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Digital and Community Outreach for Home Healthcare Access and the Choice of an Assisted Route

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Abstract
Digital outreach and community outreach perform different tasks and often serve different entry populations. This conceptual analysis examines selected literature published through 2024 and develops a framework for assigning information, assistance and referral support according to the barrier identified. Digital participation research, community health worker reviews and home health access studies inform the design, but they do not provide a direct comparative estimate for the proposed routes. The framework therefore avoids ranking channels by unadjusted conversion rates. It specifies a common service endpoint, consistent event definitions and measures of offer, uptake and completion. Parallel access routes and assistance within a digital route remain available according to preference and need. A comparative design is outlined for estimating the effect of offering assistance among a defined population. The contribution is a route-selection and evaluation structure, rather than a claim that digital or community outreach is generally superior. Local capacity, partner roles and missing outcome records require assessment before expansion.

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1. Introduction

Digital communication supplies information through websites, messages and other interfaces. Community outreach supplies contact through organisations and workers connected with a service area. Either route might include assistance, and either might end before a referral is completed. A comparison based only on contact totals therefore compares activity rather than access. [1-28]

This paper treats route selection as a response to a specified barrier. Lack of understandable information, difficulty using an interface, uncertainty about the next step and unavailable service capacity require different responses. The contribution is to connect the barrier, route and endpoint while preserving the distinction between choosing a route and evaluating its effect. [29-33] The framework rejects a mandatory digital-first sequence. An individual should have an accessible route matching preference and need, while assistance remains available inside a digital route. The scope is access to a defined home health service, rather than digital skills training, telehealth treatment or a general recommendation to replace community provision. [18, 34-45]

2. Research Method

2.1. Question Addressed and Source Extent

This paper addresses the following question. Which contact or assistance route addresses the observed barrier, and how should its contribution be evaluated with different entry populations?

The analysis draws on selected conceptual, measurement and empirical literature published no later than 2024. Sources are used according to their intervention, setting and outcome. Conceptual sources inform definitions and proposed relationships. Empirical studies inform the problem or an adjacent mechanism, with their findings kept within the evaluated intervention and population. The synthesis is interpretive and does not follow a registered systematic review protocol or provide an exhaustive study census. [46-54]

The analytical procedure separates the target construct, the observation used to represent it and the claim supported by that observation. The resulting framework specifies process records, outcome boundaries and a prospective evaluation question. Design recommendations are identified as proposals. No participant dataset, new clinical results or validated composite score is reported, and no pooled effect is estimated from unlike interventions. [18, 55-62]

The synthesis proceeds through three steps: define the communication or service task, identify the observation supported by each relevant source, and specify a comparison which would test the proposed relationship. Table 1 records construct boundaries; Table 2 operationalises a study or audit. Numerical illustrations demonstrate definitions and accounting only. They are not empirical results. [63]

2.2. Evidence Review and Transfer Constraints

Grossman *et al*. [65] review interventions to increase portal use in vulnerable populations, and Okoye *et al*. [67] examine broadband and telehealth use among older adults. Richardson *et al*. [68] provide a framework for digital health equity. These sources concern conditions for digital participation. They do not establish that a digital outreach contact produces a home health referral or first visit. [66, 69-102]

Community health worker reviews span settings and tasks [2, 103-105]. Mistry *et al*. [67] focus on navigation in primary care chronic disease management, while Agarwal *et al*. [65] propose a workforce performance framework. The evidence informs role definition and implementation assessment without providing a single effect estimate transferable to the proposed home health route. [42, 65, 107-122]

Balaban *et al*. [123] test navigation in a hospital transition context, and Tyler *et al*. [110] synthesise transitional care interventions. Home health agency access and rural or urban differences concern the receiving service rather than the message channel [125, 126]. This distinction limits a claim of outreach success where the available agencies cannot serve the referred population. [127-145]

