer sponsored insurance. Her PCP was not in communication with the specialists to which he referred her and the specialists were not in communication with each other. Her insurance changed as she moved and as her income fluctuated. She kept a large file of her medical records and took them to appointments; there was no central repository and they were often lost. She had to walk her lab order from the PCP to the lab and then fax the bill to her insurance company. She experienced adverse medication interactions and sometimes took her medication every other day because she could not afford the non-formulary drug the physician prescribed. There was a generic that was shown to be equally effective, but she did not know about it. Managing her care is a full time job – on top of the full time job she already has. Care coordination is even more essential for patients with more severe conditions and less ability to advocate for themselves.



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Fibromyalgia *is a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues. Many people who have fibromyalgia also have tension headaches, irritable bowel syndrome, anxiety and depression. While there is no cure for fibromyalgia, a variety of medications can help control symptoms. Exercise, relaxation and stress-reduction measures also may help. (Mayo Clinic, 2011) This patient has a second chronic condition, asthma, which is managed by her allergist.*

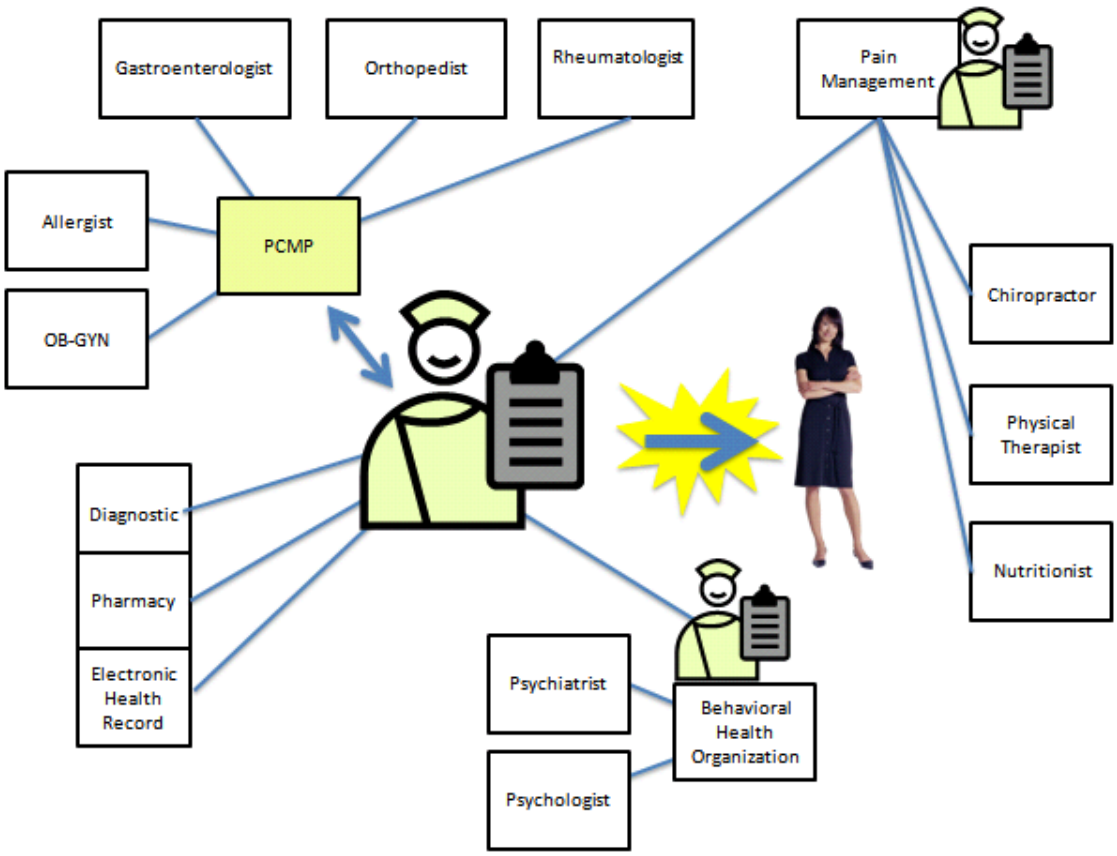
Too many care coordinators

The other problem is having too many care coordinators. This will be discussed in future papers that will include the results of the client survey. Anecdotal evidence suggests that some patients have so many care coordinators, who are working in silos, that care coordination leads to confusion and delay rather than to simplification and speed.

Improving care coordination

The figure below shows one possible scenario for improved care coordination, in which the patient and care coordinator are at the center and information flows through the care coordinator. In this scenario there are secondary care coordinators at the pain management clinic (a private clinic that accepts Medicaid) and at the Behavioral Health Organization (a Medicaid program). The PCMP (Primary Care Medical Provider, the RCCO term for PCP) coordinates the specialists and feeds that information to the primary care coordinator. The primary care coordinator, a nurse or health coach, works directly with the lab and pharmacy, and manages the electronic health record. The primary care coordinator works directly with the patient, when needed, and otherwise manages operations without burdening the patient. The benefits of such a model include:

1. Increased patient safety
2. Streamlined business process
3. Improved patient experience
4. Reduction of over-utilization



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Increased patient safety
Patient safety is at risk when information about the patient's care is decentralized and communication channels are weak. The most common risk, which is potentially life threatening, is adverse medication interaction. Risk is also high during transitions from one specialist or setting to another. A care coordinator can help manage communications and transitions by maintaining a care plan and ensuring that everyone involved in the patient's care understands and contributes to the plan.

