

Engagement that extends beyond the exam room

How RN Health Coaches, Community Health Workers, and Behavioral Health Case Managers help patients build confidence, connection, and trust.

Patient engagement & activation | October 2026

Our commitment is bigger than a visit

Patient engagement is not a single conversation—it is an ongoing relationship.

- Activation grows when patients have the knowledge, skills, confidence, and support to participate in their care.
- At SCHC, support extends across clinical, dental, behavioral health, and community settings.
- Our shared aim is to help each patient feel heard, supported, and able to take a next step that matters to them.

Engagement and activation are related—but distinct

Engagement

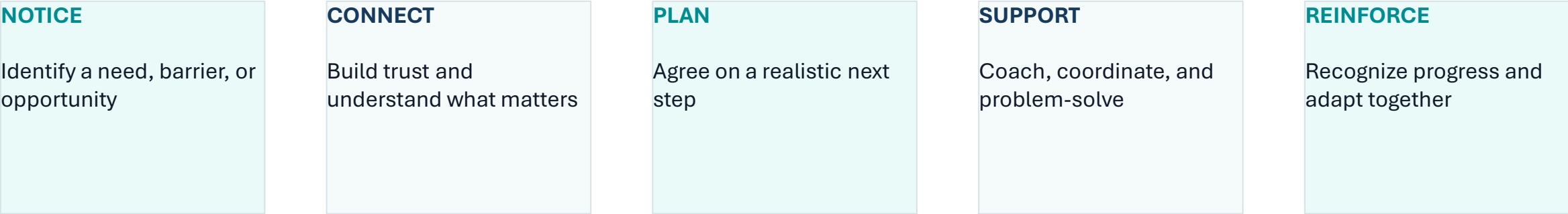
The ways we invite, listen, partner, and stay connected with patients.

Activation

A patient's growing confidence and ability to manage health and participate in decisions.

**Engagement is something we do with patients.
Activation is something patients build—with the right partnership and support.**

A connected team can meet patients at many points



The patient’s goals and voice should travel with them through every handoff.

Engagement starts through many doors

Enabling services team identifies patients through daily care-team workflows.

Care-team referrals

Provider/team requests for extra coaching, navigation, or follow-up
Concerns after missed visits, difficult care plans, or repeated barriers

Medicare Wellness Visits

Preventive gaps, functional concerns, safety risks, or new support needs
Opportunities to connect patients before problems escalate

New patient orientation and SDOH / PRAPARE screening

Food, housing, transportation, safety, financial stress, language, or health-literacy needs
Screening creates a doorway to practical support and follow-up

Behavioral health triggers

Newly diagnosed depression or positive screenings
Patients struggling to connect with BH care or follow through

The common thread: someone notices a need, makes a connection, and invites the right support.

NEEDS DETERMINE WHO HELPS

The discipline is matched to the main barrier—not just the diagnosis

Clinical complexity → RN Health Coach

Chronic disease education, medication understanding, clinical goals, transitions, and care-plan follow-through.

Social/practical barriers → CHW

Transportation, food, housing, resource navigation, outreach, and closing the loop with community supports.

Behavioral health → BH Case Manager

Coping, behavioral health engagement, care continuity, motivation, and behavioral barriers to medical care.

When needs overlap, the team overlaps.

The lead can change as the patient's situation changes.

Best fit when the care plan needs extra coaching, education, and coordination

- Clinical coaching, education, and care planning
- Help patients understand diagnoses, medications, monitoring, and follow-up
- Chronic Care Management, transitions of care, and self-management support
- Coordinate with PCPs, clinical pharmacists, specialists, and other care partners

Best fit: “The biggest barrier is understanding and managing the care plan.”

Best fit when real-life barriers are blocking the care plan

- Build bridges between the clinic, the patient, and the community
- Explore transportation, food, housing, insurance, financial, language, and system barriers
- Provide outreach, navigation, encouragement, and closed-loop follow-up
- Bring community context back to the care team so the plan is realistic

Best fit: “The patient knows what to do, but life is making it hard to do it.”

Best fit when behavioral health affects engagement and follow-through

- Support behavioral health goals and care continuity
- Help patients stay connected with behavioral health services and community supports
- Reinforce coping, motivation, follow-through, and patient voice
- Coordinate with PCPs, therapists, RN Health Coaches, and CHWs

Best fit: “Behavioral health symptoms or stress are limiting the patient’s ability to move forward.”

A handoff is an engagement moment

- Explain why another team member is being included and how they can help
- Ask permission and share only relevant information
- Avoid making patients repeat their story whenever possible
- Introduce the patient's priorities, strengths, and next step—not just the problem list
- Close the loop so the patient experiences one connected team

**The patient should feel passed forward—
not passed off.**

Start with what matters to the patient

Ask before advising

“What feels most important to you right now?”

