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The Rural Health Action Network Enhanced Outreach Initiative: Year 2 Interim Evaluation Report

Mary Lindsey Smith PhD
University of Southern Maine, Catherine Cutler Institute, m.lindsey.smith@maine.edu

Evelyn Ali BS
University of Southern Maine, Muskie School of Public Service, Cutler Institute, evelyn.ali@maine.edu

Tyler Egeland BA
University of Southern Maine, Catherine Cutler Institute, tyler.egeland@maine.edu

Katie Rosingana BA
University of Southern Maine, Catherine Cutler Institute, katherine.rosingana@maine.edu

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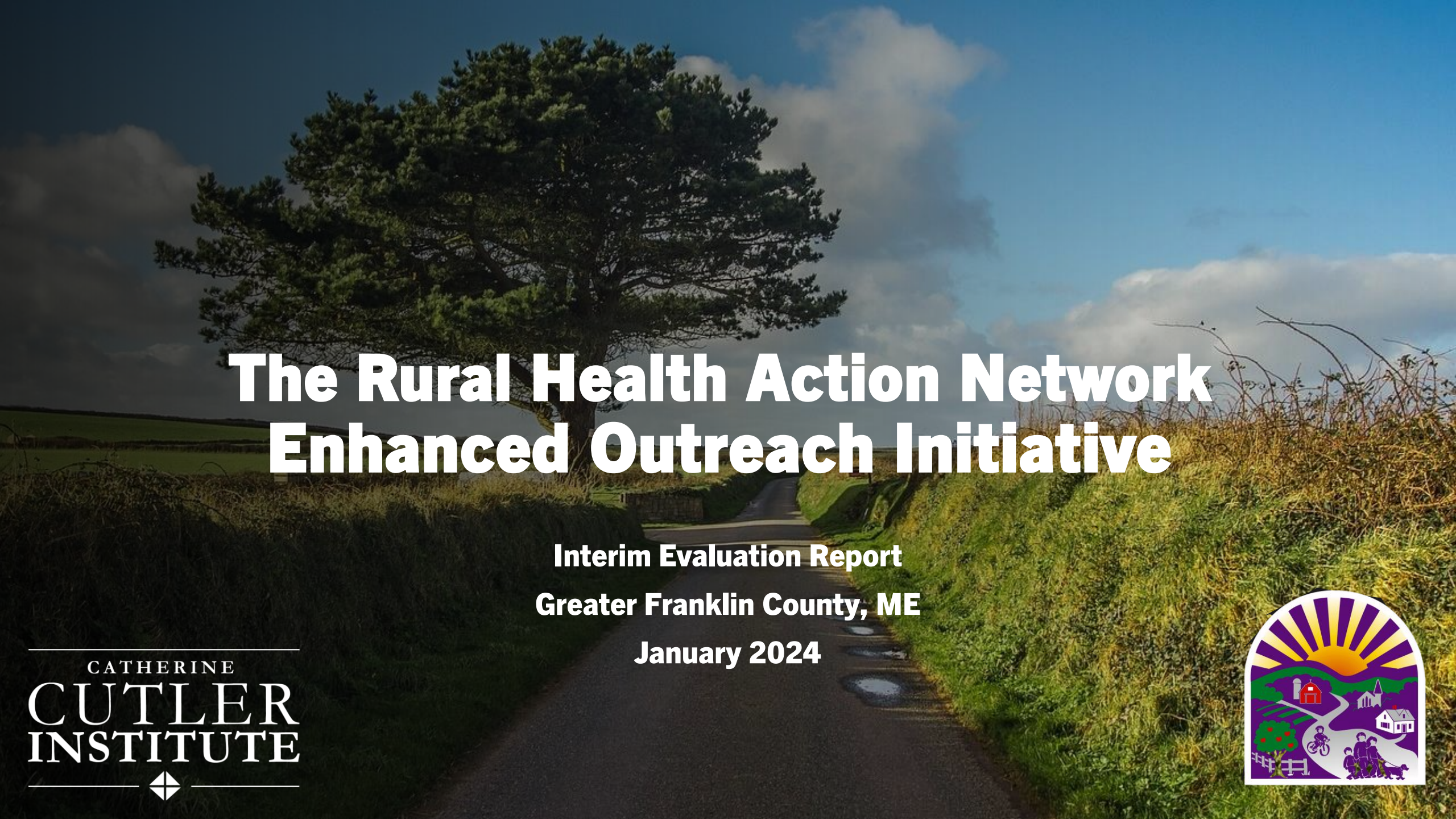


The Rural Health Action Network Enhanced Outreach Initiative

Interim Evaluation Report

Greater Franklin County, ME

January 2024

CATHERINE CUTLER INSTITUTE

Overview

I. Background

RHAN-EOI Interim Summary

Background

The Evaluation team from the Catherine Cutler Institute, at the University of Southern Maine is conducting an evaluation of the implementation process and impact of the RHAN-EOI project. The evaluation team used primary and secondary data collection to collect data to support the process (partnership-level) and outcomes (client-level) evaluations.

Partnership-level Data
- Partnership self-assessment
- Key informant interviews
- Collaborative Multiplier Tool (2022 only)

Client-level Data
- Client interviews
- Client SF-12 Surveys

HRSA Performance Measures

Grant Year 1	Grant Year 2	Grant Year 3	Grant Year 4
May 1, 2021 – Apr 30, 2022	May 1, 2022 – Apr 30, 2023	May 1, 2023 – Apr 30, 2024	May 1, 2024 – Apr 30, 2025

II. Partnership Self-assessment

RHAN-EOI Interim 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.

Overview of Findings

- The Partnership Self-Assessment was deployed in October of 2023, asking participants to reflect on year 2 of the grant. There were 9 respondents, compared to 8 in 2021 (year 1).
- Composite scores for partnership efficiency, resources, and synergy were in the work zone. However, ratings of non-financial resources and synergy in 2023 were greater than in 2021.
- Scores for administration and management and leadership were in the headway zone.
- Notably, HCC RHAN leadership has incorporated staffing and organizational changes that align with needs identified in the PSA.

Partnership Self-assessment Composite Scores

2021 data shown in grey; 2023 data shown in color corresponding to zone

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

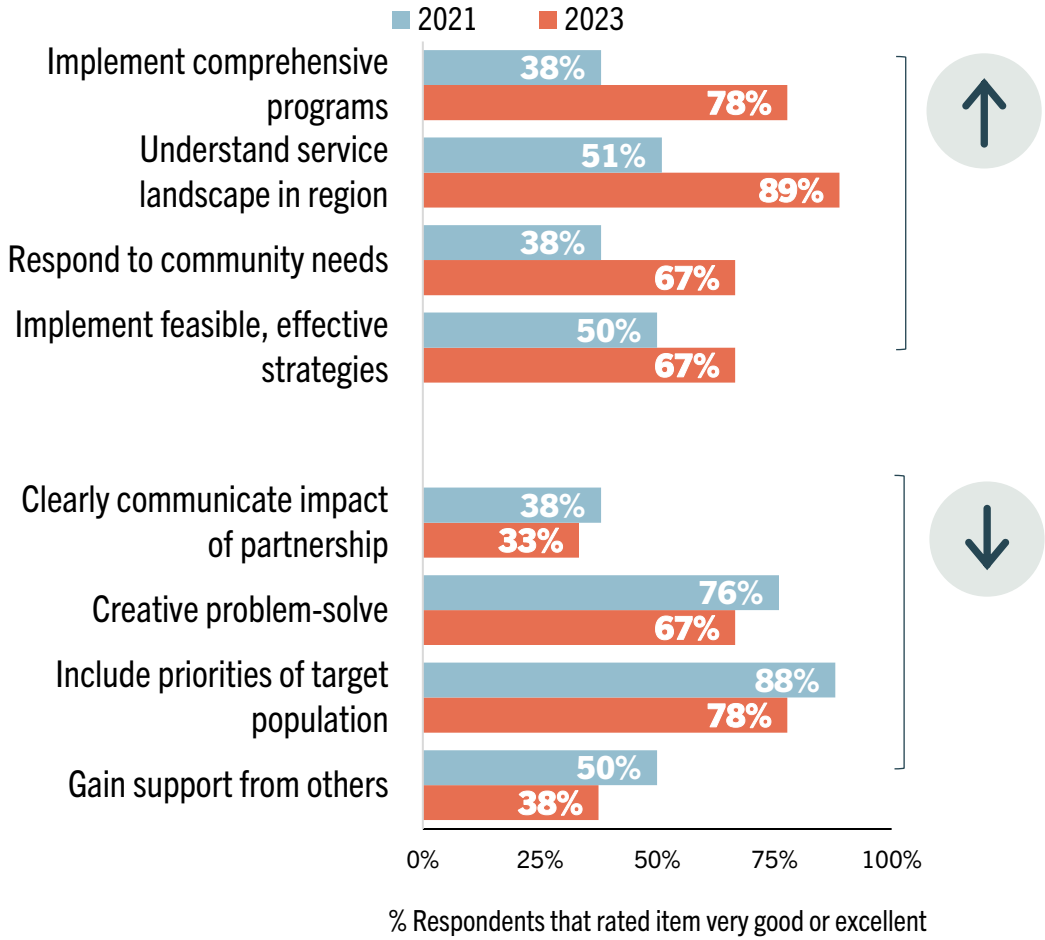
Work Zone (3 – 3.9): More effort is needed in this area to maximize partnership's collaborative potential

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

Partnership Self-Assessment: Synergy

- The synergy composite score was in the **work zone.**
- Respondents responded favorably to the partnership's ability to implement comprehensive programs and understand the service landscape (increased by over 38%) . Ratings of ability to respond to community needs and implement effective strategies also increased.
- Four synergy items received slightly fewer ratings of very good or excellent. These items mainly dealt with the partnership's ability to communicate and network; strategies have been put in place by HCC to address these issues and support the Consortium moving forward.

