Welcome to the SDOH Panel

2021 Virtual Forum for Migrant and Community Health

Tuesday, March 23, 2021

Speakers of SDOH Panel

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Farmworker Health Network

Best Practices: Social Determinants of Health Screening Among Migrant Farmworkers

Farmworker Health Network

FHN SDOH Screening Tool Learning Collaborative

4-part Learning Collaborative gave an overview of existing SDOH tools and how they address barriers for Migrant Seasonal Agricultural Workers (MSAWs) in accessing healthcare.

- This Learning Collaborative focused on 3 main SDOH topics:
  - Transportation
  - Housing
  - Food Security
- 21 Federally Qualified Health Centers participated

SDOH Overview

What are SDOH?

- **Social determinants of health** are conditions in the environments in which people are **born, live, learn, work, play, worship, and age** that affect a wide range of health, functioning, and life outcomes and risks.
- Resources that could enhance or diminish quality of life and can have a significant influence on population health outcomes.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

SDOH can be grouped into 5 domains:

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Why do SDOH matter to Health Centers?

- Addressing social determinants of health is a primary approach to **achieving health equity.**
- Social determinants of health such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying, contributing factors of health inequities.

Source: Health Equity, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Retrieved from https://www.cdc.gov/chronicdisease/healthequity/index.htm#:~:text=Health%20equity%20is%20achieved%20when,length%20of%20life%3B%20quality%20of.

Impact of SDOH on MSAW population

Education Access & Quality

- Limited formal schooling
- Low literacy levels

Economic Stability

- Poverty
- Lack of employment benefits

Social & Community Context

- Community and workplace barriers
- Immigration system and laws
- Lack of awareness challenges

Schmalzried H & Fleming Fallon L. (2012). Reducing barriers associated with delivering health care to migratory agricultural workers. https://www.rrh.org.au/journal/article/2088
Kozhimannil KB & Hennings-Smith C. (2018). Racism and health in rural America. https://muse.jhu.edu/article/686951/summary
Hacker K, Anies M, Folb B & Zallman L. (2015). Barriers to health care for undocumented immigrants: A literature review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4634824/
Portes A & Fernandez Kelly P. (2012). Life on the edge: Immigrants confront the American health system. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3622255 /

Impact of SDOH on MSAW population Cont.

Health Care Access & Quality

- Lack of health insurance
- Limited understanding of health system
- Health beliefs and cultural practices
- Limited health care sites

Neighborhood & Built Environment

- Transportation
- Housing
- Food insecurity

Schmalzried H & Fleming Fallon L. (2012). Reducing barriers associated with delivering health care to migratory agricultural workers. https://www.rrh.org.au/journal/article/2088
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Portes A & Fernandez Kelly P. (2012). Life on the edge: Immigrants confront the American health system. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3622255 /

Additional SDOH Factors resulting from COVID

- Increase risk for illness/health conditions
- Lack social support and connection to others
- Not accessing healthcare services and COVID testing (or vaccines)
- Limited transportation options (even more so in rural areas)
- Added food insecurity
- Lack of childcare
- Lack of adequate education and nutrition programs for children
- Lack and/or limited access to technology and digital literacy

Introduction to SDOH Screening Tools

PRAPARE

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

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
   Street:_____
   City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

