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

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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
## 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...
How it Looks to Consumers
How it Should Look

- Hospitals
- Oral Health
- Primary Care
- Councils on Aging
- WIC
- Substance Abuse
- Mental Health
- Skilled Nursing Facility
- Social Services
- EMS
- Housing
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
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
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
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
- Collect data to track patient progress
- Identify gaps in services

- Mental health services
- Substance abuse services
- Homelessness/housing assistance
- Medical care
- Case management
- Social services, etc.
<table>
<thead>
<tr>
<th>Domain</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Score</th>
<th>Participant goal? (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing</strong></td>
<td>Homeless or threatened with eviction.</td>
<td>In transitional, temporary or</td>
<td>In stable housing that is safe but</td>
<td>Household is in safe, adequate</td>
<td>Household is safe, adequate,</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>substandard housing; and/or</td>
<td>only marginally adequate</td>
<td>subsidized housing.</td>
<td>unsubsidized housing.</td>
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<tr>
<td></td>
<td></td>
<td>current rent/ mortgage payment is</td>
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<tr>
<td></td>
<td></td>
<td>unaffordable (over 30% of income).</td>
<td></td>
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</tr>
<tr>
<td><strong>Employment</strong></td>
<td>No job.</td>
<td>Temporary, part-time or</td>
<td>Employed full time; inadequate pay;</td>
<td>Maintains permanent employment with</td>
<td></td>
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<td></td>
<td></td>
<td>seasonal; inadequate pay, no</td>
<td>few or no benefits.</td>
<td>adequate income and benefits.</td>
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<td></td>
<td></td>
<td>benefits.</td>
<td></td>
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<tr>
<td><strong>Income</strong></td>
<td>No income.</td>
<td>Inadequate income and/or</td>
<td>Can meet basic needs with subsidy;</td>
<td>Income is sufficient, well managed,</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>spontaneous or inappropriate</td>
<td>appropriate spending.</td>
<td>has discretionary income and is able to</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>spending.</td>
<td></td>
<td>save.</td>
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</tr>
<tr>
<td><strong>Food</strong></td>
<td>No food or means to prepare it. Relies</td>
<td>Household is on food stamps.</td>
<td>Can meet basic food needs, but</td>
<td>Can meet basic food needs without</td>
<td>Can choose to purchase any food</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>to a significant degree on</td>
<td></td>
<td>occasional assistance.</td>
<td>assistance.</td>
<td>household desires.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>other sources of free or low-cost</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>food.</td>
<td></td>
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</tr>
<tr>
<td><strong>Child Care</strong></td>
<td>Needs childcare, but none is</td>
<td>Childcare is unreliable or</td>
<td>Affordable subsidized childcare is</td>
<td>Reliable, affordable childcare is</td>
<td>Able to select quality childcare of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>available/accessible and/or child is</td>
<td>unavailable, inadequate supervision</td>
<td>available, but limited.</td>
<td>available, no need for subsidies.</td>
<td>choice.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>not eligible.</td>
<td>for childcare that is available.</td>
<td></td>
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</tr>
<tr>
<td>**Children's</td>
<td>One or more school-aged children</td>
<td>One or more school-aged children</td>
<td>Enrolled in school, but one or</td>
<td>Enrolled in school and attending</td>
<td>All school-aged children enrolled and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>not enrolled in school.</td>
<td>enrolled in school, but not</td>
<td>more children only occasionally</td>
<td>classes most of the time.</td>
<td>attending on a regular basis.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>attending classes.</td>
<td>attending classes.</td>
<td></td>
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</tr>
<tr>
<td><strong>Adult Education</strong></td>
<td>Literacy problems and/or no</td>
<td>Enrolled in literacy and/or</td>
<td>Has high school diploma/GED.</td>
<td>Has completed education/training to</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>high school diploma/GED are</td>
<td>GED program and/or has sufficient</td>
<td></td>
<td>improve employment situation and/or to</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>serious barriers to employment.</td>
<td>command of English to where language</td>
<td></td>
<td>resolve literacy problems to where</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>is not a barrier to employment.</td>
<td></td>
<td>they are able to function effectively</td>
<td></td>
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</tr>
<tr>
<td>**Health Care</td>
<td>No medical coverage with immediate</td>
<td>No medical coverage and great</td>
<td>Some members (e.g. Children) have</td>
<td>All members can get medical care when</td>
<td>All members are covered by affordable,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage</td>
<td>need.</td>
<td>difficulty accessing medical care when</td>
<td>medical coverage.</td>
<td>needed, but may strain budget.</td>
<td>adequate health insurance.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>needed.</td>
<td></td>
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<tr>
<td><strong>Life Skills</strong></td>
<td>Unable to meet basic needs such as</td>
<td>Can meet a few but not all</td>
<td>Can meet most but not all daily</td>
<td>Able to meet all basic needs of daily</td>
<td>Able to provide beyond basic needs of</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>hygiene, food, activities of daily</td>
<td>needs of daily living without</td>
<td>living needs without assistance.</td>
<td>living for self and family.</td>
<td></td>
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<tr>
<td></td>
<td>living.</td>
<td>assistance.</td>
<td></td>
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</tr>
<tr>
<td>**Family/Social</td>
<td>Lack of necessary support from family</td>
<td>Family/friends may be supportive, but</td>
<td>Some support from family/friends;</td>
<td>Has healthy/support network; household</td>
<td></td>
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<tr>
<td>Relations</td>
<td>or friends; abuse (DV, child) is</td>
<td>lack ability or resources to help,</td>
<td>family members acknowledge and seek to</td>
<td>is stable and communication is</td>
<td></td>
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<td></td>
<td>present or there is child neglect.</td>
<td>family members do not relate well with</td>
<td>change negative behaviors; are learning</td>
<td>consistently open.</td>
<td></td>
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<td></td>
<td></td>
<td>another; potential to communicate and</td>
<td>to communicate and support;</td>
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<td></td>
<td></td>
<td>support.</td>
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</tr>
<tr>
<td>Domain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Score</td>
<td>Participant goal? (✓)</td>
</tr>
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<td>----------------------------------------</td>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>Mobility</td>
<td>No access to transportation, public or private; may have car that is inoperable.</td>
<td>Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.</td>
<td>Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.</td>
<td>Transportation is generally accessible to meet basic travel needs.</td>
<td>Transportation is readily available and affordable; car is adequately insured.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Involvement</td>
<td>Not applicable due to crisis situation; in &quot;survival&quot; mode.</td>
<td>Socially isolated and/or no social skills and/or lacks motivation to become involved.</td>
<td>Lacks knowledge of ways to become involved.</td>
<td>Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.</td>
<td>Actively involved in community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Skills</td>
<td>There are safety concerns regarding parenting skills.</td>
<td>Parenting skills are minimal.</td>
<td>Parenting skills are apparent but not adequate.</td>
<td>Parenting skills are adequate.</td>
<td>Parenting skills are well developed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>Current outstanding tickets or warrants.</td>
<td>Current charges/trial pending, noncompliance with probation/parole.</td>
<td>Fully compliant with probation/parole terms.</td>
<td>Has successfully completed probation/parole within past 12 months, no new charges filed.</td>
<td>No active criminal justice involvement in more than 12 months and/or no felony criminal history.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.</td>
<td>Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.</td>
<td>Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.</td>
<td>Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.</td>
<td>Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns.</td>
<td></td>
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</tr>
<tr>
<td>Substance Abuse</td>
<td>Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.</td>
<td>Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidant or neglect of essential life activities.</td>
<td>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.</td>
<td>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.</td>
<td>No drug use/alcohol abuse in last 6 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.</td>
<td>Safety is threatened/temporary protection is available; level of lethality is high.</td>
<td>Current level of safety is minimally adequate; ongoing safety planning is essential.</td>
<td>Environment is safe, however, future of such is uncertain; safety planning is important.</td>
<td>Environment is apparently safe and stable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabilities</td>
<td>In crisis – acute or chronic symptoms affecting housing, employment, social interactions, etc.</td>
<td>Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.</td>
<td>Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.</td>
<td>Building Capacity – asymptomatic; condition controlled by services or medication</td>
<td>Thriving – no identified disability.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Optional)</td>
<td>In Crisis</td>
<td>Vulnerable</td>
<td>Safe</td>
<td>Building Capacity</td>
<td>Empowered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
## Admissions to DPH Funded Treatment Programs (2011)