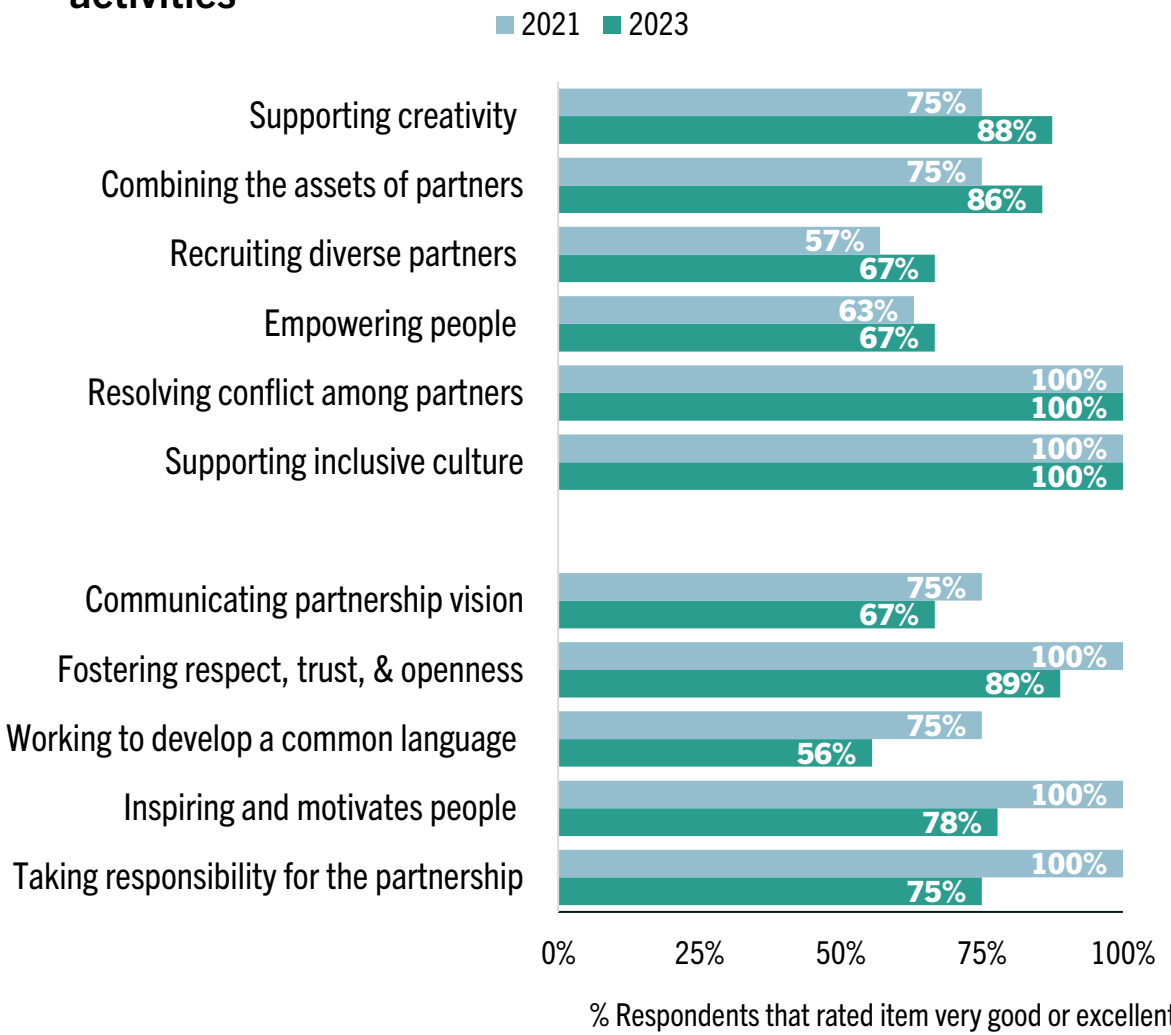
Respondent perspectives on partnership synergy activities



Partnership Self-Assessment: Leadership

- The leadership composite score is in the **headway zone.** It had the highest composite score among all of the domains.
- The majority of activities saw an increase in the percent of respondents who rated that activity as very good or excellent. **Greatest leadership strengths include cross-leveraging and aligning perspectives and assets, creativity, and inclusivity.**
- Among items with a decrease in ratings were the ability to motivate partners and develop a common language; these issues are common in multi-year cross sector collaboratives.

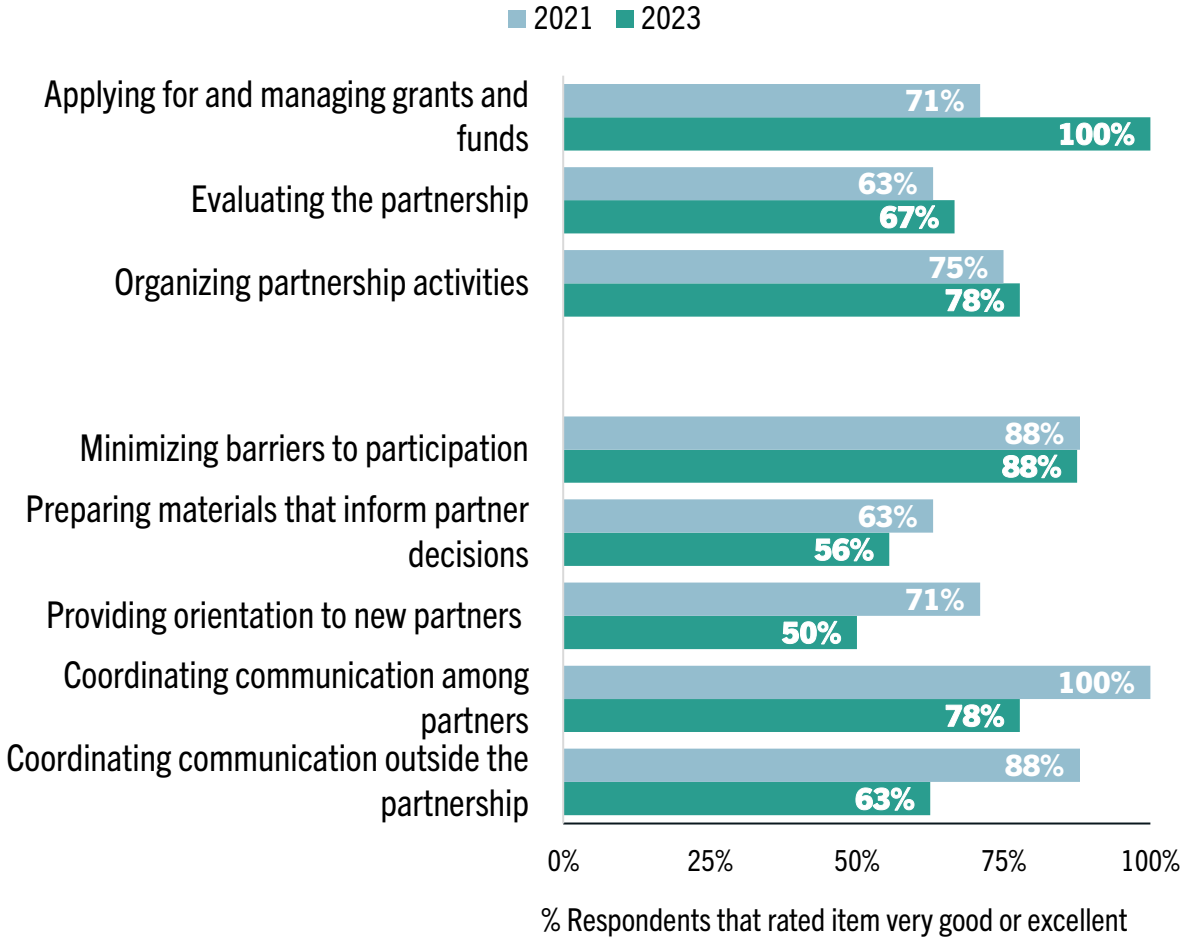
Respondent perspectives on partnership leadership activities



Partnership Self-Assessment: Administration and Management

- The administration and management composite score was in the headway zone.
- **All participants believed the partnership's ability to apply for and manage grant funds was very good or excellent.**
- At least 50% of respondents believed all administration and management items had very good or excellent effectiveness.
- Several item ratings fell compared to 2021. Notable areas for improvement include providing orientation to new partners and coordination external communication.