Streamlined business process
Well-functioning businesses commit resources to organizing their processes into the most streamlined, efficient, and effective models possible. There are a few examples of best-practices in healthcare organization and management, but most of the system is poorly organized and outcomes suffer as a result. Money is wasted, the system is ripe for abuse, and patients' health outcomes remain at risk. The care coordinator can serve as a liaison between the delivery system and the patients, translating patients' needs to a system that can respond effectively.

Improved patient experience
Some patients have a phobia of going to the doctor; others avoid the healthcare delivery system because of the frustration it causes or because it is so complex and difficult to navigate. Good healthcare should reduce stress rather than increase it. Patients and families are often dealing with medical issues that are emotionally taxing. Care coordination can shift the administrative burden from patients and families to professionals; these professionals can also provide emotional support from the patient and/or family, when requested. When patients have negative experiences, they only use the healthcare system when they see no other option. Preventive care, however, requires that patients understand the benefit, feel comfortable in healthcare settings, and be willing to participate in their health and healthcare. Improving the patient experience is an essential starting point in improving population health.

Reduced over-utilization
Care coordinators can help patients manage their own care as well as teach patients to use the healthcare system appropriately. Care coordinators can assist patients in determining the appropriate amount of healthcare. Care coordinators will be the first to flag patients who are over-utilizing the system. The alternative method is to use claims data to identify such patients. However, claims data is delayed at least three months from the time of service and, while data systems can identify the problem, they cannot solve the problem. Care coordinators can use their relationships with patients to modify patient behavior.

Care coordinators are in position to help patients in shared decision processes. Care coordinators are unbiased patient advocates who can explain the risks and benefits of various treatments. When patients have a better understanding of their options, they are more likely to elect less invasive, and less expensive, treatment options. Care coordinators can serve as a micro-level review board for treatment effectiveness and can direct patients and providers to more cost-effective options when evidence does not favor the most expensive treatment.

Next Steps for Colorado

Changes to the system of care coordination should be slow. The first phase is to study the problems and to approach stakeholders for input for developing solutions. Pilots should be tested: first on a small scale and then carefully expanded to include more clients. Clients should be at the center of the process and should always be aware of their rights to request more or less care coordination and to choose or change their care coordinators.

Project Plan

No.	Phase	Tasks	Progress
0	Concept Papers	Paper 1: Literature review Paper 2: Landscape of Colorado Medicaid programs Paper 3: Next steps for Colorado Paper dissemination	✓ ✓ ✓ started
1	Proposals	Encourage care coordination in SIM to CMS Encourage care coordination in 1281 applications	
2	Study	Other government agency programs Non-governmental programs Create multi-State work-group to exchange ideas Study CMMI grant awardees for care coordination Study 1281 grant awardees for care coordination	
3	Stakeholder Engagement	Survey clients Survey care coordinators Work with RCCOs Hold stakeholder feedback sessions Identify best-practices in Colorado Concept paper 4	started started
4	Small-Scale Pilot	Analyze legal restrictions around care coordination Identify funding sources for pilot Design process Round 1 Evaluate Report 1 Design process Round 2 applying lessons from Round 1 Evaluate Report 2 Feasibility study for scaling up	started started

Staffing

The concept of care coordination is of great importance to the Department; yet, because it is so fundamental and cross-cutting, no one position is devoted to its study and implementation. As demonstrated in this series of papers, there is a need for further study of most topics relating to care coordination. If the Department could devote one FTE to care coordination, that person could collect and disseminate information to the programs to avoid duplication of efforts and to connect various elements, internal and external, of the Department to one another.

Request for Information

A Request for Information is recommended to take place at stakeholder meetings and through written comment.

