It Takes a Village: Assessing & Responding to Social Determinants of Health in Primary Care



South Dakota Chronic Disease Partners – October 12, 2021

Shannon Bacon, MSW, Health Equity Manager, CHAD

Nancy Miller, LSWA, Case Manager, Community Health Center of the Black Hills

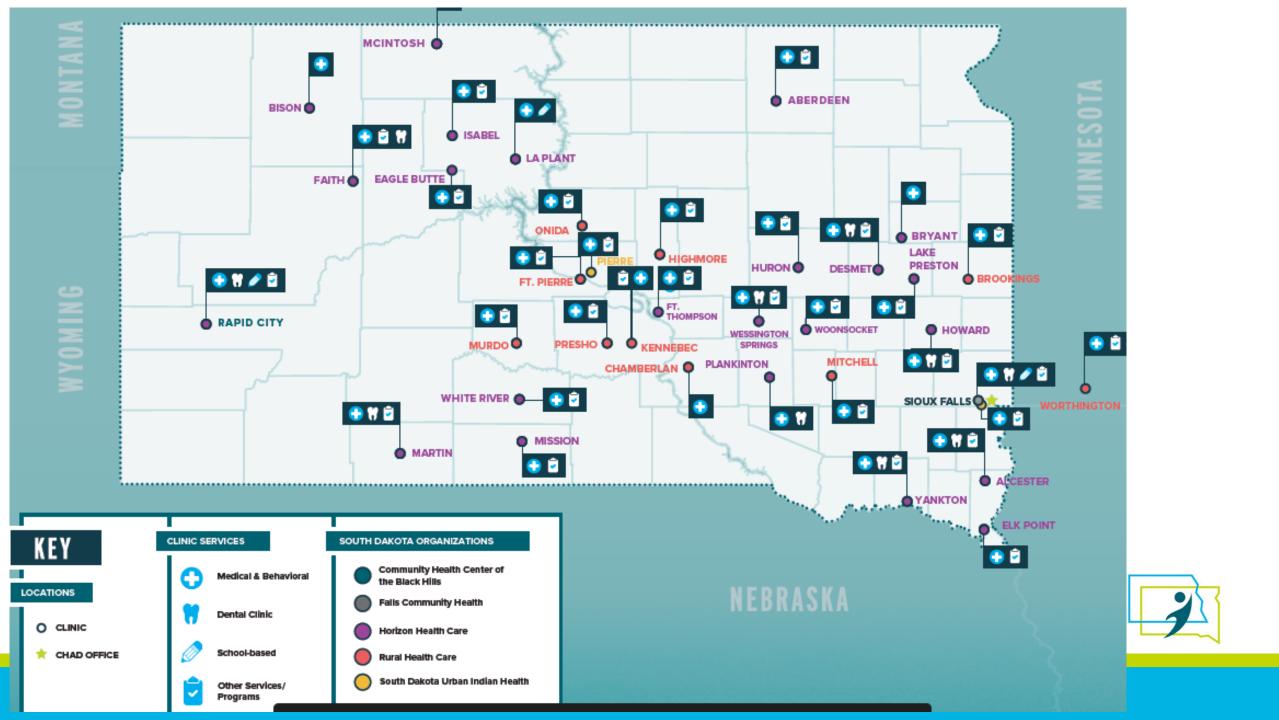
Tanja Cutting, MS, RD, CDE, LN, Community Health Center of the Black Hills

Agenda

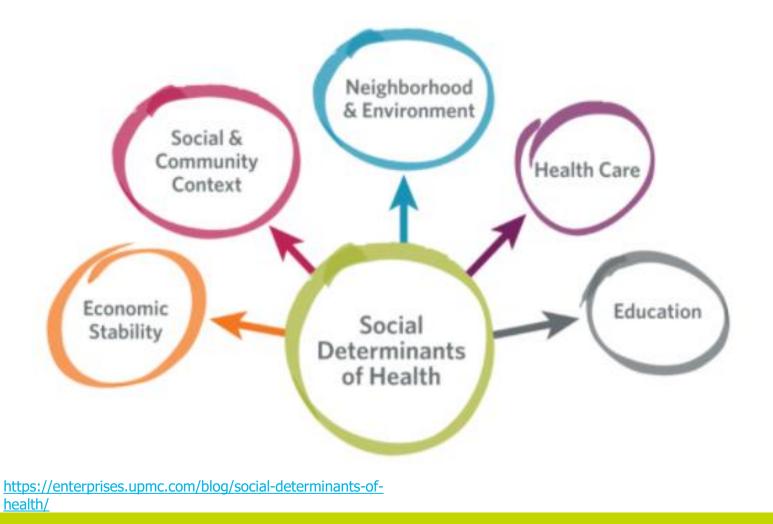
- Introduction to community health centers & CHAD
- Introduction to social determinants of health and PRAPARE screening tool
- Integrating case management & social work into primary care
- Addressing food insecurity within primary care
- Discussion