Respondent perspectives on effectiveness of administration and management activities



Partnership Self-Assessment: Efficiency and Resources

While ratings of financial resources and non-financial resources were relatively stable, the composite score for efficiency fell in 2023 compared to 2021. This indicates that efforts should be made to foster partnership connections and skills and use them efficiently.

Non-Financial Resources

- There was a decrease in the percent of respondents who believed the partnership had most or all of the convening power, data, and skills and expertise it needed. These ratings remained high (>56%)
- There was an increase in the partnership's rating of its connections to stakeholders and legitimacy.

Financial/Capital Resources

- Despite a small decline (<9%) , the majority of respondents believed the partnership had most or all of the space and equipment it needed.
- There was an increase from 43% to 57% of partners that thought the partnership had most or all of the money it needed.

Efficiency

- There were small decreases (<7%) in percent of partners that thought the partnership's efficiency with financial resources (67%) and time (56%)
- The percent of partners that believed efficiency with in-kind resources fell from 88% in 2021 to 56% in 2023.

Partnership Self-Assessment: Benefits and Drawbacks

- All partners believed that the benefits of partnership participation exceeded or greatly exceeded the drawbacks
- In 2023, all partners reportedly received the following benefits:

  Improved awareness of service landscape

  Increased impact than they would have had alone

  Relationship building

- Respondents reportedly experienced very limited drawbacks. The most commonly reported drawback, diversion of time and resources from other priorities, was reported by a third of respondents. The percent of participants that reported experiencing frustration as a result of the partnership decreased from 2021 (29%) to 2023 (11%).

Partnership Self-Assessment: Key Takeaways

Leadership had the highest mean composite score of all domains. Greatest leadership strengths include cross-leveraging and aligning perspectives and assets, creativity, and inclusivity.

Synergy had a mean score that rose compared to 2021. Respondents highly approved of the partnership's ability to implement comprehensive programs, include priorities of the service population, and understand the service landscape

Resources. Ratings of non-financial resources and efficiency scores rose compared to 2021, and ratings of financial resources remained high. Specific item ratings suggest a need to foster partnership connections and skills.

Admin & Management had a mean composite score in the headway zone. Respondents were satisfied with the ability to apply for and manage grant funds. Notable areas for improvement include coordination external communication and partner onboarding.

HCC RHAN leadership has incorporated staffing and organizational changes that align with needs identified in the PSA.

III. Key Informant Interviews

RHAN-EOI Interim Summary

Key Informant Interviews

- The evaluation team conducted key informant interviews with staff-members at the participating partner organization to inform both the process and outcome evaluations.
  - *5 interviews were conducted in August of 2022 (Grant Year 2)*
  - *5 interviews were conducted from August to September of 2023 (Grant Year 3)*

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

- Interviews were recorded and transcribed verbatim for analysis. The following section presents the results of the analysis of key informant feedback from both rounds of interviewing.

Key Informant Interviews: Access to Care

Key informants shared their perspective on several ways in which project components have contributed to the RHAN project goal of improving access to care in the region:

Enhanced community outreach and improves access to low-barrier care and reduces stigma in the community

Overall improvements in the availability of resources, highlighting harm reduction resources and food pantries

RHAN project staff improves care coordination, including referrals and warm hand-offs

Community paramedicine provides enhanced value to patients by delivering care to where they are

"You see [their] outreach. Because not only do they go to the towns, they go to the fairs. They go to the festivals… So, especially like in our small community here, we've become really well-known, for, providing resources and providing information that people wouldn't get otherwise."

"If I talk to a patient after they get out of the hospital, and they're telling me that they can't get out to get to the grocery store, …I can reach out to HCC for the food -- they'll connect me to the food pantry, and I can try to coordinate maybe somebody making a delivery. The paramedicine program has just impacted our communities so much"

Key Informant Interviews: Access to Care

Key informants discussed several ongoing barriers to maintaining program activities that enhance access to care:

The region is experiencing widespread staffing shortages for providers, social service providers, case workers, crisis workers, and social workers

There are ongoing challenges to outreach to the community during the winter months, which requires enhanced focus on outreach strategies during winter

Despite program initiatives' positive impact on communication, there remains an ongoing need for improved communication between providers

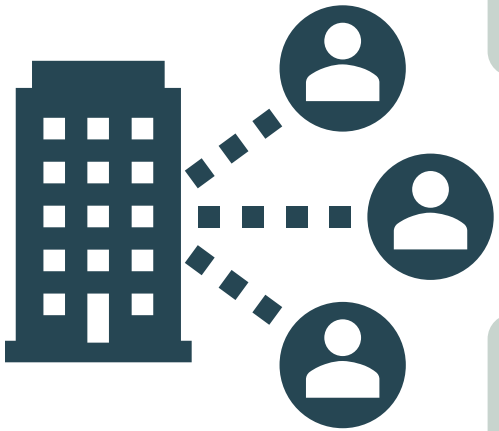
Lack of public transportation, coupled with a very large and rural service area, is a persistent barrier which impacts patient access to care

"We've all talked about . . . what [outreach] looks like, especially as we're heading into fair season, and then winter . . . Are we sitting out on this unit in the middle of winter when nobody wants to come see us?"

"There needs to be better communication between providers, in all honesty, and they need to work together a little more"

Key Informant Interviews: Role of Collaboration

Key informants discussed the significant value that the collaboration of the RHAN consortium brings to population in their service area.



Community engagement is very important, and effective relationships fuel the growth of this engagement

The consortium is effective at filling gaps and meeting needs in the community as they arise through collaboration with new and existing partners

Consortium partners are effective conduits of information sharing

"There's lots of other people out there that are a resource, and bringing them in and listening to their ideas…getting the community involved, I think that's where you have successes when you have people that are integrated into the community and they want to help. And when people start to see that, you start to form relationships, and you get more -- it's a snowball effect. You get more and more people that care, and more people that can do things"

IV. Collaboration Multiplier Tool

RHAN-EOI Interim Summary

Collaborative Multiplier Tool

- The Collaborative Multiplier Tool (CMT) was completed with RAHN Consortium members during a regularly scheduled monthly meeting in November 2022, in the Grant Year 2.
- The CMT is an interactive tool designed to analyze collaborative and strengthen collaborative cross-sector efforts.
- The evaluation team led the Consortium through the CMT 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

Target Population- Focus on maintaining and improving engagement with rural Maine seniors.

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

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 providers, UMF)
- Collaboratively identify solutions to gaps in care, including in-home support services

V. Performance Measurement Data

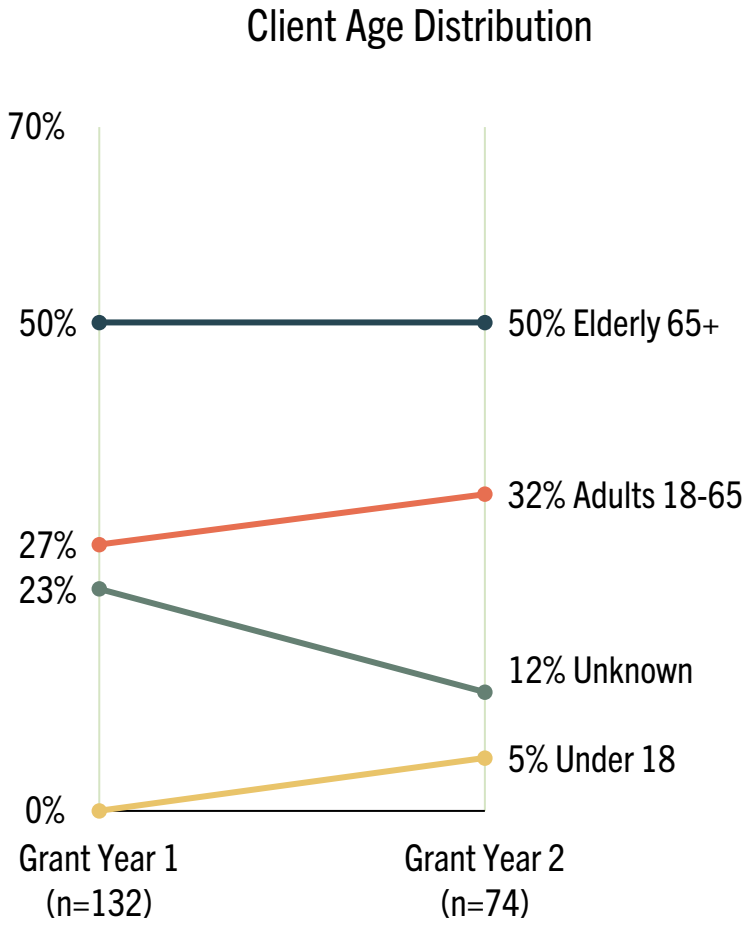
RHAN-EOI Interim Summary

Performance Measurement Data

- **HRSA requires that some organizational and service provision data be collected by grantees.**
- This data reflects services delivered by NorthStar Community Paramedicine (CP) Program and the Community Health Worker (CHW) Program, and relevant clinical data as retrieved from electronic medical records in HCC data
- HRSA collects data related to:
  - *Demographics*
  - *Service Delivery*
  - *Clinical Outcome Data*
    - ***The following slides show data from Years 1 and 2 of the 4-year grant***

