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Outer Cape Community Resource Navigator Program: Rural Community Engagement-Driven Service Delivery

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CCTS Community Engagement and Research

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The Need

Municipalities seeing increased numbers of people with mental health/substance abuse diagnoses resulting in:

- Increased police calls
- Increased EMS calls
- Increased ED visits
- Increased costs to communities

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So Many Agencies

AIDS Support Group of Cape Cod
Alzheimer's Family Support Center of Cape Cod
Barnstable Forum for Homelessness & Social Services
Church of St. Mary's of the Harbor
Church of St. Mary's
Community Development Meeting
Community Development Partnership
CORD, Cape Representing Disabled
Council on Aging, Provincetown
Elder Services of Cape Cod
Gosnold
Housing Assistance Corp.
Healthy Connections
Helping Our Women
Hoarding Task Force of Cape Cod
Homeless Not Hopeless
Homeless Prevention Coalition
Independence House
Massachusetts Department of Mental Health
Methodist Church
Noah Shelter
OCHS Care Coordination
OCHS OBOT
Open Doorways of Cape Cod
Orleans District Court
Provincetown Council on Aging
Provincetown Housing Authority
Seashore Point
Sober Housing Conversation
St. Peter the Apostle
Truro Council on Aging
Unitarian Universalist Church
Vinfen
WE CAN...

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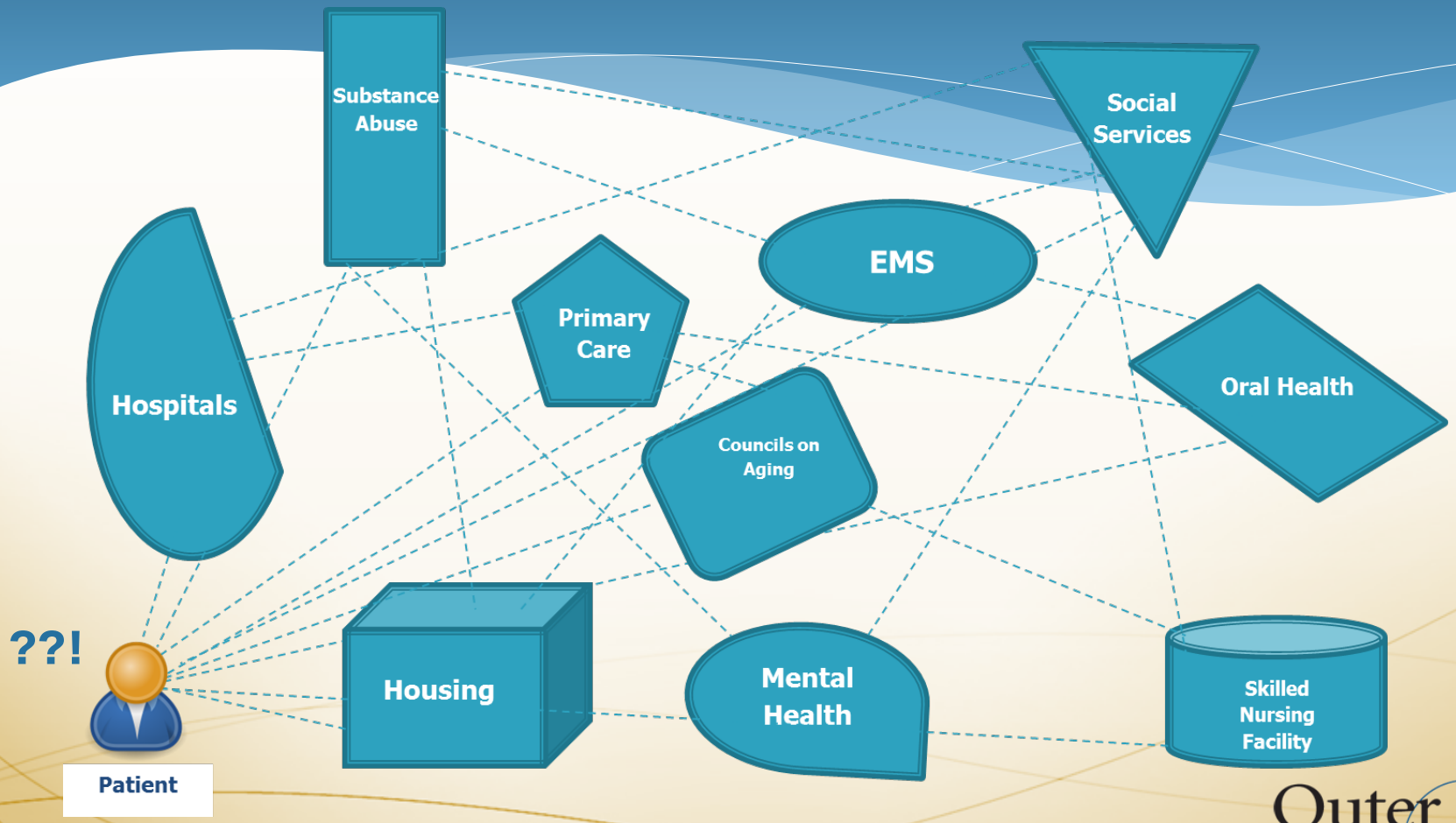
How it Looks to Consumers