1. How do you define care coordination? To what extent should the definition be flexible versus standardized?
2. What activities are expected as part of care coordination? To what extent are these formalized? To what extent are these fulfilled?
3. What level of training is required to provide care coordination services? To what extent should this be regulated?
4. What is the ideal role for a PCP to play in care coordination?
5. Are there models in which care coordinators work in pairs, perhaps where the training of each person differs? What are best practices?
6. To what extent are care coordinators over-burdened in your community? To what extent are care coordinators territorial in your community?
7. What is an appropriate caseload for care coordinators? What are the risks and benefits associated with caseload size?
8. What resources do care coordinators require? Are these resource needs met in your community?
9. What is your experience with telephone versus in-person care coordination?
10. Through what mechanisms are care coordinators paid? To what extent is there a dollar amount associated with a care coordination activity?
11. Do you believe a global payment, FFS payment, or hybrid model such as the ACC, that provides a care coordination (PMPM) payment in addition to FFS reimbursement, is most effective for delivering coordinated care? For reducing healthcare costs? For improving patient health outcomes?
12. What components are essential to a client's care plan? At what point should a plan be developed? How often should it be updated? Should care plans be flexible or standardized? Or have standard elements with the option to add?
13. What are the best ways to encourage patient and family engagement in care coordination?
14. Does care coordination have a role to play in encouraging evidence-based medicine?
15. Should care coordinators be gatekeepers to ensure appropriate use of the healthcare system or should they be patient advocates? How would we achieve this?
16. What information about the client is most important to the care coordinator? What information is available to care coordinators now? What information is not available or easily accessible?
17. What data must be collected to evaluate the success of a care coordination program? To what extent should this data be captured in a standardized way and compared across programs?
18. If patients were to receive a certain level of care coordination based on some condition, what would that condition be? What level of care coordination would be available to which groups of clients?

Appendix

Client Survey

Note: This has not gone through clearance. We are waiting for consensus on the population categories.

Dear Program Manager or Healthcare Professional:

The Colorado Department of Health Care Policy and Financing is seeking clients who can articulate their experience in the health care system, or who would agree to be interviewed by a care giver or case manager who can articulate that experience. We will interview about 20 clients. We are looking for a mix of clients who fit the following categories:

> **Healthy:** *Patient rarely sees a doctor; when he/she does, it is for an annual physical, sore throat or broken finger, etc.*
>
> **Maternity or Infant:** *Patient seeks healthcare for purposes of family planning, pregnancy care, or newborn check-ups.*
>
> **Acutely Ill:** ***Patient has experienced*** *broken bones, short stints in hospital for infection, minor procedures, etc.; issues are resolved within six months or less.*
>
> **Chronic condition, normal function:** *Patient has a condition such as asthma, heart disease, or diabetes, which is managed with regular check-ups and medication; he/she may experience occasional complications.*
>
> **Stable but serious disability:** *Patient has a condition which affects daily life, independence and functioning; patient may be blind, use a wheel chair, need an oxygen tank, or have a serious mental health condition such as schizophrenia.*
>
> **Unstable condition:** *Patient is no longer able to take care him/herself and is no longer able to work; patient needs nursing home or hospice services; his/her condition is not improving.*

We are not collecting personally identifiable information, but will need to know how to contact clients who are interested in participating. If a client prefers that the Department does not know his/her contact information, the survey can be given to a nurse or care coordinator who can protect the identity of the client and administer the survey on behalf of the Department.

Do you know of clients who are willing to share their experience who fit into any of the groups listed above? If so, please e-mail XXXXXX by XXXXX with information about which of the listed categories he/she fits and his/her level of willingness to speak with someone about his/her experience. Below is the language of the consent section of the survey that you can share with clients who have questions about their privacy.

Consent Language on Survey

This is a survey to understand how the health care system works. The information you are asked is general and your answers are confidential. You have the right to decline any or all questions. You have a right to request a copy of any reports that are generated using this information. All of your information will be kept confidential and will only be used by the staff at the Department of Health Care Policy and Financing.

Instructions to Surveyor

- ☐ When possible please read the questions to the client to reduce confusion.
- ☐ When conducting the survey orally, all answer choices must be read aloud.
- ☐ One respondent can complete the survey for multiple people, but each individual must be represented by a different survey. For example if a woman completes the survey for herself, her child, and her elderly parent, there should be 3 surveys.
- ☐ When possible, include a family member, care coordinator, or patient advocate to help the respondent remember details.

Consent

This is a survey to understand how the health care system works. The information you are asked is general and your answers are confidential. You have the right to decline any or all questions. You have a right to request a copy of any reports that are generated using this information. All of your information will be kept confidential and will only be used by the staff at the Colorado Department of Health Care Policy and Financing.

Sign: _____ Date:_____

Survey Completion

Is it ok if we contact you again in the future to ask more questions about your satisfaction and to get your ideas about improving the system? If yes, please list contact information:

If yes, but would like to remain anonymous, separate this page from the survey.

☐ If a copy of the report is requested, check this box and include email or mailing address information above.

GENERAL INFORMATION

1. Demographic Information

Age	Sex	Race	Eligibility (in past 5 years)	Eligibility (current)	Zip Code (current)
☐ Under 21 ☐ 21-34 ☐ 35-44 ☐ 45-54 ☐ 55- 64 ☐ 65+	☐ Male ☐ Female ☐ Other	☐ White ☐ Black ☐ Latino ☐ Asian ☐ Native American ☐ Other	☐ Medicaid ☐ Medicare ☐ CHP+ ☐ SSI ☐ I don't know	☐ Medicaid ☐ Medicare ☐ CHP+ ☐ SSI ☐ I don't know	

2. Whose health care are you in charge of? (Enter number of people in each box)

Myself only	Children (<18)	Spouse	Parent	Other
No one				

Answer the following questions only for one person. Circle above which person this survey represents.