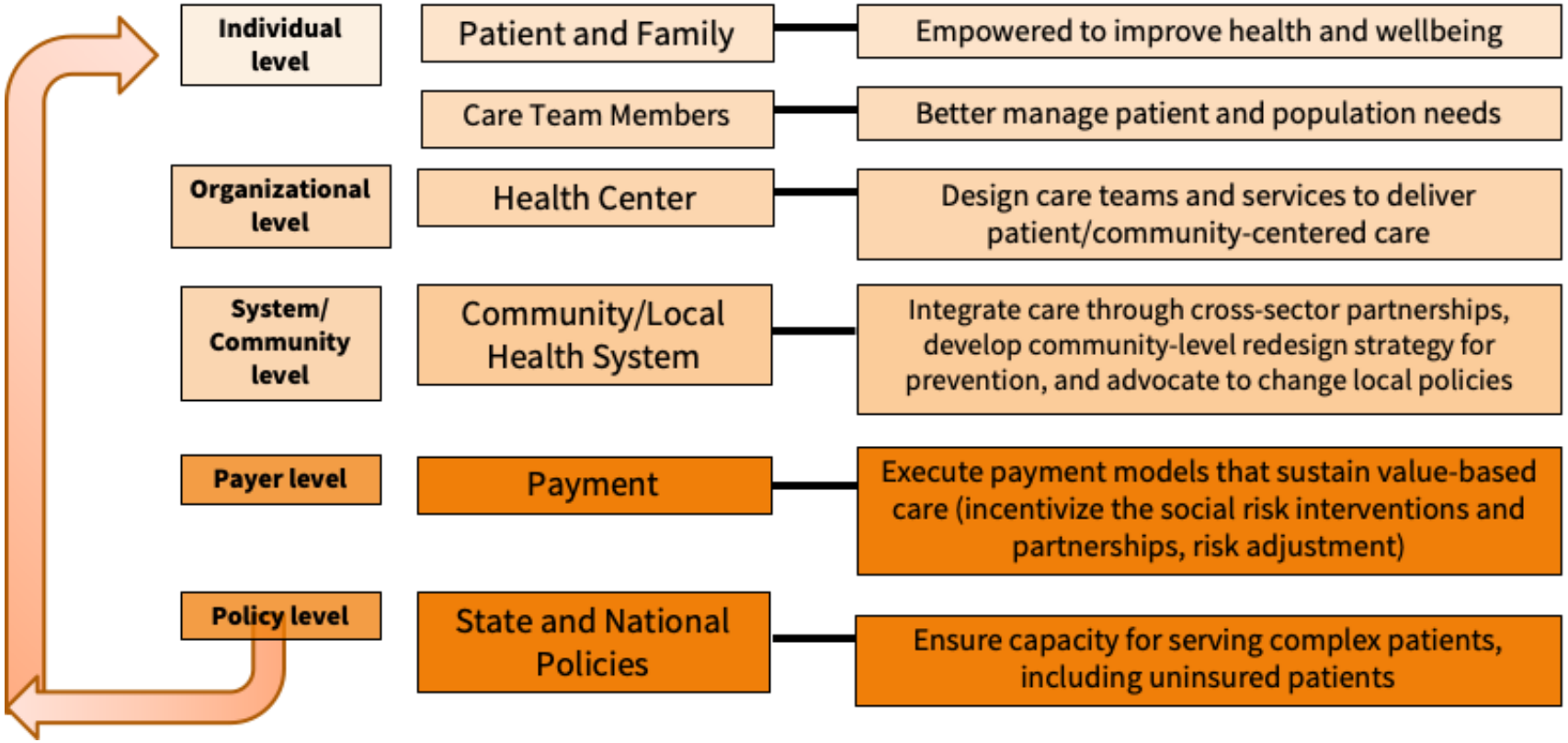
	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)				

Source: PRAPARE, National Association of Community Health Centers, In., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Retrieved from https://www.nachc.org/research-and-data/prapare/toolkit/

Why collect standardized SDOH data?



PRAPARE

Source: PRAPARE, National Association of Community Health Centers, In., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Retrieved from https://www.nachc.org/research-and-data/prapare/toolkit/

SDOH Screening Tools

National Association of Community Health Centers (NACHC)

- PREPARE Screening Tool
- PREPARE Implementation & Action Toolkit

Centers for Medicaid and Medicare Services (CMS)

- AHC SDOH Screening Tool

NCFH

- NCFH Self-Assessment Tool
- NCFH Patient SDOH Screening Tool and Action Plan

SDOH Screening Tools

Everyone Project:

- Guide to SDOH Screening
- Screening Tool
- Neighborhood Navigator
- Action Plan

Uniform Data System (UDS)