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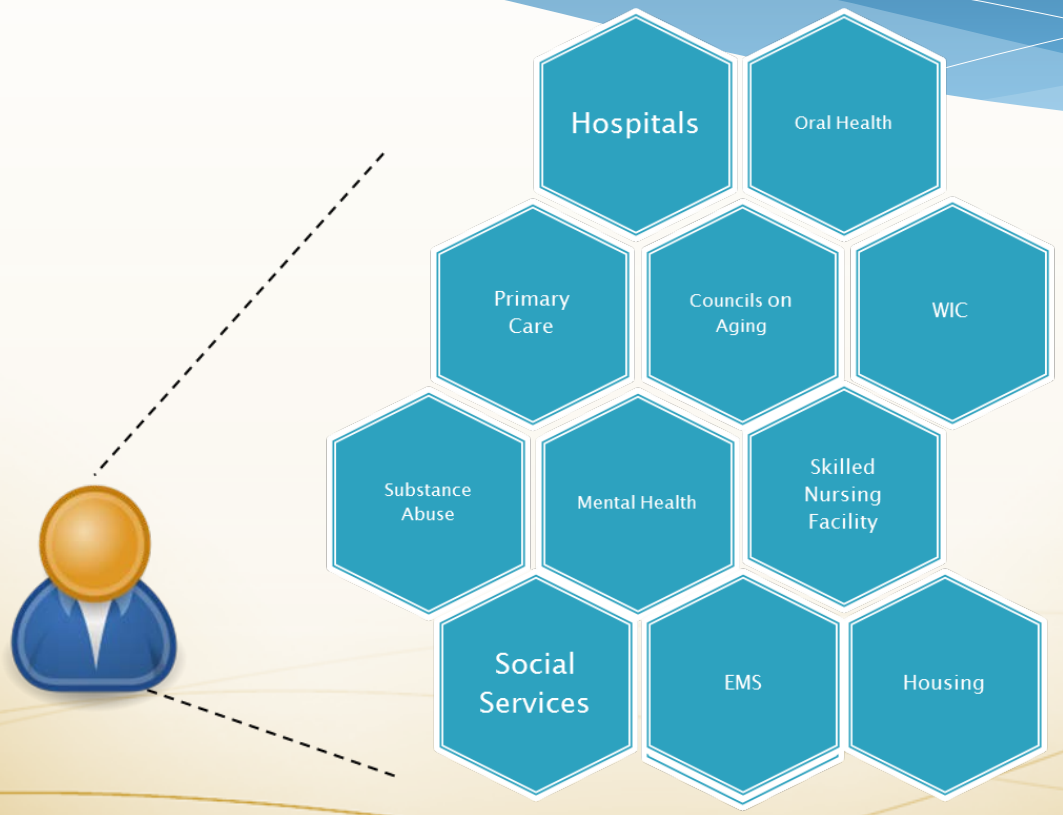
How it Should Look



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One Solution: Navigators

- A Community Health Worker
- The “Glue”: Connect/refer individuals to services (e.g., mental health, substance use, housing, legal, medical, etc.)
- Identify clients through referrals from community partners/agencies
- Build strong relationship, assess needs
- Develop service plan to address priority issues
- Collect data, track progress, identify gaps in services

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One Community's Answer

Provincetown Human Services Grant:

- Case management for people with social determinants of health-based issues:
  - Substance use
  - Behavioral health
  - Insecure housing, etc.
- Data key: annual extensions based on results

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Provincetown Model

- Staffing: 1 FTE Navigator, .2 MSW
- Referrals from community partners (police, EMS, etc.)
- Contact clients in the field
- Needs assessment: Self Sufficiency Matrix
- Connect client to treatment/services
- Participant emergency assistance

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What Does a Navigator Do?

