Continuing the Conversation

Health Disparities and Social Determinants of Health

May 31, 2023

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains

Quality Innovation Network

Series Objectives

Understand	• Understand health equity and how it applies to healthcare facilities (of all sizes and locations)
Describe	• Describe the various components of health equity and their impact on achieving equitable care
Identify	• Identify opportunities of growth for organizations and individuals
Access	• Access resources to help with ensuring equitable care

The Purpose of the National CLAS Standards

- Advance health equity
- Improve quality of services
- Help eliminate disparities

Conversation Topics and CLAS Standard Themes

Topic 2 | Social Determinants of Health and Health Disparities

- The Principal Standard
- Theme 1: Governance, Leadership and Workforce
- Theme 2: Communication and Language Assistance
- Theme 3: Engagement, Continuous Improvement and Accountability

Our Speakers

Shannon Bacon, MSW
Senior Health Equity & Partnerships Manager
Community Healthcare Association of the Dakotas

Shauna Batcheller, MSS, CPH
Program Director
Helpline Center

Continuing the Conversation

Health Disparities & Social Drivers of Health

Shannon Bacon, Senior Health Equity & Partnerships Manager

Community HealthCare Association of the Dakotas (CHAD)

WHO WE ARE

CHAD supports community health centers (CHCs) in their mission to provide access to health care for all Dakotans regardless of insurance status or ability to pay.

WHAT WE BELIEVE

As the **Community HealthCare Association of the Dakotas**, we believe that everyone has a right to high-quality, reliable, affordable health care, regardless of where they live. We work with health centers, community leaders, and partners to increase access and improve health care services in areas of the Dakotas that need it most.

HEALTH CENTERS IN THE DAKOTAS

IN NORTH DAKOTA & SOUTH DAKOTA

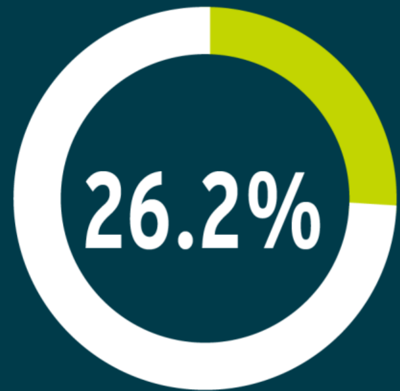
10 HEALTH CENTERS

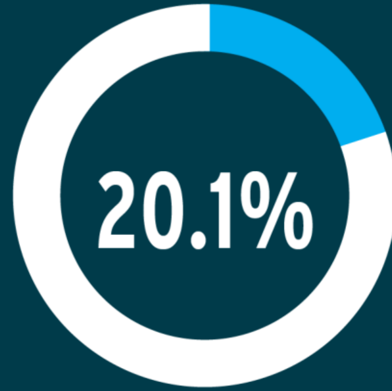
OVER **60** DELIVERY SITES

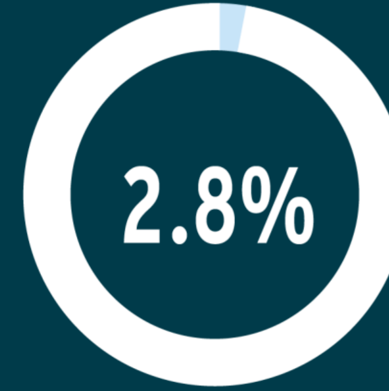
OVER **50** COMMUNITIES

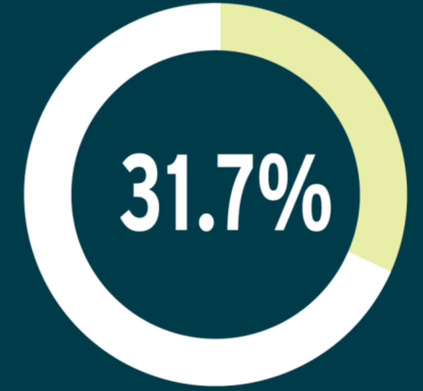
SNAPSHOT OF THE DAKOTAS

In 2021 health centers served over **136,500 patients,** from those patients:









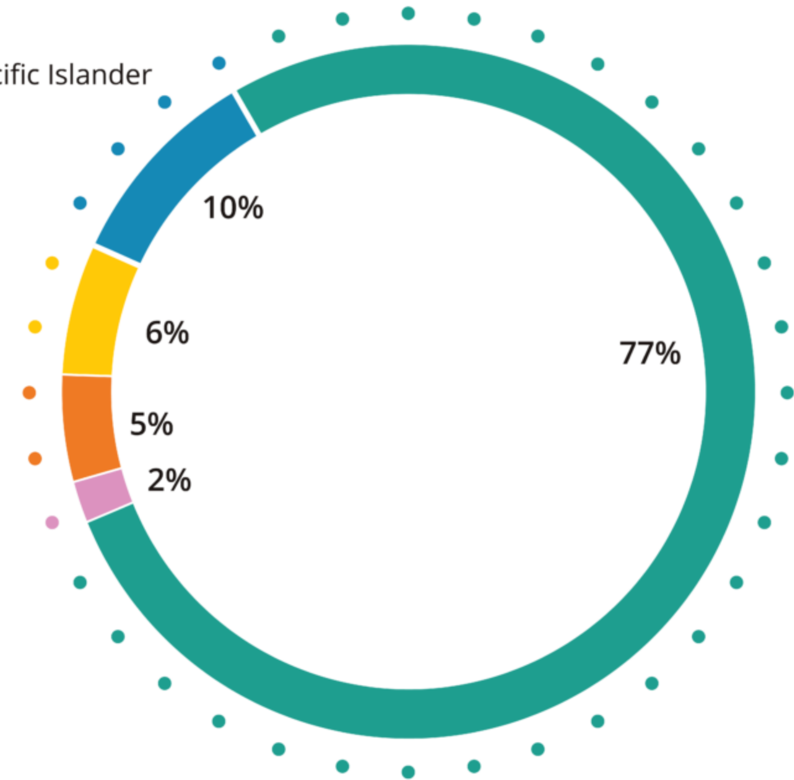
In 2021 **67.9%** of patients served at ND and SD health centers were under 200% of the federal poverty level. A family of four would be at 100% of the poverty level if they made less than $26,500 annually.

