



Improving Health in Rural Counties:

*Local Communities Address
Social Determinants of Health*

MARIANNE BURDISON, Senior Director, Strategic Alliances & Development, Centene

STEVE HORNBERGER, Director, San Diego State University Social Policy Institute

Introduction



Many factors beyond access to clinical care can and do contribute to an individual's health and wellness. These contributing factors, known as social determinants of health, include such things as poverty, food insecurity, housing instability, justice system involvement, education level, inadequate employment, deficient health literacy and limited access to transportation, among others. Social determinants of health are often at the core of health disparities among underserved and vulnerable populations.

Centene Corporation (Centene), a diversified, multi-national healthcare enterprise, provides a portfolio of services to government-sponsored healthcare programs, focusing on underinsured and uninsured individuals. Many of Centene's 12.8 million members live in rural communities, where specific social, economic and environmental factors play a significant role in determining the health of individuals and communities. Centene recognizes that these factors must be addressed in a healthcare system that seeks to achieve integrated, whole-person health and wellness.

Centene also understands that there are disparities of resources and variation in the issues across states, counties and cities, and therefore healthcare is best delivered locally. Likewise, social determinants vary and solutions often need to be customized for communities that are experiencing similar factors. Centene utilizes the **Centene Foundation for Quality Healthcare (CFQH)** to fund initiatives that address the social determinants of health or health needs of the underserved population. This is accomplished through a philanthropic giving plan that promotes efforts and activities that identify and address core causes of unequal access and treatment in healthcare.

In July 2015, the CFQH released a request for proposals (RFP) to rural counties/parishes in California, Kansas, Louisiana and Massachusetts, seeking community-based solutions for health issues related to locally defined social determinants of health. Centene's behavioral health division, Engolve PeopleCare (formerly Cenpatico), provided technical

assistance throughout the procurement process. The Improving Health in Rural Counties RFP was released via Cenpatico's website and announced at the 2015 National Association of Counties (NACo) Annual Conference, with a questions and answer session hosted onsite at the conference. A subsequent question and answer webinar was hosted by NACo, with all answers also posted online. NACo also provided resource materials about social determinants of health to potential applicants.

The RFP required, at minimum, collaboration between a county official or office as the primary applicant and a local nongovernmental, nonprofit stakeholder to take fiduciary responsibility for any funds awarded.

Proposals were received from counties/parishes in three states: California, Kansas and Louisiana. No proposals were received from Massachusetts, perhaps because local government in the state is less structured around counties. One project from each of the states that submitted proposals was selected and awarded funding.

Responses to the RFP were required to address five key areas:

- 1** Identify a specific social determinant and provide evidence of the related negative impact on the health of the community.
- 2** Include a broad cross section of relevant public and private stakeholders in the planning, implementation and evaluation of the proposed solution.
- 3** Provide a detailed description of the proposed solution.
- 4** Support a reasonable expectation of significant measurable outcomes within two years.
- 5** Define metrics, and provide a detailed description of data collection and reporting structures.

A volunteer panel of external experts assisted the CFQH in the selection of three projects for funding. The CFQH thanks these individuals for their help in making this process a success through the broad scope of their expertise:

PATRICK FLEMING, MPA: Mr. Fleming is the former director for the Division of Behavioral Health Services, Salt Lake County Department of Human Services (2002-2015/retired), served as special consultant on the Utah System Improvement Model for Integration of Behavioral Health into Primary Care Service Practice (2016), has been a senior fellow with the National Association of Counties, and has been a consultant to the Utah Department of Health.

PAUL FORCE-EMERY MACKIE, PHD, LISW: Dr. Mackie is professor of social work at Minnesota State University, Mankato. He has focused his research on addressing rural behavioral healthcare services, delivery and policy and has published several academic papers and two books on these subjects. He has worked with members of Congress, as well as state and federal agencies, to support and develop

effective health and behavioral healthcare services across underserved rural America.

MARC OVERBECK, BA, HANSFORD SCHOLAR: Mr. Overbeck is the director of the Primary Care Office, Oregon Health Authority (2011-present). He has worked for the past three decades within a number of Oregon state agencies, beginning with his service in the governor's office as a legislative aide and then director (1991-1995) and including his work in other agencies focusing on workforce development and employment, and services for seniors. His stated goal is to ensure that government empowers citizens to realize what is possible in their lives through engaging in authentic dialogue and operating with integrity, accountability and transparency.

Once the projects were chosen and funds awarded by CFQH, Centene's local health plans in each state promoted and supported the launch of each project: Sunflower Health Plan, Kansas; Louisiana Healthcare Connections; and California Health & Wellness.



Using Technology to Address Behavioral Health in Rural Communities

Central Kansas

SOCIAL DETERMINANTS OF HEALTH FOCUS: CULTURAL STIGMA AND RURAL ACCESS

Background

Four counties in rural Central Kansas face a large prevalence of unmet behavioral health needs, a lack of awareness of community resources, and low utilization of current services. Recent community health needs assessments from Barton, Pawnee, Rice and Stafford counties identified mental health services and the reduction of chemical/substance abuse as top priorities. Using these assessments — plus national, state and local statistics on suicide rates — and community mental health center utilization data, local public officials and the community mental health center, The Center for Counseling and Consultation (The Center), determined that cultural stigma surrounding mental health disorders and distance from providers were acting as barriers to accessing behavioral health services.