What are social determinants of health?

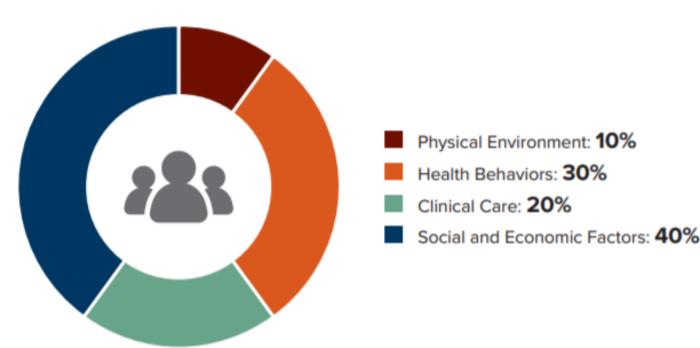




Why are social determinants of health important?

FIGURE 1.1. Social, Economic, and Environmental Factors Play a Large Role in Impacting

Health Outcomes





CHAPTER 1: Understand the PRAPARE Project

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

A national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health.





What does PRAPARE screen?

Core									
UDS SDOH Domains	Non-UDS SDOH Domains (MU-3)								
1. Race	10. Education								
2. Ethnicity	11. Employment								
3. Veteran Status	12. Material Security*								
4. Farmworker Status	13. Social Isolation								
5. English Proficiency	14. Stress								
6. Income	15. Transportation								
7. Insurance	16. Housing Stability								
8. Neighborhood									
9. Housing Status									

Optional								
1. Incarceration History	3. Domestic Violence							
2. Safety 4. Refugee Status								

Optional Granular										
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?									
2. Employment: # of jobs worked	4. Social Support: Who is your support network?									



*Food, Utilities, Clothing, Childcare, Medicine or any Health Care, Phone, Other

Resources to support implementation

- PRAPARE Implementation and Action Toolkit
- <u>PRAPARE site NACHC</u>
- <u>PRAPARE YouTube Page</u>
- PRAPARE Readiness Assessment
- OPCA Empathic Inquiry Video
- OPCA PRAPARE Workflow Tools
- PRAPARE Tiger Team EHR Support





