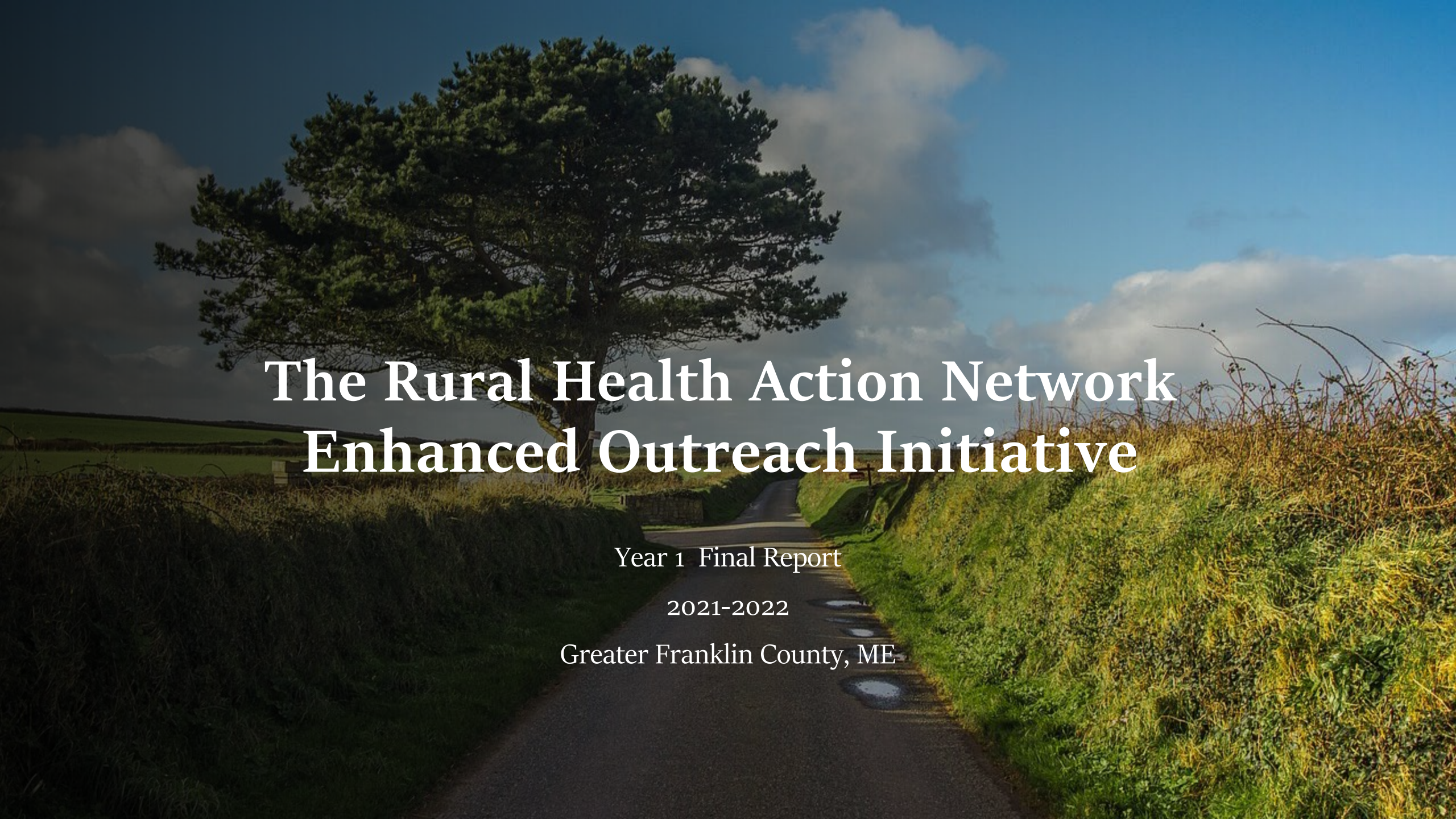
12-2022

Rural Health Action Network Enhanced Outreach Initiative. Year One Final Report

Mary Lindsey Smith PhD

Karen Pearson MLIS, MA

Evelyn Ali BS



The Rural Health Action Network Enhanced Outreach Initiative

Year 1 Final Report

2021-2022

Greater Franklin County, ME

Overview

I. Background

RHAN-EOI Y1 Summary

Background

Healthy Community Coalition (HCC), in coordination with the Rural Health Action Network (RHAN) of greater Franklin County, is implementing a multi-faceted outreach program to improve health outcomes among the rural poor living with chronic conditions in greater Franklin County, Maine. The goal of the Franklin County Rural Health Action Network Enhanced Outreach Initiative (RHAN-EOI) is to:

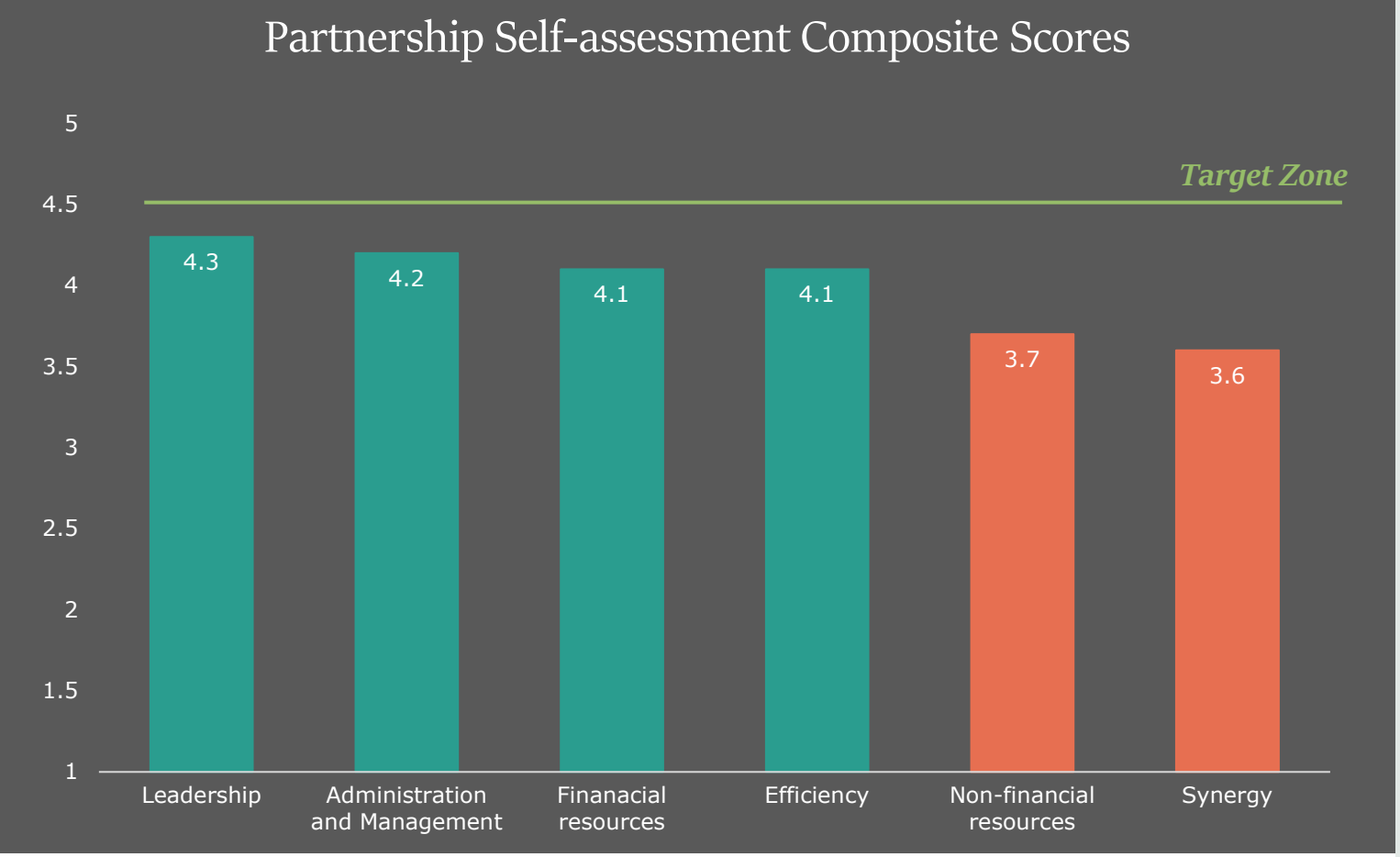
- Expand access to quality services;
- Expand training for community health extenders;
- Decrease hospital admissions, emergency department use, and costs; and
- Improve communication and care coordination across project partners