- Annually, health centers report patients' social risk factors

Sample Workflow Models

Who	Where	When	How	Rationale
Non-clinical staff (patient navigator, community health workers)	In waiting room or in staff office	Before of after provider visit	Administered PRAPARE with patients who would be waiting 30+ mins for provider	Provided enough time to discuss SDH needs. Wanted same person to ask question and address need. Often administer PRAPARE with other data collection effort (Patient Activation Measure) to assess patent's ability and motivation to respond to their situation.
Nursing staff and/or MAs	In exam room	Before provider enters exam room	Administered it after vitals and reason for visit. Provider reviews PRAPARE data and refers to case manager	Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info
Care Coordinators	In office of care coordinator	When Completing chart reviews and administering Health Risk Assessments	Administered PRAPARE in conjunction with Health Risk Assessments	Allows care coordinators to address similar issues in real time that may arise from both PRAPARE and HRA
Any staff (from Front Desk Staff to Providers)	No wrong door approach	No wrong door approach		Allows everyone to be part of larger process of "painting a fuller picture of the patient" and taking part in helping the patient
Patient Self-Assessment	At home, in waiting room, etc.	Before visit with provider	Self-administered using email, mobile, tablets, kiosks, etc.	Low burden on staff to collect data. Privacy for patient to complete assessment. Utilize time when patient would otherwise be waiting. Staff time can be used to discuss results with patients to address needs.

PRAPARE

Source: PRAPARE, National Association of Community Health Centers, In., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Retrieved from https://www.nachc.org/research-and-data/prapare/toolkit/

Health Center Goals:

- Hoping to collaborate with other agencies to avoid duplication of efforts
- Problem-solving on administering the screening
- Expanding and/or adapting an existing SDOH tool to capture new needs.
- Learn about resources and engagement tools, including outreach strategies

What Works Well

- Multilingual Staff administering the tool/questionnaire
- Building rapport/trust with the community
- Using culturally informed terminology
- Cross train staff to administer screener among patients
- Identifying critical community partnerships
- Referral processes to connect patients to services

What Needs Improvement

- Invasion of private information leads to hesitation in answering questions. (i.e. income)
- Data incompleteness and/or inaccuracy
  - Patient circumstances change
  - Backlog on follow-up due to staffing/resource limitations.
- Few provider visits with farmworkers (i.e. 1-2/yr)
- Adaptation to COVID-19 (i.e. roles have shifted; training and priorities changed).

Best Practices for Addressing Food Insecurity

- Trust must be built with patient before admitting to food insecurity
- Partnerships are essential
- Prepare for changes in community partnerships
- Drive through markets
- Boxed food deliveries/pickups
- Create opportunities for participant input
- Distribute culturally relevant foods

Best Practices for Addressing Housing Insecurity

- Connect with your local resources:
  - Housing Authority
  - Workforce Development Agencies
  - Medical-Legal partnerships
  - Public Health
- Consider needs of patients with limited literacy/English
- Set up a referral process
- Federal and state programs: Section 8; Emergency Rental Assistance (COVID relief); etc.
- Connecting with housing Community Based Organizations