HEALTH STATUS

3. What description best describes you and your health status? (See descriptions below in italics. Please choose one.)

☐ Healthy
I do not see the doctor, or I see the doctor for an annual physical and for small things like a sore throat or broken finger.

☐ Maternity or Infant
I see the doctor for family planning, pregnancy, or newborn check-ups.

☐ Acutely Ill
Examples 1: I went to the hospital for a broken leg, had minor surgery, and returned to get the cast off and for a follow-up appointment to see how everything healed.
Example 2: I was in the hospital with pneumonia for a week and then at home resting.

☐ Chronic condition, normal function
I have a condition like asthma, heart disease, or diabetes that I manage with regular check-ups and medication. I see the doctor when I have complications.

☐ Stable but serious disability
My condition affects my daily life. For example, I am in a wheelchair, I'm blind, I have oxygen delivered to my home, or I am unable to work or sometimes miss work because of my disability.

☐ Unstable condition
I am no longer able to take care of myself. I use nursing home or hospice services. My condition is not improving.

TRAVEL

4. Travel

How far do you have to travel to see your primary doctor (PCP)?

☐ 0-30 Miles
☐ More than 30 miles
☐ I don't know

5. How far do you have to travel to see the specialist you most often visit?

☐ 0-30 Miles
☐ More than 30 miles
☐ I don't know

What is that specialty? _____

6. How far do you have to travel to see the specialist you see most often after the specialist listed above?

☐ 0-30 Miles
☐ More than 30 miles
☐ I don't know

What is that specialty? _____

7. Is travel a barrier for you? (Select all that apply)

☐ Yes, my doctors are too far away
☐ Yes, I have trouble arranging transportation to go to the doctor
☐ Yes, it is difficult for me / I prefer not to leave my home
☐ Yes, I do not have the time it takes to see my doctors
☐ No, it's worth the trouble most of the time
☐ No, it's convenient for me most of the time
☐ No, I receive transportation assistance through Medicaid or another program

Additional Comments:

PHARMACY AND LABS

8. Estimate the number of unique prescriptions (no refills of the same prescription) you've filled (just for the one person represented by this survey) in the past 6 months. This includes anything you get at the pharmacy: pills, creams, liquids, sprays, inhalers, injections you administer at home.

- ☐ 0 - 5
- ☐ 6 - 10
- ☐ 11 - 15
- ☐ 16 - 20
- ☐ 21 - 30
- ☐ More than 30

9. How many pharmacies (not mail-order) have you used in the past 3 months?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 or more
- ☐ Check here if you use mail-order in addition to a pharmacy
- ☐ Check here if you only use mail-order and do not pick up prescriptions at a pharmacy

10. When you get lab results where do they go? (Select all that apply)

☐	To me	N/A	Never	Sometimes	Always
☐	To my primary care physician (PCP)	N/A	Never	Sometimes	Always
☐	To my care coordinator	N/A	Never	Sometimes	Always
☐	They sit at the lab or are lost	N/A	Never	Sometimes	Always
☐	To my health insurance	N/A	Never	Sometimes	Always
☐	To my electronic medical record	N/A	Never	Sometimes	Always
☐	Other:	N/A	Never	Sometimes	Always
☐	I don't know				

DOCTORS AND CONDITIONS

11. What doctors and specialists have you seen in the past 2 years? (Select all that apply)

- ☐ Allergist
- ☐ Cardiologist
- ☐ Dentist
- ☐ Emergency room
- ☐ Endocrinologist
- ☐ Otolaryngology (ENT)
- ☐ Gastroenterologist
- ☐ Internist
- ☐ Lab technician
- ☐ Neurologist
- ☐ OB-GYN
- ☐ Oncologist
- ☐ Ophthalmologist
- ☐ Orthodontist
- ☐ Orthopedic
- ☐ Podiatrist
- ☐ Pulmonologist
- ☐ Rheumatologist
- ☐ Primary care provider (PCP)*
- ☐ Prosthodonist
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Urologist
- ☐ Other:

*PCPs may be health centers, clinics or other group practices that provide the majority of comprehensive primary, preventive and sick care. A PCP can be a physician, advanced practice nurse, or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology (women's health).