“Would it be okay if we explored a few options together?”

Make the next step theirs

“Which step feels manageable this week?”

“What might get in the way—and what support would help?”

Respect readiness. Use motivational interviewing. Build on strengths. Celebrate progress.

Small practices can strengthen activation

- Use plain language and check understanding with teach-back
- Set one SMART goal together and document it in the patient's words
- Offer options and invite shared decisions rather than prescribing a single path
- Recognize effort and progress—not only outcomes
- Follow up in a way that fits the patient's preferences

Activation grows when the next step feels possible.

A practical example: from patient need to shared action

A need is identified

A concern is identified through referral, screening, outreach, utilization, or care-team discussion.

Team reviews the drivers

Which component is driving risk?
What does the patient say is most important? Who has the best first connection?

Discipline leads or joins

RN HC, CHW, BH Case Manager, or shared team based on the dominant need and patient readiness.

Patient goal guides success

The care plan is anchored to what matters to the patient—not only to quality measures or risk score.

Identification helps us find the patient.
The relationship helps the patient take the next step.

SHOWING THE VALUE OF ENABLING SERVICES

Best practices for documenting ROI and sustaining the work

Measure outcomes

ED/hospital use, kept appointments, AWW completion, screening follow-up, quality metrics, patient-stated goals.

Standardize charting

Use structured notes, shared care plans, documented barriers, interventions, time, handoffs, and closed-loop follow-up.

Leverage reimbursable models

Medicare CHI, BHI, CCM/APCM when criteria are met; Medicaid Health Home or CHW payment where available.

Report the value

Compare before/after trends by risk tier. Pair metrics with de-identified patient stories and payer-ready reports.

**ROI is strongest when we can show:
who we served, what changed, and which service supported the change.**

Risk scoring helps us decide where extra support is most needed.

This section explains how we identify higher-risk patients, match them to the right discipline, and use limited enabling-services resources wisely.

Limited resources should be aimed where they can do the most good

The reality

Many patients could benefit from additional support, but RN Health Coaches, CHWs, and BH Case Managers are limited resources.

The purpose

Risk scoring helps us identify patients most likely to need extra outreach, care coordination, and case management.

- Makes higher-risk patients visible before the next crisis occurs
- Supports proactive outreach instead of waiting for avoidable ED or hospital use
- Helps prioritize intensive services for patients most likely to benefit
- Creates a common language for care-team discussions and payer conversations

**Risk scoring identifies who may need help.
The care team decides what kind of help.**

Complexity is more than diagnoses alone

Medical complexity

Chronic conditions, disease control, medication complexity, clinical monitoring needs.

Behavioral health complexity

Depression, anxiety, substance use concerns, coping, treatment engagement.

Social drivers of health

Food, transportation, housing, safety, financial stress, language, health literacy.

Utilization

Emergency-department visits, hospitalizations, readmissions, escalating acute-care use.

The components combine to create a fuller picture of patient complexity.

Adapted from PRAPARE risk stratification concepts: clinical + behavioral health + SDOH + utilization.

A score starts the conversation—it does not replace it

The score helps us...

- Identify patients for outreach
- Prioritize limited resources
- Recognize complexity across domains
- Track risk at the population level

The score does not...

- Replace clinical judgment
- Tell us what matters most to the patient
- Automatically assign a discipline
- Mean every high-risk patient needs the same intensity

Local capacity matters. We may adjust thresholds so intensive case management goes to the patients who need it most.

Example from patient-level risk scoring

Age	Clinical	BH	Util.	SDH	Total	Likely lead / team focus
31	1	5	1	10	17	BH CM + CHW
44	1	4	1	10	16	CHW + BH CM
56	5	4	5	2	16	RN HC + BH CM
57	1	2	4	8	15	CHW + RN HC
44	2	4	1	8	15	CHW + BH CM
47	3	2	5	4	14	RN HC + CHW
70	4	3	5	2	14	RN HC + BH CM

Total = Clinical + Behavioral Health + Utilization + SDH. Suggested lead is based on the dominant drivers of risk, not the total score alone.

A high total score tells us to look closer. The component scores tell us where to start.

What meaningful engagement can make possible

For patients

Greater understanding, confidence, connection, and ability to act on personal goals.

For care teams

Better visibility into patient priorities, coordinated follow-through, and shared accountability.

For the community

Stronger links between healthcare and the resources that shape health outside the clinic.

Care is more than a clinical encounter.

Every connection can help a patient feel heard, build confidence, and take a next step that matters.