Partnership and transcreation frameworks inform the community route's design [146-148]. Campaign research and entertainment framing supply additional communication perspectives [149-151]. These literatures address different intervention features, so combining their conclusions does not establish an effect for the proposed integrated route. [152-172]

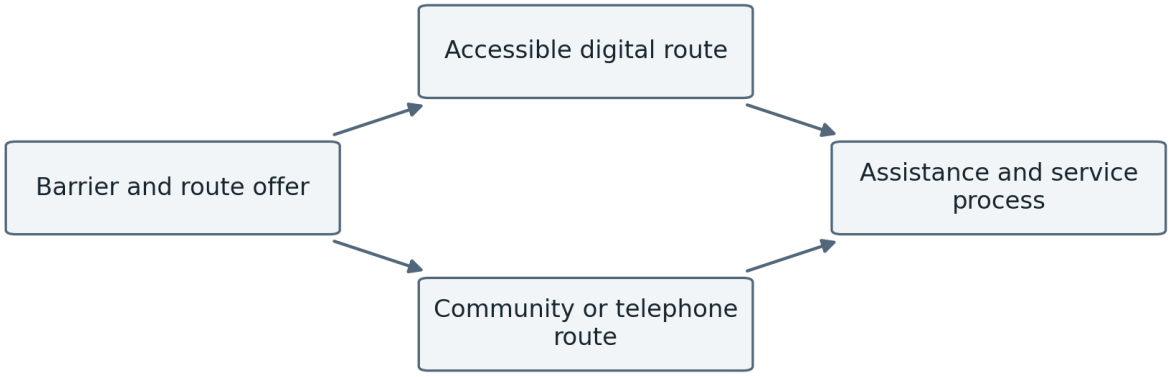
Norman and Skinner [173] describe the skills involved in working with electronic health information. Kreps and Sparks [174] discuss health information needs in immigrant populations. These perspectives support separate assessment of digital tasks and language needs. A digital route should document what the person must find, understand and submit, while an assisted route should document the help provided. [174-179]

McCaffery *et al*. [127] examine health literacy differences in pandemic knowledge and related responses. Their cross-sectional setting provides a reason to assess understanding, not an estimate of home healthcare outreach effectiveness. Sheridan *et al*. [181] review low health literacy interventions. The proposed route comparison should specify which communication changes address understanding and which changes provide practical assistance. [180, 182-186]

Parker *et al*. [127] describe tools for collaborative reflection in participatory research. A comparable reflection task in outreach would ask community partners whether the assisted route solves the barrier identified and how unresolved requests return to the service organisation. This is a proposed operational use of partnership review, not a tested extension of those tools. [187, 188]

3. Results and Discussion

3.1. Assisted Route and Outreach Framework



***Source*:** Author-developed conceptual framework. Arrows represent proposed relationships or process order, not estimated effects.

Fig 1: *Barrier assessment and parallel assisted access routes*

Table 1: Barrier assessment and parallel assisted access routes measurement boundaries

Evidence domain	Relevant outcome	Transfer to home health	Boundary
Digital outreach	Reach and information use	Accessible information and contact routes	Does not establish agency capacity
Community navigation	Help with a defined care task	Assistance and follow-up roles	Effects from other conditions require local testing
Transitional care	Continuity after discharge	Attention to handoffs and follow-up	Clinical package effects do not identify outreach effects
Home health receipt	First completed visit	Direct service-use endpoint	Administrative records omit some unmet need

Table 1 provides an analytical specification. Its entries are proposed distinctions rather than empirical ratings or validated instrument properties.

