



Outer Cape Health Services: Community-Based Care Immersion, Analysis, and Enhancement for Rural Populations Facing Multiple Health Challenges

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> Population Health Clerkship November 4, 2019

Outer Cape Health Services (OCHS) Overview



HEALTH SERVICES

Mission

Provide a full range of healthcare and supportive social services that promote the health and well-being of all

who live in or visit the ten outermost towns of Cape Cod.

Overview

- Federally Supported Health Center
- 501(c)(3) non-profit organization
- Provides care for patients in the Outer Cape
- Serves more than nearly 17,000 patients per year
- No one is denied access to services due to an inability to pay
- Home to the Navigator Program

Navigator Program O<u>verview</u>



HEALTH SERVICES

Mission

To improve the quality of care and increase access to community services for vulnerable populations by acting as a temporary support system that helps clients overcome overcome large barriers, address social determinants of health challenges/disparities, and equip them with skills to manage life on their own

What is it? A community-based resource serving the Lower and Outer Cape Cod, MA

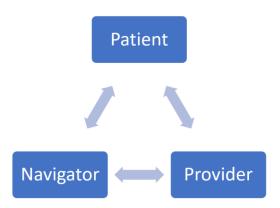
Community Health Workers, referred to as Navigators, are used in the Navigator program as one key intervention. They are members of the health care team with a multifaceted role in patient screening, support, outreach organization, and education

Navigator Program: Interprofessional Teams



Navigators are licensed social workers or have had experience in social work prior to working in the program.

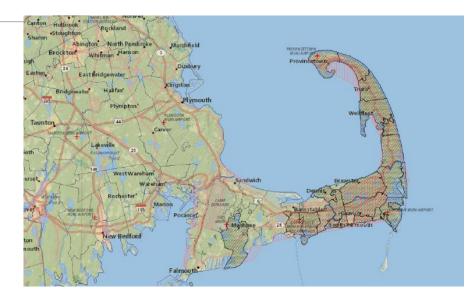
- Providers flag in-need patients to Navigators and vice versa.
- Providers and Navigators remain in constant communication throughout the patient's enrollment



Who does the OCHS Navigator Program serve?

Demographic Overview of the Navigator Program Regions

- Population ~84,000
- Median Age: 53.5
- Diversity
 - ➤ Race
 - 89.7% White
 - 3% Black or African American
 - Ethnicity
 - 2.65% Hispanic or LatinX
- Median Household Income: \$65,140



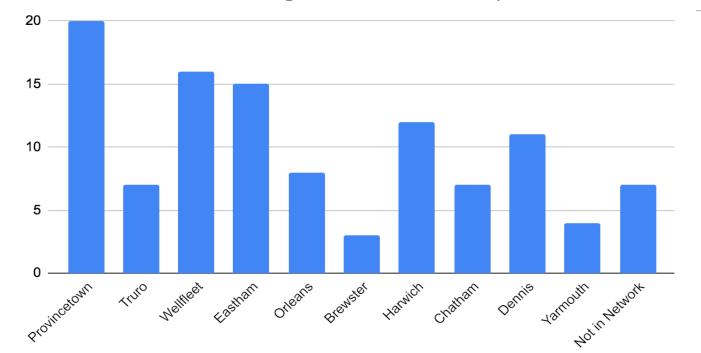


Patient Data Zip Codes with Overlying Underserved Areas



Cape towns represented in our research

Number of Navigator Patients Per Zip Code



Self-Sufficiency Matrix

SSM Categories

Mental Health	Income
Community Involvement	Food
Disabilities	Safety
Employment	Health
Family/Social Relationships	Life Skills
Transportation	Adult Education
Housing	Substance Abuse
Legal	Parenting Skills
Child Care	
Child Education	

Scoring

- Each category scored 1-5
 - \circ 1 and 2 = In crisis
 - \circ 3 = Stable
 - \circ 4 and 5 = Sufficient

Overall SSM Score

- Range from 18-90
- Data is captured at baseline (i.e., at intake) and at 90-day intervals to assess longitudinal progress throughout the program

