Using data sharing to improve health and housing outcomes in rural regions

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Homebase

Using Data Sharing to Improve Health and Housing Outcomes in Rural Regions: Session Outline

1. Background and Baseline (10 minutes)
    a. What is the need?
    b. How might you approach the design?
2. Community Design Discussion (10 minutes)
    c. What might you have chosen for a design?
3. The Design and evaluation metrics (10 minutes)
4. 1 year review (10 minutes)

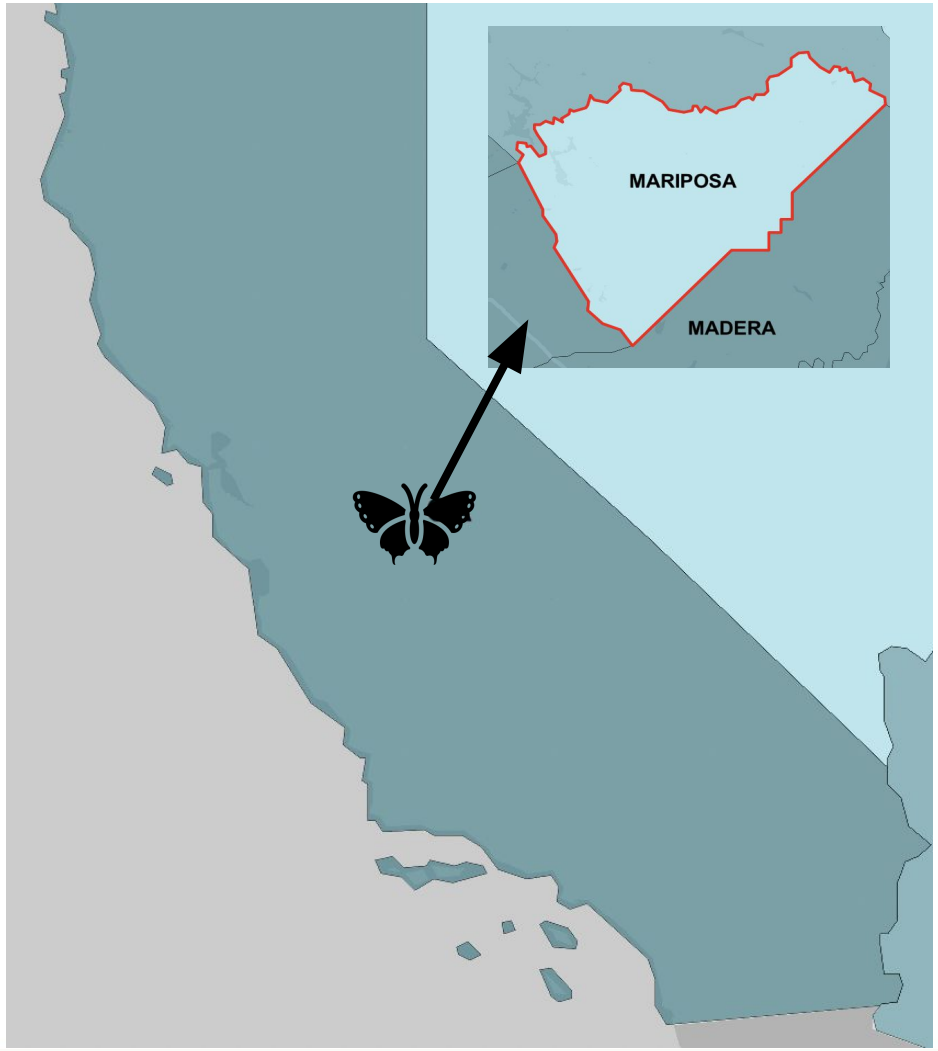
Learning Objectives

- Learn how cross-system data sharing can galvanize community collaboration and relationship building
- Witness how data can inform intervention design to address challenges to healthcare and housing access in rural communities
- Leave with a blueprint for recreating this community process

A note on your (potential) role in this presentation :

- When we pause for reflection, we want you to pretend to be focus group participants
- We will poll you and compare the results to what we found in the community or what the community chose

Mariposa, California



Rural County of 17,147 people across 1449 square miles.