In Action: Health Center Example



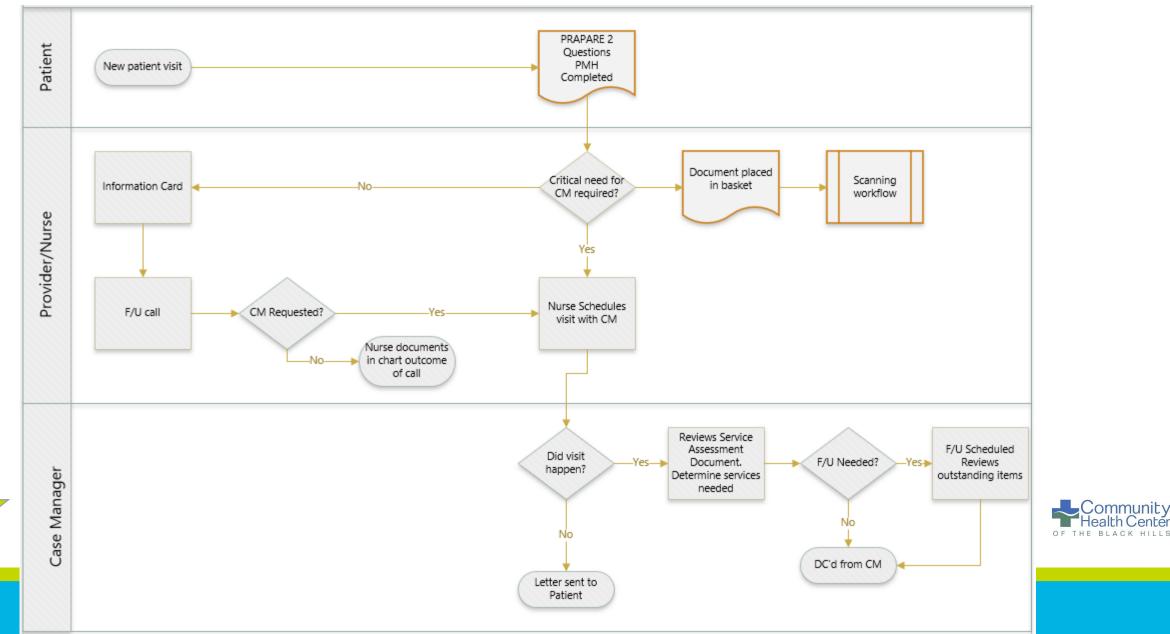


Integrating Case Management and Social Work into Primary Care

- How can we improve social determinants <u>and</u> clinic outcomes?
 - Identify "at risk" patients
 - Provide a needs assessment
 - Connect patients to community resources
 - Eliminate barriers for patients to access resources
 - Provide immediate assistance when available (vouchers, gift cards)
 - Partner with other community organizations using referral systems



CHC of the Black Hills: PRAPARE Workflow



ommunity lealth Center

Case Manager Receives Referral... Now What?

- In depth needs assessment
- Connecting patient to resources
 - Service Assessment Talking Points



Community Health Center of the Black Hills Needs Assessment

Patient Name:	Case Manager:	Date Completed:		
Patient Number:	Phone Number:	Message Ok?	Yes	No
Email Address:	Address (if different than file):			

Н	ousing										
3	Stable housing	Safe and	secure	Enough room for household size		Pay mortgage/ rent on time		Pays Utilities/ on LEAP		Weatherization	
2	Temporary housing	Relatively	/ safe	Household members share rooms		Need help to pay rent/		Need help to pay utilities		not a priority	
1	Homeless I risk of losing housing	Dangerous	housing	Not enough room for household size		Facing eviction or foreclosure		Received shut off notice		f Unable to make repairs/Landlord not making repairs	
	omments:			•						· • •	
Fo	od/Clothing										
3	Purchase own food	/On SNAP	Eats a	t least 3 me	eals/day		althy food grou	•		No clothing needs	
2	Need help to acc	ess food	Eats tw	o or less m	eals/day	Sometimes eat from healthy food groups			Needs seasonal clothing		
1	No food in hous	sehold	Sk	ips daily me	eals	Never eat from healthy food groups			Needs clothing		
	omments:										
Ir	ansportation										
3	Have reliable vehicl		Driver's Lice Certificate/			ransportation to Vehicle repairements value va value value v				Vehicle payments made n time or vehicle paid for	
2	Have unreliable vehi		voked/sus driver's licen:			transportation to Has resources to pay pintments maintenance/		for 🔲	Payments are behind		
1	Have no vehicle		Driver's Licen Certificate/			ansportation to Unable to pay for pintments or mainter		intenance		ehicle was repossessed/ on the verge of being repossessed/no vehicle	
Co	omments:										
E	Employment										
	3 Employed/ choose not to work/ disabled/ Veteran Have skills/training Has resume established Has dependable child ca								dependable <u>child care</u>		
2	employm		Upgr	ading skills/	/training	Access to create/update resume			Un-reliable <u>child care</u>		
1	Unemploy	yed	d Need skills/training No resume Needs information on <u>child care</u>								
(Comments:										