12. Have you been treated for any of the following conditions in the past 2 years? Treatment includes medication, doctor or hospital visit, therapy, medical device like a knee brace, testing through blood work or an X-Ray or having a procedure such as surgery. (Select all that apply)

- ☐ Acute Problem (<3 months)
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Medical Device
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Pace Maker
- ☐ Prostrate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Ulcers
- ☐ Vision Problems (not Blind)
- ☐ X-Ray, MRI, CT
- ☐ Other:
- ☐ Other:
- ☐ Other:

PROGRAMS AND PAYMENT

13. How have you PAID for healthcare in the past 2 years? (Select all that apply)

- ☐ Medicaid
- ☐ CHP+
- ☐ Medicare
- ☐ Tricare
- ☐ VA
- ☐ Indian Health Service
- ☐ No insurance, used emergency room
- ☐ No insurance, used clinic
- ☐ Other
- ☐ I don't know

14. What programs have you been enrolled in during the past 2 years? (Select all that apply)

- ☐ Accountable Care Collaborative (ACC)
- ☐ Behavioral Health Organization (BHO)
- ☐ Community Center Boards (CCB)
- ☐ CHP+/Healthy Communities
- ☐ Children with life limiting illness
- ☐ Children's Medical Home
- ☐ Dual Eligible Demonstration
- ☐ EPSDT/Healthy Communities
- ☐ Long Term Care, Long-Term Services and Supports (LTC, LTSS)
- ☐ Home and Community Based Services (HCBS) for Brain Injury, Mental Health, Living with AIDS, Spinal Cord Injury, Supported Living Services, Developmental Disabilities
- ☐ Home and Community Based Services for Elderly, Blind and Disabled
- ☐ Home Health (other than HCBS)
- ☐ Hospice
- ☐ PACE
- ☐ Ryan White or ADAP
- ☐ Single Entry Point
- ☐ Other:
- ☐ Just Medicaid / I don't know

CARE CORDINATION / CASE MANAGEMENT

15. Below are some things that we consider care coordination or case management. Please tell us whether you have received these services in the past 6 months, who has helped you, and whether you need it.

Care Coordination Service	Do you receive this service?				If you answered yes, who provides this service?	
	No, and I don't need it	No, but I need it	Yes, but I don't need it	Yes, and I need it →	Family or friend	Professional
						
Someone went to my appointment with me to help me answer questions, to take notes, or just so I wouldn't be alone	☐	☐	☐	☐	☐	☐
Help understanding insurance and bills and co-pays	☐	☐	☐	☐	☐	☐
Asked me and my family about my preferences	☐	☐	☐	☐	☐	☐
When I had a choice between medication, surgery, or physical therapy someone explained each choice, including the risk of the treatment and the risk of not doing the treatment	☐	☐	☐	☐	☐	☐
Helped get me connected to programs and services in my neighborhood or community	☐	☐	☐	☐	☐	☐
Explained my situation to new doctors, explained one doctor's opinion to another doctor	☐	☐	☐	☐	☐	☐
Helps keep track of my medical records, lab results, etc.	☐	☐	☐	☐	☐	☐
Came to my house to make it easier for me to get around	☐	☐	☐	☐	☐	☐

Care Coordination Service	Do you receive this service?	If you answered yes, who provides this service?				
	No, and I don't need it	No, but I need it	Yes, but I don't need it	Yes, and I need it →	Family or friend	Professional
						
Helps me find doctors and transportation to appointments, makes my appointments, reminds me when I have an appointment coming up	☐	☐	☐	☐	☐	☐
Is there for me when I'm feeling down or frustrated	☐	☐	☐	☐	☐	☐
Helped make a plan for how to manage my healthcare needs	☐	☐	☐	☐	☐	☐
Asked me about my goals for improving my health, managing my condition, or becoming better able to do things on my own	☐	☐	☐	☐	☐	☐
Stands up for me and helps solve problems, filed a complaint	☐	☐	☐	☐	☐	☐
Helped me understand my illness or condition better and how to take care of myself	☐	☐	☐	☐	☐	☐
Translates into my language	☐	☐	☐	☐	☐	☐
Talked to me family about my wishes for end-of-life care	☐	☐	☐	☐	☐	☐

16. How often do you use care coordination services (see the list above)? These activities can be by phone or in person.

- ☐ Never
- ☐ Some weeks but not every week
- ☐ 1-2 time a week
- ☐ 3-5 times a week
- ☐ Almost every day
- ☐ I don't know

17. How happy are you with care coordination (services listed above)?

- ☐ I don't need care coordination
- ☐ I am very happy with these services
- ☐ I am usually happy with these services
- ☐ I am happy with the services I get, but wish I got more
- ☐ I am unhappy with the services I get
- ☐ I am unhappy with the services I get, and wish I got more
- ☐ I do not get the services I need
- ☐ I don't know

Additional comments:

End of Survey. Thank you for participating!

Camden Coalition AmeriCorps Job Description

Organization

The Camden Coalition of Healthcare Providers is a ten-year old nonprofit designed to improve the quality, capacity, and accessibility of the healthcare system for vulnerable residents of Camden, New Jersey. Our philosophy is that innovative thinking, rigorous data analysis, and community-based solutions can both improve quality of care and bend the cost curve of healthcare. The Coalition is spearheading multiple initiatives to achieve this mission, including care management, patient engagement, and health information exchange, among others. Please see www.camdenhealth.org for more information.