- 11.8 people per square mile
- County Seat = Mariposa CDP = 1526 people

Home to the Southern Sierra Miwuk Nation
Sits in the foothills of the Sierra Nevada Mountains at the base of the Yosemite National Park

Alliance For Community Transformation (Alliance) Offers shelter, housing resources and other supportive services in many different locations across Mariposa county

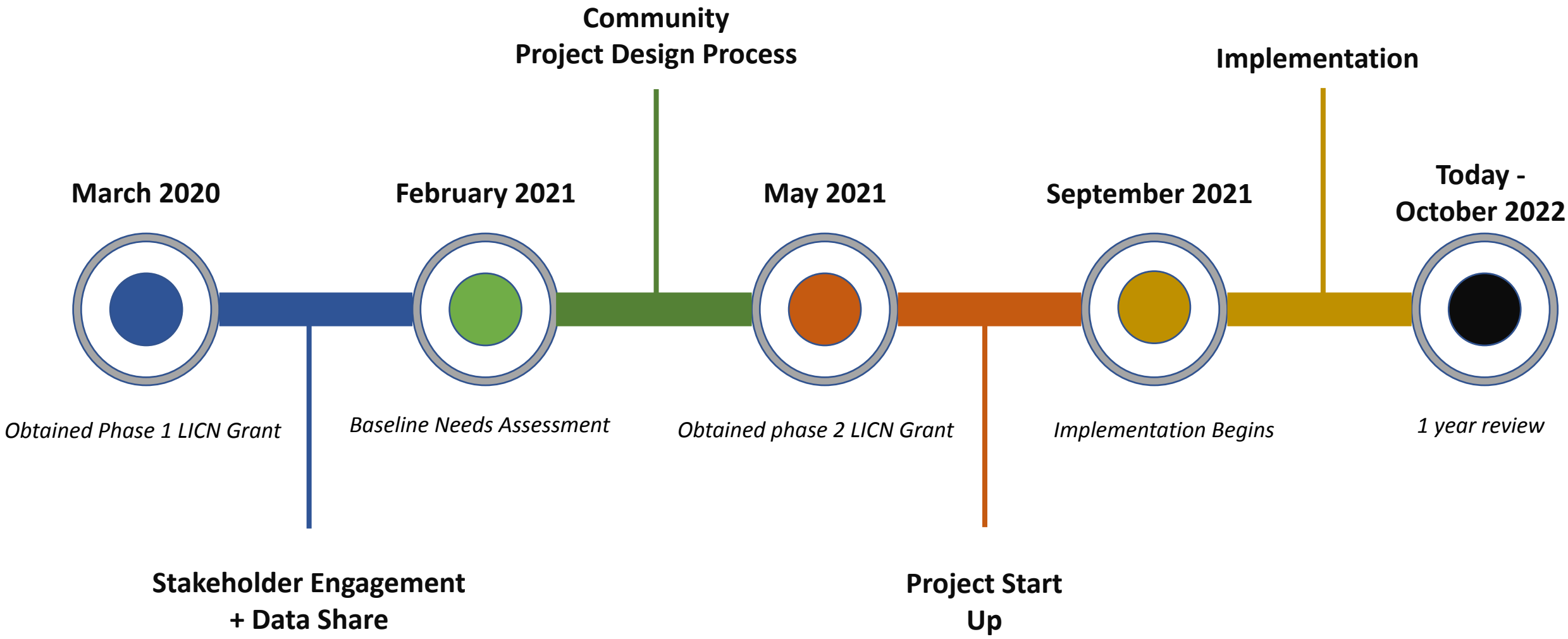
Target Population:

- Adults experiencing houselessness, at-risk of becoming houseless, or released from incarceration with complex health, behavioral health needs

Known Problem:

- Access to healthcare is a problem for many residents in rural Mariposa county, and especially for those in poverty and experiencing houselessness

Project Timeline



Assessing Healthcare Needs

Qualitative:

- Interviews, focus groups, surveys with stakeholder including people using these systems

Quantitative:

- Data match between the Homeless System of Care and the District Health System

Stakeholders

Data collected through Stakeholders from the community including Behavioral Health, Medical Health, Probation, Corrections, Health and Human services, Medical insurance providers, and people using the systems.

Poll 1: Baseline Needs Assessment

We conducted a Baseline needs assessment to measure the type and scale of need that included the barriers and facilitators of healthcare.