Fi	nancial													
3	Reliable income	Pays all or most bills on time		Good credit		Follow a budget		Established bank accounts		Retirement plan set up				
2	Adequate income	Struggle to pay bills		ills	Establishing credit		redit	Need help with budgeting skills limited budgeting skills		Difficulty adding to bank accounts		Wants information on retirement		
1	Little to No Income	Unable to pay bills		ls	No credit/poor credit		No budgeting skills		No bank accounts		No resources to establish retirement			
Comments:														
E	ducation													
3	Attending college Knowledgeabl college degree computer/internet training certificate computer/inter				access to Utilize publi			c library regula	library regularly Possesses		ability to read		peak pread and write in English	
2	Have High Schoo Diploma GED	ol	Some compu	ter/inter	net skills			public library asionally		Has trout	le reading		ning to speak, read and write in English	
1	No High School Diploma/GED		No compute	er/interne	et skills	Does	s not uti	ilize public libra	ary	Unable	to read	Una	Unable to speak, read or write English	
C	omments:													
W	ellness/Relationships													
3	Good support system	Have stable A relationships		Able to cope with stress		ith	Able to function			o mental health concerns with self family	No legal concerns		Use positive parenting skills	
2	Limited support system		ewhat stable ationships		times able with stres			imes able to unction	M h witl	lanaged Mental ealth concerns h self fami	concer	<u> </u>	Sometimes uses positive parenting skills	
1	No support system		Jnstable ationships	Unable	e to cope v stress	with		y functioning ost days	h	managed ment ealth concerns h <u>self f</u> ami	Major le	-	Needs information about positive parenting	
	omments:													
	ealth Care													
3	Have private health dental vision Rx insurance VA	exams, household a						es No alcohol abuse			No drug use		Exercise regularly	
2	Medicaid or Medicare		Health con managed/ee immunizations	xams, overdu	e assist	okes/wa tance t	io quit	Receiving intervention services avants assistance		Receiving treatment wants assistance self- medicating		Exercise occasionally		
1	No health denta	No health dental Unmanaged health Smokes vision Rx insurance concerns interest in c						Needs assistance with addiction			Needs assista with addiction		Do not exercise	
C	omments:													





Service Assessment Talking Points (Examples)

Housing:

- LEAP (Energy Assistance) automatically eligible if on SNAP still need to apply
- Weatherization
- Home Repair Programs
- Housing Assistance
- Housing Counseling (CCC)
- The Governors House/Habitat for Humanity
- Furniture
- Safe Housing (poisons, violence, lead)
- Tenant's Rights & Responsibilities
- Coordinated Entry System (CES)
- ESG programs

Food/Clothing

- SNAP
- WIC
- Free/Reduced lunch (parent ask school for application) automatically eligible if on SNAPstill need to apply
- Food Pantries/FeedingSD
- Diapers
- Mommy's Closet (diapers/clothing/care seats) VOA
- Clothing Vouchers
- Meal Planning/Nutrition
- Eat together as a family



Addressing Food Insecurity within Primary Care

- How can we improve eating behaviors <u>and</u> clinic outcomes?
- Pilot Study with Diabetes Patients
- Onsite Pantry
- Community Garden
- Mobile Food Pantry Regularly On Site
- Farmer's Market Produce Prescriptions





Pilot Study with Diabetes Patients

- Partnered with BHACF, Feeding SD Food Bank
- 12 patients
- Seen monthly for 6 months for Diabetes Education and Given:
 - Food Stuffs ordered through the food bank; attempted to optimize healthy choices
 - 2, \$10 produce vouchers at local grocery store
- Results
 - Slight decrease in A1C down ~.5
 - Slight increase in wt, up ~5#s







Onsite Food Pantry & Produce Vouchers



- Again partnering with BHACF and Feeding SD Food Bank
- Meant to be an emergency supply for patients, 1x, not ongoing as with pilot
- Patients encouraged to make use of other community organizations
- Food Pantry was very successful
- Produce Vouchers, not so much most not redeemed



Community Garden

- Partnering with SDSU Extension and other groups
- Grow fruit and vegetables for patients
- Planted several apple trees maturing
- 12 box garden
- Attempted partnerships with Mission, Wellfully, Fork Real
- Now provide to staff, patients and occasionally Fork Real
 - Best method for getting to patients has been leaving vegetables in entrance





Mobile Food Distribution-September 2021

Wednesday September 1st

10:00-11:00 St. Andrews--910 Sioux San Dr., RC SD

3:00-4:00 Open Heart--202 E. Indiana St., RC SD

Thursday September 2nd

5:00-6:00 PM Open Bible Church – 2225 E. St. Patrick St., RC SD

Wednesday September 8th

10:00-11:00 He Sapa-- 415 Mac Arthur St., RC SD

3:00-4:00 Lakota Homes—719 Wambli Dr. (by the office), RC SD

Friday September 10th

10:00-11:00 Bible Fellowship Church--1212 Fairmont, RC SD

3:00-4:00 Rural America Initiatives--2112 South Valley Dr., RC SD

Saturday September 11th

10:00-11:00 Church of Jesus Christ Latter-day Saints-- 2822 Canyon Lake Dr., RC SD