The Center itself understood the problem posed by the distance required to see clients across the four-county area. Under state law, The Center provides mental health screenings for individuals and juveniles prior to inpatient hospitalization. When a law enforcement agency or local hospital emergency room has an individual in their custody who needs to be screened for mental health services, they contact the Kansas Health Solutions (KHS) hotline. KHS then notifies The Center's on-call staff – clinicians who reside in or near the four-county catchment area.

Long waits in excess of two hours are not uncommon, particularly at night. As part of the screening process, the screening clinician provides crisis intervention services in an effort to divert the individual to a community-based service rather than inpatient hospitalization in a state psychiatric facility. These diversion efforts can be hampered, and resources of law enforcement and ER staff strained, while waiting for the clinician to arrive.

Program Overview

The Center, County Health Departments and Court Services/Community Corrections Programs of Central Kansas implemented a public mental health awareness and utilization campaign focusing on (1) recognition and understanding of the importance of mental health and substance abuse issues; (2) recognition of local behavior health resources/services; and (3) utilization of those services.

The program consisted of an awareness campaign that included partnership building, media, presence at local community events, mental health response training for professionals, and drug and alcohol training in schools. The program also focused on using technology to address barriers by introducing televideo crisis screenings and publically available mental health screening stations (kiosks).

Engaging a broad array of community partners serving the same populations was essential to the success of this project. The Center leadership dedicated staff time to developing a successful collaborative.

County departments of health and local law enforcement were original supporters and assisted in engaging other local stakeholders. Existing collaborative community groups with multiple service agencies — such as the Rice County Coalition, Communities that Serve, and the Central Kansas Partnership — were identified and engaged. Other stakeholders included county hospitals, several Federally Qualified Health Centers, other behavioral health providers, school districts, local community-based organizations, local media companies, Juvenile Justice Services, Tri-County Special Services, United Way of Central Kansas, Catholic Charities of Southwest Kansas, local elected officials and several state legislators. The Stafford County Economic Development Director and her staff attended many of the collaborative meetings. When asked why she was attending, her response was, “Because good health is an economic development issue.”

Program Goals and Evaluation

Initial goals identified for the program included:

- > By April 1, 2016, installation of mental health screening kiosk stations at 12 locations (with one rotating kiosk for schools and libraries) and staff trained on use. Report at least 1,200 surveys accessed through the kiosks by December 31, 2017.

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“...good health is an economic development issue.”

- > By April 1, 2016, telemedicine portable technology made available in community hospitals and law enforcement agencies in The Center’s catchment area, and staff trained on use. Report at least 10 telemedicine crisis screenings performed monthly by May 1, 2016, and throughout the project.
- > By January 1, 2017 all community partners in each county report a 50 percent increase in recognition and understanding of the importance of mental health and substance abuse issues, with an additional increase of 25 percent by December 31, 2017.
- > By December 31, 2017, a 10 percent increase in non-Medicaid client utilization of The Center’s services.

To measure recognition and understanding of the importance of mental health and substance abuse issues, The Center contracted with a state university to develop and analyze an online behavioral health survey of community partners and stakeholders. The plan was to have annual follow-up surveys to determine the program’s effectiveness. Two attempts to re-administer the survey at six months and twelve months had minimal return rates, requiring project leaders to instead use focus groups in each county to gather the information.



The team also compared preutilization and postutilization of behavioral health services as indicators of both increased knowledge and access. This data was collected via The Center’s electronic medical record system. Baseline data, shown below in Figure 1.1, indicated that utilization was lower than would be expected given the local suicide rates and CDC data on general prevalence of mental health conditions.

Figure 1.1 Utilization of The Center for Counseling and Consultation’s Behavioral Health Services

	Barton	Rice	Stafford	Pawnee	Total
Population*	28,205	10,761	4,789	7,233	50,988
% of Catchment Pop.	55.32%	21.10%	9.39%	14.19%	100.0%
% of Pop. Utilizing Services	6.16%	3.23%	2.07%	5.54%	5.07%

**Based on the latest available census data (2010).*

Activities and Key Learnings

Community Collaborative

The Center’s executive director facilitated a project team and a collaborative that spanned four counties in central Kansas, which included public health, hospitals, law enforcement, County Health and Human Service agencies, and many other stakeholders. The project team met at least monthly and scheduled a quarterly collaborative meeting with all partners and community stakeholders to review project deliverables and find solutions to identified problems.

Late in the first year, the quarterly collaborative created working sub-committees (televideo crisis screens, kiosks and community relations) to strengthen working relations and focus on continuous quality improvement. Encouraging all community partners to participate in a committee gave those that were apprehensive about change a voice in designing the changes. Several Center staff (from the Clinical, IT and Community Engagement teams) also became more actively involved to help address implementation and operational issues.

Leadership turnover was a challenge. When the Center’s executive director was elected county prosecutor in the second quarter of the first year, the clinical director

assumed interim responsibilities and the Pawnee health administrator became a co-chair for the project. This shared leadership approach was effective. In the third quarter of the second year, the Pawnee health administrator left her position. The Pawnee County commissioners requested The Center’s executive director provide oversight on behalf of Pawnee County for the remainder of the project. While the turnover of key leadership slowed the momentum on the project, the willingness of staff involved to do more to achieve the common goals (typical in rural communities) allowed the project to move forward.