II. Partnership Self-assessment

RHAN-EOI Y1 Summary

Partnership Self-Assessment

- The partnership self-assessment tool is a questionnaire designed to measure indicators of successful collaboration.
- The purpose of the tool is to identify strengths and weaknesses of the partnership as well as to define key areas to focus on to make the partnership more successful.
- The tool measures the following domains on a standardized scale:
  - **Synergy**: how well the partners work together to set goals or problem-solve
  - **Leadership**: ability of formal or informal leadership to problem-solve and motivate partners
  - **Efficiency**: use of financial and non-financial resources
  - **Administration and Management**: effective communication, meetings, and materials
  - **Non-financial resources**: access to skills, influence, and credibility
  - **Financial/capital resources**: availability of money, space, and time
- In addition, the tool also describes aspects of the partnership related to decision-making and the benefits and draw-backs of participation.



Target Zone (4.6 – 5): Partnership is currently excelling in this area and should focus attention on maintaining a high score, *represented with line*

Headway Zone (4 – 4.5): Partnership is coalescing in this area but has potential to progress further

Work Zone (3 – 3.9): More effort is needed in this area to maximize partnership's collaborative potential

Danger zone (0 – 2.9): Area needs significant improvement

Overview of Findings

- Survey deployed October 2021
- N=8 partners responded
- The partnership has strong scores in the domains of leadership, administration and management, financial resources, and efficiency
- The partnership should continue to work on synergy and maintaining/enhancing non-financial resources

Key Findings: Partnership Strengths

Partnership Self-assessment

Partnership Self-Assessment: Partnership Strengths

The following are the partnership's highest-rated items in each domain

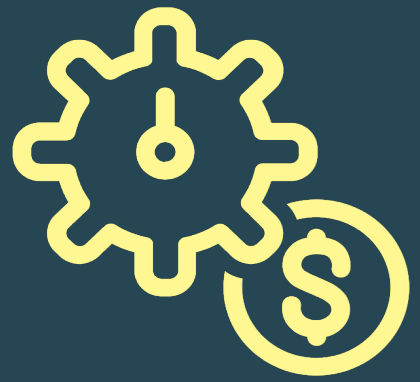
Leadership

- Fostering respect, openness, and inclusivity
- Ensuring opinions are heard
- Motivating partners

Administration and Management

- Coordinating communication among internal and external partnership
- Minimizing barriers to participation

Financial Resources and Efficiency



- Securing space for partnership activities
- Using in-kind or financial resources efficiently

Headway Zone Domains

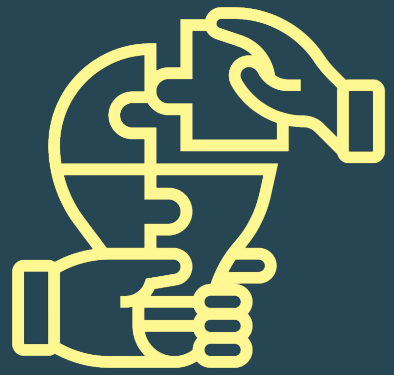
Partnership Self-Assessment: Partnership Strengths (continued)

The following are the partnership's highest-rated items in each domain

Non-financial Resources

- Maintaining relevant skills and expertise
- Necessary influence to convene partners

Synergy



- Considering views of affected individuals
- Identifying new ways to solve problems

Work Zone Domains

Key Findings: Areas for Improvement

Partnership Self-assessment

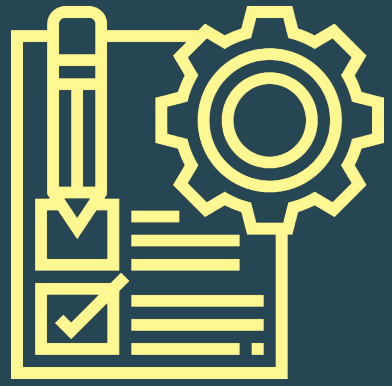
Partnership Self-Assessment: Areas for Improvement

The following are the partnership's lowest-rated items in each domain, indicating potential to increase scores

Leadership

- Recruit diverse people and organizations

Administration and Management



- Evaluate the progress and impact of the partnership
- Prepare materials that inform partner decisions

Financial Resources and Efficiency

- Use partner time efficiently
- Engage new funding streams

Headway Zone Domains

Partnership Self-Assessment: Areas for Improvement (continued)

The following are the partnership's lowest-rated items in each domain, indicating potential to increase scores

Non-financial Resources

- Engage with appropriate government stakeholders

Synergy

- Coordinate comprehensive activities
- Communicate impact of partnership to community

Work Zone Domains

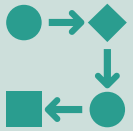
Findings: Other Key Takeaways

Partnership Self-Assessment

Partnership Self-Assessment: Decision-making

86% of respondents are very or extremely comfortable with how decisions are made in the partnership

88% of respondents support decisions made by the partnership most or all of the time



14% of partners feel they had been left out of the decision-making process some of the time

Partnership Self-Assessment: Benefits and Drawbacks

Benefits reported by respondents as a result of participating in the partnership included:

- Learning new things
- Contributing to the community
- Developing relationships
- Meeting the needs of clients
- Utilizing partnership expertise/services

Drawbacks reported by respondents as a result of participating in the partnership included:

- Frustration
- Diversion of time and resources

100% of respondents believed that benefits of participation outweighed the drawbacks

III. Key Informant Interviews

RHAN-EOI Y1 Summary

Key Informant Interviews

- We conducted key informant interviews with five key staff-members at the participating partner organizations to inform both the process and outcome evaluations.

- The interview questions were designed to elicit feedback on a broad range of topics, including enhancing access to care and cross-sector care coordination and integration of care; impact of COVID-19; factors influencing the implementation of the HCC RHAN project; and enhancement of consortium participation.

Key Informant Interviews: Access to Care

Key informants identified successes and challenges to delivering accessible, integrated care to target population during year 1.