AmeriCorps Health Coach (CCHP Community HealthCorps Program)

The Coalition is looking for bright, driven, and service-oriented individuals to serve as AmeriCorps health coaches in the medically underserved city of Camden. This is an exciting opportunity for those passionate about community service and healthcare to serve on the frontlines of healthcare delivery. Based in CCHP or its local partners, members will work with clinical staff to coordinate care for low-acuity patients with a history of inpatient and emergency room visits. They will target patients with chronic conditions like asthma, depression, hypertension, and heart disease, many of whom may also have a history of substance use, mental health issues, unstable housing, or trauma. Members will meet with the patients regularly at the hospital, home, and primary care practice, where they will provide emotional support, coordinate care, and refer patients to relevant resources. As project needs and interests intersect, members may also work with local partners to improve community health and enhance primary and preventative care capacity in Camden. In doing so, you will make a difference in the lives you touch, and learn a great deal about care coordination, community health, and system design.

The HealthCorps program requires members to serve full-time (37.5 hours a week) for 11 months and complete 1,700 hours of service. The program will begin in September 2012 and end in July 2013. Members will receive the standard AmeriCorps benefits, which includes a $12,100 annual living stipend through the term, health insurance and other benefits, and a $5,350* educational stipend (at the completion of 1,700 hours of service). There will be a weeklong pre-service orientation and training program, which will introduce the volunteer to issues in patient care and community health. The volunteers will be mentored by nonclinical and clinical staff throughout the term of service. A successful candidate will be self-motivated, enjoys working with a diverse panel of patients, and can achieve results in challenging and dynamic situations. A Bachelor's degree is required.

*These amounts are determined by AmeriCorps and are subject to change based on regulations

AmeriCorps Health Coach Program Operation Manual

May 17, 2012

Table of Contents

I. Introduction

There is increasing recognition that care coordination, investments in community health, and strengthened primary care can improve healthcare quality and lower its cost. Unfortunately, the current U.S. reimbursement system does not pay for such activities, which makes it difficult for healthcare providers, nonprofits, and other entities to fund, implement, and sustain these efforts. One way that interested organizations can staff and operationalize care coordination programs is to start or partner with the AmeriCorps program.

Established in 1993, the AmeriCorps program is a public-private partnership that provides community service opportunities to adults of all ages. The Corporation of National and Community Service (CNCS), a federal agency, provides funding to state and nonprofit organizations to serve as Program Sponsors and Placement Sites for AmeriCorps members. Once trained and placed at a site, members perform direct service and capacity building activities to meet unmet needs in the community, including those that are healthcare-related.

The Camden Coalition of Healthcare Providers has developed some expertise on starting an AmeriCorps program and incorporating health coaches into its care coordination efforts. The principal challenge of establishing an AmeriCorps program is to meet its significant regulatory requirements, which can be difficult as most human resource departments are not familiar with the unique nature of the AmeriCorps program. Once the program is set up, recruiting suitable people and appropriately incorporating health coaching into care coordination is also integral to the success of the project. This manual provides guidance on reaching these goals.

Interested organizations can serve as Program Sponsors or Placement Sites. Program Sponsors are responsible for the overall operation of the program: they manage the grant, recruit qualified members, handle human resource issues, place members at Placement Sites, and ensure regulatory compliance. Placement Sites, on the other hand, provide service opportunities and manage the day-to-day activities of the members. If there is an existing health-related Program Sponsor in your area interested in sponsoring health coaches, then you should become a Placement Site. If not, then you may have to become

a Program Sponsor and build the programmatic infrastructure yourself before you can host health coaches.

Either way, partnering with AmeriCorps requires significant initiative, a dedicated budget, and a willingness to work closely with government regulators, local partners, and members. In return, the program can significantly enhance the capacity of a care coordination team in a cost-effective manner, and provide a rich learning experience for people interested in the health professions. This guide is based on the Coalition's experience starting its own program as a Program Sponsor with the National Association of Community Health Centers (NACHC) and is designed to help your organization design and implement your own program.

II. Required Resources

The required resources are a direct function of service term length and member count. AmeriCorps allows members to serve the following term: full-time (1,700 hours), half-time (900 hours), quarter time (450 hours), and minimum time (300 hours). CCHP decided to limit its program to full-time members, as we find that such commitment is necessary to reliably integrate health coach efforts into our care coordination process. The projected budget below estimates the resources needed for a six-member program.

Table I: Projected Budget for Program with Six Members

Item	Cost	FTE	Total
Personnel			
Program manager	$75,000	0.10	$7,500
Program assistant	$40,000	0.50	$20,000
Per member costs	Cost	Members	Total
Living stipend	$12,100	6	$72,600
Health Insurance	$1,551	6	$9,307
Medicare (1.5%)	$182	6	$1,089
FICA - Social Security (6.2%)	$750	6	$4,501
Worker's compensation	$195	6	$1,170
Computer	$800	6	$4,800
Background Check	$96	6	$576
Subtotal			$121,540
Reimbursements	($10,275)	6	($61,650)
Total Cost			$59,894

In terms of personnel, the program requires a program manager and a program assistant, who serves as the Program Coordinator. Together, they work together to apply to AmeriCorps, establish relationships with local partners, recruit suitable candidates, train

project managers to act as Site Supervisors, facilitate health coach and care coordination trainings, and conduct mid-year and end-year reviews. The required time and effort is most significant in the beginning of the program, when both program manager and program assistant must secure the funding, set up the infrastructure, and recruit the best talent. Once the members are placed, however, the program manager and Program Coordinator can dedicate less time to this program.