3.1.1. Information Assistance and Service Availability

An information task concerns what the person understands. An assistance task concerns completing a step the person wants to take. A service capacity task concerns whether the receiving system offers the required service. Figure 1 maps these functions to an access sequence, while Table 1 distinguishes route features and outcome boundaries. [189-191]

The first conversation or interaction should identify the task without assuming it from the contact channel. A person using a website might need assistance with a referral; a person meeting a community worker might need only a factual answer. An apparent lack of response might reflect preference, inaccessible delivery or inaccurate contact information. Record what is known and leave the explanation open where the evidence is insufficient. [192-195]

3.1.2. Route Offer and Uptake

The proposed model offers an accessible digital route and an accessible telephone or community route where feasible. The service question, next-step instructions and expected response should be consistent across routes. Assistance should not depend on completing a difficult digital step first. Record which routes were offered, which was selected and whether the requested support was available. [196-198]

The community route needs defined staffing and a route for clinical questions. Its role should reflect the agreement with participating organisations rather than a generic expectation that a worker resolves every access barrier. Digital assistance likewise requires a named response process. An online form with no acknowledged receipt should not be reported as a completed assisted contact.

3.1.3. A Common Endpoint with Route Specific Process Records

Select the service endpoint before comparing routes. For the home health application, a documented first visit is different from a request for information, clinical assessment or referral acceptance. Use common event definitions for the outcome, while retaining route-specific measures of delivery and assistance. A community attendance count and a digital impression count are not equivalent contacts. [68, 199, 200]

Report the original target population, route offers, uptake and endpoint completion. Where a household uses both routes, preserve the sequence instead of forcing a single-channel classification. State how identity linkage and shared accounts were handled. Show unresolved service outcomes separately, because excluding them creates a selected completion rate. Report declines and alternative dispositions without treating every nonvisit as a failure. [198, 201]

3.1.4. Comparison Design and Route Changes

A direct comparison of voluntary route users is descriptive. People who select community assistance might face more barriers than digital users. The proposed causal question concerns the effect of offering a defined assistance service among a specified cohort with an opportunity to use it. Randomised or defensibly controlled allocation should preserve usual access and measure receipt separately from assignment. [202]

A rollout evaluation should record timing, staffing, referral availability and concurrent changes. A new community partner and a revised eligibility process introduced together form a package. Report the package rather than attributing the outcome to one channel. Decisions to remove a route should consider who has no alternative access, not only the average cost per recorded contact. [203, 204]

3.1.5. Assistance Demand and Equitable Route Evaluation

A route-selection record should state the options available at the moment of contact. A person's apparent preference for the digital route has a different interpretation if no telephone or community option was offered. Likewise, an apparent preference for assistance might reflect an inaccessible interface rather than a general rejection of digital communication. Record the offered choice and known accessibility requirement without assigning a permanent label to the person. [205]

Assistance availability includes response time and task scope. A route advertised as assisted but staffed only intermittently might create more waiting rather than reduce a barrier. The pilot should record requests for help, acknowledgments, tasks completed and unresolved requests. Measure waiting from the same event definition across routes, while retaining differences in urgency and service question.

Content equivalence matters in comparisons. Digital content might contain detail unavailable in a printed leaflet, while a community worker might provide explanations beyond the standard script. Document these differences. A route comparison then concerns the actual package delivered rather than a pure medium effect. Attempting to force complete equivalence could remove the assistance feature the programme wants to evaluate, so the chosen estimand should guide the design. [206]

A community partner's contact does not prove coverage of the whole community. Report the partner's service area, participation boundary and populations absent from the contact record. The digital route has an analogous boundary in platform use and delivery. Comparing each route with the target population is more informative than treating either as inherently representative. [207]

Route continuity should extend to the receiving process. Information or assistance records should indicate the next

responsible organisation and whether the household knows how to obtain a response. Record missed or unresolved handoffs rather than returning the person to the start of the route. If assistance cannot obtain a feasible receiving option, describe the constraint and the agreed next action.