<u>What do you expect we found?</u>

- What do you hear, witnessed, or experience in your communities regarding the barriers to accessing healthcare?

<u>Target Population</u>

Adults
experiencing houselessness,
at-risk of becoming houseless,
or released
from incarceration
with complex health, and
behavioral health needs

Baseline Needs Assessment Results

Qualitative Summary

Healthcare Stakeholder	Client / Patient Stakeholder
People don't show up for appointments	There are transportation barriers
People don't schedule appointments with a primary care physician	There is a lack of phones, and the process isn't clear. People are asked to leave and follow up on their own
We are overstretched and are working as fast as we can.	The wait times are too long (its sometimes 6 months to see a doctor).
People are drug seeking and overusing the emergency room.	People feel disrespected and stigma is apparent.

Emerging Themes

1. **Transportation**
2. **Communication / Coordination**
3. **Difficulty Establishing care**

Quantitative Summary

Healthcare Use	Clinic Use	ER Use
62%	38%	55%
Overlap 50% of health clients used both clinic and ER	82% of Clinic patients used the ER	57% of ER patients used the Clinic
10+ times in 2 years	29 of 99 [72% of total clinic visits]	17 of 144 [42.1 percent of total ER visits]
Top Diagnosis	Mental Health Chronic Health Substance use	Chronic Health Mental Health Substance use

Poll 2: Project Design Ideas by Criteria

What do you think would be most helpful for the community?

Grant Requirements	**Option 1:** Mobile Healthcare Unit	**Option 2:** Healthcare Navigators	**Option 3:** Community Health Worker Program/ Outreach	**Option 4:** Transport Unit	**Option 5:** Do you have other ideas?
1 Reaches Target Population					
2 Achievable in 3 years, with $500k per year					
3 Plan for sustainability					
4 Addresses Transportation Barrier					
5 Addresses Communication Barrier					
6 Addresses Difficulty Barrier					

Emerging Themes

1. **Transportation**
2. **Communication / Coordination**
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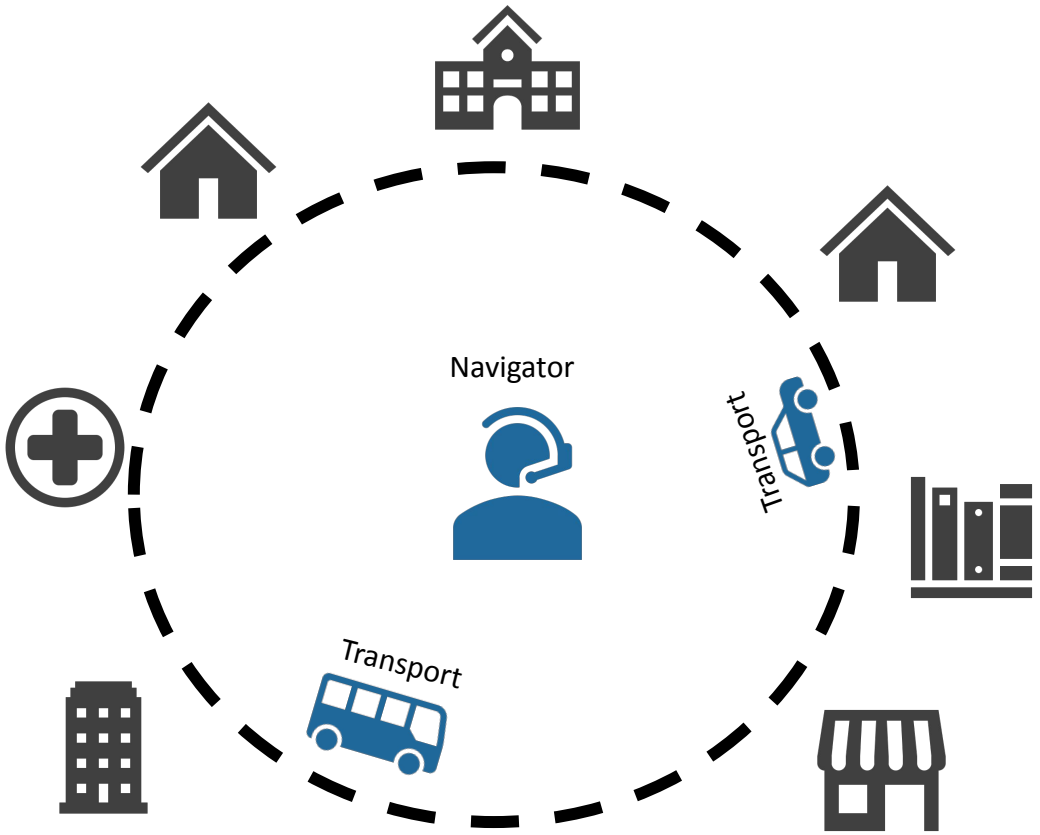
Project Design: The Communities Selection