Awareness Campaign

The collaborative participated in a multitude of community activities such as parades, fairs, agency open houses, school events and local health department activities. Participation at the flu shot clinic provided opportunities for drug and alcohol prevention education, promoting the kiosk as a resource. Cards with QR codes linked to the screening were distributed. Participating in community events — such as The Glow Run for Life, Zoo Boo, and Breakfast with Santa — helped community members see access to mental health services as necessary and as routine as all other community wellness checks.

A media campaign was designed to increase awareness on available mental health resources, and promoted the idea

of asking for help as a sign of strength, not weakness. The Center hosted a regular radio show and advertised in special feature sections in local newspapers to highlight mental health topics, key community issues and upcoming events.

Televideo Crisis Screenings

For the initial rollout of the televideo equipment, collaborative partners had to resolve technological, clinical and operational issues ranging from Wi-Fi strength and computer compatibility, to clinical protocols and staffing workloads. HIPAA requirements and memorandums of understanding (MOUs) between respective agencies also posed a challenge. While several of the law enforcement sites began with minimal instruction and setup, others were marked with miscommunication, distrust and frustration. Several law enforcement leaders believed the use of tablets and inconsistent Wi-Fi unduly shifted the monitoring of individuals in crisis onto law enforcement, increased the risk of behavior escalation, and was less effective than face-to-face assessments.

Once these issues were highlighted at a collaborative meeting, Center staff and law enforcement leadership met to problem solve and engaged with County officials and The Center's board of directors. Staff developed an MOU that defined roles and responsibilities, provided additional individualized training on televideo screening, upgraded tele-video equipment, and installed wireless hotspots and network boosters where needed. These actions resolved the problems and, in fact, one of the sheriffs who had been a vocal critic of the project's implementation became a strong advocate for the program.

Screening Kiosks

The Center purchased 12 Internet-connected [kiosks and software](#) to offer mental health screenings in public locations, including libraries, malls, stores, etc. It had researched a [successful project in Philadelphia](#) that located a kiosk with a two-minute mental health screening tool in a supermarket. The intent was to offer the opportunity in a variety of public spaces to raise awareness about mental health and create a user-friendly, anonymous means to “get a checkup from the neck up.”

The surveys prompted users to enter demographic information (optional) and choose one of eight screenings for mental health disorders (see Figure 1.2). They could also answer more general questions about their feelings and recent behavior, from which the kiosk could suggest additional screenings. When finished with the survey, the kiosk provided resources for seeking help, if indicated. A wallet-sized card with resource information was also available for users to take away.

Initially, there were technological issues to work through that delayed launch, including securing the tablets, preventing unauthorized Internet use, spotty Internet connectivity, securing good locations, and making connections for referrals to local resources.

The team also recognized a need for users to access the screening from their personal electronic devices. In response they created an additional takeaway card with a QR code that users could scan with a mobile device to access the survey.

Behavioral Health Training

Center staff provided training to collaborative partners on mental health and substance abuse topics such as making a referral, trauma-informed care, prevention strategies, treatment options and the importance of recovery. As the project progressed, several Center staff became certified trainers in Mental Health First Aid and have been offering the training to collaborative partners across the region. The Center has also been able to provide Mental Health First Aid books to law enforcement, area churches, the Juvenile Justice Authority and community members so that more people have the ability to respond appropriately and safely to someone struggling with a mental health issue.



Outcomes

Mental health screening kiosks were installed in late 2016 (original goal April 2016). Despite the delay, 1,027 screening surveys were completed by the end of 2017, very close to the originally stated goal of 1,200. As shown in Figure 1.2, of the 877 screenings completed in 2017, 76 percent scored positive for symptoms:

Figure 1.2 2017 Mental Health Screening Kiosk Usage

Screening Type	Screenings	Percentage Positive for Symptoms
Depression	330	68%
Anxiety	208	84%
Disordered Eating	99	81%
Bipolar	83	75%
PTSD	63	86%
Adolescent Depression	37	76%
Alcohol	33	76%
Substance	24	87%
TOTAL	877	76%

Adoption of the televideo crisis screening technology was also delayed until later in 2016. However, The Center was still able to perform 336 crisis screens in 2016, with 93 done by televideo (28%). In 2017 that rate increased to 67 percent, with 319 of 479 screens performed using the technology.

As noted in the evaluation design, the original plan to gather data via community surveys was not successful. However, focus groups were implemented to identify progress against the mental health and substance abuse awareness goals. As another measure of awareness, the project team reported greater attendance at the annual Mental Health Awareness Day events – from 210 in 2016 to more than 400 in 2017, demonstrating increased community engagement. Project leadership believes the consistency and frequency of media messages and the significantly increased presence of partners at community

events has decreased stigma and raised the visibility and acceptance of mental health services.

In regards to utilization of existing services, The Center had 30 percent more non-Medicaid clients accessing treatment from 2015 to 2017, far exceeding the 10 percent goal. There was also an increase in uninsured persons seeking treatment, from 21.9 percent in 2015 to 28.9 percent in 2017.

Data on the overall percentage of the population utilizing services was inconclusive. However, it should be noted these results rely on 2010 census data for both the 2014 and 2017 calculations. Local leaders acknowledge a steady stream of out-migration from the four counties. This would indicate the percentage of population served would be higher in 2017 than data in Figure 1.3 reflects.