Our Commitment to Diversity, Equity, Inclusion & Belonging

We acknowledge that unfair policies and practices have led to health inequities across race, ethnicity, gender identity, sexual orientation, geography, and other identities. Health centers are rooted in the civil rights movement, and we aspire to build on this legacy by working collaboratively with others to see equitable health outcomes in our communities. We bring with us a commitment to continued learning and growth, as well as a recognition of the need for urgent action.

Growing Diversity

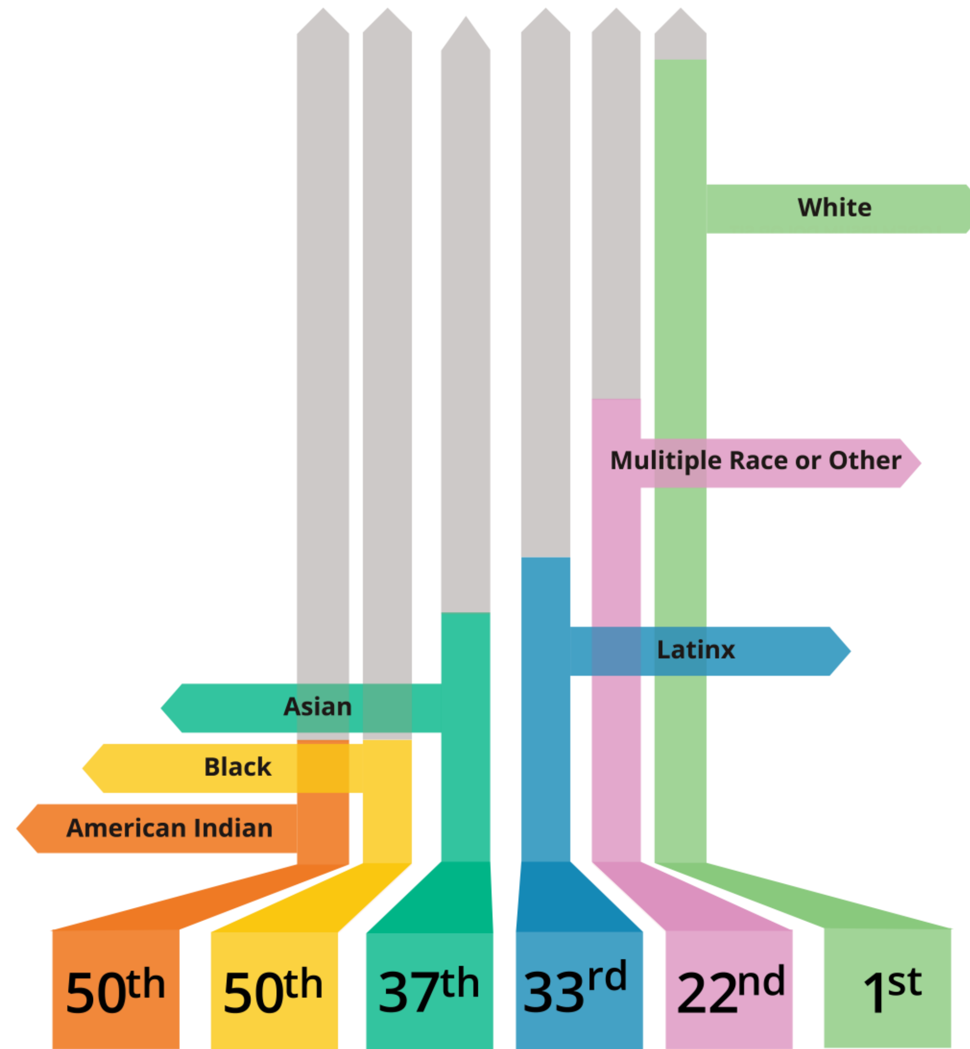
In North Dakota and South Dakota, about **1 in 4 children are Black, Indigenous, or People of Color.**



North Dakota & South Dakota have both been ranked among the states with the best quality of life in the nation.

…But not everyone is experiencing the same opportunities for quality of life and health.

Locally, our children's economic security is impacted by systemic racism.

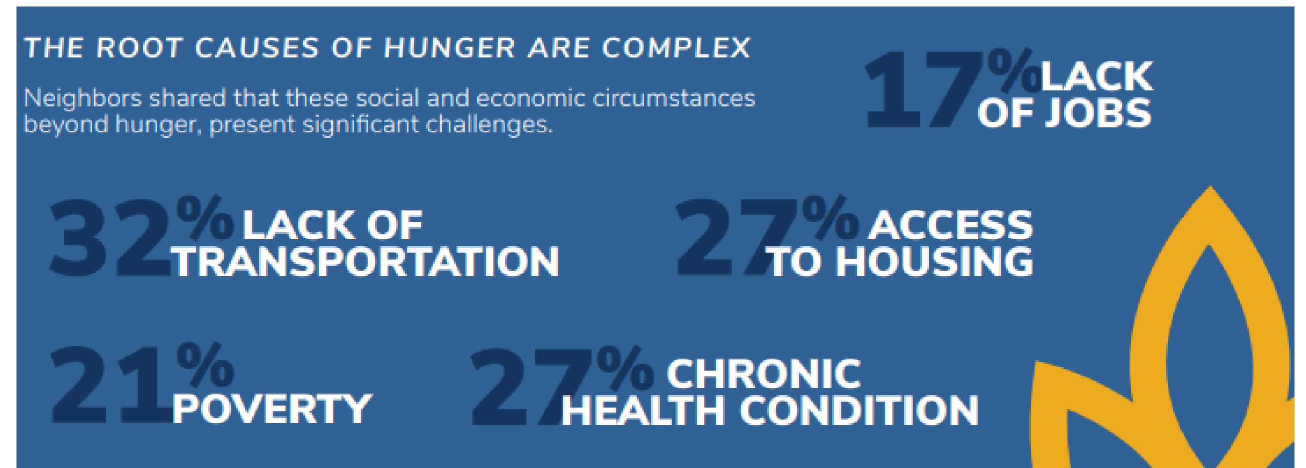


Food insecurity is a problem locally, and there is a disproportionate burden on Native Americans.