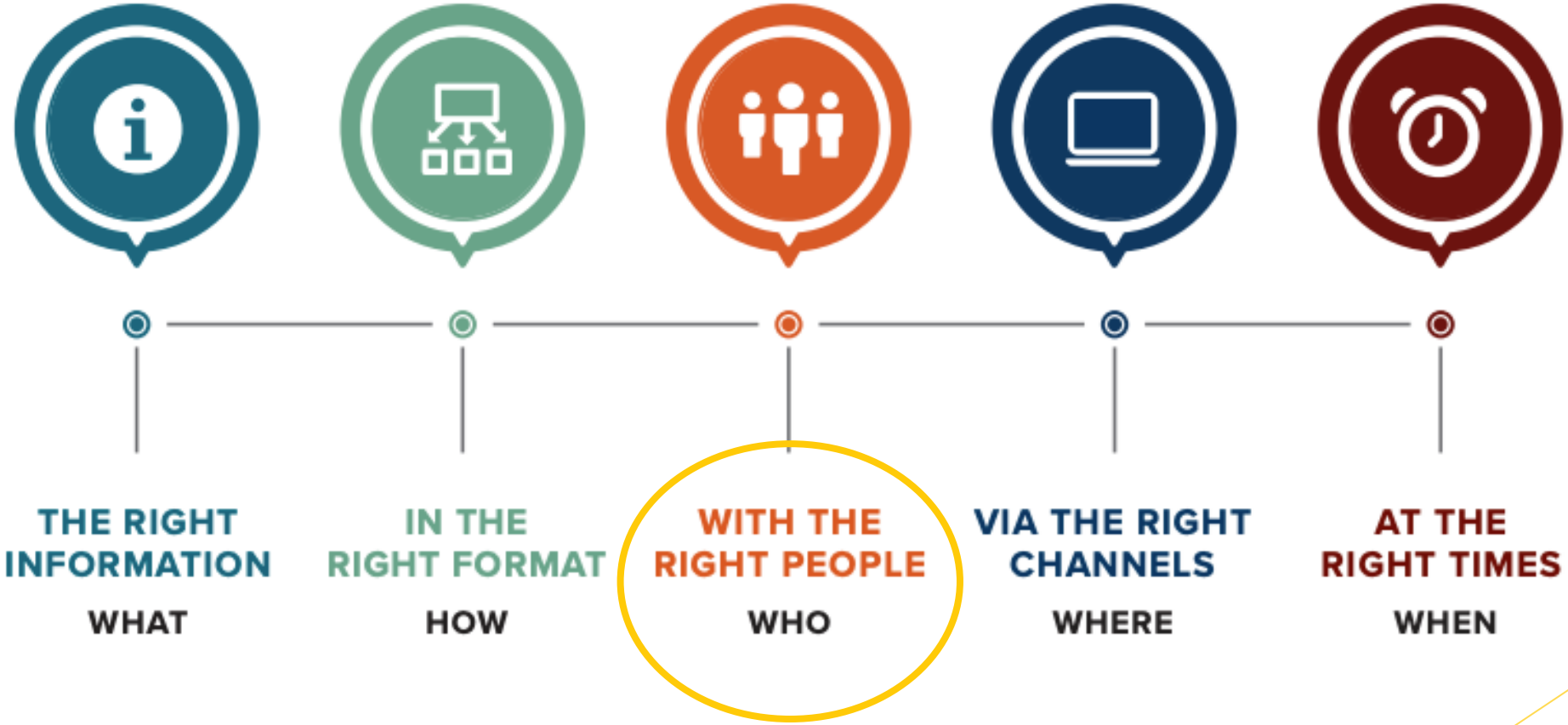
Best Practices for Addressing Transportation Barriers

- Track missed appointments
- New hours of operation
- Connecting with your state Medicaid Program for transportation benefits
- Partner with rideshare programs
- Strategic partnerships with other transportation services within farms
- Adopt volunteer driver models
- Telehealth appointments and virtual outreach

Community Health Worker Role in Screening for SDOH

MHP Salud

SDOH Implementation



PRAPARE

Source: PRAPARE, National Association of Community Health Centers, In., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Retrieved from https://www.nachc.org/research-and-data/prapare/toolkit/

Community Health Worker/ *Promotor(a) de Salud*

A **Community Health Worker (CHW)** is a trusted member of the community who empowers their peers through education and connections to health and social resources. CHWs are widely known to improve the health of their communities by **linking** their neighbors to health care and social services, **educating** their peers about disease and injury prevention, working to make health services more **accessible**, and by mobilizing their communities to **create positive change**.

Source: MHP Salud. Retrieved from https://mhpsalud.org/our-chw-initiatives/community-health-workers/

Serving Key Communities

CHWs serve key populations that are vulnerable to adverse health outcomes due to socioeconomic factors, such as:

- Poverty
- Unsafe work conditions
- Food insecurity
- Lack of transportation
- Substandard housing