Figure 1.3 Utilization of The Center for Counseling and Consultation’s Behavioral Health Services

% of Pop. Utilizing Services	Barton	Rice	Stafford	Pawnee	Total
2014	6.16%	3.23%	2.07%	5.54%	5.07%
2017	5.8%	3.1%	2.3%	5.0%	4.8%

Sustainability

The ability to use televideo to assess crisis situations in minutes versus hours not only benefited the people in crisis, but also first responders. With the experience gained from the project, The Center continues to see and implement more applications for this type of connectivity. Most recently it provided a tablet for screenings to the 20th Judicial District Juvenile Justice Authority, as well as to a long-term care facility in Pawnee County. The Center has made a commitment to pursue such collaborations in the future as needs arise.

The increase in uninsured patients accessing services precipitated a revenue deficit, as these clients pay on a sliding scale. In response, The Center is piloting a short-term “Gap” program designed to use funds from another grant program to cover these fees and ensure no one is denied services due to an inability to pay. This Gap project will determine if health navigation can assist this population in securing coverage through the state’s federally facilitated Health Exchange or if case management would be valuable

to connect them with resources (e.g., SOAR) or support them through a short-term event (e.g., college students with no insurance who are temporarily in the area).

The partnerships developed through this project will continue to be cultivated. In fact, collaborative partners are now participating in the [National Association of County Behavioral Health and Developmental Disability Directors Decarceration Initiative](#) (for which Centene Corporation is a corporate partner) and the [National Association of Counties’ Stepping Up Initiative](#), both of which aim to improve mental health services for justice-involved individuals. Law enforcement, the state hospital, the health departments, churches, emergency services, the county commissioners and other community partners are engaged through these programs to learn more about strategic interventions and how to implement a model that works for Pawnee County – and that can be replicated in the other three counties. The group also applied for a [GAINS Training grant](#) and, though not successful, were able to access technical assistance and learn best practices to apply locally.

For more information, contact:

Julie Kramp, Executive Director
 The Center for Counseling and Consultation
juliek@thecentergb.org

Ag and Nutrition Education for Youth and Families to Promote Healthy Habits

Iberia Parish, Louisiana

SOCIAL DETERMINANTS OF HEALTH FOCUS: FOOD INSECURITY

Background

In Iberia Parish, Louisiana, poor nutrition is a driver of high risk for coronary diseases, which are often correlated with obesity. The percentage of overweight or obese adults in Iberia Parish increased from 49 percent to 60 percent in the previous decade, and the percentage of overweight children participating in the WIC program is increasing locally and across the state. These health risks are exacerbated by the scarcity of fresh, locally grown foods, and lack of knowledge of basic nutrition information in the community. Only 18 percent of the population eats the recommended five servings of fruits and vegetables daily.

At the start of this project, nearly 20 percent of parish households with children under the age of 18 had an income at or below the federal poverty level. In what was once an area where residents grew enough fruits and vegetables in large backyard gardens to sustain their family's needs, economic conditions today mean few households have backyard gardens, and options for purchasing fresh produce and other nutritional foods are limited.



Community Stakeholders

Iberia Parish Government

Iberia Parish Foundation

FM Boley School Board

Acadiana Growers Alliance

Farmers Market Alliance

City of Jeanerette

Iberia Parish Library System

First National Bank of Jeanerette

Iberia Industrial Development Foundation

Iberia Parish Parks and Recreation

Ace Hardware

Chaney Lumber

LSU/Louisiana Sea Grant

Port of Delcambre

Program Overview

The Iberia Development Foundation (IDF) and the Iberia Parish government originally proposed establishing a specialized STEM-Ag academy charter school on the site of a vacant elementary school, and to work with stakeholders to create a basic gardening and nutrition education program that the school would implement. Although the charter school was delayed for reasons outside the scope of the project, IDF was successful in moving the project forward by partnering with existing area schools. IDF redesigned the program to be a summer school and after-school program for local elementary and middle school students.

A garden facility and instructional greenhouse were built to serve as a lab for students to learn the basic growing skills. The project also included a weekly farmers market at the school site, where extra produce from the project was sold and where students could use vouchers to purchase healthy foods for their families to use at home. Additionally, a nutrition education program taught students the importance of good nutrition and helped them develop healthy eating habits.

In the second year, the project added an aquaponics system to the greenhouse to increase the amount of protein available to the students and their families.

The project team sought to involve as many stakeholders from diverse sectors as possible. Throughout the program, many new partnerships were formed with local organizations all working together toward a common goal of bettering the health and welfare of the children and families of Iberia Parish.

Goals

Initial goals identified for the program included:

- Increase the frequency and amounts of fresh fruits and vegetable consumed by students.
- Improve student's knowledge of gardening methods and basic nutrition education.
- Increase the amount of fresh produce students' families prepare and consume in their homes.

The baseline data for the program was gathered through separate surveys for students and families. Surveys were administered at the start of the program and every six months thereafter until the program's conclusion. A data analysis program was used to analyze results each period.

Activities and Key Learnings

Community Engagement

A work plan was created for the project by three core team members: the project manager (a staff member at IDF and liaison to the school board), the instructor (a retired elementary school teacher with an extensive background in gardening), and the Acadiana representative (chairman of the Acadiana Growers Alliance and liaison to the Farmers Market Alliance).