Successes

Increased awareness of resources and programs to facilitate outreach and access to care for community-members

Increased use of community paramedicine as strategy to improve access to care

Challenges

Transportation is a persistent barrier to service population accessing needed resources

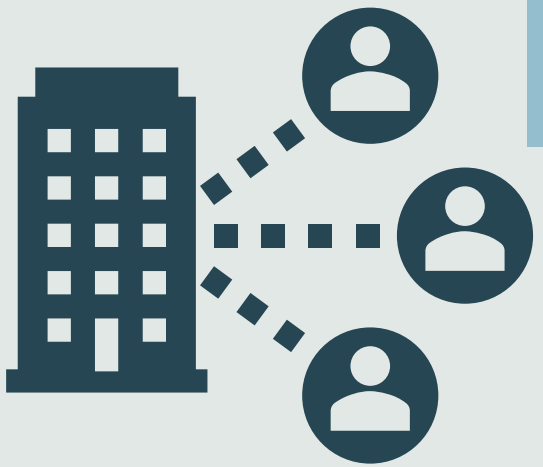
Strain on resources, including internal and external provider staffing capacity. COVID-19 added additional constraints.

"The community paramedicine was a big component for folks because transportation was challenging, getting folks up into the rural part of the state so they didn't have to travel was key."

"I think transportation is honestly the biggest thing that's lacking right now."

Key Informant Interviews: Role of Collaboration

Key Informants discussed the significant value that the collaboration of the RHAN Consortium brought to their service population.

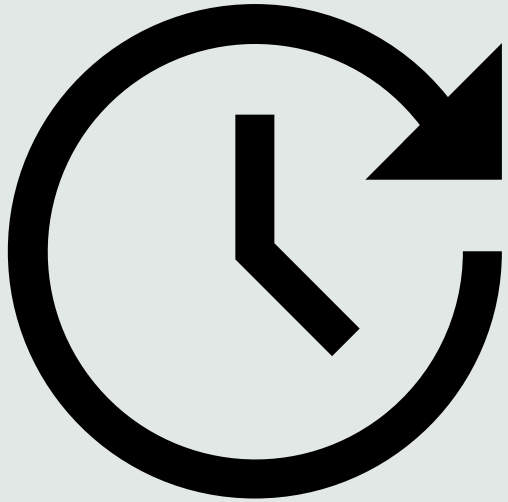


Alleviate barriers to care for service populations by increasing connections to mobile services (e.g., Mobile Health Unit, Community Paramedicine, food pantry deliveries)

Improved use of expertise and resources to solve problems and meet community member needs.

Enhanced ability to adapt to COVID-19 by pivoting resources collaboratively

"The communication of the RHAN group has been great, I feel like if someone needs something and they're not the right resource for it, they know who to check in with. If they don't know who to check in with, they know that coming to the group collectively we can figure out resources and tools for folks."



IV. Collaboration Multiplier Tool

RHAN-EOI Y1 Summary

Collaborative Multiplier Tool

- The Collaborative Multiplier Tool was completed with RAHN Consortium members during a regularly scheduled monthly meeting.
- The Collaboration Multiplier Tool is an interactive tool designed to analyzing collaborative and strengthen collaborative cross-sector efforts.
- The evaluation lead the Consortium through an exercise to identify shared goals, strengths and opportunities for enhancing group efforts in the upcoming year.

Collaborative Multiplier Findings

Shared Goals

Increased awareness – diverse partner perspectives inform collaborative learning about resources and problem-solving

Impact – Identifying opportunities and meeting them to improve partner organization efficacy and reach

Focused on maintaining and improving engagement with rural Maine seniors.

Strengths

Committed partners - engaged over long periods of time and in the absence of funding

Trusting relationships – allows partners to identify internal and external needs and meet them in order to support each other's organizations to support the community

Flexible and adaptable– able to rapidly identify problems and pivot strategies and approaches due to shared goals

Opportunities

Meetings

- increasing meeting frequency will improve program effectiveness
- Holding designated space in each meeting to identify accomplishments and next steps.

Partners

- Engage with new partners to improve awareness and increase impact (i.e. mental health, UMF)
- Collaboratively identify solutions to gaps in care, including in-home support services

Key Findings

- Collaborative efforts to connect service population with low-barrier services has been largely successful.
- In order to supported shared goals, the greatest opportunity lies in sustaining partnership momentum when new strategies are identified.
- Limited staffing capacity remains a key barrier to program implementation and service provision. Potential solutions include continuing to recruit new partner organizations and utilizing innovative staffing solutions.

V. HRSA Performance Measures

RHAN-EOI Y1 Summary

HRSA Performance Measurement Data

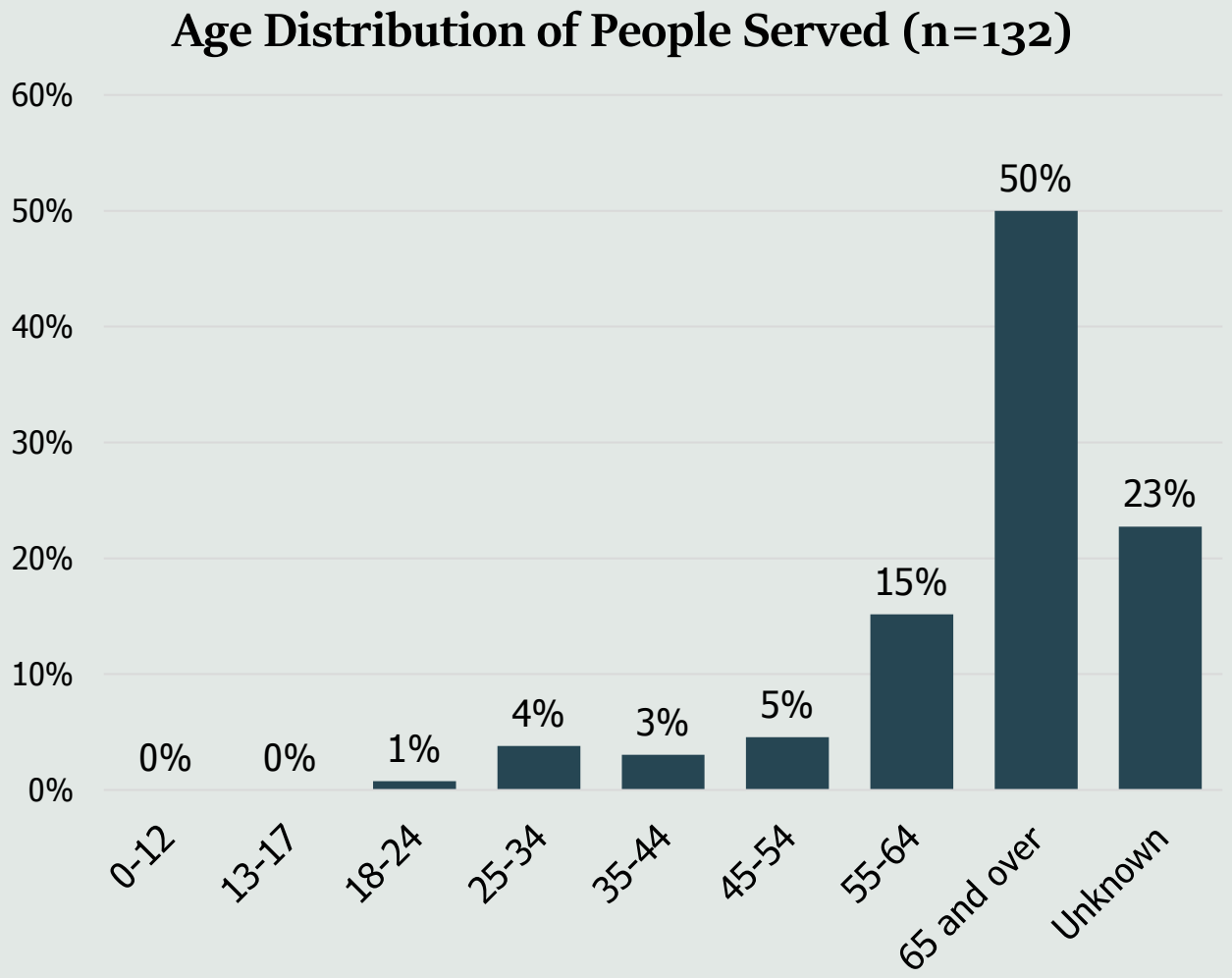
- HRSA requires that some organizational and service provision data be collected by grantees.
- This data reflects services delivered by NorthStar and service utilization and clinical outcomes in HCC data
- HRSA collects data related to:
  - *Demographics*
  - *Service Delivery*
  - *Clinical Outcome Data*