Equity evaluation should preserve absolute counts as well as rates. A route might have a lower completion percentage because it serves people with more barriers, while contributing access unavailable elsewhere. That observation does not establish effectiveness, but it affects the decision to maintain the route. A credible evaluation reports offered access, entry conditions, completion, unresolved cases and cost before drawing a general recommendation about substitution. [208, 209]

3.1.6. An Assistance Offer Comparison with a Common Denominator

The most useful comparison asks whether offering assistance changes completion of a specified task among people eligible for the offer. A digital-versus-community comparison among voluntary users answers a different question because the users select their route under different circumstances. Digital equity, portal intervention and community workforce research identify conditions affecting that selection [1, 2, 64]. The proposed evaluation therefore treats route received as a process observation and the assistance offer as the primary comparison. [210-217]

Table 2 demonstrates the problem with hypothetical numbers. Suppose 80 people choose a digital route and 40 complete the task, while 120 choose community assistance and 48 complete. The completion rates are 50 and 40 percent. Yet the assisted route delivers eight more completions and serves a larger population. Neither the rate comparison nor the absolute count establishes which route causes more completion. Baseline barriers, available options and the selected denominator determine what the observations mean. [218]

Table 2: Hypothetical voluntary route comparison

Route	People choosing route	Completed tasks	Observed completion rate
Digital route	80	40	50 percent
Community assisted route	120	48	40 percent
Combined routes	200	88	44 percent
Interpretation	Different self selected populations	Counts describe delivery	Rates do not establish a causal ranking

Source: Author-developed analytical example. Numerical values, where shown, are hypothetical and do not represent study observations.

A prospective assistance-offer study would identify the cohort before route choice, assign or introduce a defined support offer under an appropriate comparison, and follow all entrants to the same endpoint. Both groups should retain usual access, including clinically required assistance. The intervention should specify the worker's task, response availability and escalation route. Navigation reviews describe different roles across settings, so a generic label such as navigator is insufficient to define the offer [106, 219, 123, 220]

Assistance uptake is informative but secondary to assignment. A person assigned an offer might not use assistance because the task is already manageable, because the response is unavailable or because the offer does not fit preference. These explanations require observation. Restricting the primary analysis to people who use assistance selects on behaviour after the offer. The process report should show offer, acknowledgment, use, task completion and unresolved status without converting the resulting sequence into a causal attribution rule. [221]

Cost should follow the same original cohort. Digital production, maintenance and response staffing belong in the digital package; community supervision, travel, interpretation and coordination belong in the assisted package. Shared clinical and receiving-service costs require a stated allocation rule. The unit-cost denominator should represent the programme's decision, such as the cost per cohort member offered access or per documented completed task. An additional completion is not automatically a clinical benefit, and the comparison should retain distributional consequences for people without an alternative route. [222, 237]

The framework proposes two tests. Accessible assistance should reduce a barrier-specific task failure among people experiencing that barrier. Improved task completion should translate into service receipt only where clinical assessment and receiving capacity permit. Health literacy and numeracy research inform the first assessment; home health access and transitional care research inform the second [124, 125, 181, 223]. A null service result should prompt review of the stages rather than automatic substitution of a more favourable channel activity measure. The practical decision is whether the defined offer warrants continuation or redesign under documented conditions. [173, 224-233, 236, 239]

Access to home healthcare depends on a sequence of steps that begins with awareness and ends with completed service receipt, and each step can fail for reasons that differ from those that affect the others. A person may never learn that a service exists, may learn of it but not understand whether they qualify, may understand that they qualify but not know how to initiate a referral, may initiate a referral that is not accepted, or may be accepted but not receive a visit. Outreach that addresses only the first of these steps may increase awareness while leaving access unchanged, and a programme that measures only its own activity may believe it has succeeded when people remain unserved. This stepwise structure is central to the framework advanced in this paper, because it locates the points at which different outreach approaches can contribute and identifies the measures needed to observe whether they have. Recognising the sequence also clarifies that outreach and service capacity are linked, since a programme that generates demand the service cannot absorb will show worsening results rather than better ones.