Throughout the two-year project, the team met weekly, communicated by phone several times a week, and held a quarterly meeting for community stakeholders. The project manager and instructor met monthly with the school board to provide updates. This regular, ongoing communication allowed each person to have a clear understanding of their role, what they were responsible for, and how they fit into the project as a whole.

The team promoted the program at numerous large community events such as the Gumbo Cook-off, Sugar Cane Fair and Festival, Iberia Parish Christmas Parade and Celebration, New Iberia Spanish Festival and more.

A variety of community stakeholders were eager to contribute to the project. Iberia Parish Parks and Recreation Department conducted a weekly physical fitness component for the program. The local Girl Scout troop helped plant the original vegetables, and the local 4-H home school group had several children attend both the summer and fall classes.

The Iberia Parish library system developed a reading list of gardening, nutrition and children's cooking books and conducted a monthly arts-and-crafts activity at the school that focused on gardening activities and/or things grown in the garden. They even held a monthly "Gardening Day" at the library to showcase the program to the local residents. The recipes from the program's weekly cooking demonstrations were prepared by a local chef and restaurant owner.

Educational Program

The instructor adapted the Texas Ag curriculum for both the summer school and after-school gardening programs, as well as the complementary nutrition curriculum based on the fruits and vegetables the students would be growing in the school garden and greenhouse. For educational materials, each student was provided with gardening tools, gloves, aprons, etc., as well as student handouts, journals and workbooks for both gardening and nutrition classes. Family members were also invited to participate in the classroom activities and be volunteers in the ongoing project.

Students were enrolled in afterschool agriculture and nutrition classes during fall, spring and summer sessions. All sessions included working in the greenhouse and growing areas, classroom instruction using an evidence-based curriculum on nutrition, and weekly recipe preparation. The summer program schedule consisted of agriculture classes on Mondays, Tuesdays, Wednesdays and Fridays, with the nutrition classes on Thursdays.

There was tremendous participation in the summer program, but participation lagged in the after-school program during the first year. To increase participation, the program reached out to a local home-schooling group to invite their students to attend the program.

Garden Facility and Greenhouse

The instructor engaged a network of small local gardeners to build the school garden and greenhouse facility. Some of the produce grown was distributed directly to the students to take home to their families, some used in cooking demonstrations, and some sold at the program's farmers market.

In the second year, the project added an aquaponics system to the greenhouse to increase the amount of protein available to the students and their families. The Port of Delcambre offered the use of their new mobile seafood packaging facility as a learning lab for students to learn the "business of seafood" and how the aquaculture products are brought to market. The curriculum developed was integrated into the overall greenhouse curriculum package, as well as a stand-alone aquaculture curriculum.

Farmers Market

Two volunteers (retired teachers) assisted in training the 7th and 8th grade-level students to staff the greenhouse vendor booth at a farmers market held every Friday, which also included other local vendors. The students sold produce grown in the greenhouse that was in excess of what was needed for the agriculture and nutrition classes. These students learned how to conduct basic financial transactions, as well as "soft skills" — such as customer service, personal presentation, etc. — needed to successfully interact with customers and sell their products.

The project also provided each student with weekly \$10 farmers market vouchers to purchase vegetables and fruits at the farmers market. A "Recipe of the Week" featured the vegetable used in classroom cooking demonstration. All proceeds from the greenhouse booth at the farmers market were given to the school to pay the monthly utility expenses of the greenhouse and garden facility.

Promotion and Outreach

In April 2017, the project received a donation of \$2,500 from the First National Bank of Jeanerette to fund a student intern to help promote the project through posters, flyers and social media. The bank also distributed information about the program to their customers in a promotional flyer.

The project used a [Facebook page](#) to chronicle progress as well as inform the community, engage new partners, and recruit families to participate. Several videos were also produced to disseminate information and promote the project, including a [tour of the garden and greenhouse facility](#) and [students working in the garden](#).

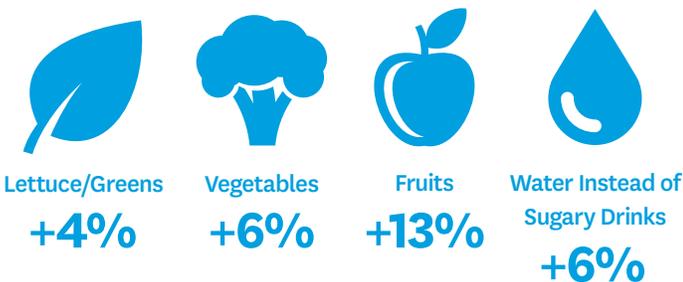


Outcomes

More than 200 students and their families (1512 individuals) participated in the program and completed surveys (822 in 2016 and 690 in 2017). Participants were mainly from minority households (90 percent) making under \$50,000 per year (88 percent). Demographic data also showed that 35 percent were single-parent households and 42 percent made under \$25,000 per year.

Surveys indicated students had increased their knowledge of healthy eating and were making smarter food choices. Parents were making more mindful changes to their family's eating habits by reducing the number of fast food meals, as well as increasing the percentage of healthy foods their families ate and prepared at home.

Students reported adding healthy foods to their daily meals:



Family support and reinforcement of healthy eating habits was integral in achieving positive project outcomes. According to the surveys, students' families encouraged them to eat more fruits and vegetables and to be more active.