The following slides show data from Year 1 of the 4-year grant

HRSA Performance Measurement Data: Year 1 Demographics

50% of people served by RHAN were over 65

49% were insured by Medicaid

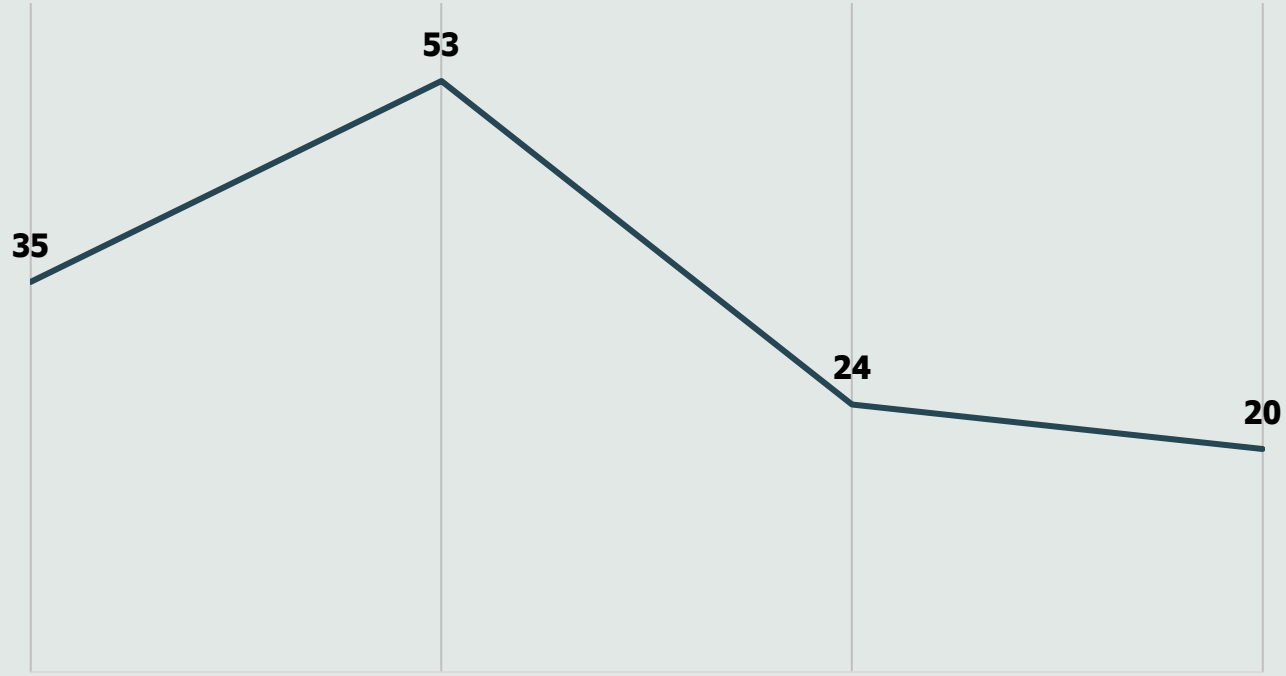


HRSA Performance Measurement Data: Number of people served

RHAN served 132 people through NorthStar services from May 1, 2021 to March 30, 2022.

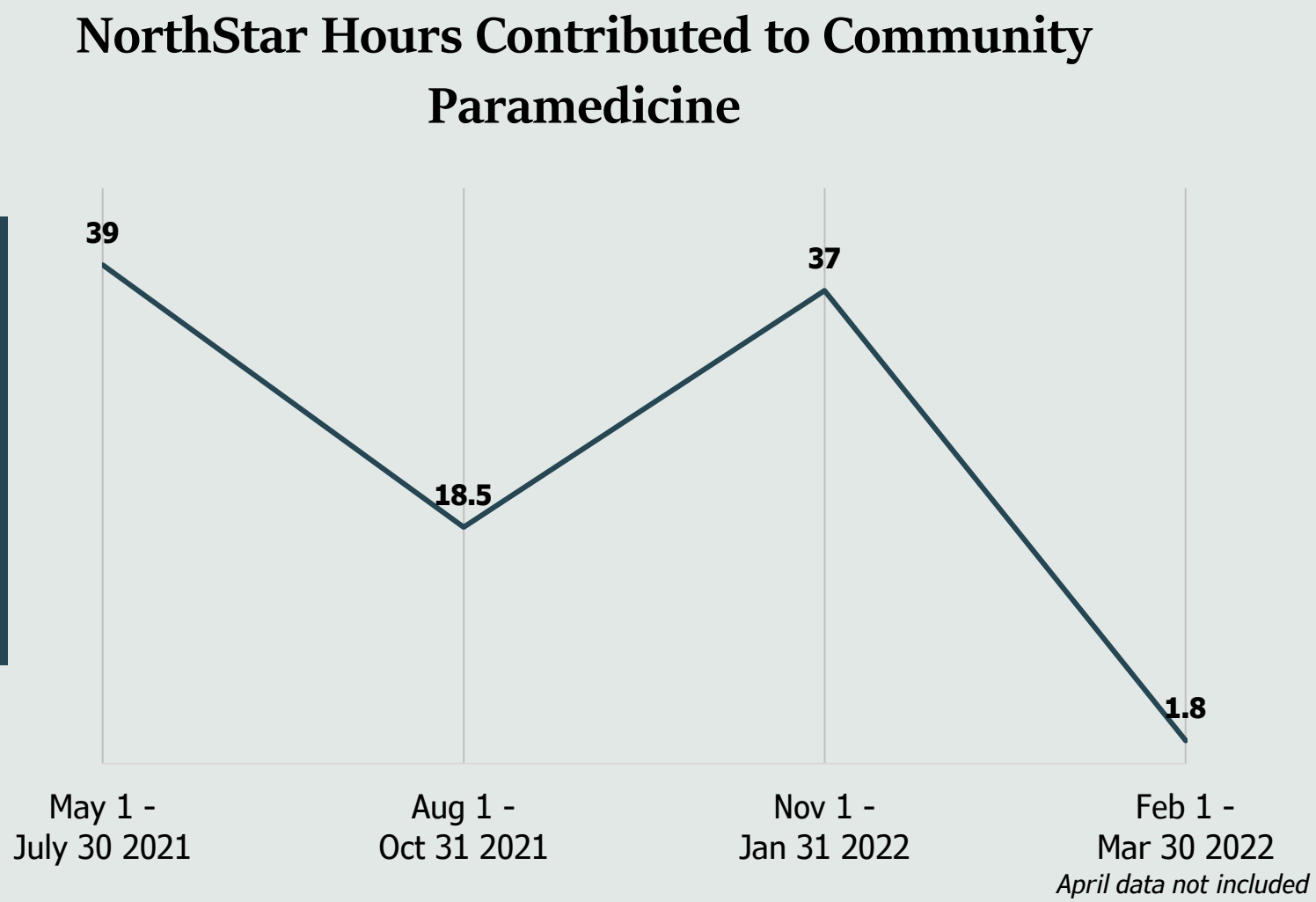
RHAN served the most people between August 1 and October 31, 2021.