- Native Americans in North Dakota face hunger at a rate of **7 times the rate of other communities.**

- In North Dakota, **individuals experiencing hunger are three times more likely** than the general population to be diagnosed with **Type 2 Diabetes.**

- **75 percent of neighbors** accessing Great Plains Food Bank programs report experiencing **at least one chronic health condition.**



Source: Great Plains Food Bank, 2023

Disparities in Diabetes Deaths in South Dakota

In South Dakota, American Indian & Alaska Native individuals account for **29% of diabetes deaths**, despite making up 7.6% of the total state population.

South Dakota

Source: Kaiser Family Foundation

Local Housing Discrimination

Even after controlling for income level, families of color are denied mortgage loans at a higher rate in North Dakota.

- Between 2004 – 2014, mortgage loan denial rates for American Indian and Latinx families were more than double the rate for white families within the same income bracket.
- When families of color are denied the same opportunities to purchase homes, they are also denied the opportunity to build wealth across their lifetime that can be passed on to their children.

Source: ND Kids Count, 2022

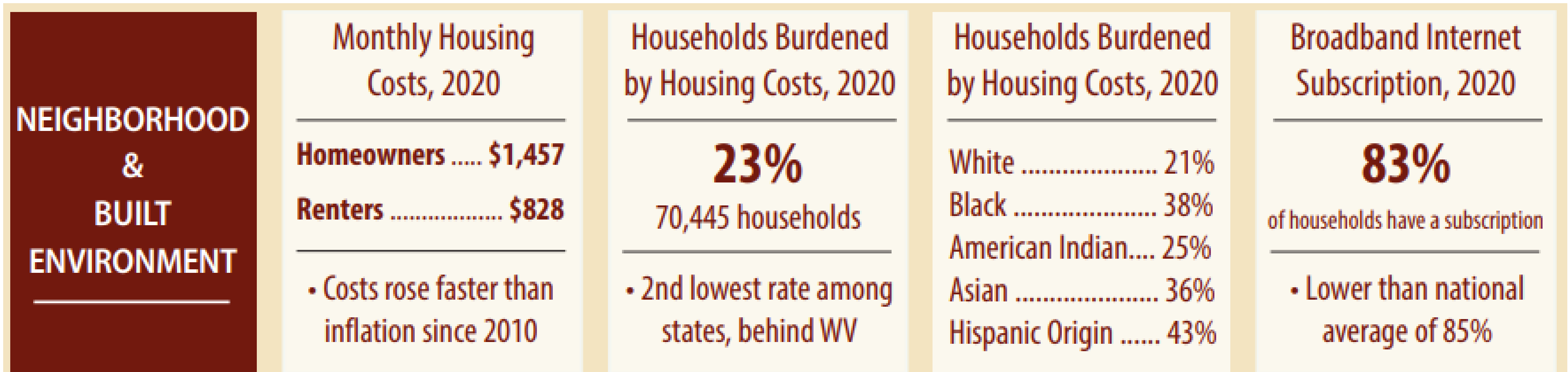
Local Resources for Housing Discrimination:

High Plains Fair Housing Center (ND)

South Dakota Housing

Black, Indigenous, and People of Color are disproportionately burdened by housing costs.

In North Dakota:



Source: Report on the Health & Well-being of North Dakotans, 2023, Blue Cross Blue Shield of North Dakota

Queer youth feel the impacts of oppression and are at increased risk for suicide because of it.

North Dakota Queer Youth Are:

- 222% more likely to consider attempting suicide
- 270% more likely to plan suicide attempt
- 354% more likely to attempt suicide

For 24/7 Crisis Services for LGBTQ+ Youth, visit The Trevor Project

Source: ND YRBS Survey

Local Resources:

988 Suicide & Crisis Lifeline

North Dakota Human Rights Coalition

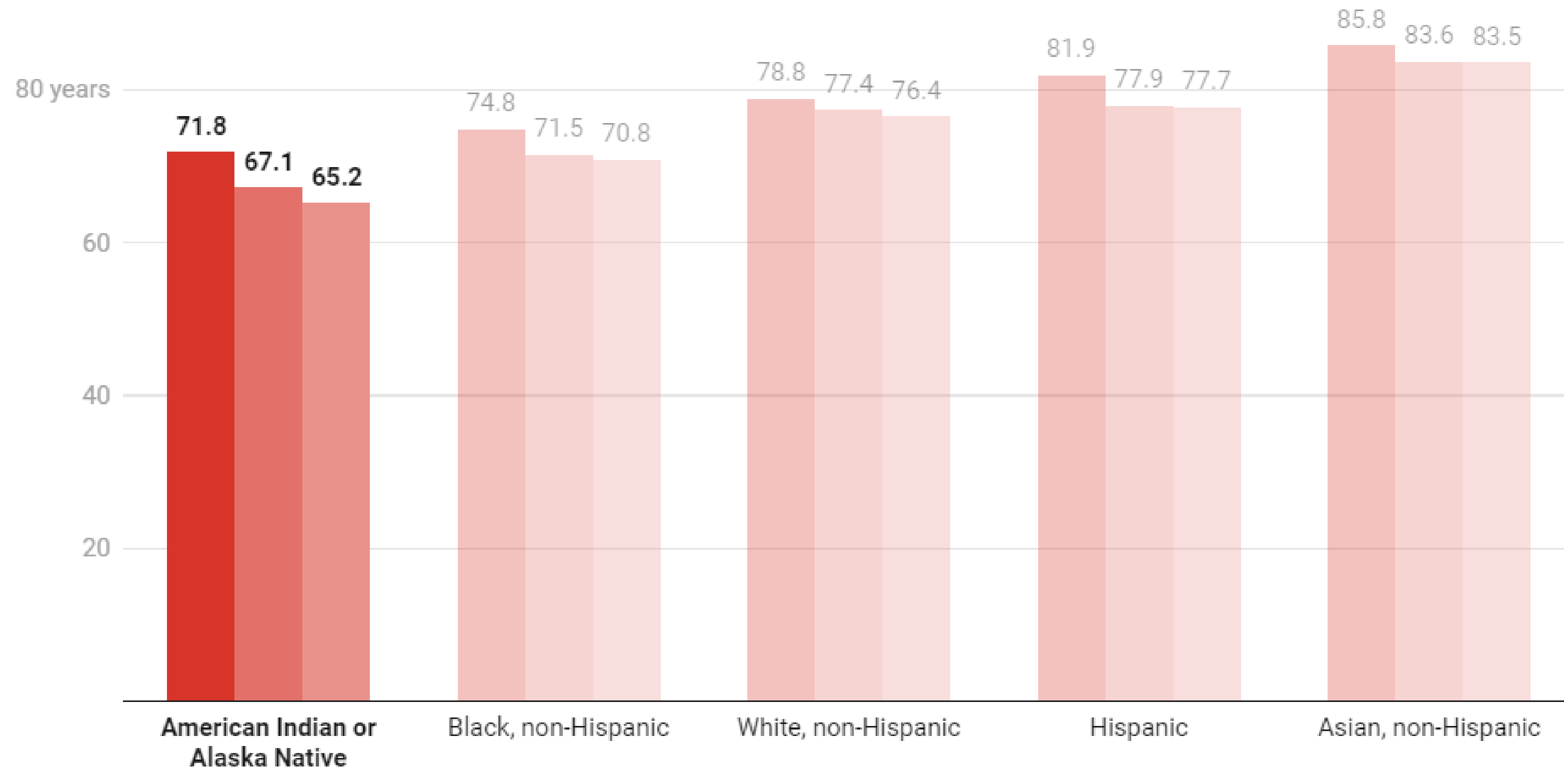
Community Uplift Program

Equality South Dakota

The Transformation Project

Faye Seidler Consulting

Native Americans’ Life Expectancy Has Fallen



More details: [Native Americans have experienced a dramatic decline in life expectancy during the COVID-19 pandemic – but the drop has been in the making for generations (theconversation.com)]

We must ask ourselves … why?

- Poverty, Unemployment, and Lack of Health Care
- Historical Trauma

Pine Ridge

What can we do?

- Apply an equity lens to your data … who is experiencing inequities?
    - Through your program/organization / in your community?
- What are the most prevalent needs? How do these intersect with other needs or with demographic data?
- What efforts are underway to address these? Are the people most impacted involved? Are their voices guiding the solutions?
- Partner, partner, partner!

Example: Sicangu Health Initiative in Rosebud

STAY CONNECTED

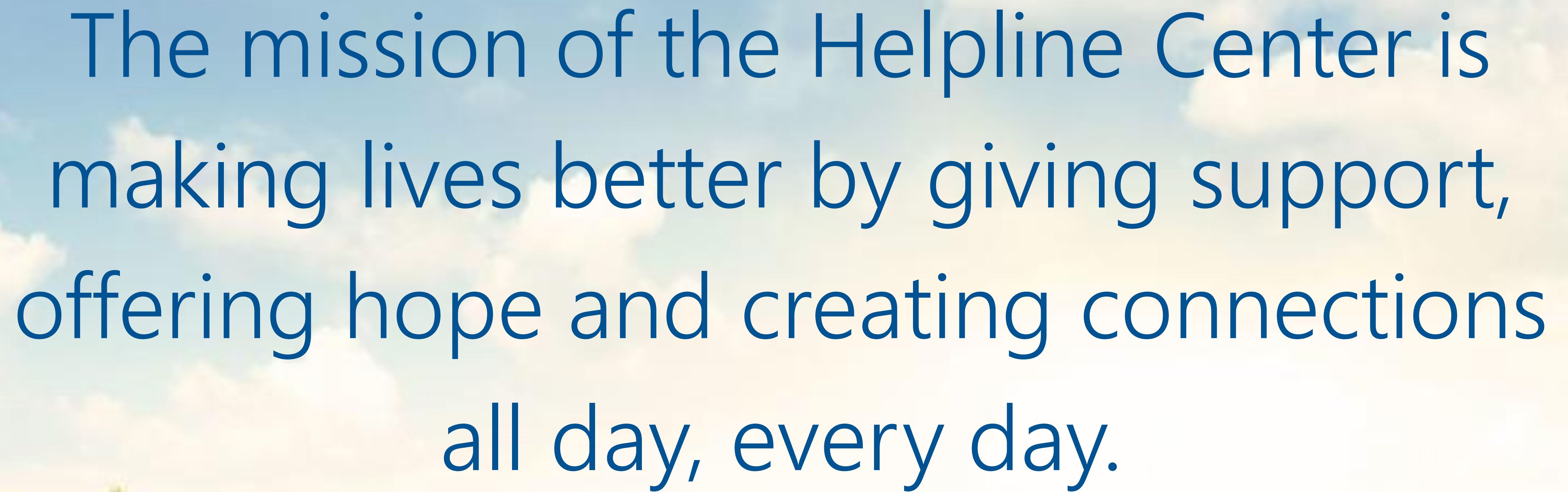
- CHAD Connection – Bi-weekly
  The CHAD Connection includes health center news, state and federal legislative updates, a curated list of educational opportunities, CHAD events, and relevant updates on current events like COVID-19 and health-related awareness dates.
- Facebook:@CHADinc
- Twitter: @PCACHAD
- Website: http://communityhealthcare.net

THANK
YOU!

CIE

Community Information Exchange

Social Health Care Coordination for Whole Person Care


The mission of the Helpline Center is
making lives better by giving support,
offering hope and creating connections
all day, every day.