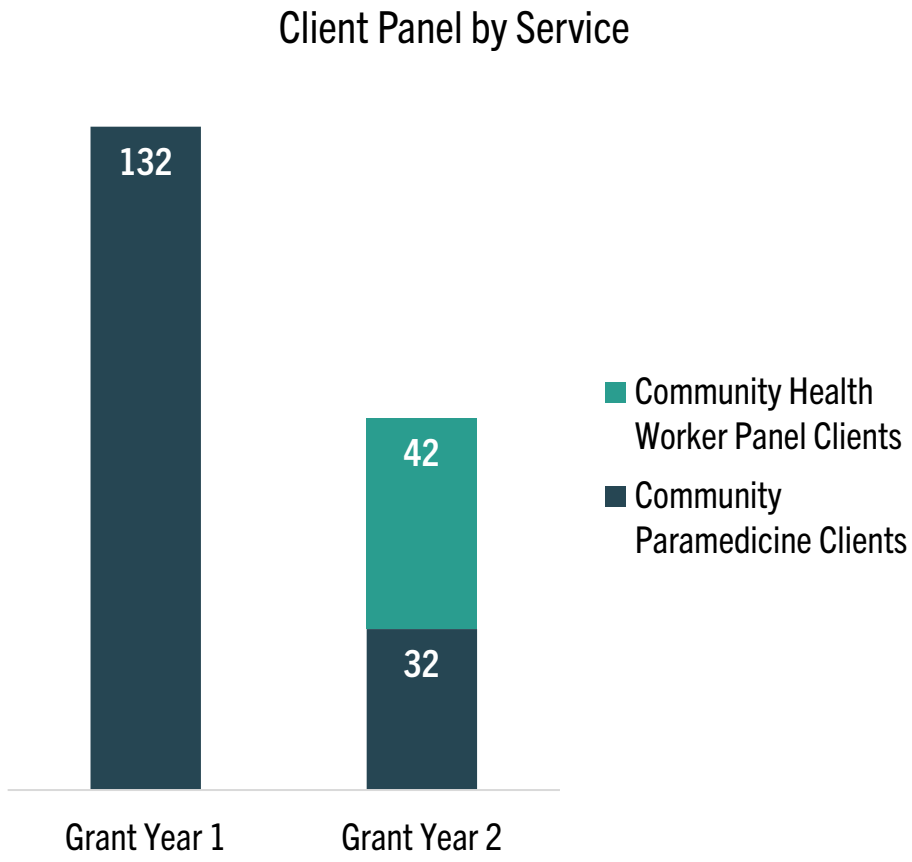
HRSA Performance Measurement Data: Demographics

- In both grant years, the majority of HCC clients were White (over 99% of clients with available race information).
- Exactly half of clients in both grant years were 65 years or older. Adults between the age of 18 and 65 made up 32% of the client population in year 2.
- The majority of clients in both grant years were insured by Medicare (y1 = 50%, y2= 58%). In year 2, 20% of clients had Medicaid coverage and only 3% had third party coverage.



HRSA Performance Measurement Data: Service Population

- **The number of clients in the overall service panel decreased in the second year of the grant from 132 to 74.**
- This was primarily driven by a decrease in the staffing capacity of community paramedicine.
- Community health worker services were expanded in year 2 with 42 unique clients received CHW services in the first year of deployment of the CHW services.



Performance Measurement Data: Referrals

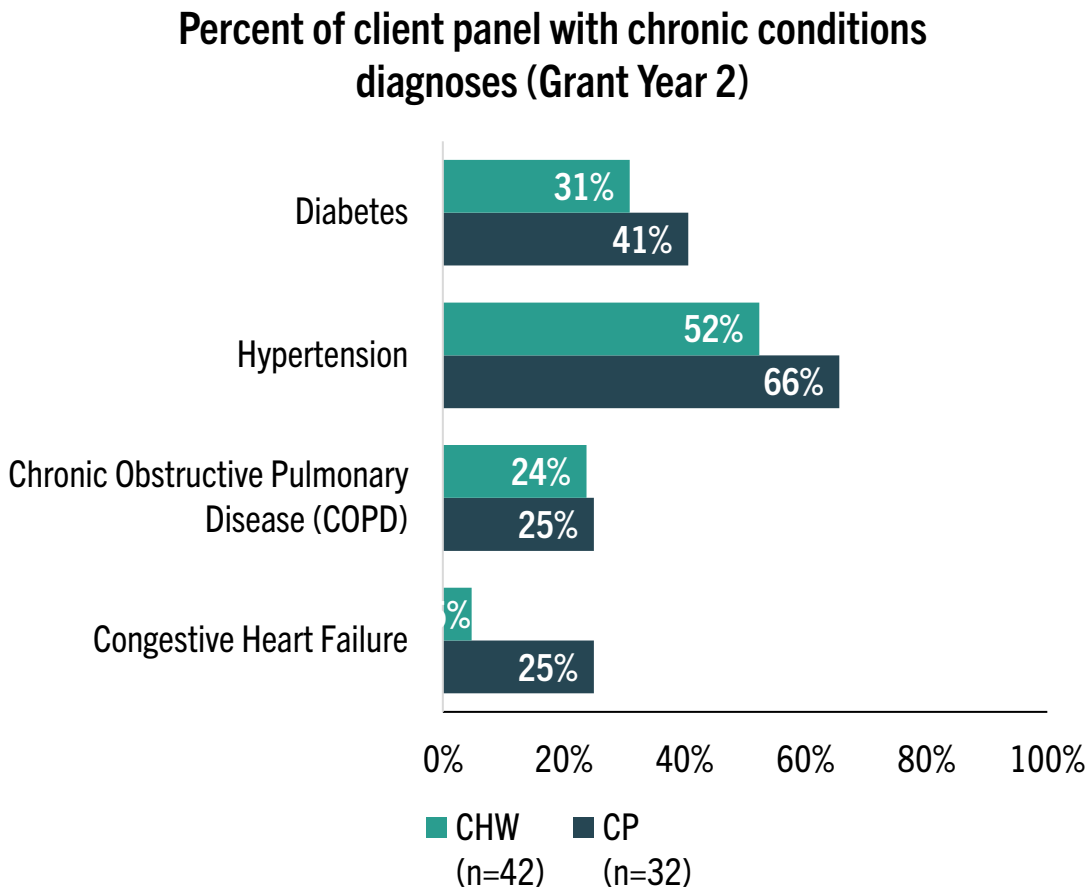
During the second reporting period, the greatest number of referrals to the RHAN-EOI CP and CHW programs came from primary care practices in the Franklin Community Health Network. For the CHW program, self-referrals were also common. Several other CP referrals came from HealthReach.

Year 2 Referrals by Source

	Franklin Community Health Network PCP	HealthReach PCP	Private Practice PCP	FCHN Care Management	FCHN ED Care Management	Androscoggin Home Health	RHAN Partner Organization	Community Member Self-Referral
CP Referrals	33	10	0	0	0	0	0	0
CHW Referrals	19	0	0	0	4	0	2	18

Performance Measurement Data: Chronic Conditions

- **Chronic diseases were common among the patient panel.** Overall, the chronic conditions examined were more common among CP patients.
- Hypertension was the most common chronic condition among CHW patients and CP patients.
- Diabetes was the second most common chronic diagnosis among both patient groups.