2:30-3:30 Community Health of the Black Hills--350 Pine St., RC SD

Thursday September 16th

4:30-5:30 Douglas School District- Francis Case Elementary, 441 Don Williams Dr. Box Elder SD

Saturday September 18th

10:00-11:00 Real Life Church, 4024 Sheridan Lake Rd

2:30-3:30 Journey Museum- 222 New York St., RC SD

Wednesday September 22nd

10:00-11:00 Star Village-27 Signal Dr. (behind the office), RC SD

3:00-4:00 Rapid Valley United Methodist Church – 5103 Longview Dr., RC SD

Friday September 24th

10:00-11:00 Mother Butler-231 Knollwood Dr., RC SD

5:00-6:00 Career Learning Center-730 E. Watertown St., RC SD

Mobile Food Pantry On Site

- Food Bank has gone to mobile distributions throughout community
- On Site at CHCBH 1x/month, but several throughout Rapid City
 - Distribution Sites Listed to the left



Piloting with Farmer's Market



- Community Partners: SDSU Extension, Living Well Black Hills
- Started this June and will run through October
- Farmer's Market open Wednesdays, Saturday
- \$20 voucher given to patients so they can buy fresh produce at farmer's market
- Additional benefit if they have SNAP, \$20 = \$40
- Bus Passes provided to those who lack reliable transportation
- Stats 25% redeemed

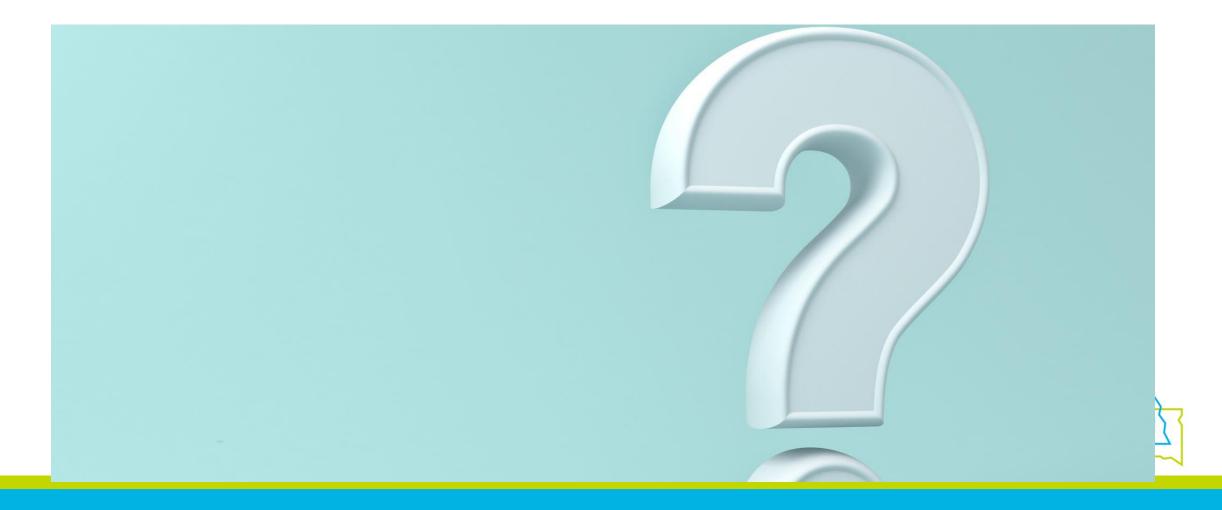


Lessons Learned RE: Addressing Food Insecurity in Primary Care

- 1. Line Up Your Community Partners
- 2. Whenever possible bring the food stuffs to the patients
- 3. Attempt to remove as many barriers as possible, ie transportation, financial



Q & A







Closing



• What is ONE next step you will take to address social determinants of health?





Thank You!



Community HealthCare Association of the Dakotas