The Helpline Center has been helping people in need since 1974. We serve thousands of people each year.

Helpline Center Program and Service Overview

- Connecting individuals to resources and support
  - Community Resource Database
  - 211 – Information and Referral Line
  - Support Programs / Case Management
  - Technology Infrastructure for Social Care – Helpline Center Network of Care & CIE
- Offering hope to individuals during times of crisis
  - 988 Mental Health Crisis Line
  - Suicide Prevention and Loss Services
- Linking people with volunteer opportunities in their community
  - Volunteer Connections

South Dakota's Community Information Exchange (SD CIE)

A project of the SD Department of Health

is a statewide collaboration of health care, human and social service providers sharing information using an integrated technology platform and referral system to coordinate whole-person care.

Vision

To streamline connection between health care, human and social service providers to address social needs and advance health improvement among populations at higher risk and that are underserved.

Project Overview

The South Dakota Community Information Exchange (SD CIE) Team has been working diligently over the past year and has learned a lot about how the SD CIE should look. We are in the process of making some adjustments to our original project to best meet the needs of our partners and will be transitioning to a new software system this summer.

Our team continues to refine system requirements to ensure we are delivering a product that will suit our state. We anticipate pilot communities (Rapid City and Mitchell) will be able to use the SD CIE sometime in the fall. After our pilot communities have had the opportunity to provide feedback, the Team will work on incorporating any necessary adjustments prior to bringing on more users.

Onboarding of additional partners will likely take place in late winter/spring of 2024 and continue after that time as more partners are identified.

SD CIE Early Adopter Partners

Mitchell

1. The Caring Closet
2. Mitchell Snack Pack
3. Big Friend Little Friend
4. Communities that Care
5. Rural Office of Community Services ROCS
6. Safe Place of Eastern SD
7. City of Mitchell Rec Center
8. Abbott House

Rapid City

1. City of Rapid City
2. Rapid City Fire/EMS Department
3. Rapid City Police Department
4. Journey On!
5. Volunteers of America Northern Rockies VOANR
6. Great Plains Tribal Leaders' Health Board GPTLHB
7. Monument Health

helpline center

NETWORK OF CARE

Active Partners

Sioux Falls

Center of Hope
Community Outreach
Embe - Dress for Success
Furniture Mission
Family Services
Habitat for Humanity - NR
Health Connect
Helpline Center Support Programs
Avera Sioux Falls
Ransom Church
Shift Garage
St. Francis House
Sioux Falls Hope Coalition
Transforming Wealth

Brookings

Brookings Avera Behavioral Health
Brookings Area United Way
Brookings Backpack Project
Brookings Behavioral Health & Wellness
Brookings County Human Services Office
Brookings County Youth Mentoring Program
Brookings Salvation Army
Option 1
Volunteer Service Bank

Watertown

Brothers & Sisters Behind Bars
Codington County Welfare Office
Glacial Lakes Multicultural Center
Watertown Human Service Agency
Watertown Job Service Office
Watertown Salvation Army
Watertown School District

Updated 4/27/23

Why are social needs important?

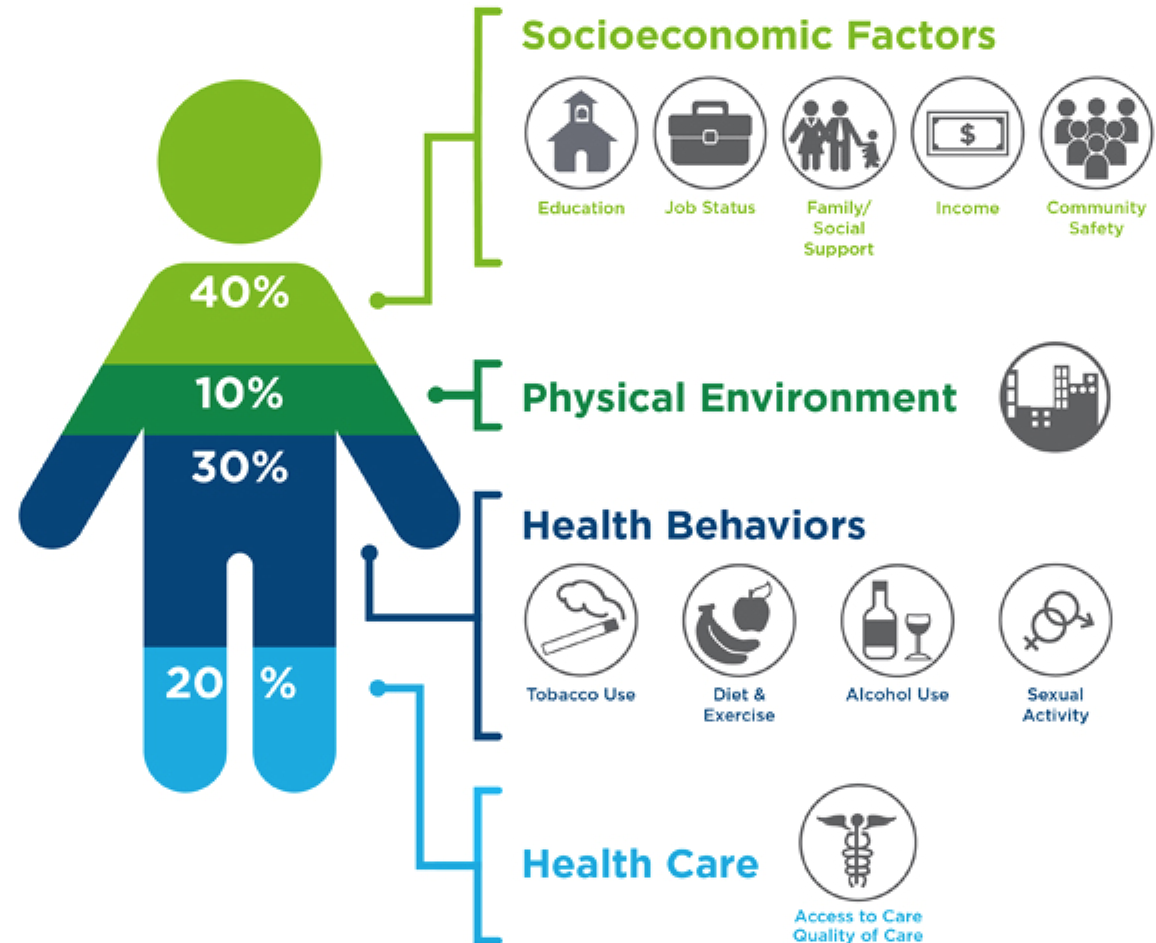
There is growing awareness that SDOH information improves whole person care and lowers cost. Unmet social needs negatively impact health outcomes.