VI. SF-12 Survey

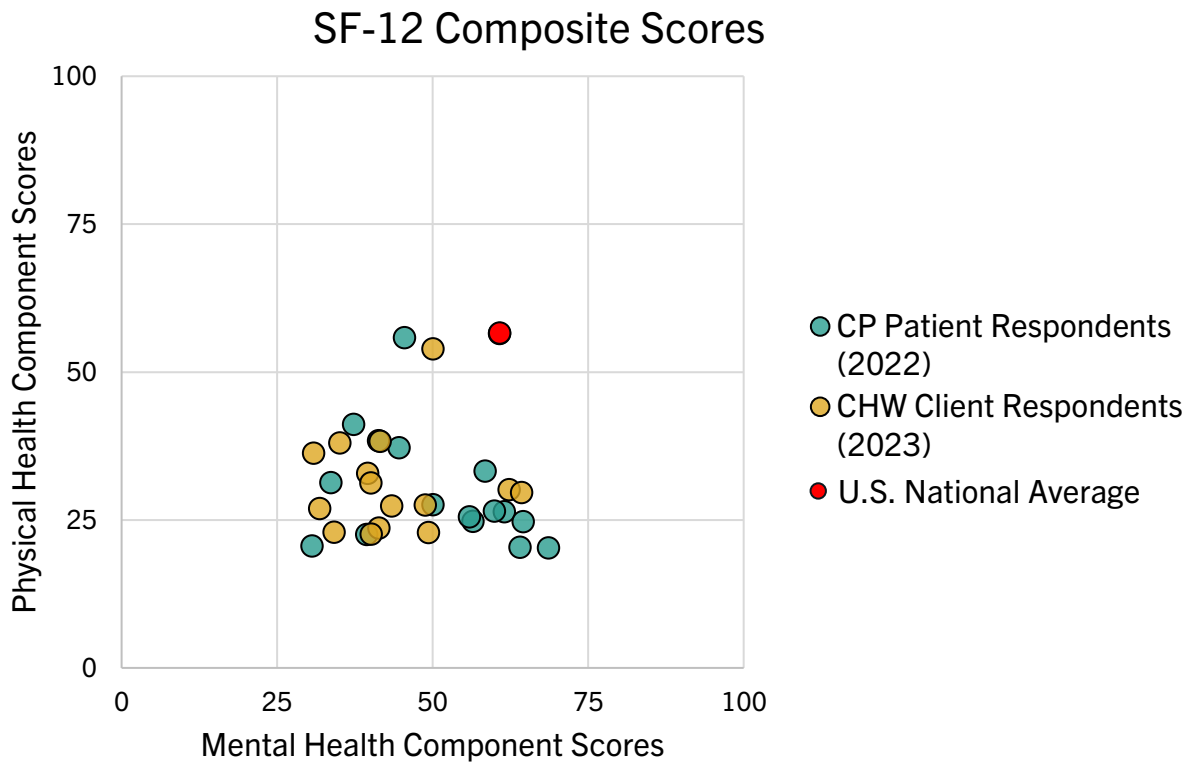
RHAN-EOI Interim Summary

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 individuals who had engaged with RHAN program services; $N_{(2022)} = 16$; $N_{(2023)} = 15$
  - *From April to May of 2022, the SF-12 was conducted with 16 patients who received community paramedicine (CP) services (Grant Year 1)*
  - *In June of 2023, SF-12 was conducted with 15 patients who received community health worker (CHW) services (Grant Year 3)*
- 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

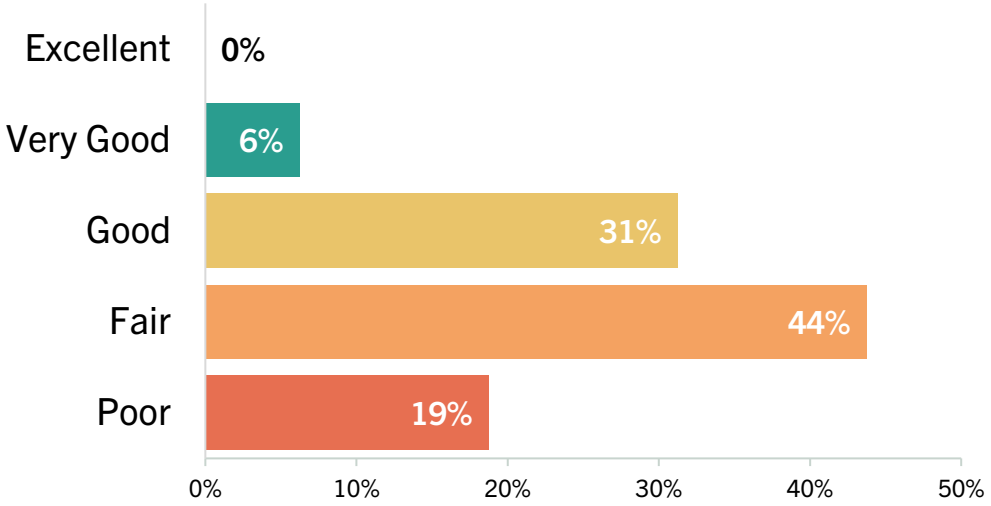
Overall, Physical and Mental Health Composite scores among respondents were generally lower than the U.S. population average, but several program participants did have Mental Health Composite scores that were higher.



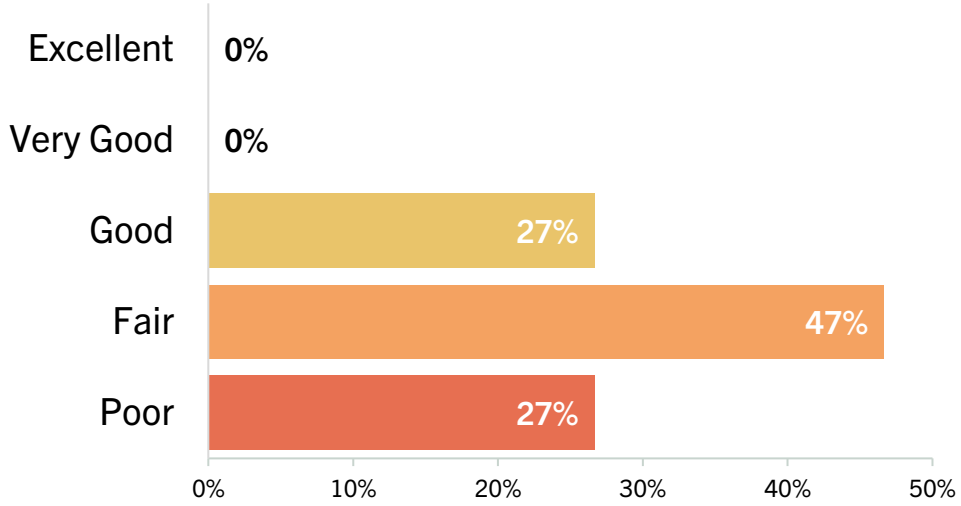
Overall Ratings of Health

When reflecting on their own health, **63% of CP respondents (2022)** and **73% of CHW respondents (2023)** considered their health to be either fair or poor. No respondents believed their overall health was excellent.

CP Patient Respondents (2022)



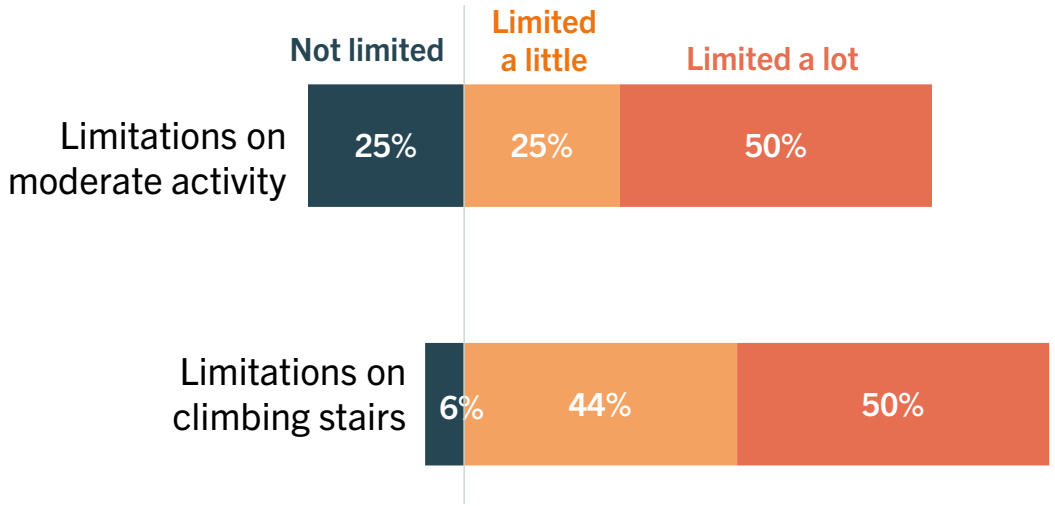
CHW Client Respondents (2023)



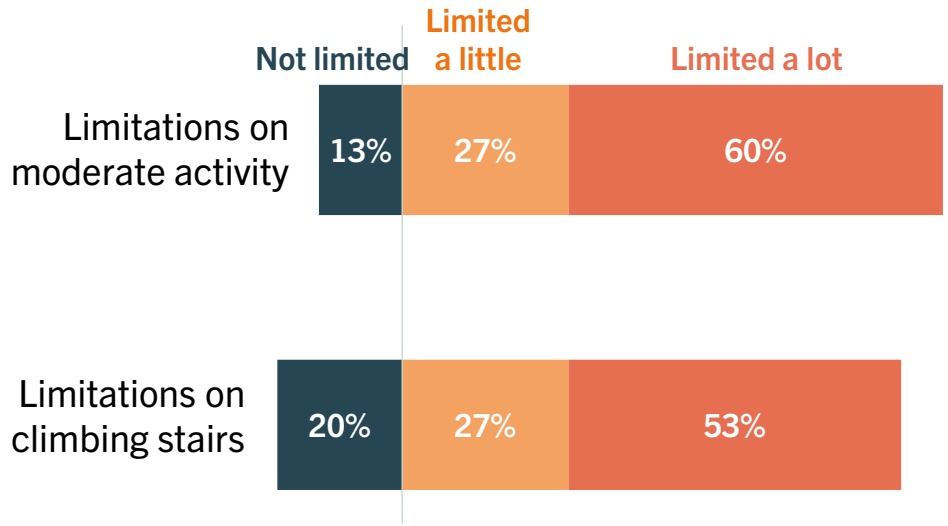
Physical Health and Limitations on Daily Life

- Most respondents, **75%** (CP, 2022) and **87%** (CHW, 2023) reported that they were at least *limited a little* in moderate activity. Compared to CP clients, CHW clients were more likely to indicate they were limited a lot in moderate activity.
- Similarly, **94%** (CP, 2022) and **80%** (CHW, 2023) of respondents reported they had limitations on climbing stairs.