Digital outreach offers distinctive advantages that have made it increasingly central to health communication. It can reach large audiences at low marginal cost, deliver consistent information without the variation that accompanies personal contact, be updated quickly as guidance changes, and generate data about exposure and engagement that support continuous improvement. These advantages are real, but they are advantages of scale and consistency rather than of persuasion or support. Digital content can inform people and prompt them to act, but it cannot resolve the individual questions that often stand between intention and action, such

as whether a person qualifies, what documentation is needed, how transport will be arranged or whom to contact. Where those questions are left unanswered, digital campaigns may generate interest that does not convert. Programs relying on digital outreach alone should therefore expect strong reach and weaker completion, and should plan accordingly rather than attributing the gap to audience apathy.

Community outreach supplies the characteristics that digital channels lack. Community health workers, local organisations and trusted individuals can explain services in terms that fit a person's circumstances, answer questions, provide reassurance, help with forms and arrangements, and follow up when a person's first attempt fails. These activities are labour-intensive and difficult to scale, but they are frequently the difference between awareness and completed access. Community outreach also carries forms of credibility that formal systems may not possess, particularly in populations with histories of mistreatment or neglect. The contribution of community partners is often invisible in programme metrics because it occurs in conversations and follow-ups that do not generate digital records, and a programme that fails to record this work will understate its value and may under-resource it. Recognising assistance as a designed component, rather than as an informal convenience, is essential to managing it effectively.

The concept of an assisted route describes the people, processes and supports that bridge the gap between information and action. An assisted route may be operated by a community health worker who takes a person through the referral process, by a patient navigator who resolves logistical obstacles, or by a local organisation that coordinates with the service on the person's behalf. The route may be triggered by a digital enquiry, by a community contact or by a referral from another service, and the design question is how these triggers connect to the assistance available. Where the connection is clear and reliable, a person who expresses interest is met with support that helps them act. Where it is unclear, interest dissipates. Programmes should therefore design the transitions between channels deliberately, specifying what triggers assistance, who provides it and how completion is confirmed. This design work is the substance of coordination and is more consequential than the choice of channels themselves.

Capacity planning is a practical requirement that coordination makes unavoidable. A successful digital campaign can generate demand at a rate and volume that community partners and the service itself cannot absorb, producing delays, frustration and reputational damage for both the campaign and the partners who manage the consequences. Conversely, an assisted route without sufficient demand wastes resources. Matching demand to capacity requires the programme to estimate how many people its outreach is likely to reach, how many of those will seek assistance, and whether the service can accommodate them. Where capacity is constrained, the programme may need to calibrate its messaging, sequence its channels or invest in additional service capacity before scaling outreach. Treating outreach and service capacity as separate decisions is a common error, and it produces the paradox of a programme that succeeds in generating interest while failing to deliver care.

Consistency of information across channels is another requirement that coordination makes visible. Where digital content and community workers give different accounts of eligibility, cost or process, the person receiving both must reconcile them, and the resulting uncertainty undermines confidence in the programme. Consistency requires a shared, current understanding of the service, maintained through regular communication among the parties and updated as the service changes. It also requires that community partners have the information they need to answer questions accurately, which in turn requires investment in their preparation. A programme that treats consistency as an administrative detail will find that discrepancies accumulate and that trust erodes. Maintaining a single, accurate account of the service across all channels is therefore part of the intervention, and the effort it requires should be planned and resourced rather than assumed.

Finally, the coordination that complements digital and community outreach is frequently impeded by organisational factors that have nothing to do with the design of the communication itself. Digital and community activities are often managed by different teams with different objectives, reporting lines and funding sources, which makes joint planning difficult even when the value of coordination is acknowledged. Community partners may have limited capacity to engage in planning processes that consume time without immediate benefit. Decision-making may be distributed across organisations that do not share authority. These factors mean that coordination is as much an organisational problem as a design problem, and that a programme seeking complementarity must address governance and incentives as well as content and channels. Recognising these obstacles is not defeatism; it is a precondition for planning coordination realistically and for anticipating the points at which it is most likely to break down.