- **Food Insecurity** correlates to higher levels of diabetes, hypertension, and heart failure
- **Housing instability** factors into lower treatment adherence
- **Transportation barriers** result in missed appointments, delayed care, and lower medication compliance

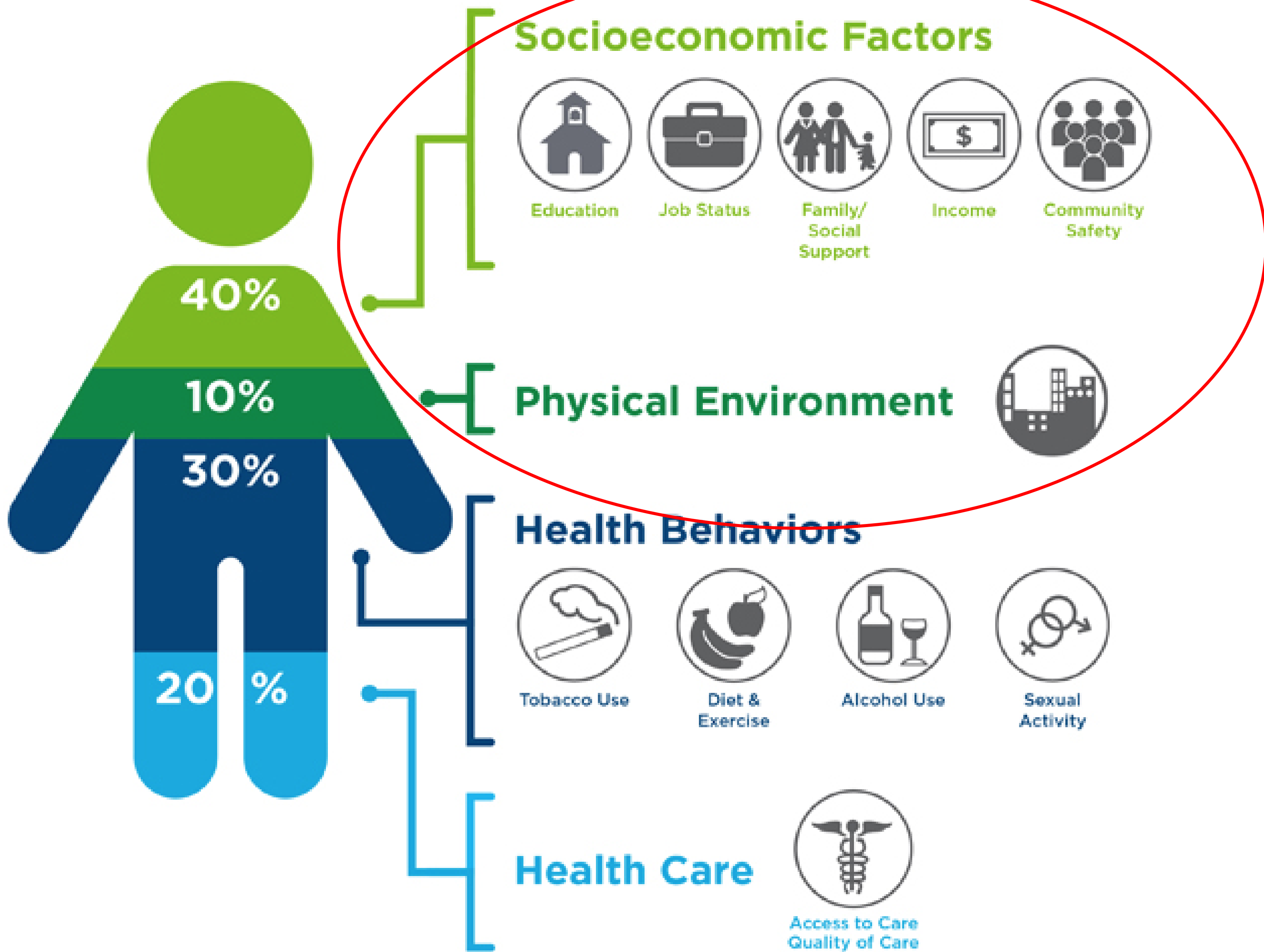
Addressing SDOH is a primary approach to achieve health improvement.

https://www.cdc.gov/nchhstp/socialdeterminants/faq.html
https://www.bridgespan.org/insights/library/public-health/the-community-cure-for-health-care-(1)

What contributes to health?



helpline center



- Services provided by multi-sector partners with different metrics, standards (i.e. HUD, HMIS, DOE, DOL)
- No universal measuring system for the person's needs. There are MANY social needs screening tools or categories of SDOH (Healthy people, Social Sufficiency Matrix, ICD 10 Z codes, Taxonomy)

helpline center

Moving Care Upstream
CIE Community Directory Search
Data Sharing of Client Info and
Service Outcomes Across Providers
Education
Job Status
Family Support
Income
Housing
Tobacco Use
Diet &
Exercise
Alcohol Use
Government Programs
Non-profit Programs
Civic Programs
For Profit Programs
Volunteer-Run Programs
HealthCare Programs
Medicaid
SNAP
TANF
Employment Support
Housing Funding / HUD
Homeless Prevention
Rent Payment Assistance
Utilities Payment Assistance
Medical Bills Assistance
Transportation
Car Repairs
Tuition Assistance
Food Pantries
Personal Care Items
Holiday Items
Children and Family
Clothing and Household
Work Clothing
School-Based Supports
Police Resource Officers
Alcoholics Anonymous
Homeownership Education
Tenant-Landlord Mediation
Nutrition Education
Smoking Cessation
Exercise Programs
Requirements to Access SDOH Supports Varies Program by Program
Eligibility:
Gender
Veteran Status
Income Limits (Varies)
Household Size
Have Children?
Current Employment
ID, SS Card Required
Disability Status
Diagnoses
Frequent Personal Requirements:
Internet Access
Vehicle or Transportation
Phone
Did the person get the help?
What was the result?
Is SDOH support leading to health improvement and lower costs?
Streamlining Communication and Closing the Loop!
helpline center

- **Traditional Linear Referral:** We provide the resource information to the client.
  - The responsibility is the on the client to go to that resource.