### Substance Use Treatment

<table>
<thead>
<tr>
<th></th>
<th>Eastham</th>
<th>Wellfleet</th>
<th>Truro</th>
</tr>
</thead>
<tbody>
<tr>
<td># Individuals</td>
<td>84</td>
<td>63</td>
<td>42</td>
</tr>
<tr>
<td>Area Crude Rate*</td>
<td>1513</td>
<td>2233</td>
<td>1943</td>
</tr>
<tr>
<td>State Crude Rate*</td>
<td>1532</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Injection Drug Use Treatment

<table>
<thead>
<tr>
<th></th>
<th>Eastham</th>
<th>Wellfleet</th>
<th>Truro</th>
</tr>
</thead>
<tbody>
<tr>
<td># Individuals</td>
<td>24</td>
<td>16</td>
<td>N/A**</td>
</tr>
<tr>
<td>Area Crude Rate*</td>
<td>432</td>
<td>567</td>
<td>N/A**</td>
</tr>
<tr>
<td>State Crude Rate*</td>
<td></td>
<td>621</td>
<td></td>
</tr>
</tbody>
</table>

*per 100,000 persons  
**Sample size driven
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
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
**Self Sufficiency Progress**

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total possible SSM score</td>
<td>90</td>
</tr>
<tr>
<td>Average score at baseline</td>
<td>49</td>
</tr>
<tr>
<td>Average score at 3-month follow-up</td>
<td>53</td>
</tr>
<tr>
<td>% clients demonstrating improvement</td>
<td>85%</td>
</tr>
</tbody>
</table>
Multiple Needs Common

Issues Reported as Severe Need

Co-occurrence of domains with moderate to severe needs
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
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
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
OCHS Community-Based Coordinated Care:
- A virtual health center for community-based services
- 4 Community Navigators
- 2 Care Coordinators (transition from I/P to community)
- HIV Medical Case Manager
- MAT Outreach Worker
- Etc.
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)
Thank You!

Questions and Discussion