In terms of per-member expenses, the national AmeriCorps program sets a consistent annual living stipend for all programs across the country ($12,100 in 2011). The Program Sponsor and the member are responsible for paying the employer and employee portions of the Medicare and FICA-Social Security tax. The Program Sponsor is also responsible for providing health and worker's compensation insurance. There are several AmeriCorps-approved insurance companies that sell affordable policies for AmeriCorps members to Program Sponsors. Lastly, AmeriCorps requires the Program Sponsor to conduct three background checks on all members.

In a fixed-cost grant, the AmeriCorps program reimburses Program Sponsors a set amount for each member for the above-mentioned costs ($10,275 in 2011). Unfortunately, this amount is less than the true cost of hosting members, which is estimated to be $15,674 in 2011. The Program Sponsor is expected to fund this per-member difference and pay for the personnel costs of a program manager and program assistant. When all costs are taken into account, AmeriCorps reimburse the Program Sponsor for approximately one half ($61,650 in 2011) of the total costs of the program ($121,540 in 2011). The Program Sponsor is responsible for the remainder.

II. Application, Contract, and Payroll

As discussed in the Introduction, you must first determine if you can apply to be a Placement Site with a health-related Program Sponsor interested in funding a health coaching program. Most states have a state commission of volunteerism that administers AmeriCorps slots. There are also smaller nonprofits serving as Program Sponsors for national AmeriCorps grantee organizations like NACHC. If this option is not available, your organization can apply directly to national grantee organizations like NACHC to become a Program Sponsor. To aid in writing your application, a description of the health coach position is included in Appendix A.

If you are approved as a Program Sponsor, you have to work with your legal and human resources departments to sign the subrecipient contract and set up an intake/payroll process for the AmeriCorps members. The principal difficulty is the fact that most executive, legal, and human resource staff are not familiar with the concept of an AmeriCorps member, as it does not fit under the traditional employee or volunteer categories. They are not employees, as they are only allowed to perform prescribed set of direct service or capacity building activities. They are also not volunteers, as they paid to a modest living stipend. Because this income is taxed as regular income, moreover, the member must be processed in a payroll system and a W-2 form must be provided. Some staff may be uncomfortable with the fact that the living stipend, depending on how it is calculated, may be less than the minimum wage. The best way to overcome these

challenges is to be clear that AmeriCorps is a government program and that the members, though not employees, must be processed in payroll to meet AmeriCorps regulatory requirements. Some documents related to its legal background are attached in Appendix B.

III. Site Supervisors

The Program Sponsor must rely on Site Supervisors to supervise, mentor, and manage the member in their respective projects. As such, providing adequate training on AmeriCorps and the Site Supervisor role, developing a strong coordinator/supervisor relationship, and setting clear expectations for Placement Sites is critical to operationalizing a successful AmeriCorps program. As a Program Sponsor, you can elect to place your members internally or externally. If you elect to place your members on internal projects, the project managers for those initiatives should serve as the site supervisor for that member. If you elect to place your members with external Placement Sites, however, you must identify a project manager who is willing to serve as a Site Supervisor and be a local advocate for the AmeriCorps program and its members. This section discusses the process of working with each type of Site Supervisor.

Internal Placements

Step 1: Introduction

The Program Coordinator provides a broad overview of the program, allowable activities, and site supervisor responsibilities. The coordinator should ask what type of service projects the placement site had in mind for the member, and if they are prepared to dedicate sufficient time and resources (e.g. computer, workspace, etc.) to support the member's term of service. The coordinator should then discuss the timeline of implementation.

Step 2: Site Supervisor Training

During the second meeting, the coordinator provides formal training on the role and responsibilities of the site supervisor in relation to the AmeriCorps program. Moreover, the coordinator and supervisor should discuss in greater detail and agree upon a set of prescribed member activities and projects. This will give the site supervisor an opportunity to comment on, revise, and endorse this document. Agreeing upon a set of prescribed activities and projects is important in making sure that members perform community service, not do someone else's job.

External Placements

In addition to the above-mentioned steps, an external placement will likely require a letter agreement and placement site fee. The letter agreement is a legal document between the Program Sponsor and the Placement Site. It discusses agreed-upon member activities, the responsibilities of both parties, Placement Site fee, and other matters. A sample letter agreement is contained in Appendix C. Lastly, many Program Sponsors charge Placement Site a one-time fee that covers the per-member costs estimated in Table A ($5,400). It is important to talk about this fee in the initial conversations with Placement Sites because they often need time to secure sufficient funding to pay this fee.