Times per week that families ate the following foods, at least one serving:

Food	Percent
Fruit (fresh, frozen or canned)	+13%
Dark green vegetables	+20%
Other vegetables	+70%
Cooked or canned beans	+50%
Whole grain breads and cereals	+47%
Fresh fish or seafood	+50%
Chicken or other white meat	+37%

The times per week that families reported eating meals that were prepared at a restaurant or fast food business decreased by 32 percent.

Sustainability

The school board assumed responsibility for the project on January 1, 2018, and have made sustaining the project a priority. A project manager has been retained to oversee the maintenance of the gardens, greenhouse and aquaponics project. The fish that were grown during the project have been harvested, fruits and vegetables are being replanted, and a new batch of fish fingerlings have been ordered. The gardens have also been replanted and the plan is to enlarge the facility to grow okra. First National Bank of Jeanerette committed to help the school board negotiate with the stores to sell some of the produce grown in in the greenhouse and garden facility. Proceeds from the produce and fish sold in stores will be used to sustain the project.

The program is also considering building a worm composting system that will allow the greenhouse to compost all organic plant refuse materials generated by the facility. The compost generated will be used in future garden bed developments. As the number of worms in the system increases, the students can sell the worms as fishing bait and bagged worm castings for fertilizer. The money raised from the sale of castings and worms can be used to support future greenhouse expenses and activities.

If your organization is interested in learning more, please reach out to the contact below. Example materials such as the *Gardening Through the Seasons* curriculum and garden design plans are available.

For more information, contact:

Evelyn Ducote, Project Manager
 Iberia Development Foundation
educote@iberiabiz.org

Building Partnerships to Address Health and Housing for the Justice-Involved

Tuolumne, CA

SOCIAL DETERMINANTS OF HEALTH FOCUS: POVERTY, HOUSING INSTABILITY, AND UNINSURED STATUS

Background

Tuolumne County, California, is designated as a Medically Underserved Area, meaning that there is a shortage of healthcare professionals to meet the population needs as determined by the U.S. Department of Health and Human Services. The county is also designated as a Mental Health Professional Shortage Area. There is only one psychiatrist in the entire county to serve all of those in the public mental health system. Additionally, the rate of jail admissions in Tuolumne County is nearly triple the state average, and the Tuolumne County Sheriff's Office reports that approximately 38 percent of the individuals incarcerated in jail have a mental health or co-occurring disorder.

In California, enrollment in Supplemental Security Income/Social Security Disability (SSI/SSDI) provides access to Medi-Cal health insurance, and Medicare for income-eligible individuals. SSI/SSDI then provides income for rent and food, and Medi-Cal/Medicare provides access to primary care and outpatient behavioral health services.

Nationally, less than 15 percent of homeless individuals who apply for Supplemental Security Income/Social Security Disability (SSI/SSDI) are approved on the initial application. Some of the circumstances that impede the application process for persons who are homeless and have a mental illness or co-occurring disorder are:

- > The Social Security Administration communicates mainly by mail, which is a challenge when one does not have a permanent, reliable address.
- > People who are experiencing homelessness often have sporadic medical care, making it difficult to access medical records to document the disability.
- > Persons who are experiencing homelessness lack transportation to travel to appointments necessary for establishing eligibility.
- > Once a person exits an institution (e.g., hospital, jail or prison), that person's transient status results in loss of contact and inability to establish eligibility.

As a result of these barriers and complicating factors, individuals with mental illness and addictions who are homeless or at risk of homelessness upon leaving incarceration often cycle in and out of jails and prisons.

Program Overview

The Tuolumne County Behavioral Health Department (TCBH) sought to develop a program that would address people with mental illness or addictions, impacted by the intersection of lack of income, lack of health insurance, and homelessness. After some early lessons learned, the program narrowed to focus on those individuals with mental illness and/or addictions exiting jails or prisons.

The California Institute for Behavioral Health Solutions (CIBHS) collaborated with TCBH to engage local stakeholders and create the Tuolumne SOAR (SSI/SSDI Outreach, Access, and Recovery) Collaborative (TSC). TSC was modeled on the SAMHSA-recognized promising practice, SOAR, which is designed to assist potentially eligible individuals in navigating the often difficult and confusing process of applying for SSI/SSDI.

TSC employed a SOAR advocate — a peer specialist with lived experience — to help design, coordinate and champion the program. For participants who faced a particularly high risk of homelessness, TSC used grant funds to lease and manage temporary housing for participants awaiting approval of benefits, along with programming to build self-reliance.

Throughout the program, local community-based organizations, alternative and higher education, and peer support groups were engaged to provide services to individual clients.

Goals and Evaluation Plan

Initially, the following outcomes were projected as results of implementing TSC:

- > Increased access to affordable stable housing.
- > Increased access to health insurance, outpatient treatment, case management and recovery support services.
- > Increased income.
- > Reduction in recidivism rates.

Key metrics were to include applications received and approved each month, referrals to services, number of days for application/decision, and number of clients receiving SOAR benefits. Short-term outcomes were to include income and housing status, number of days in stable housing, and participant satisfaction. Long-term outcomes included leveraging of new Medi-Cal and Medicare funds for eligible participants, decrease in local General Assistance funding, and number of re-arrests.