CP Patient Respondents (2022)



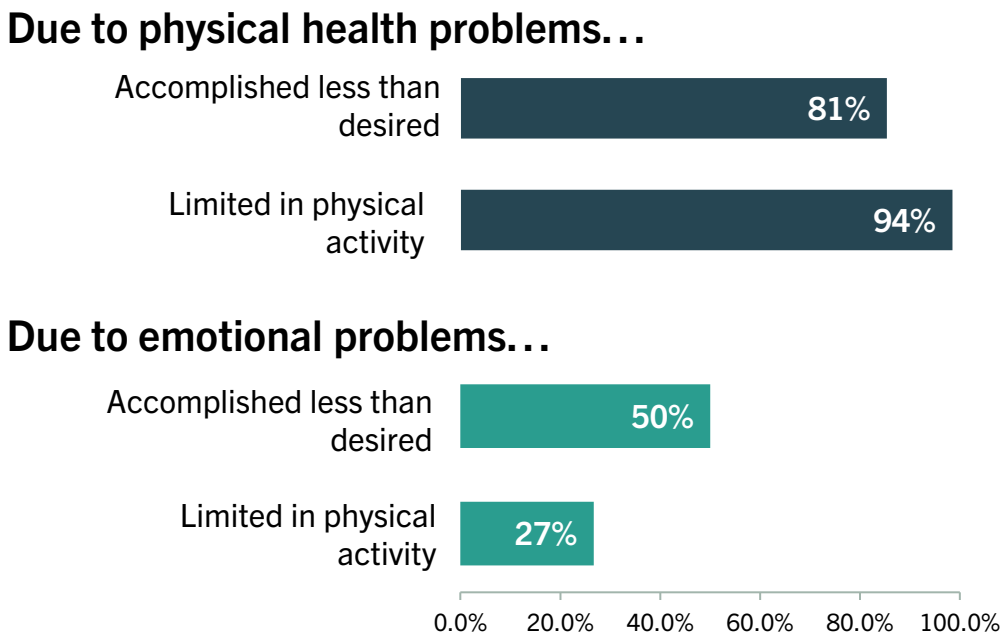
CHW Client Respondents (2023)



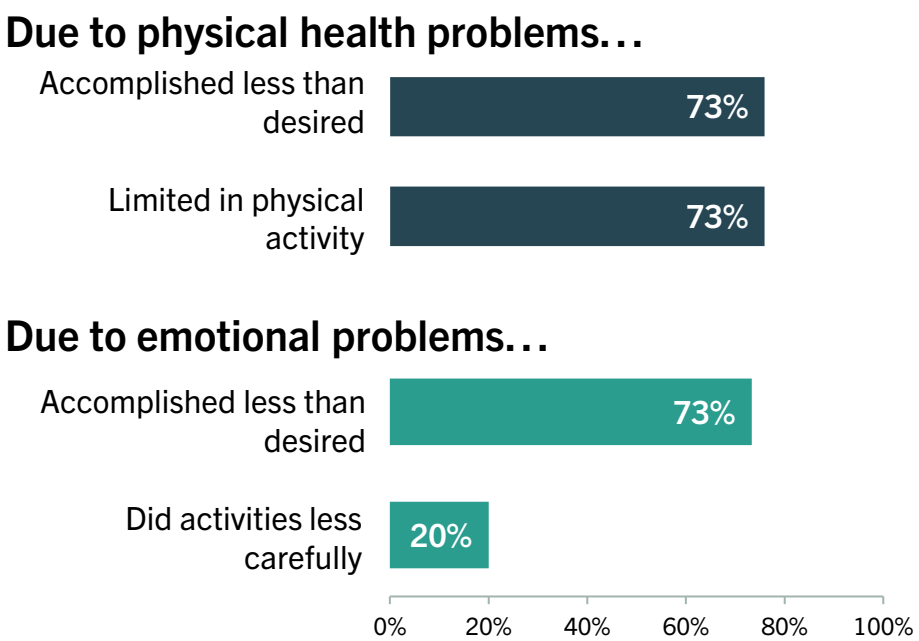
Physical and Emotional Problems

81% (CP, 2022) and **73%** (CHW, 2023) reported that they accomplished less than desired because of their physical health. Overall respondents were more likely to report that physical health, rather than emotional problems, interfered with their daily activities. However, **50%** (CP, 2022) and **73%** (CHW, 2023) said they accomplished less and **27%** (CP, 2022) and 20% (CHW, 2023) said they did activities less carefully because of emotional problems.

CP Patient Respondents (2022)

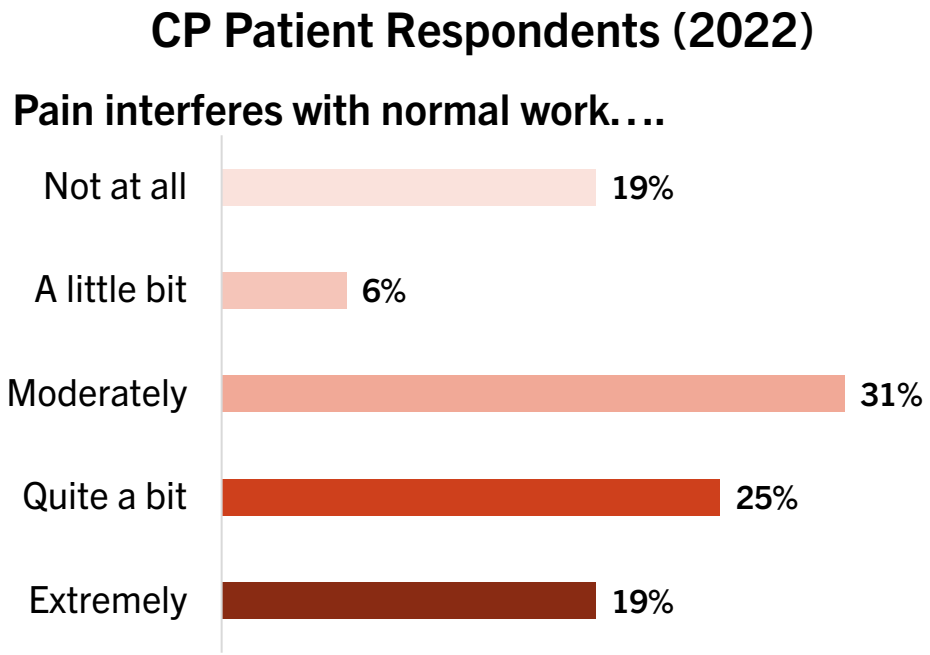


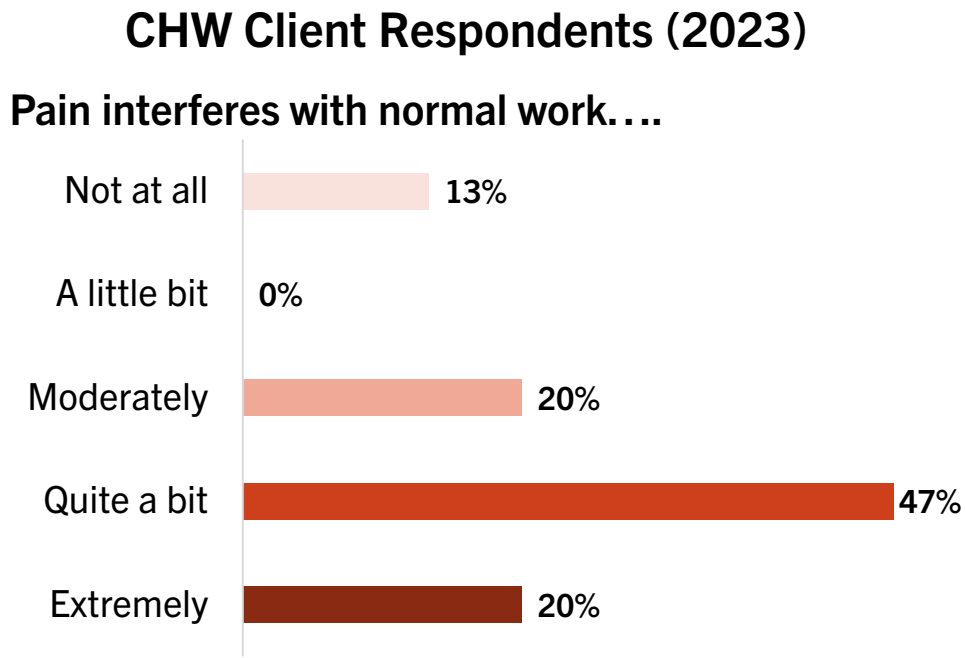
CHW Client Respondents (2023)



Pain and Well-being

CHW client respondents were more likely than CP client respondents to indicate that pain at least moderately interfered with their normal work (67% of CHW 2023 vs. 44% CP 2022).