Data Collection

eClinicalWorks Electronic Health Record + SSM data file

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Hospitalization:				14.00 Coronary attery disease 17	14			12/7/2017					+			+
Family History:			E E 2	50.00 Type II diabetes melitus 18	15			12/28/2017						-		+
Social History:				65.10 Preterm infant 19	16	3/18/2017	6/16/2017	12/20/2011	Unschanged						1	-
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				27	23			Discharged				-	+	1		4
				28	25			12/29/2017		6/29/2018						2
				20	26		9/22/2017	1/13/2018				-		-		2
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				33	30				Discharged						c	4

Health Advocacy



•Mass health

- Insurance Enrollment Assistance at OCHS
- •Veterans Affair
- •Outer Cape Health Services
 - Navigator Program
 - Lower and outer cape
 - Advocate for, and help connect, at risk patients to existing services
 - Provide therapy and other services
 - Help providers connect navigators with patients



U.S. Department of Veterans Affairs





Risk Tiers

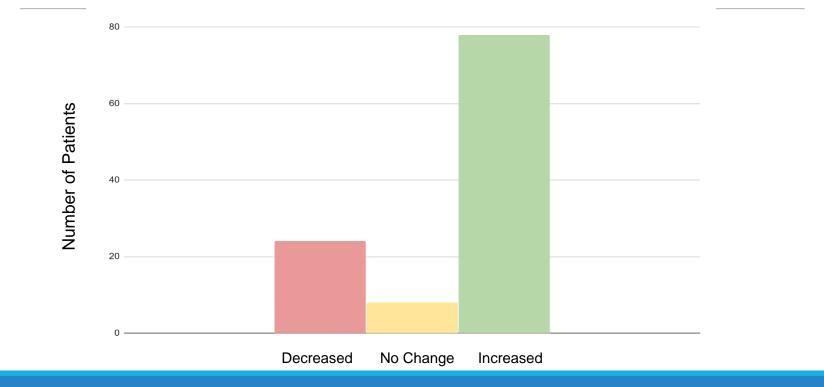
Risk tiers suggested based on Navigator experience and in current usage in field