However, cross-system data sharing regulations and lack of interoperability between IT systems became a significant barrier to gathering this information. It became



Additional TSC Representatives

Sheriff's Department

Probation Department

District Attorney's Office

Court System

TCBH Substance Use Disorders

TCBH Crisis, Access, Intervention Program

TCBH Enrichment Center

TCBH Benefits and Resources

SOAR TA Center

Amador-Tuolumne Community Action Agency

insurmountable when a key county leader retired suddenly and there was a delay in the recruitment and hiring of a replacement. Ultimately, TSC decided the focus would be on collecting client demographics, specific functional outcomes, client satisfaction feedback, and the status of referrals and SOAR applications.

The program used the CIBHS eBHS (electronic behavioral health solutions) platform for real-time reporting and analysis of data and to facilitate cross-system communication and continuous quality improvements with TSC partners.

Activities and Key Learnings

Tuolumne SOAR Collaborative

TSC met monthly and became the vehicle for working through identified systemic and client issues. Getting a broad cross-section of agencies working together required a concerted push to counteract the inclination to work within single systems. Through persistent communication, TSC was able to engage even initially reticent partners: The Probation Department, while initially slow to engage, became a key partner in the collaborative.

The initial purpose of TSC was to provide targeted assistance in applying for SSI/SSDI while an individual was in the hospital, jail or prison, so that income and health insurance benefits would be available as soon as possible upon release. To receive SOAR services, participants must have a severe mental health diagnosis or co-occurring disorder, be enrolled as a client of Tuolumne County Behavioral Health (TCBH), and be homeless or at risk of becoming homeless. TSC staff assisted participants with completing and filing applications for SSA benefits, navigating the review and approval process, and making connections to other resources as necessary. TSC staff also provided integrated case management to all participants throughout the benefits enrollment process.

As the program was implemented, it became apparent that individuals released from correctional facilities had different needs than individuals leaving psychiatric treatment institutions. As one justice-involved client said, “this is the first time in many years that I don’t have anyone telling me when to get up, what to do hour by hour, and when and what to eat.” There was also a significant difference in the experience with behavioral health treatment and recovery models. The team recognized that successful community re-entry is a process that requires greater focus on daily living skills, more intensive case management and community supports. TSC decided to focus on those individuals returning from correctional facilities and include basic recovery education and supports.

A major challenge throughout the project was that many Tuolumne County health and human service agencies had difficulty in recruiting and retaining qualified staff and lacked adequate funding. Collaborative partners often relied on workarounds and staff going above and beyond their job descriptions to serve clients. Ongoing communication, trust and adaptations were necessary to drive successful, cross-system solutions.

SOAR Peer Advocate

The SOAR advocate, a peer specialist with lived experience, was a key driver of communication and program solving for the project. The advocate coordinated the intake form design, orientation and referral processes, documentation procedures, transitional housing guidelines, and law

enforcement in-custody and probationer access guidelines. He worked closely with TSC partners to identify eligible applicants, conduct intakes, process SSI/SSDI applications, and bridge the gap between clients and resources. He was the “authentic voice” for the project that provided hope of recovery for clients and motivation for community stakeholders. The advocate was so successful he was recommended for, and completed, a National SOAR Leadership Academy training. Following this training, the SOAR advocate applied for and became the local SOAR lead in Tuolumne County. He worked with the local SSA office to streamline the SOAR process by creating a single point of contact at SSA for all SOAR claims.



Jason Turzai, SOAR Advocate

“ I was paroled from state prison, vowing NEVER to go back, willing to do whatever it takes to work on myself and turn my life around. On release, I was homeless and destitute in Tuolumne County while the SSI reinstatement application filed by the prison was being processed. I was involved in an accident soon thereafter that resulted in multiple hospitalizations and surgeries. During this time, I was referred to Tuolumne County’s new SOAR program. I was accepted as one of the first two members. I moved into a beautiful apartment and was reminded that I had worth, that I mattered.

As I slowly recovered from the accident, I began volunteering at the Enrichment Center, facilitating a support group. I was given the opportunity and hired as a peer advocate with lived experience. I excelled in my role and was then promoted to my current position as coordinator of the Tuolumne County SOAR Program — the very same program that gave me a chance when I was down and out, hurt and destitute. The program brought me into the work force and changed my life forever. This is the first job I’ve ever had with a paycheck. My family is supportive of me again. I’ve made peace with all the bad decisions I’ve made.

I am now a Mental Health First Aid Instructor and a UC Davis LEAD NOW Leadership Training Instructor. I’ve completed the Psychosocial Rehabilitation and Peer Support Certificate Program at Columbia College, and I’m looking forward to a new life in recovery. It is possible! I am the proof that if given the chance, anyone can succeed. Thank you to the SOAR project, Centene and all the people that believed in me when I had lost sight of who I was and what I was. ”

Transitional Housing

For participants who faced a particularly high risk of homelessness, TSC used grant funds to lease and manage transitional housing that provided temporary housing to participants awaiting approval of SSA benefits and participating in programming designed to help them move toward greater self-reliance. TSC developed a structure of support and expectations for all house residents. Residents were also provided intensive case management that included enrollment assistance for Medi-Cal and CalFresh benefits, transportation to the Tuolumne County Enrichment Center for self-help groups and services, bus vouchers and accompaniment to appointments as needed, and linkages to additional resources for recovery.