Equity considerations run through every element of this framework. Digital-first strategies may reach the populations that are easiest to reach while the populations with the greatest unmet need remain outside their reach, and a programme that measures only aggregate outcomes may not notice. Community outreach, by contrast, is often most effective precisely where digital channels are weakest, which is part of why the complementarity matters. Measuring reach, assistance and completion by population segment reveals whether the programme is broadening access or reinforcing existing patterns of use, and it allows adjustment where gaps appear. It also allows the programme to identify groups for whom no assisted route currently exists, and to consider whether such routes should be created. Because access is unevenly distributed and shaped by factors that differ across communities, complementarity between digital and community outreach is not merely a matter of efficiency; it is a condition for equitable service, and it should be designed and evaluated with that goal in view.

The evidence on digital and community outreach is strongest for the proposition that neither alone reliably completes the access pathway, and this finding has practical implications for programme design. Studies of digital campaigns report gains in awareness and, less consistently, in service use, with the latter depending substantially on whether a practical route to the service accompanies the campaign. Studies of community outreach report gains in trust, comprehension and completed contacts, with limited reach and relatively high cost per person. These patterns are consistent with the framework advanced here, which treats the two approaches as performing different tasks in a single pathway. They also caution against expecting a single channel to deliver an

outcome that depends on several steps, and they support the design of coordinated systems in which each channel performs the task for which it is suited rather than being stretched to cover the whole pathway.

Trust dynamics differ between digital and community channels and affect how they should be used. Digital communication operates at arm's length, and trust in it depends on the perceived credibility of the source, the consistency of the message and the audience's prior experience with similar content. Community communication operates through relationships, and trust in it depends on the credibility of a known person, the continuity of their engagement and the community's assessment of their motives. Because these dynamics differ, a message that works through one channel may not work through the other, and content developed for a digital campaign may need adaptation before it is used by community partners. The framework recommends that content be tested in the form and channel in which it will be delivered, and that community partners be involved in adapting material so that it suits the relational context in which they operate. Treating content as interchangeable across channels risks undermining trust in the channel where it was not tested.

Measurement of assistance is a specific practical challenge, because the work of community partners is often invisible in the data systems that record programme activity. A conversation that resolves a person's doubt, a form that is completed with help, a phone call that arranges transport and a follow-up that recovers a stalled enquiry are all part of the pathway but none may appear in a digital record. A programme that measures only digital activity will therefore understate the contribution of assistance and may under-resource it, while a programme that tries to record everything will impose a burden that partners resist. The framework recommends that assistance be measured with a small number of meaningful indicators, such as the number of people supported to complete a step and the proportion of those who complete it, and that the indicators be designed with partners to ensure they are feasible. Measuring assistance is valuable not only for accountability but for learning, because it reveals where the pathway most often requires support.

Cost considerations differ substantially between the two approaches and should inform how they are combined. Digital channels have low marginal cost, so expanding reach within a population that can be reached digitally is inexpensive. Community outreach has high marginal cost because it depends on people's time, so expanding reach through community channels is expensive and scales slowly. This asymmetry has implications for where each approach is best deployed. Digital channels are efficient for reaching populations that are digitally reachable, while community channels are relatively more valuable for populations that are not, since for those populations the alternative is no reach at all. A programme that allocates resources between channels on the basis of cost per contact alone will favour digital channels and may systematically under-serve populations that require personal support. The framework recommends that resource allocation consider cost per completed outcome for each population rather than cost per contact overall.

Governance arrangements determine whether coordination can be sustained, and they deserve attention as a design element rather than an administrative afterthought. Integration requires decisions about who owns the pathway, how performance is reviewed, how disputes are resolved and how resources are shared among partners. Where governance is absent, coordination depends on individual goodwill and is vulnerable to staff changes. Where governance is well designed, it provides a structure within which partners can plan, review and adjust together. The framework recommends that governance arrangements be established early, that they include clear roles and decision rights, and that they provide a forum in which performance is reviewed jointly rather than reported separately. It also recommends that governance include representation from the populations served, so that the system is accountable to the people it exists to help rather than only to the organisations that operate it. Governance of this kind is what makes integration durable.