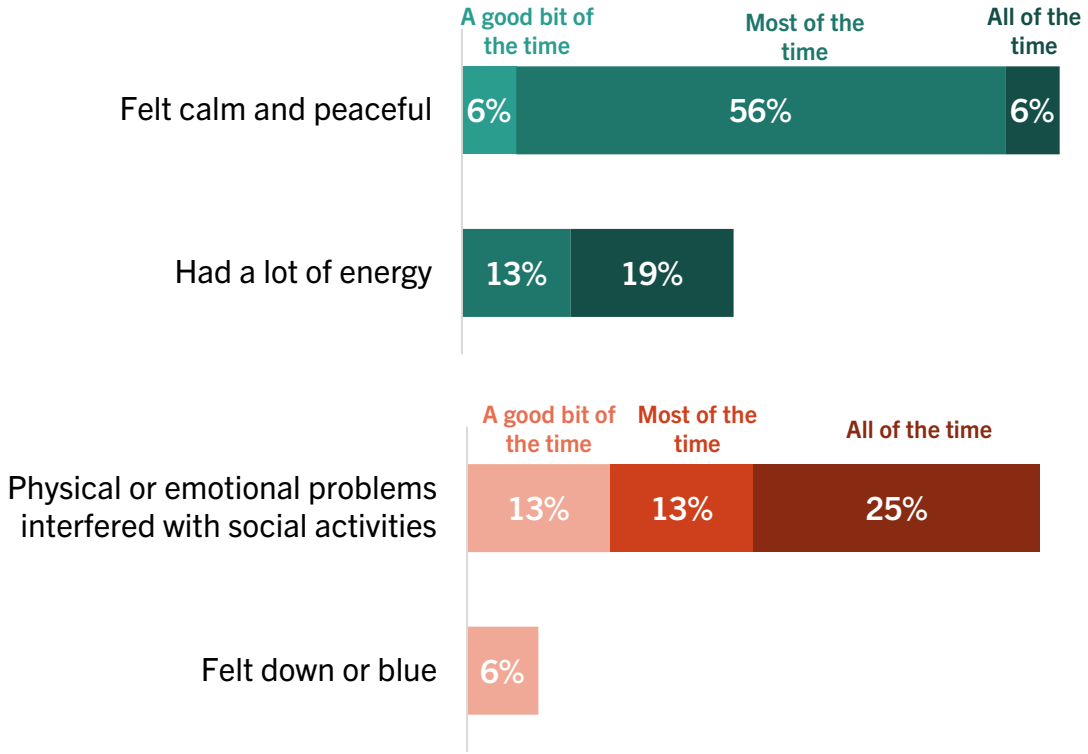




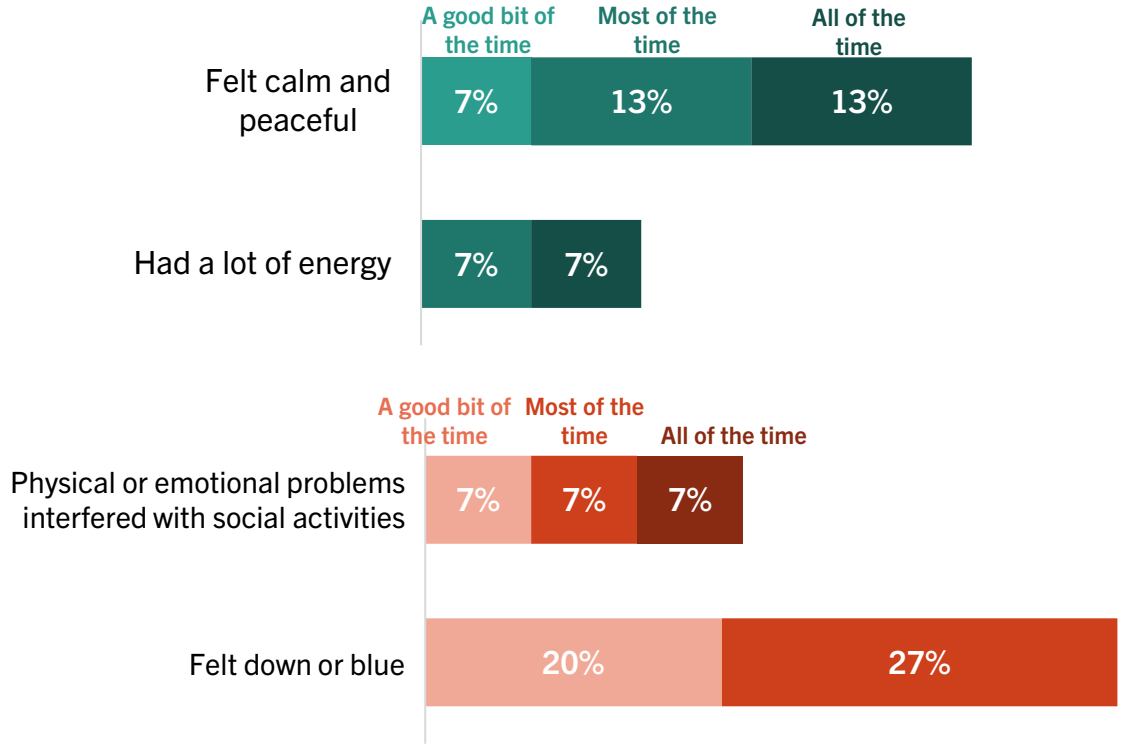
Physical Health and Limitations on Daily Life

50% of CP patient respondents and **21%** of CHW client respondents reported that physical or emotional problems interfered with social activities at least a good bit of the time. More CHW client respondents (2023) reported that they felt down or blue at least a good bit of the time, while CP patient respondents (2022) were much more likely to report that physical or emotional problems interfered with their social activities.

CP Patient Respondents (2022)



CHW Client Respondents (2023)



VII.Patient Interviews

RHAN-EOI Interim Summary

Background

Evaluators conducted phone interviews with clients who received community health worker (CHW) services or CP services based on a list provided by the RHAN program coordinator.

- Interviews were conducted by phone
  - 16 clients who had received CP services in 2022 were interviewed in April to May of 2022, providing a view of CP services in Grant Year 1
  - 15 clients who had received CHW services in 2022 and 2023 were interviewed in June 2023, providing a view of CHW services in Grant Year 2.
- Topics covered included:
  - Experience working with program services
  - Impact of services on access to care
  - Recommendations for improving care

Experience with CP

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. All participants reported that the paramedic explained things in a way they could understand.

"We've got an awful good bunch of paramedics."

"They were very, very, very nice people… I don't know what I'd have done without them"

CP Program and Access to Care

Interviewees reported on their experience with CP and how CP services influenced their access to care.

In-home care was patient-centered, reduced transportation barriers, and limited their need and use of emergency services.

"That was a service I didn't know was available prior to needing it, so that gives me another level of protection and service that I didn't know I had before."