Number of people served by HCC and Northstar through RHAN services



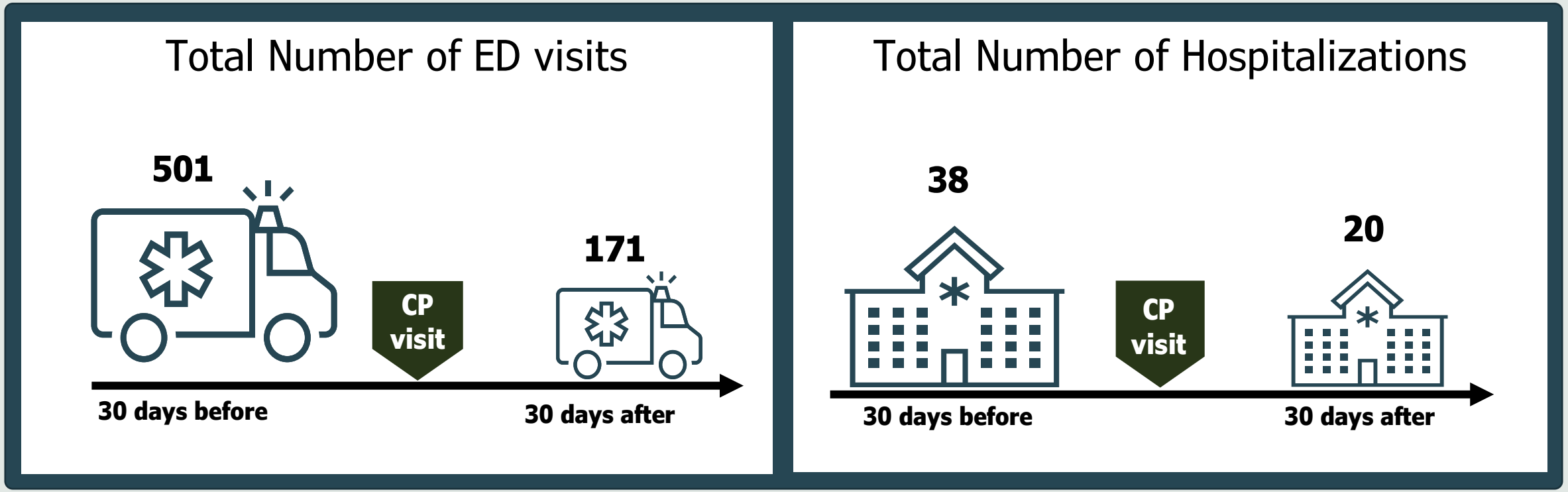
HRSA Performance Measurement Data: Paramedicine Hours

NorthStar contributed a total of 96.3 hours to community paramedicine from May 1, 2021 to March 30, 2022.



HRSA Performance Measurement Data: Outcomes

Data indicate that among patients with CP visits, utilization of the ED and hospital **declines** in the 30 days after a visit from May 1, 2021 – March 31, 2022



VI. SF-12 Survey

RHAN-EOI Y1 Summary

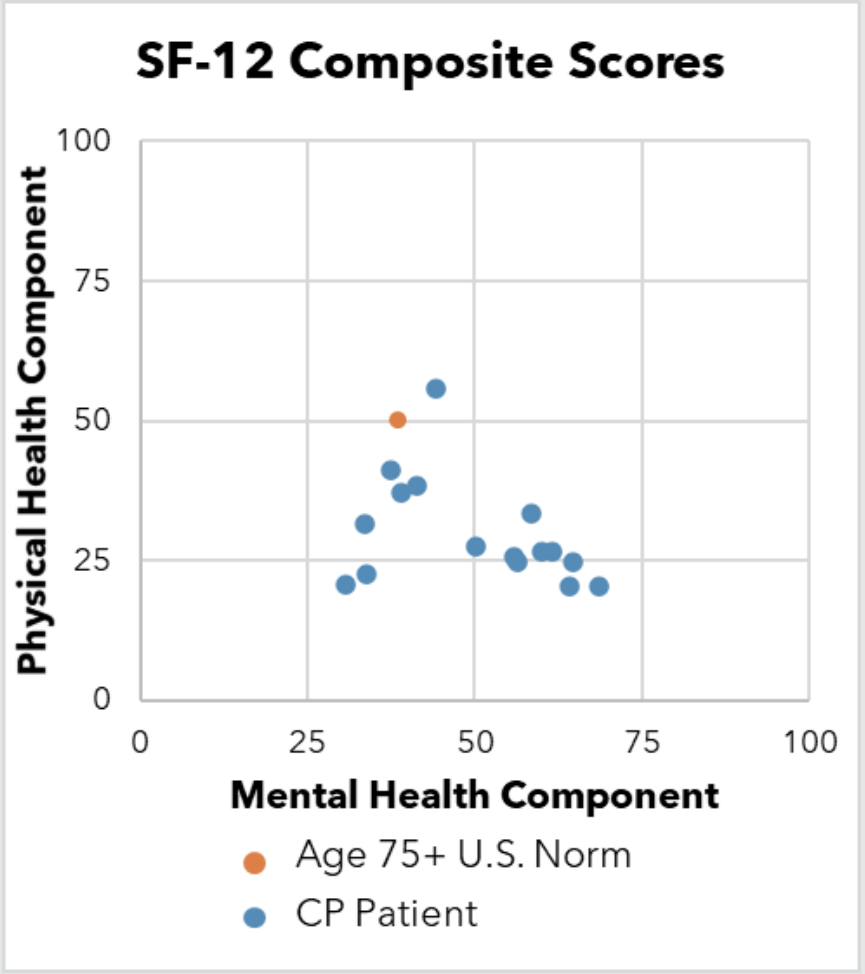
SF-12 Survey

- The SF-12 is a survey used to measure how a patient's health affects their everyday life. It was used to measure quality of life in community paramedicine patients because of its high validity and reliability in diverse patient populations.
- The SF-12 was completed as a part of the patient interviews with 16 individuals who had a CP visit in the last 2 years.
- The survey was conducted between April and May of 2022

- The survey has two parts:
  - *The Physical Component Score (PCS)*
  - *The Mental Component Score (MCS)*
- Both the PCS and MCS have an average score of 50 in the U.S. Population.