- **Closed-Loop Referral:** Through technology, we send e-referrals to resource partners to connect the client. The resource partner reports back to the system about the outcome of the service.
  - The responsibility is on the resource partners and technology processes to connect the client and track outcomes.

What's the Problem for People in Need?

1. Navigating systems

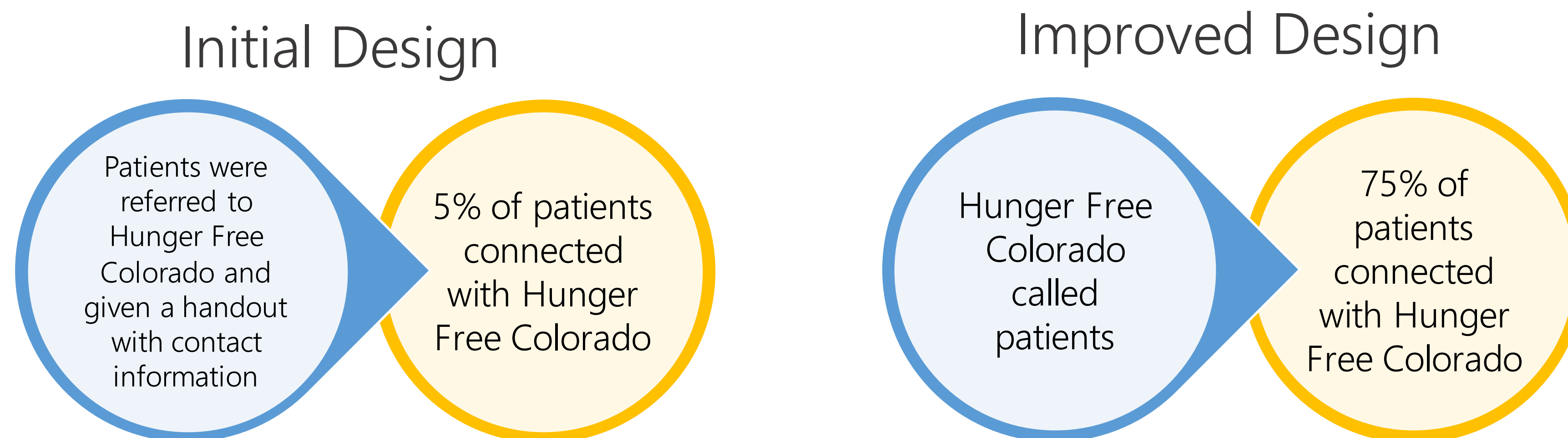
What’s the Problem for Providers?

Data Sharing is DIFFICULT

- Multi-sector providers have different data needs tied to funding sources
  - Examples: Insurers, Federal Programs, United Way, etc.
- There is no cross-sector industry standard of privacy protocols
  - Examples: HIPAA, Part 2, Victim’s Services, FERPA, etc.

What Research Shows

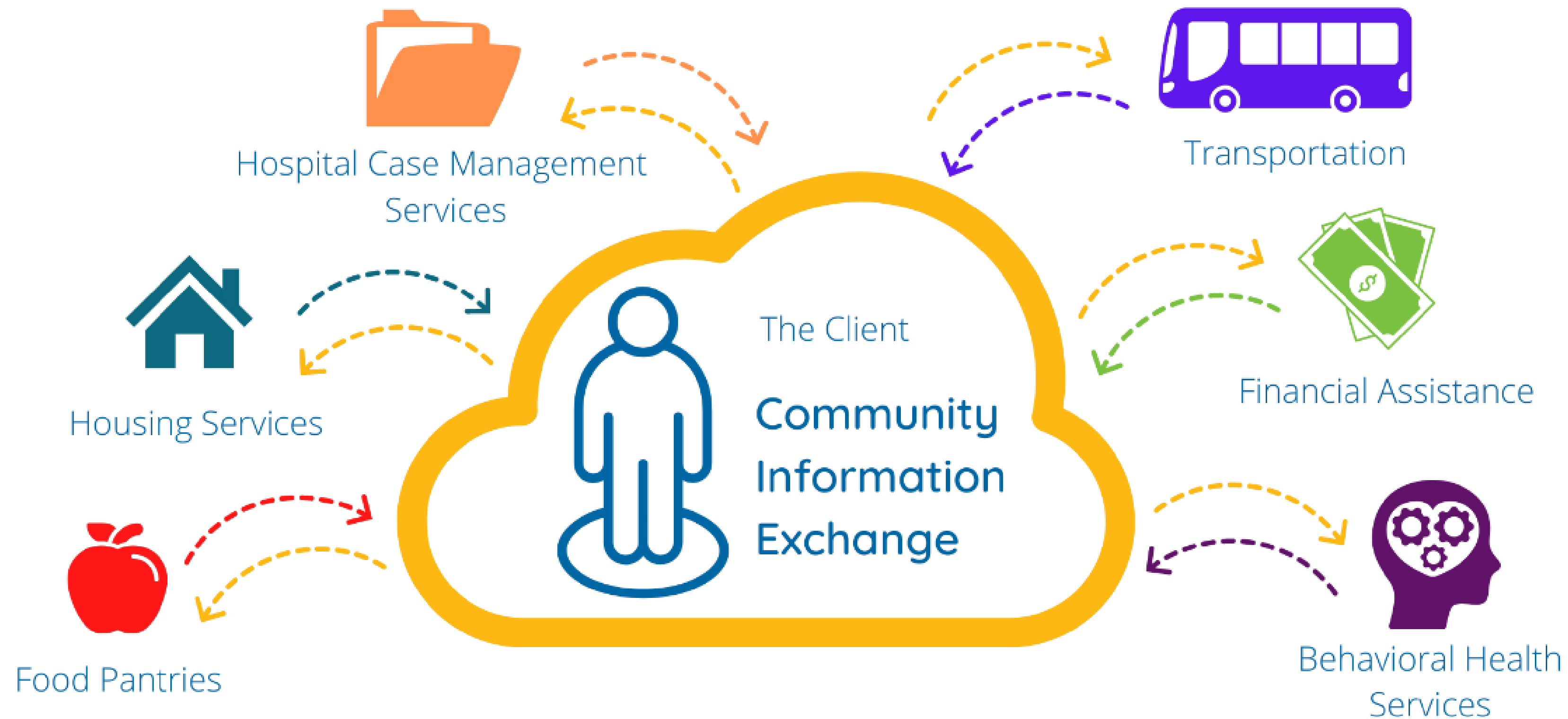
- Kaiser Permanente Colorado Study:



When the Provider reached out to the client, they were **15x more successful** in connecting!

(Permanente, Kaiser, 2018)

Longitudinal Record of Social Care = Shared Language



SD CIE Levels of Impact

Individual Benefits:

Quicker connection to appropriate services
Telling story only once
Screening identifies additional needs

Partner Benefits:

Access to comprehensive resource database
Streamlined referrals and communication between providers
Shared client story promotes rapid identification of social needs
Organizations can more effectively serve community members
Access to outcome data for measuring impact

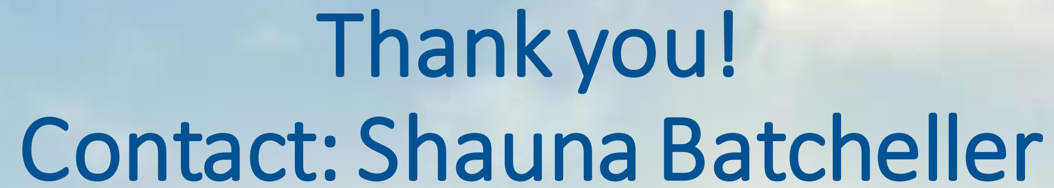
Community Benefits:

Community data to inform policy, planning, and investment
Identification of unmet needs and barriers to access services
Infrastructure more effectively serves community members

Takeaway

An electronic closed-loop referral network shifts the responsibility of finding resources from community members to organizations.

This relieves community members experiencing hardships from the burden of identifying and contacting resources in a fragmented system of care. At the same time, referral networks deliver more value to organizations when they do not require additional work to document referrals across multiple platforms.



shauna.Batcheller@helplinecenter.org
cie@helplinecenter.org

Questions

Resources

- North Dakota
  - FirstLink Community Resources
    - https://myfirstlink.org/
    - 211
  - 988 Mental Health Crisis Line

- South Dakota
  - Helpline Center Community Resources
    - https://www.helplinecenter.org/
    - 211
  - 988 Mental Health Crisis Line

- FindHelp
  - https://www.findhelp.org/?ref=ab_redirect

Next Conversation:
June 14 | Health Literacy

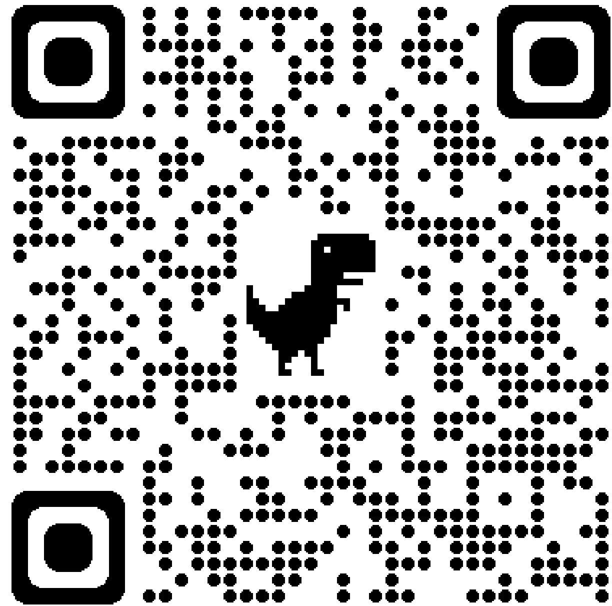
Session Overview: Learn more about health literacy and its impact on achieving health equity. Hear from community health workers addressing health literacy barriers in our communities.

Kuol Malou
CEO & Co-Founder
The HUB SD

Allie Wanner
Community Health Worker
CHI St. Alexius Health

Kendra Jasso-Chukwuyem
Community Health Worker
Avera Community Health
Resource Center

We Would Love Your Feedback



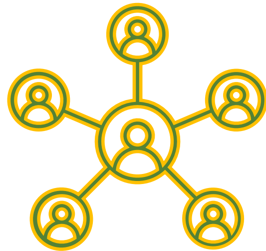
https://gpqin.wufoo.com/forms/continuing-the-conversation-health-equity-series/

Get Connected

Podcast: Q Tips for Your Ears

Looking for health care information and quality resources?

greatplainsqin.org/q-tips-for-your-ears/



Join Our Community Coalition Listserv

gaggle.email/join/communitycoalition@groups.greatplainsqin.org

Connect with QI Advisors

greatplainsqin.org/about-us/who-we-are/

THANK YOU!

https://greatplainsqin.org/about-us/who-we-are/

This material was prepared by Great Plains Quality Innovation Network, a Quality Innovation Network – Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/GPQIN/QIN-QIO-322/0523