- Identify residents with unmet needs
- Referrals from/collaboration with local agencies, providers, community groups
- Build relationship with individual and identify support network
- Develop treatment/service plan to address priority issues
- Connect/refer individuals to services
  - Mental health services
  - Substance abuse services
  - Homelessness/housing assistance
  - Medical care
  - Case management
  - Social services, etc.
- Collect data to track patient progress
- identify gaps in services

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Self-Sufficiency Matrix Participant Name _____ DOB __/__/____ Assessment Date __/__/____ Initial Interim Exit

OCHS CRN Program ID _____

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.		
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.		
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.		
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.		
Child Care	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.		
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.		
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.		
Health Care Coverage	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) have medical coverage.	All members can get medical care when needed, but may strain budget.	All members are covered by affordable, adequate health insurance.		
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.		
Family /Social Relations	Lack of necessary support form family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Strong support from family or friends. Household members support each other's efforts.	Has healthy/expanding support network; household is stable and communication is consistently open.		

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable; car is adequately insured.		
Community Involvement	Not applicable due to crisis situation; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.	Actively involved in community.		
Parenting Skills	There are safety concerns regarding parenting skills.	Parenting skills are minimal.	Parenting skills are apparent but not adequate.	Parenting skills are adequate.	Parenting skills are well developed.		
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.	No active criminal justice involvement in more that 12 months and/or no felony criminal history.		
Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns.		
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.		
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.	Safety is threatened/temporary protection is available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe, however, future of such is uncertain; safety planning is important.	Environment is apparently safe and stable.		
Disabilities	In crisis – acute or chronic symptoms affecting housing, employment, social interactions, etc.	Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Building Capacity – asymptomatic – condition controlled by services or medication	Thriving – no identified disability.		
Other: (Optional)	In Crisis	Vulnerable	Safe	Building Capacity	Empowered		

A Different Challenge

- Small rural towns face similar challenges
- Residents with social determinant disparities
- Same problem, but lower density & numbers
- Limited funding potential
- One size does not fit all
- Adjust the model

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Admissions to DPH Funded Treatment Programs (2011)

Substance Use Treatment

	Eastham	Wellfleet	Truro
# Individuals	84	63	42
Area Crude Rate*	1513	2233	1943
State Crude Rate*		1532	

Injection Drug Use Treatment

	Eastham	Wellfleet	Truro
# Individuals	24	16	N/A**
Area Crude Rate*	432	567	N/A**
State Crude Rate*		621	

*per 100,000 persons **Sample size driven

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It Takes a Village

- A Shared Solution
- “Recovery 349” the champion/catalyst
- Wellfleet, Truro, and Eastham join forces
- Proposal: One shared Navigator
- Different model
- Adapt to larger geographic area
  - Travel
  - Multiple town agencies

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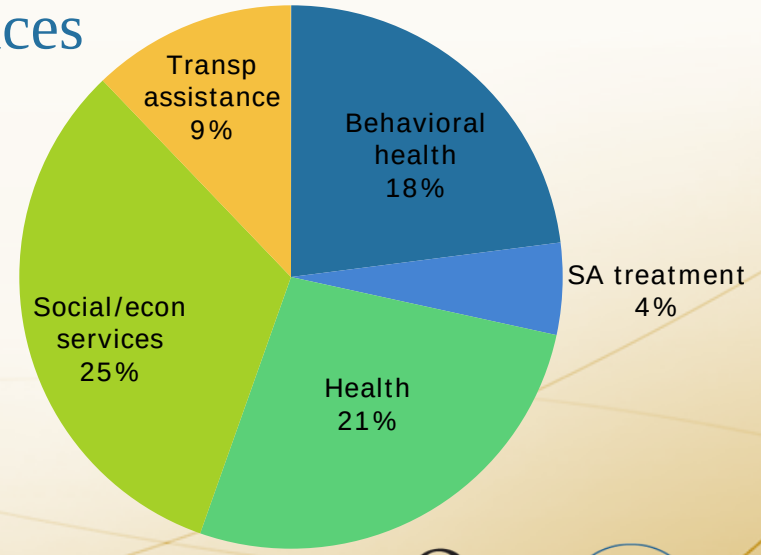
Provincetown at 6 Months

- 36 clients enrolled in program
- 100% of clients referred for services
- 95 referrals for services
- Behavioral Health Referrals:
  - Counseling:12
  - Psychiatry: 5
  - OBOT: 3
  - Detox: 1
- 44 Agencies contacted