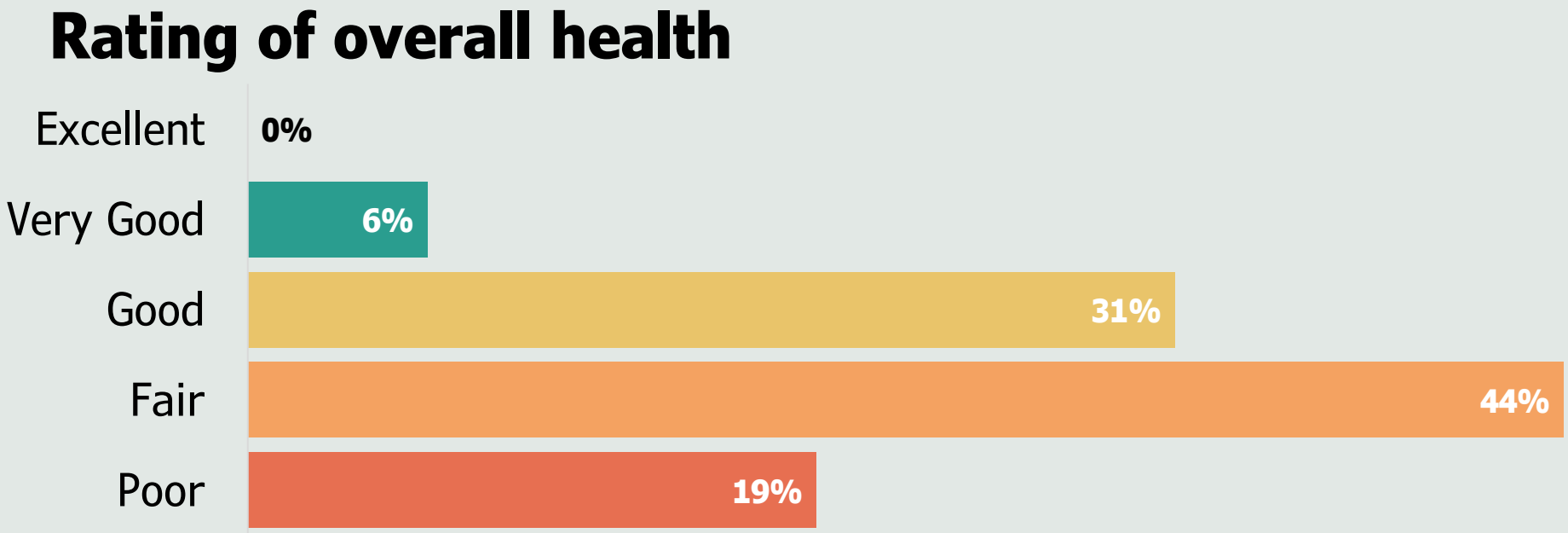
Physical and Mental Component Scores

Physical Health Component scores were generally lower than those of 75+ year olds in the U.S., but many had Mental Health Component scores that were higher.



Overall Ratings of Health

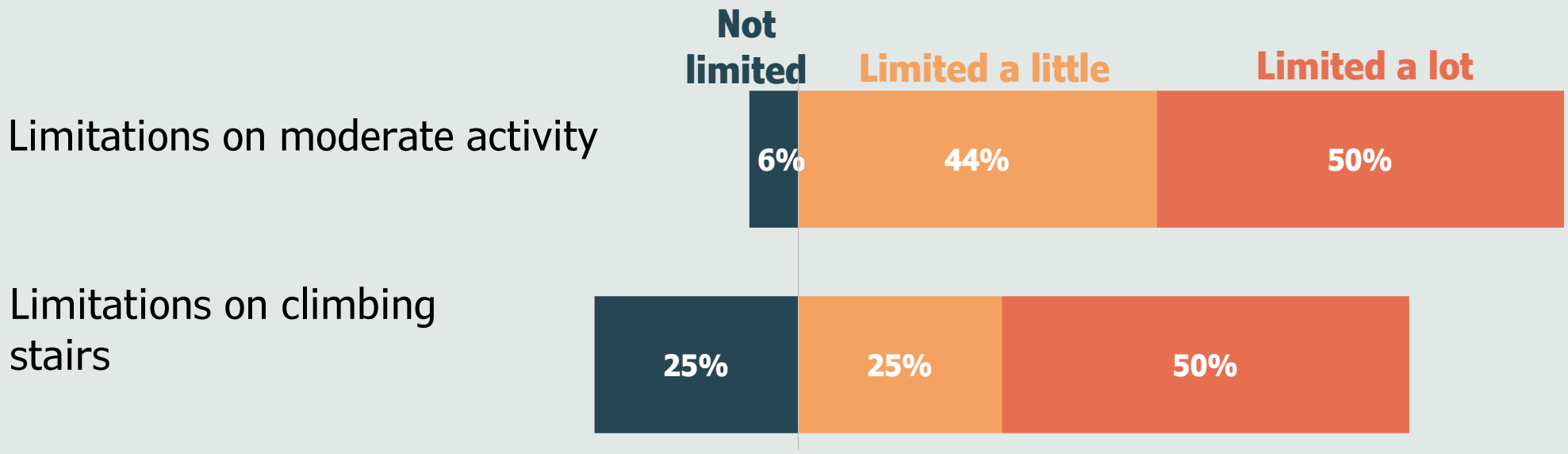
When reflecting on their own health, **63% of respondents considered their health to be either fair or poor.** No respondents believed their overall health was excellent.



Physical Health and Limitations on Daily Life

Almost all (94%) of respondents reported that they were at least limited a little in moderate activity, and 75% of respondents reported they had limitations on climbing stairs.

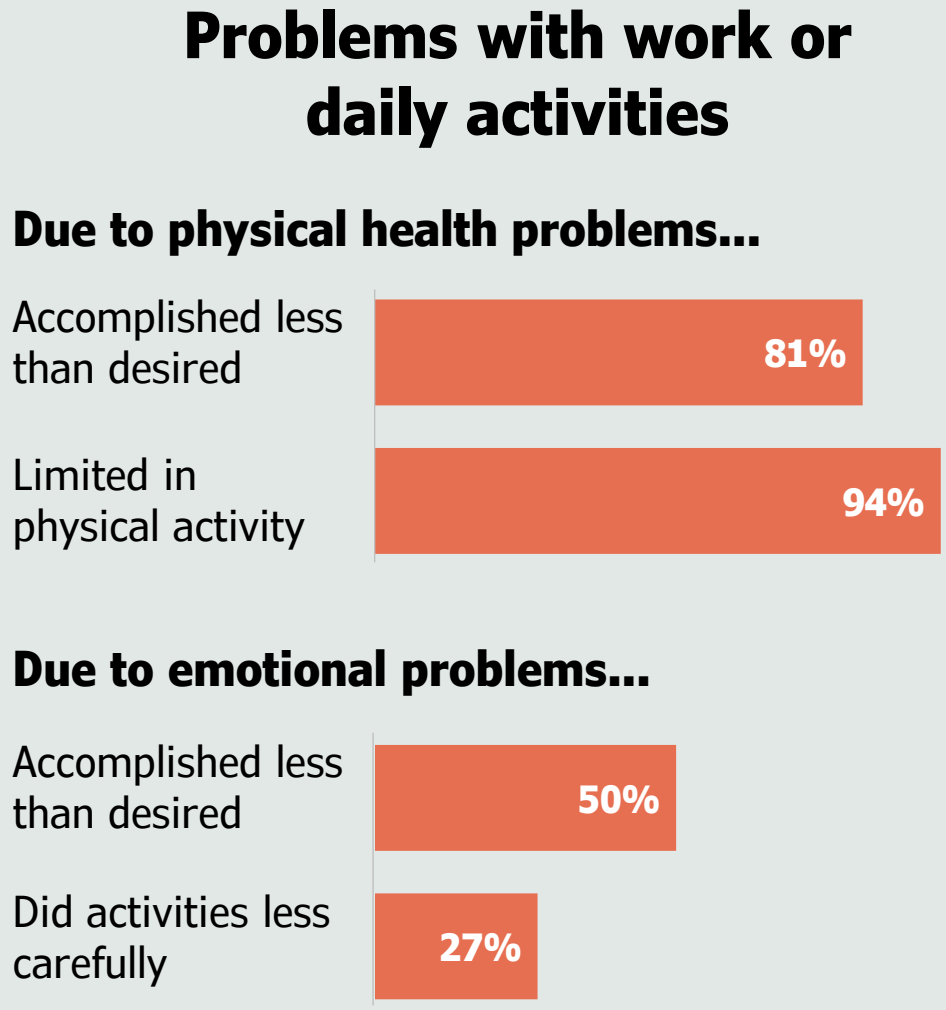
Physical Health and Limitations



Physical and Emotional Problems

81% reported that they accomplished less than desired because of their physical health. Respondents were more likely to report that physical health, rather than emotional problems interfered with their daily activities.