Sustainability of coordination depends on embedding it in the routines of the organisations involved rather than relying on project funding and individual commitment. Coordination that exists only for the duration of a funded programme tends to dissolve when the funding ends, taking with it the relationships and capabilities that were built. Embedding requires that coordination be written into job roles, that interfaces be documented as standard process, that data sharing be governed by standing agreements and that partnership relationships be maintained beyond any single initiative. The framework recommends that sustainability be planned from the outset, that partners consider how coordination will continue after initial funding and that the value of coordination be demonstrated so that it can justify continued investment. Where coordination is embedded, it becomes part of how the system works rather than an additional activity that competes for attention.

The framework's practical implication is that digital and community outreach should be planned as a single system whose components perform different tasks. Digital channels create reach and consistency; community partners create trust and resolve practical obstacles; the interfaces between them determine whether people move from awareness to completed access. Designing these interfaces deliberately, resourcing the assistance on which completion depends, and measuring the pathway as a whole are the practices that distinguish a coordinated programme from a collection of activities.

Programmes that adopt this approach should expect to invest more in coordination than in any single channel, and they should expect coordination to require maintenance rather than to remain stable once established. That investment is what makes complementarity real. Without it, digital and community activities may coexist without producing the access that a programme intends and that the people it serves require.

The framework also implies that evaluation should focus on completed access rather than on channel activity, because completion is the outcome that matters to the people the programme exists to serve. Measuring it, interpreting it by population segment and using what is learned to adjust the interfaces allows a programme to improve over time. This orientation toward outcomes rather than activities is the framework's central practical message and the basis on which it should be judged.

3.2. Discussion of Route Choice and Limits

The framework avoids both a general ranking of channels and an assumption of automatic complementarity. The functions complement one another only when the pathway connects

them and the service endpoint is available. An information page, an assistance conversation and an agency decision are separate observations. Their joint presence does not demonstrate an integrated process without an auditable handoff. [240-259]

Cost assessment should distinguish development, staffing, partner coordination and outcome tracking. Compare costs for a defined population and endpoint, retaining unsuccessful and unresolved cases. Lower cost per contact could coexist with weaker population coverage. A route serving people absent from the other route has a value not represented by an average across readily reached users. [234]

The conceptual framework has no validated route-selection rule, direct digital-versus-community effect estimate or universal cost threshold. The evidence spans services and populations, limiting transfer. A local pilot should test accessibility, role boundaries, common outcome definitions and linkage completeness. Subsequent evaluation should measure whether an offered route changes appropriate service access without increasing unresolved referrals or excluding people with greater assistance needs.

The framework clarifies that digital and community outreach are complementary channels performing different tasks rather than competing strategies for the same purpose. Digital outreach excels at reach, speed and low marginal cost, and it can deliver consistent information to large audiences. Community outreach excels at trust, explanation and the resolution of practical obstacles, and its strength is precisely the personal contact that digital channels lack. When programmes treat them as substitutes, they tend to over-invest in the channel that is easier to scale and to underestimate the relational work that determines whether people act. The framework therefore recommends that the two be planned as a coordinated system in which digital communication creates awareness and community partners support the transition to a completed service contact. This separation of roles allows each channel to be measured against the task it is actually suited to perform, rather than against a single generic engagement target.

The concept of an assisted route is central to the framework. Many people who receive information about home healthcare do not act on it unaided, because the steps involved, such as securing a referral, arranging transport or completing paperwork, exceed what a leaflet or web page can support. An assisted route inserts a person or process between information and action, converting intention into a completed step. Community health workers, patient navigators and trusted local organisations are the usual operators of such routes, and their contribution is invisible in standard reach metrics. The framework accordingly treats assistance as a designed component of the outreach system rather than an informal convenience, and it recommends that assistance activity be recorded and evaluated alongside message exposure. Where the assisted route is absent, improvements in awareness may produce little change in access, a pattern that has repeatedly puzzled programmes relying on information alone.