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Self Sufficiency Progress

Total possible SSM score	90
Average score at baseline	49
Average score at 3-month follow-up	53
% clients demonstrating improvement	85%

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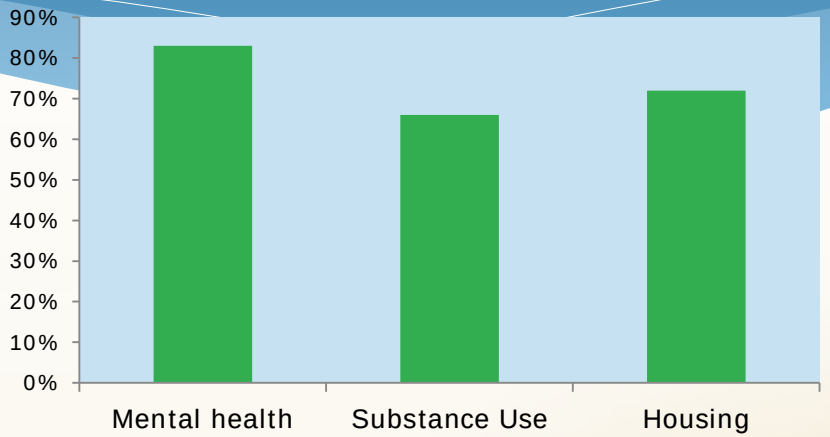
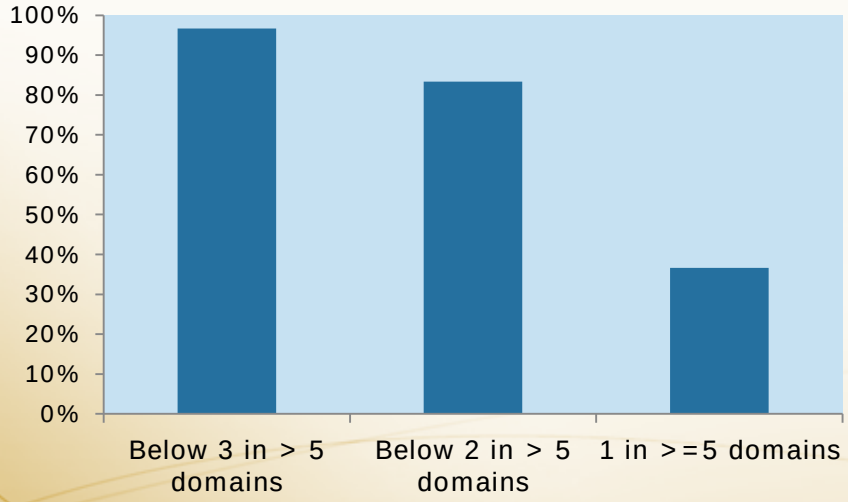
Multiple Needs Common



Issues Reported as Severe Need



Co-occurrence of domains with moderate to severe needs

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Data Key to Sustainability

- Grant funding for start-up phase
- Long-term funding sources:
  - Medicare
  - Medicaid
  - ACOs
- Data must demonstrate savings:
  - ED Visits
  - Repeat I/P, ED
  - Hospital LOS

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Adding More Tools

Expand Navigator screening tools using additional evidence-based instruments such as:

- PRAPARE (Social Determinants of Health Tool)
- SBIRT
- PHQ-2/PHQ-9

Technology to facilitate service connections

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Navigating from the ED

- Cape Cod Hospital implementing an ED Navigator
- CCH funding a complementary OCHS Community Navigator
- Direct line to OBOT (MAT), BH services in community
- Insurance eligibility/enrollment assistance

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The Future

OCHS Community-Based Coordinated Care:

- A virtual health center for community-based services
- 4 Community Navigators
- 2 Care Coordinators (transition from I/P ➡ community)
- HIV Medical Case Manager
- MAT Outreach Worker
- Etc.

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CHW/Navigator Literature

- Addressing Chronic Disease through Community Health Workers (www.cdc.gov/dhdsp/docs/chw_brief.pdf)
- A Cost Analysis of a Community Health Worker Program in Rural Vermont (www.ncbi.nlm.nih.gov/pmc/articles/PMC4602368/)
- Community Health Workers and Medicaid Managed Care in New Mexico (www.ncbi.nlm.nih.gov/pubmed/21953498)

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Thank You!

Questions and Discussion

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