Option 2
(Healthcare Navigators)

+

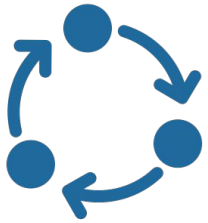
Option 4
(Transport Unit)

A Healthcare Navigation Program with a Transportation Component

Goals:

1. Improve Access to Healthcare
   a. Coordinate care
   b. Build and Expand Referral/linkages Networks between sectors
   c. Remove transportation barriers

Built in Feedback Loops!



Quarterly meetings

- With all stakeholders to see quarterly data and troubleshoot
  - Each quarter JCFD matches Alliance data and sends back a deidentified data set.

Clients - Every 6 months

- Surveys collected at enrollment of Healthcare Navigation Program and every 6 months following

Clients - Every 10th ride

- Surveys collected per person during a transport

One Year Review

Strength: Meeting all output measures and collaboration with partners have grown exponentially

- Healthcare Navigation Enrolments are up (48)
- Transportation use is through the roof (102 people used 1576 times)
- Community partners are trained to know how to access the model (50)
- Transport and Navigation referrals are coming in (118)

Weakness: These partnerships are not yet self-sustaining /self-generating.

- Alliance and the navigator are still essential to maintaining direction and momentum

One Year Review

Opportunity: New data each quarter presents an opportunity to maintain sense of urgency.

- Example of ER visits rising and community response
- Opportunities to reduce stigma are emerging
- Long term funding opportunities are in development

Threat: Staffing!

- The navigator is stretched thin
- Higher turnover for the driver
- The healthcare system has not increased capacity and
- The Covid-19 Pandemic and Oak Hill Fire creates increased need for all

Conclusions and Recreating the Process

- Data sharing is worth it – not just for the analysis, but the process that can grow from it.
- You may need a person that understands both data systems and can translate between sectors
- Building in accountability mechanisms can keep data flowing.
- By including Community partners at the beginning AND by incorporating feedback loops as foundational to programing we can better capitalize on opportunities as they emerge.

Questions:

How could you do this in your community?

Measure Category	Quarterly Monitoring and Evaluation Questions
Work Plan Assessment	Where all scheduled Activities completed?
Output Measures	How much was done?
Quality Measures	How well was it done?
Outcome Measures	Is anyone better off?

Measure Category	Quarterly Monitoring and Evaluation Questions
Work Plan Assessment (Where all scheduled Activities completed?)	• Continue patient navigation program and transportation components • Schedule and Coordinate Meetings between partners • Establish and maintain a system of communication with JCFD • Establish and maintain referral processes with Project Partners Collect, analyze and report data quarterly (data match with JCF) • Develop a resource guide/pocket card for clients to learn about primary care services
Output Measures (How much was done?)	• How many clients enrolled in Healthcare Navigation Program? • How many clients received transportation support services? • How many referrals from project partners to Alliance ? • How many Alliance clients are connected to a Primary Care Provider? • Number of partners trained? (people)
Quality Measures (How well was it done?)	• Increase client confidence and motivation in accessing primary and preventative services • Decrease primary healthcare clinic appointment no-shows • Schedule a primary care appointment for 60% of all first time ER users within 3 business days of discharge • Increase volume of services sought out/engaged in by 15%
Outcome Measures (Is anyone better off?)	• Reduce Emergency Room visits for Alliance clients • Reduce the average number of ER visits per person by 50% • Reduce the number of “high ER utilizers” in a 2-year period by 50%