Risk Tier	SSM Score
Low risk	70 or above
Medium risk	61-69
High risk	60 or below

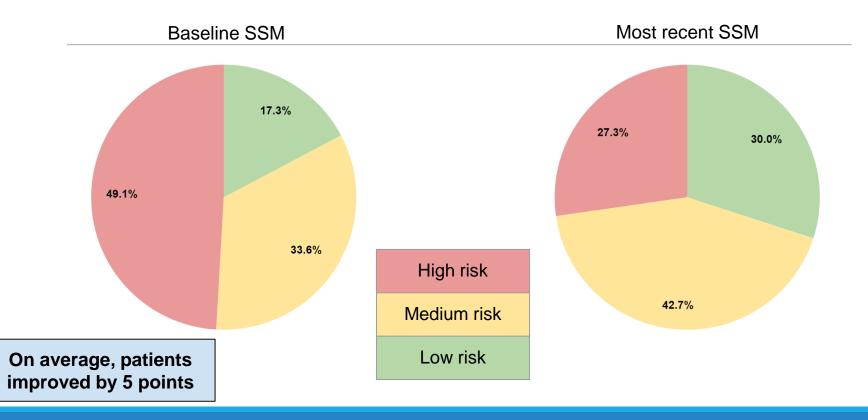
OCHS Clerkship Data Collection

Patient	Zip Code	Town	Town Ptown=1, Truro =2, Wellfleet =3, Eastham	Start Date	Length in Program (mo)	Activity Status	Initial SSM Score	Final SSM Score	Change in tier -1=worse, 0=same, 1=Improved	
Number						0=discharged, 1=active				
1	02651-0701	North Eastham	4	5/31/2017	3	0	69	75	1	
4	02639-1117	Dennis Port	9	5/3/2018	9	0	69	76	1	
6	02642-0631	Eastham	4	4/25/2017	7	0	60	74	1	
7	02633-1938	Chatham	8	4/28/2017	3	0	63	61	0	
8	02645-2010	East Harwich	7	5/9/2017	3	0	52	59	0	
9	02642-1501	Eastham	4	5/16/2017	10	0	57	54	0	
11	02653-1801	Orleans	5	5/15/2017	16	1	54	80	1	
13	02645-2414	Harwich	7	6/26/2017	2	0	55	65	1	
15	02645-1405	Harwich	7	5/18/2017	7	0	63	79	1	
17, 90	02532	Buzzards Bay	11	5/31/2017	16	0	38	53	0	
18	02638-1970	Dennis	9	6/7/2017	3	0	78	80	0	
19	02631-3019	Brewster	6	6/5/2017	5	0	66	65	0	
20	02642-2282	Eastham	4	6/16/2017	3	0	62	62	0	
21	02662-0121	South Orleans	5	6/21/2017	7	0	67	69	0	
22	02631-1218	Brewster	6	6/7/2017	6	0	65	69	0	
25	02651-0481	North Eastham	4	6/22/2017	12	1	52	45	0	
26, 168	02651-0481	North Eastham	4	7/13/2017	13	0	54	58	0	
20, 108	02031-0481	NOTHELASTIAI	4	//15/201/	15	0	54	30	0	
27	02645-1021	Harwich	7	6/4/2017	6	0	64	77	1	
28, 205	02660-2913	South Dennis	9	6/7/2017	13	0	59	61	1	
31	02645-1960	Harwich	7	6/21/2017	8	0	60	69	1	
35	02631-1782	Brewster	6	7/6/2017	11	1	68	79	1	
38	02642-2831	Eastham	4	7/27/2017	9	1	62	60	-1	
40	02645-2520	Harwich	7	7/21/2017	14	1	63	67	0	
41	02664	South Yarmouth	10	7/13/2017	9	0	68	82	1	
43, 123	02638-2515	Dennis	9	7/26/2017	18	1	61	56	-1	
50	02653	Orleans	5	8/18/2017	5	0	52	62	1	
51	02667-1151	Wellfleet	3	8/28/2017	9	1	58	72	1	
55	02645	Harwhich	7	12/11/2017	8	0	63	70	1	

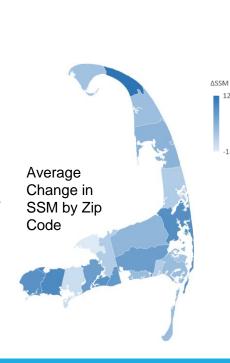
Patient Progress in Navigator Program



Change in Risk Tier throughout Program

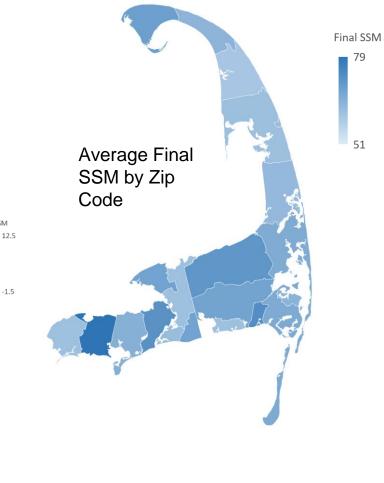


Average Initial SSM by Zip Code How does where you live affect your **SSM Score?**



Initial SSM 79

51

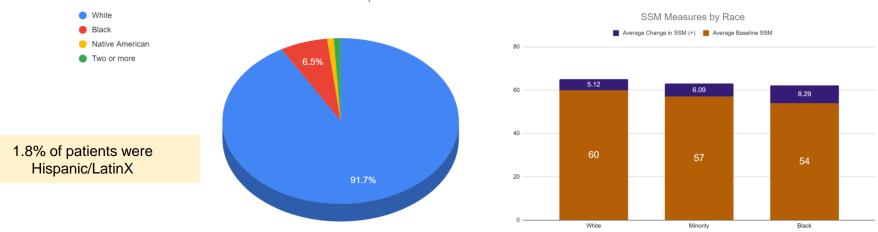


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Demographic Data (1 of 2)