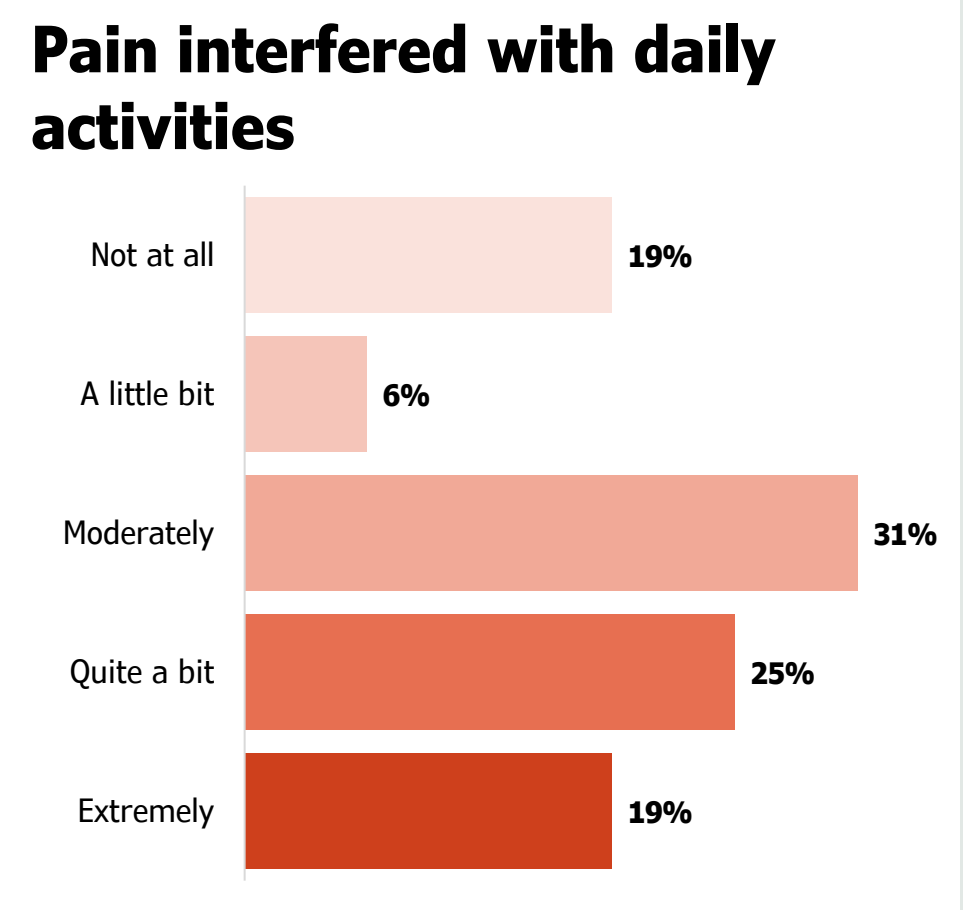
However, 50% said they accomplished less and 27% said they did activities less carefully because of emotional problems.



Pain and Well-being

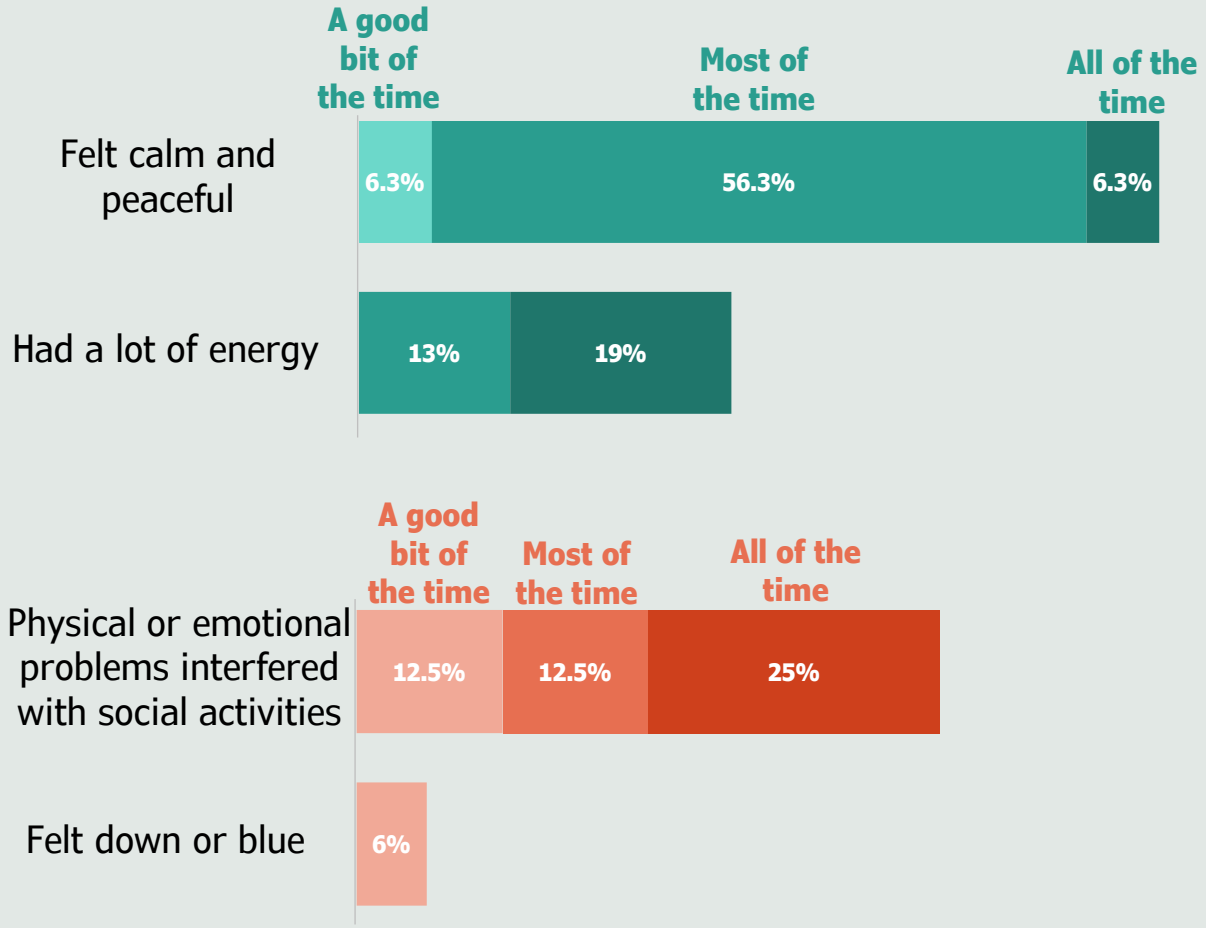
75%

of respondents said pain at least moderately interfered with their normal work



Physical Health and Limitations on Daily Life

50% reported that physical or emotional problems interfered with social activities at least a good bit of a time.