1 year later this is how

Measure Category	Quarterly Monitoring and Evaluation Questions
Work plain Assessment (Where all scheduled Activities completed?)	**Strength: M**eeting all output measures and collaboration with partners have grown exponentially **Weakness:** These partnerships are not self-sustaining – the navigator is the key **Opportunity:** New data each quarter presents an opportunity to maintain sense of urgency. **Threat:** The navigator is stretched thin, the healthcare system, has not increased capacity and the pandemic and Oak Hill Fire creates increased need for all.
Output Measures (How much was done?)	**Meeting Targets:** • Healthcare Navigation Enrolments are up (48) • Transportation use is throw the roof (102 people used 1576 times) • Community partners are trained to know how to access the model (50) • Transport and Navigation referrals are coming in (118)
Quality Measures (How well was it done?)	**Mostly Meeting Targets, but too soon to tell** • Enrolled clients feel more motivated and confident, but it is still challenging to serve people with chronic behavioral health needs • While No shows are down – the frequency of appointments / the space for appointments have not changed (On Target) - Increase client confidence and motivation in accessing primary and preventative services (On Target) - Decrease primary healthcare clinic appointment no-shows (On Target) - Schedule a primary care appointment for 60% of all first time ER users within 3 days of discharge **(No/ Not Yet/ Unknown) -** Increase volume of services sought out/engaged in by 15%
Outcome Measures	**Too soon to tell**

1 year later this is how

Measure Category	Quarterly Monitoring and Evaluation Questions
Work plain Assessment (Where all scheduled Activities completed?)	**Strength:** All planned activities were completed and collaboration with partners have grown exponentially **Weakness:** These partnerships are not self sustaining – the navigator is the key **Opportunity:** Incremental improvements and policy shifts are happening – but slowly **Threat:** The navigator is stretched thin as need rises faster than housing and turnover is high for the transportation components.
Output Measures (How much was done?)	(On Target) - How many clients enrolled in Healthcare Navigation Program (On Target) - How many clients received transportation support services (On Target) - How many referrals from project partners to Alliance (On Target) - How many Alliance clients are connected to a Primary Care Provider? (On Target) - Number of partners trained? (people)
Quality Measures (How well was it done?)	(On Target) - Increase client confidence and motivation in accessing primary and preventative services (On Target) - Decrease primary healthcare clinic appointment no-shows (On Target) - Schedule a primary care appointment for 60% of all first time ER users within 3 days of discharge **(No/ Not Yet/ Unknown) -** Increase volume of services sought out/engaged in by 15%
Outcome Measures (Is anyone better off?)	(On Target) - Reduce Emergency Room visits for Alliance clients **(No/ Not Yet) -** Reduce the average number of ER visits per person by 50% **(No/ Not Yet) -** Reduce the number of “high ER utilizers” in a 2-year period by 50%

Project Review after 1 year [This Slide needs some serious love]

What we think we know 1/3 of the way through	What we don't know but are watching for
Need more Navigators! *(47 people currently enrolled in Navigation)*	It is too early to tell if the number of high utilizers and average number of visit will fall
Need a strategy to de-intensify support over time. *(considering a CTI-like strategy)*	JCFD ER visits are down and rising while total JCFD health visits are down and rising; while (anecdotally) more clients are seeking care elsewhere (especially behavioral health)
Transportation was needed! *(104 people used transport 1572 times)*	ER to PCP follow-up rising but there are emerging challenges – "Are patients getting connected back to there Non-JCFD PCPs?"
People in the Navigation program are more likely to have established PCP connections	Motivation and Confidence is strong among those in the Navigation program (9.5 out of 10), but we don't know how much the new program is responsible.
Clinic No Shows are down *(95 of 112 made)*	
Connections to Primary Health Care are up! *(65% of Navigation)*	

Challenges	Plans	Successes
• Fully integrating Healthcare Navigator program and Transportation components into JCFD discharge process • High turnover rate for drivers • Hard to prioritize individual route patients • The Healthcare Navigator is stretched thin		• The Navigation and Transportation component was critical for the Oak Fire response. • Updating the fixed route to include 2 more medical clinics, a behavioral health center and a dental clinic • Working with these 3 new providers to integrate care • Referrals have started coming in from the probation department and the team has begun outreach to the local detention center