This perspective has implications for how outreach performance is measured. Reach and impressions describe exposure, while completed referrals, scheduled visit and first service receipt describe progress along the access pathway. A programme that reports only the former cannot tell whether its communication is working, and one that reports only the latter cannot explain why. The framework recommends that measures span the full pathway so that the point of failure becomes visible. It also suggests that digital and community channels be attributed separately, since their contribution differs and blending them obscures the value of the relational component. Where overlap between channels is substantial, the framework advises attention to duplication so that resource is not spent re-contacting people already engaged. These measurement choices make the complementarity between digital and community outreach observable rather than assumed, and they allow programme managers to rebalance investment in response to evidence.

Finally, the framework acknowledges the conditions that make coordination difficult. Digital and community outreach are frequently managed by different teams with different incentives and reporting lines, which impedes the joint planning that complementarity requires. Community partners may lack the capacity to absorb referral volume generated by a successful digital campaign, creating bottlenecks that undermine the programme's reputation. Digital campaigns may reach audiences for whom no assisted route currently exists, raising expectations that cannot be met. The framework therefore recommends that coordination mechanisms, capacity planning and route availability be addressed before, rather than after, outreach is scaled. It also emphasises that trust is built slowly and lost quickly, so that digital messages must be consistent with what community partners can actually deliver. Managing these dependencies is as important as selecting the right channels, and it is the difference between outreach that generates activity and outreach that generates access.

Coordinating the two channels in practice raises questions about capacity, sequencing and consistency that the framework addresses only in outline. A digital campaign can generate demand faster than community partners can absorb it, and a mismatch of this kind damages the credibility of both the campaign and the partners who must manage the consequences. The framework therefore recommends that demand and capacity be planned together, that digital messaging be calibrated to what the assisted routes can actually deliver, and that the sequence of awareness, enquiry and assistance be designed rather than left to chance. It also emphasises that consistency of information matters: where digital content and community workers give different accounts of eligibility, eligibility cost or process, trust erodes and completion falls. Maintaining a shared, current account of the service across both channels is therefore part of the intervention rather than an administrative detail. These requirements place a premium on joint planning between teams that are often managed separately, which is itself a practical challenge the framework identifies rather than resolves.

Ultimately, the framework asks programme teams to treat coordination as a design requirement rather than an aspiration. Digital reach and community assistance produce access only when they are planned together, resourced together and evaluated together, with demand calibrated to capacity and information kept consistent across both channels. Programmes that achieve this coordination convert awareness into completed service contact more reliably than those that rely on either channel alone. Programmes that do not will continue to generate activity that does not become access, and to explain the shortfall after the fact. Adopting the framework's measurement and planning practices is therefore not merely a reporting improvement but a means of making

the relationship between outreach and access visible, manageable and, where necessary, open to correction.

4. Conclusion

This paper has argued that digital and community outreach perform distinct and complementary tasks in supporting access to home healthcare, and that they should be planned and evaluated as a coordinated system rather than as competing alternatives. Digital channels create reach and deliver consistent information, while community partners supply the trust, explanation and practical assistance that convert awareness into action. The framework introduced the concept of an assisted route to describe the people and processes that bridge information and completed service contact, and it treats this assistance as a designed component whose contribution should be recorded rather than left invisible. It recommended that measurement span the full access pathway, from exposure through referral to first service receipt, so that the point of failure becomes apparent, and that digital and community contributions be attributed separately. It also identified the coordination, capacity and consistency conditions that determine whether complementarity is realised in practice. Where these conditions are met, the combination of digital reach and community assistance is more effective than either channel alone in moving underserved populations toward care. Matching digital demand to community capacity, and keeping both channels consistent, will determine whether coordination produces access rather than activity. These practical decisions determine whether the framework supports improvement or merely documents activity.

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