VII. Patient Interviews

RHAN-EOI Y1 Summary

Background

- Telephonic interviews were conducted in April and May of 2022
- Two rounds of outreach were conducted to patients involved with the NorthStar Community Paramedicine Program, based on a list of enrolled CP patients supplied by the Clinical Program Coordinator at the Healthy Community Coalition of Greater Franklin County
- 16 interviews were completed from a pool of 40 individuals contacted for a response rate of 40%
- Topics Covered:
  - COVID-19 Impact on Access to Care
  - Community Paramedic Visit Experience
  - Service Gaps
  - Recommendations for Provider Organizations

COVID-19 Impact on Access to Care

Participants discussed the impact of the COVID-19 pandemic on their ability to access the care they need.

Neutral Changes

- PPE requirements (face mask)
- Implementation of Telehealth visits

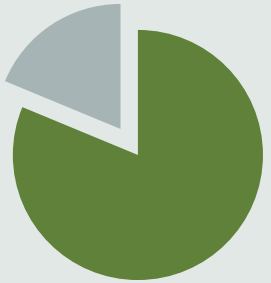
Facilitators

- In-home care reduces the need to go to the hospital

Barriers

- Challenges acquiring homemaker services
- Low provider capacity within primary care
  Office staff will sometimes send patients to urgent care when they can't accommodate them
- PPE requirements (face mask) in the hospital when patient has trouble breathing
- Not seeking care over concerns of contracting COVID

"I'm a little disgruntled with the fact that I tried to go through the correct methods, I went to my doctor first, or called, but I wasn't able to go see them."

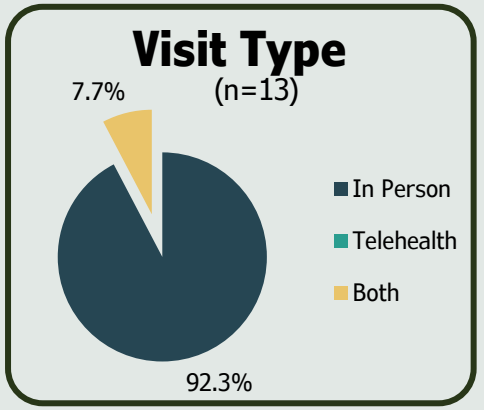


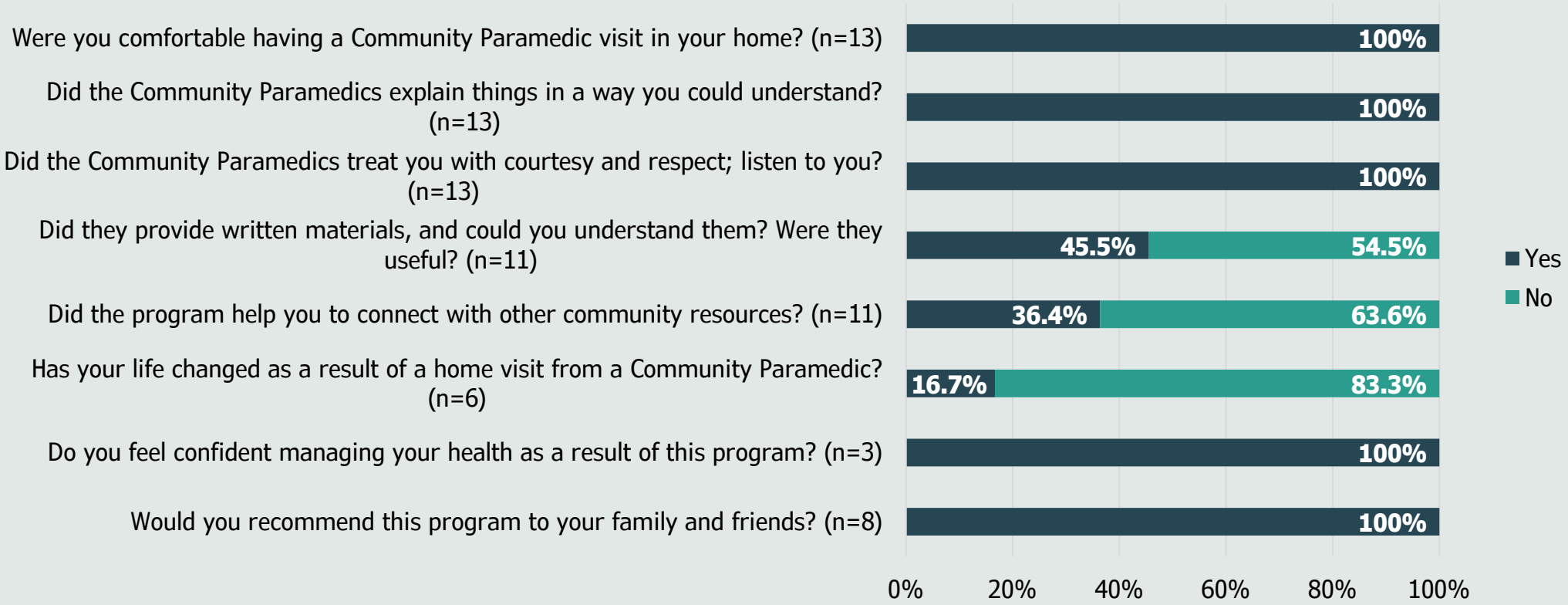
81.3% of respondents indicated that the COVID-19 pandemic has not impacted their ability to access the care they need. (n=16)

Community Paramedic Visit Experience

Participants shared their experience with community paramedicine services within the past 12 months.

- Overall, participants shared positive experiences with their community paramedic visits, highlighted by comfort, communication, and respect
- Most participants reported they were not provided written materials at their community paramedic visit





Service Gaps & Access Challenges

Participants discussed services they would like to receive but can not obtain from their current provider organization, in addition to challenges they face in attempting to access these services.

Service Gaps

In-home Services

Participants reported a lack of in-home services including help with daily tasks (i.e., bathing), blood draw, and homemaker services (i.e., cooking, mopping, sweeping, or dishes).

Oxygen Machines

Participants reported a lack of mobile, portable, high-output oxygen machines.

Access Challenges

Service Capacity & Staffing

Participants reported challenges getting appointments with providers due to limited hours of operation and lack of staff (including EMS personnel, nurses, and homemaker service personnel).

Proximity of Services

Participants reported the challenge of having to travel long distances (i.e., to Portland) for specialists who aren't available nearby.

Recommendations for Provider Organizations

Participants shared recommendations for what their current provider organization(s) could do to better meet their needs and help enhance patient-centered care. *(List is in alphabetical order.)*

- Begin offering in-home services, such as patient-directed care and help with activities of daily living
- Expand off-hours walk-in clinics to avoid going to the emergency room or urgent care
- Improve timeliness of communication
- Increase provider capacity—appointments seem rushed because providers are too busy
- Listen to patients and improve patient-centered care
- Provide structured follow-up care for patients with long COVID or post-COVID conditions

Contact Information

Catherine Cutler Institute Evaluation Team

University of Southern Maine

Principal Investigator

Lindsey Smith, PhD, MSW

m.lindsey.smith@maine.edu

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