From experience with the program, TSC developed a model that identified four phases on the path to recovery and self-reliance:

1. Needs Phase (Initial 60 days) — Participants receive intensive case management and are expected to build the foundation for their recovery and reintegration, including participating in peer support programs, fulfilling benefits requirements, complying with judicial processes, and obtaining medical care. Clients participate in self-help groups, create a WRAP plan with a career ladder, and submit benefits paperwork.
2. Acclimation Phase (60-120 days) — Participants increase group activities; follow through on all appointments for medical and behavioral health, judicial requirements and benefits eligibility; and start GED Schooling (for those with no diploma).
3. Striving Phase (120-270 days) — Participants begin volunteering at least one hour per week, continue GED

study or enroll in courses at the local college. They remain actively engaged in recovery through self-help programs and peer support groups.

4. Self-Reliant/Maintenance Phase (270 days and beyond) — Participants explore options for affordable housing and submit necessary applications, maintain contact with TSC staff if any problems arise with benefit approval processes, and continue to use available community resources for recovery.

Over half of transitional housing tenants were removed for continued substance abuse. TSC did not anticipate this level of relapse and the risk it imposed on the other tenants in the house. Therefore, a WRAP (Wellness and Recovery Action Plans) approach was implemented. The team monitored transitional housing residents by communicating with probation and obtaining results of drug/alcohol screenings, noting obvious changes in behavior, and tracking failure to meet expectations such as keeping medical and probation appointments. They also implemented new screening protocols for potential tenants.

Community Engagement

TSC participated in many community events. For example, TSC was highlighted at the local Soberfest, a community activity to celebrate National Recovery Month. Local agencies had information tables so the event offered an opportunity for networking and community-based involvement. Also, transitional housing clients attended the annual County Health Fair where they received free services such as flu shots, blood pressure screening, vision testing, podiatry examinations, body mass index analysis, etc.



Outcomes

Over two years, 53 individuals were referred to the program. TSC assisted eight individuals in obtaining SSI/SSDI benefits (seven of whom also secured housing), eight cases are still pending, and 25 clients remain active.

Outcomes for the 53 clients served during the grant period are as follows:

- > Approved for SSI benefits (n=8) 15%
- > Motion filed for reconsideration (n=2) 4%
- > Pending SSA medical/psych evaluations (n=8) 15%
- > Declined to continue/became employed (n=2) 4%
- > Incarcerated (n=12) 23%
- > Deceased (n=2) 4%, and
- > Other/unknown (n=18) 34%

For the 12 clients also living in transitional housing, all had a documented mental illness and needed help with medical documentation for their SSI/SSDI claim. Three began attending college and three became employed. Unfortunately, five clients were removed for substance abuse violations and one committed suicide.

The team significantly reduced the average SSA response time for a SOAR application from an average of 120 to 67 days. And although the time to complete the actual application remained unchanged (five to six hours), with TSC support the average approval rate for SSI/SSDI applications was 65 percent (compared to 28 percent nationwide and 10 percent in California).

The recidivism rate for persons in California released from incarceration is almost 45 percent within two years. For TSC clients during the two-year grant period, the recidivism rate was 23 percent. Finally, compared to the 12 months prior to TSC to the 12 months of TSC involvement, there was a 13

percent decrease in arrests and 40 percent of the clients reported reduced encounters with police. While these outcomes reflect a positive impact for those served during the two-year project, it must be noted that they are not statistically significant.

Sustainability

TSC recognizes that the programming offered in the two-year pilot addressed only the more immediate needs of individuals leaving incarceration, and is now seeking resources to expand the program to encourage and strengthen community integration and expand opportunities for pro-social life experiences. TSC is working to identify and apply for additional resources for initial and new programming, and are exploring ways to create a regional approach in collaboration with neighboring counties.

TSC plans to continue to access the recreational and social services available in the community, especially the peer recovery supports in the TCBH Enrichment Center, for their clients. For staffing, TCBH has agreed to fund the SOAR advocate, who will continue to engage eligible applicants, conduct intakes, process SSI/SSDI applications, connect to local community resources, and facilitate TSC quarterly meeting. In regards to housing, TSC has prepaid six months of the 2018 lease and stocked up on non-perishable supplies with remaining funds from the original grant. The three current residents of the house are contributing to ongoing expenses through monthly rent payments and using their CalFresh benefits to cover food costs.

If your organization is interested in learning more, please reach out to the contact below. Example materials such as program workflows, intake forms, rental agreements, and monthly schedules are available.

For more information, contact:

Shoshana Zatz, Associate
California Institute for Behavioral Health Solutions
szatz@cibhs.org

Summary



The Centene Foundation for Quality Healthcare is proud to have funded these programs, which will now have lasting impacts in the communities that created them. Business units across Centene — including Envolve PeopleCare, Sunflower Health Plan, Louisiana Healthcare Connections, and California Health & Wellness — are also proud to have been partners in these projects. These successful efforts confirm that local communities can bring together the broad array of partners and local stakeholders necessary to successfully create and implement solutions for issues related to social determinants of health.

The Centene Foundation for Quality Healthcare believes that while local solutions are necessary, communities can find common ground and learn from each other. Toward that end, the models developed through these projects are being shared across the country in hopes that other rural communities with similar issues can benefit from the lessons learned and processes developed by these three communities. As part of that effort, a point of contact for each project is included so that other communities have a resource to answer questions and provide general guidance.

Special Thanks to our Contributing Partners



