Good&HEALTHY
SOUTH DAKOTA HEALTHCARE

SUCCESS STORY

Overcoming Barriers Around Social Determinants of Health

Challenge

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age. They affect a wide range of health risks and outcomes. South Dakota is not immune to negative outcomes based on SDOH, so Sanford Clinic Brookings sought a way to better assist their patients with overcoming barriers to social determinants of health.

Solution

Sanford Clinic Brookings hired a full time social worker to address SDOH. The clinic began implementing regular use of a SDOH screening tool for new patients, those coming to the clinic for an annual exam, and those identified as having a diagnosis of cardiovascular disease or diabetes. If a patient had a positive response to one of the SDOH indicators, that screening was assessed by the staff and a referral was made to the social worker if appropriate. For positive screening referrals, the social worker would work with the patient on their identified area of concern to best address their area(s) of need.

Results

Sanford's leadership and staff got on board with this project right away.

The social worker began tracking SDOH screening info and in December, 132 screenings were administered. Of those, 26 had positive indicators with 12 eliciting intervention from the social worker. Although some patients were hesitant at first, several have expressed great appreciation for the assistance they have received.

Evidence Based Interventions

Supporting engagement of non-physician team members in hypertension and cholesterol management in the clinic setting through funding to support a 1.0 FTE social worker in the Sanford Clinic Brookings.

SOUTH DAKOTA Heart Disease & Stroke Prevention PROGRAM

Timeline

The Heart Disease and Stroke Prevention Program (HDSPP), through conversations with the North Dakota (ND) Division of Health Promotion, became aware of a social determinants of health project being done through Sanford in ND in April 2019. The HDSPP reached out to the Sanford grants manager, relaying interest in expanding this project to SD. The grants manager worked with her team to identify Sanford Clinic Brookings as a good location to implement this project. HDSPP first partnered with Sanford Clinic Brookings in June 2019 and in September 2019, a social worker was on-boarded to the clinic. Screenings were first administered in October/ November 2019 as part of SD's 1815 Year 2 work plan and will continue through Year 3, which ends June 29, 2021. During Year 3, the clinic and HDSPP will assess the need and desire to continue this work into Year 4.

Successes

Patient A had an appointment in Sioux Falls at the specialty clinic but lived in Brookings. Patient A did not have a cell phone, car, or know anyone who could assist with transportation to the appointment. Sanford Clinic Brookings' social worker utilized area resources to set up transportation for the patient and worked with the agency and a specific driver to coordinate a ride for the patient. Patient A was therefore able to make it to the appointment on time and saw the specialist.

Patient B had lost her health insurance coverage and stated she would need to quit taking her medication after it was gone due to not being able to afford it any more. The patient was somewhat resistant at first but the social worker worked with the patient on searching through drug company coupons and medication websites to find the best, most affordable price for the medication. The social worker found a coupon so the patient was able to afford the medication. Patient B picked up the medication from the pharmacy using the coupon. Additionally, the patient did not want to make a follow-up appointment due to the financial situation. The social worker talked with the patient about the Patient Financial Assistance Program and helped her complete and submit the application. The patient did end up coming in for basic follow up lab work.

Patient C required more services in the home due to high needs and additionally needed assistance with transportation to several appointments each week. The social worker assisted the patient to set up Meals on Wheels, increase home aide hours and add an additional day, and start the process for home health to come into the home. Due to the social worker's assistance, the patient has been able to have hot meals brought to him regularly, have increased home aide hours, which has helped with grocery shopping, house cleaning, and providing company for the patient. Additionally, the social worker was able to find volunteers in the patient's small community to help with transportation to appointments.

Patient D had been prescribed medication after visiting with their doctor. However, at Patient D's follow-up appointment, the patient stated the medication had never been picked up due to the co-pay being too expensive. The patient was referred to the social worker and the social worker was able to connect the patient to a resource in the community that met with the patient that day to cover the co-pay.

NEXT STEPS

Sanford Clinic Brookings will receive continued funding from the Heart Disease and Stroke Prevention Program to support the social worker in FY21. The social determinants of health screening tool will also be integrated into routine care for all the patients at the clinic as staff become more familiar with the screening process.

Resources:
www.sanfordhealth.org/locations/sanford-health-brookings-clinic

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