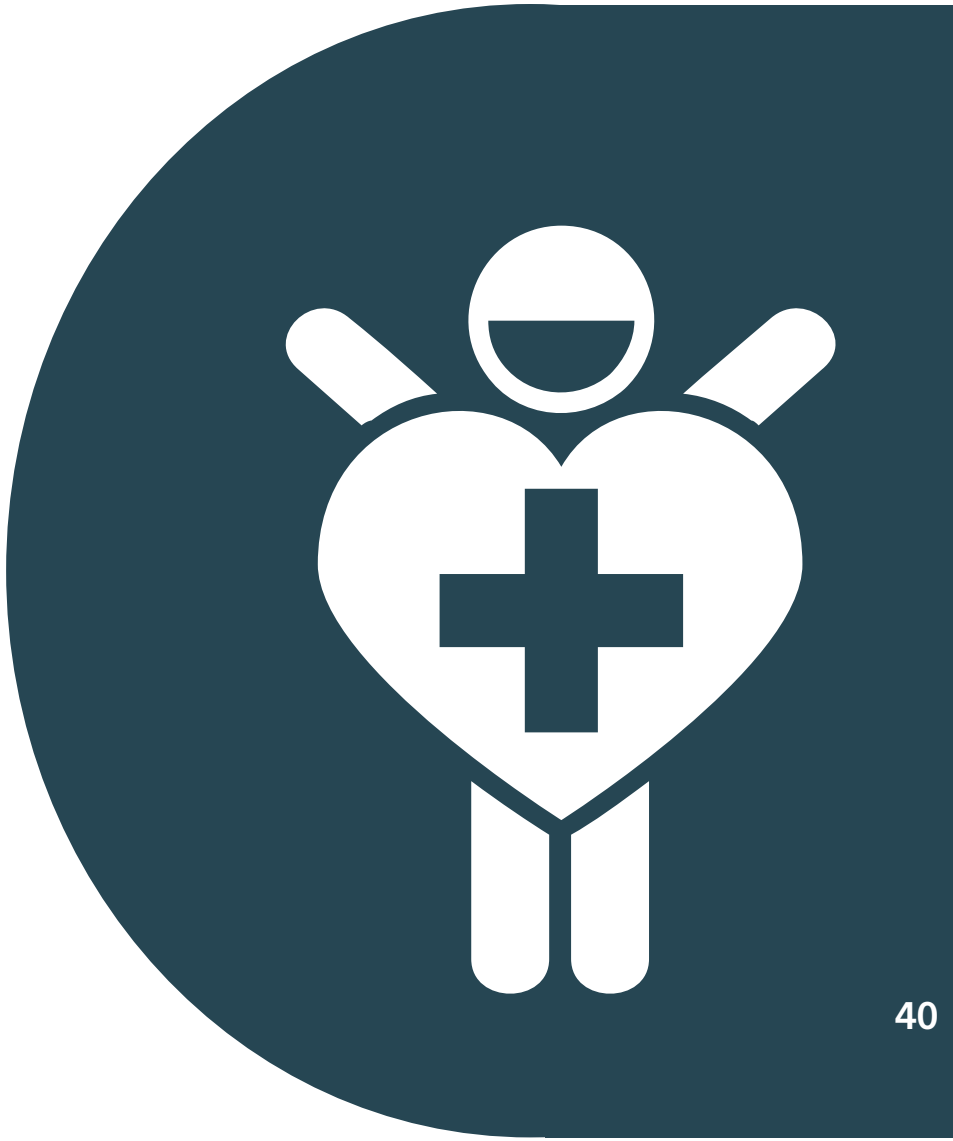
CP providers **communicated effectively with patients' primary care providers** to coordinate care.

"He kept calling my doctor to tell her how my oxygen was and how my ability to move around was."

Experience with CHW

Those interviewed who recalled working with a CHW reported that the CHW was kind, supportive, and provided appropriate resource information, if not direct connection, to a needed resource.

- Interviewees indicated they were comfortable working with the CHW, whether they received services over the phone or in-person
- Communication during the visits was positive and clear. Several noted that more written information from CHW would be helpful.



CHW Program and Access to Care

Interviewees reported on their experience with CHW and how the CHW facilitated their access to other services that met their needs:

Specific, clear information about health and wellness services that were appropriate for their unmet needs and how to obtain them

Tangible aid and connections to address social determinants of health, including food, housework, and bills.

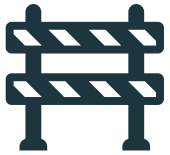
"Well, now, like, for instance… I didn't get homecare for a while and now they helped me [get] on my homecare."

"The Food is Medicine is an absolutely wonderful program. It has done so much for me. It got me out. I mean, they came and got me because I wasn't driving."

Recommendations for Provider Organizations

Interviewees discussed several ways in which provider organizations could improve services overall to better meet their needs

Improved ability to communicate effectively and clearly and listening to the specific needs of the patient



Continued barrier reduction, including more readily available information about how to access services and facilitating transportation.

"Less paper, red tape"

Resources for both informal and formal mental health support.

VIII.Key Takeaways

RHAN-EOI Y1 Summary

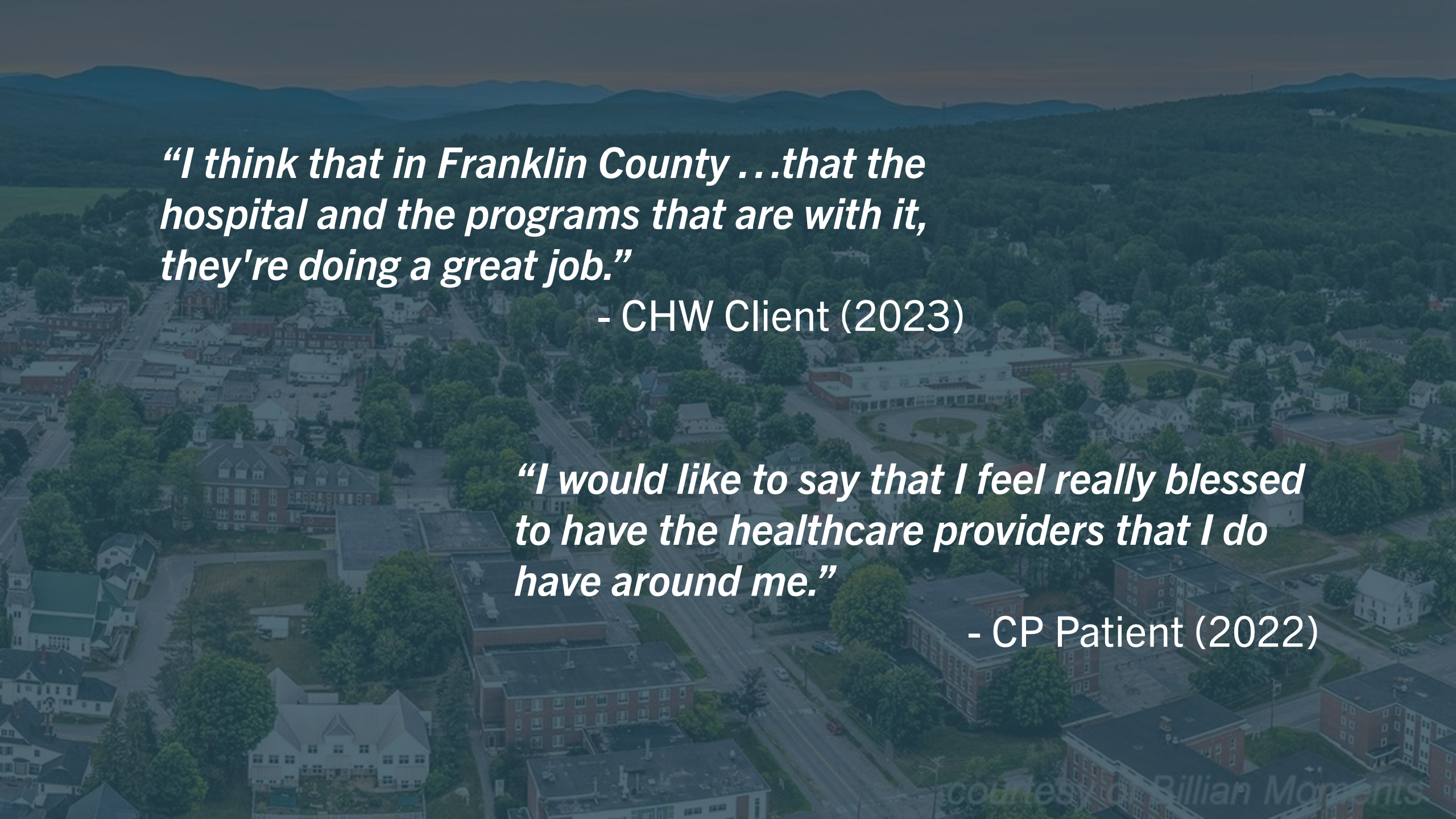
Partnership Self-Assessment: Key Takeaways

Interview and survey feedback from partners indicates that the consortium improves their impact and problem-solving ability, and that program activities are responsive to community needs. Sustainable growth and communication will further enhance these strengths.

Interview and survey feedback from program patients and clients indicates that CHW and CP programs are reaching vulnerable populations with SF-12 scores below the national average. CP and CHW services, including care coordination, are appropriate and necessary for patient-centered care.

Program data shows program changes that align with workplan activities, including expanded CHW services. A decrease was seen in CP services in year 2. Among the year 2 patient panel, only 3% of patients were privately insured in year 2, and chronic conditions diagnoses were common. This further indicates that programs are reaching patients with high needs.

HCC RHAN leadership has incorporated staffing and organizational changes that align with needs identified in the PSA.



“I think that in Franklin County . . .that the hospital and the programs that are with it, they're doing a great job.”

- CHW Client (2023)

“I would like to say that I feel really blessed to have the healthcare providers that I do have around me.”

- CP Patient (2022)

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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