IV. Recruitment

Recruiting the right people is the single most important factor in the success of the AmeriCorps program. There are several reasons for this. First, health coaches are often at the forefront of the organization, building relationships with external providers and serving patients on a daily basis. It only takes one bad interaction to disengage the patient or offend the provider, so it is imperative that members be able to carry themselves in a mature, thoughtful, and responsible way. Second, as it is with any employee, recruiting members who care about their work and behave professionally will allow the care coordination team to function better and limit the extent to which the site supervisor has to deal with discipline issues. Third, the member must be committed enough to serve full-time for a year with little compensation. With these thoughts in mind, the following guidelines may be helpful in your recruiting process.

Step 1: Resume Screen

The Coalition had two hard requirements: (1) College graduate and (2) demonstrated interest in healthcare. Beyond this, we looked for academic excellence, the initiative to pursue personal interests and goals, project management or patient care experiences, communication skills, and demonstrated commitment to community service.

Step 2: Preliminary phone call

The Program Coordinator describes the program and determines the answers to these questions:

1) Are they interested?
2) Are they OK with the time commitment, relocation, and AmeriCorps benefits?
    a. I also take an upfront and realistic look at their financial situation. I recognize that AmeriCorps benefits are slim, and I ask if they are comfortable making a living from it. I ask them to consider this carefully for a few days.

Step 3: First round interview – Program coordinator

The Program Coordinator introduces the AmeriCorps program and the health coaching role in particular. They then discuss the following topics/questions:

1) Previous education and work/volunteer experiences
2) Why do they want to volunteer, and why specifically in healthcare?
3) What is a time they have worked with an individual/patient to achieve an outcome?
    a. How do they react when the individual does not respond well?
4) What do they do well?
5) What is their philosophy of working in teams?
6) What do they want to gain from the experience?

Through these questions, the Program Coordinator should look for the following: 1) interest in healthcare and the work of care coordination, 2) leadership potential and sound judgment in “grey” situations, and 3) ability to relate with people in a mature,

professional, and empathetic manner. Moreover, applicants who view this experience as a valuable stepping stone into their future career are desirable. People who think along these terms are more forward thinking and excited about getting real responsibilities in project management and patient care. People who are doing it to make ends meet are more likely to leave their term of service.

Step 4: Reference Check – Program coordinator
The Program Coordinator calls the provided references to discuss the following topics/questions:

1) Understand what capacity and time period the reference has known the applicant
2) Ask about the projects that the applicant has worked on and the quality of work
3) Has the applicant grown throughout the previous work experience?
4) Ask about their ability to operate in situations that require judgment and leadership
5) What does the applicant do well, and what could he/she work on?
6) Why did they leave?

At this point, the Program Coordinator should look for a level of earned trust and respect between the manager and the applicant. Members must be able to lead their own projects, interact well with Program Coordinator /Site Supervisor and patients, and raise concerns as appropriate. Program Coordinators should look for applicants who finish projects, accept responsibility for its success, and look to enhance it as appropriate. Good work habits and ethics are essential. Furthermore, the Program Coordinator should look for areas of growth that can be improved upon during the member's term of service.

Step 5: Second round interview – Site supervisors
The Site Supervisor will be responsible for directly supervising the member and serving as the primary manager, mentor, and member's advocate at the Placement Site. Thus, it is critical that Site supervisors have an opportunity to interview members who make it past the reference check, and have a deciding vote on member selection. They may also ask the questions in Step 3.
The recruitment tracking tool in Appendix D might be helpful to you.

V. Onboarding, Pre-Service Orientation, and Training

Onboarding
Once the finalists have been selected, the Program Coordinator must confirm that the members meet the eligibility requirements and coordinate the background check process. The eligibility requirements can be viewed here. With regards to background checks, AmeriCorps requires a National Sex Offender Check (a sample consent form is provided in Appendix E), a FBI check, and a state check. The Program Coordinator also has to undergo these background checks.

Pre-service Orientation (PSO)

The pre-service orientation is a week of orientation and training activities that gives the AmeriCorps members an opportunity to fill out paperwork, become accustomed to the Program Sponsor and Placement Site, and receive introductory training on health coaching. A sample calendar of events is attached in Appendix F. On the first day, there must be a period of time set aside for the following administrative matters:

1. Sign the Member Services Contract. This is critical because the member cannot earn hours before the date on the member services contract.
2. Fill out the Eligibility Verification Form, and make copies of each required document.
3. Enroll in the health insurance plan or sign a waiver form, and copy proof of insurance.
4. Sign the consent form to the National Sex Offender Background Check.
5. Fill out the enrollment form.

Training

The Coalition has developed a Health Coach Manual that is attached in this guidance document. The AmeriCorps member should read over this document and discuss topics and questions with the nurse care coordinator that they will be working with. The members should receive on-the-field training with the nurse care coordinator for at least three weeks to see what care coordination looks like in reality and what their roles will be in the overall process.