- The vast majority of patients are white
- Black patient population ratio is twice as large as in the demographic data
- Black patients tend to start at lower SSM baselines
- They also tend to make more progress



Racial Breakdown of Service Population

Demographic Data (2 of 2)

- Different population groups may have different needs
- Black patients fare worse in the housing, community involvement, employment, income, and food categories
- Mental health and disabilities showed greater effect on White patients

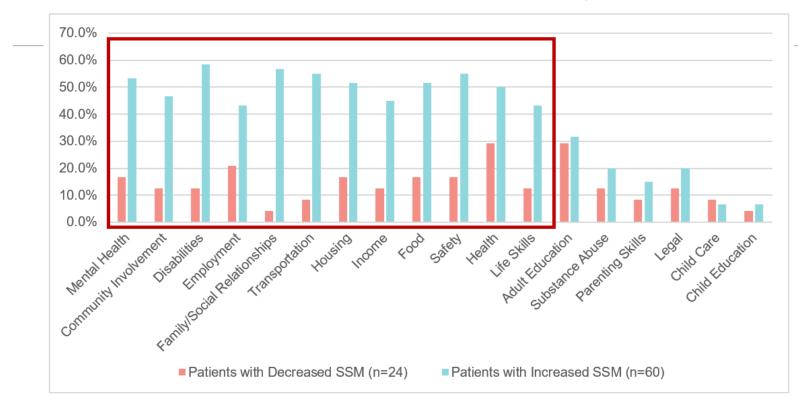
Black Patients (n=7)									
SSM Categories: Lowest to Highest Scores									
		Avg. Scores							
1	Housing, Community Involvement	1.571							
3	Employment	1.857							
4	Income, Food	2							
6	Mental Health	2.285							
7	Mobility, Family/Social Relationships	2.571							
9	Health	2.714							
10	Life Skills	3.285							
11	Adult Education, Safety, Disabilities	3.714							
14	Parenting Skills, Child Care	3.857							
16	Legal	4							
17	Child Education	4.428							
18	Substance Abuse	5							
		-							

White Patients (n=99)							
SSM Categories: Lowest to Highest Scores							
		Avg. Score					
1	Mental Health	2.134					
2	Community Involvement	2.36					
3	Disabilities	2.371					
4	Employment	2.639					
5	Family/Social Relationships	2.659					
6	Income	2.701					
7	Food	2.938					
8	Mobility	2.969					
9	Housing	3.031					
10	Safety	3.092					
11	Life Skills	3.134					
12	Substance Abuse	3.804					
13	Health	3.845					
14	Adult Education	4.103					
15	Legal	4.556					
16	Parenting Skills	4.577					
17	Child Care	4.89					
18	Child Education	4.917					

White Patients (n=99)

How does improvement in each category impact overall score?

Percent of Patients who Improved per SSM Category



Conclusion: Clinically Relevant Needs of Patients in Navigator Program

High Risk Needs Determined by Navigator Program

- Mental Health
- Health
- Housing
- Transportation

Risk Needs Determined by PHC Data Analysis

- Employment
- ✤ Income
- Life Skills
- Housing

- Transportation
- Mental Health
- Disabilities
- Community Involvement
- Family/Social Relationships

SSM Sub-Category

Mental Health **Community Involvement** Disabilities Employment Family/Social Relationships Transportation Housing Income Food Safety Life Skills Substance Abuse Adult Education Parenting Skills Legal Health Child Care Child Education

Acknowledgements

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Outer Cape Health Services

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- Thank you to the Navigators for allowing us to shadow and attend case conference





HEALTH SERVICES

Resources

- Measuring Your Impact on Loneliness Later in Life. Campaign to End Loneliness.
- Social Needs Screening Toolkit. (2016). *Health Leads.*
- ✤ "Outer Cape Cod Towns PUMA, MA." Data USA.
- ✤ "Data by Town." STATS Cape Cod, Cape Cod Commission.
- UDS Mapper, www.udsmapper.org/.
- Outer Cape Health Services, https://outercape.org/