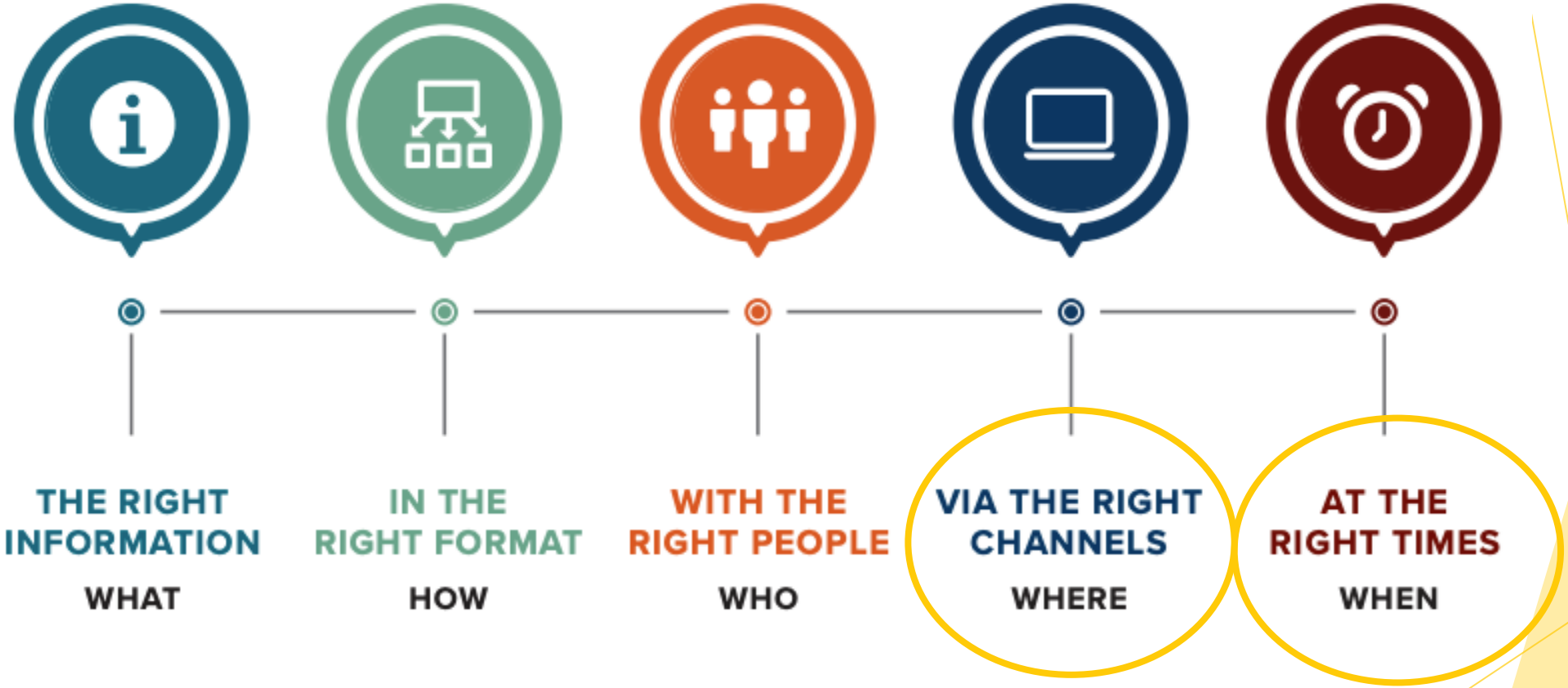
Therefore, **CHWs are unique positioned to identify and address SDOH factors** impacting patients

CHW Role in SDOH Screening

As **members of the community who empowers their peers,** CHWs can engage in a wide array of activities to screen for and identify SDOH among their patients, including:

- Collecting SDOH information/data
- Connecting patients to key resources
- Educating patients on risk factors and health alternatives

CHWs Collecting SDOH Data



PRAPARE

Source: PRAPARE, National Association of Community Health Centers, In., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Retrieved from https://www.nachc.org/research-and-data/prapare/toolkit/

Collecting SDOH Data

As **trusted members of the community**, CHWs can often facilitate patient appointments/care in a flexible, **culturally informed** manner.

For example, if your clinic will be serving migrant farmworker patients at a mobile health clinic:

- Paper forms versus electronic tablet
- Administer SDOH screeners at community site (i.e. migrant camp)
- Spanish-speaking CHWs collect SDOH data from patients
- Incorporate SDOH screening into overall wellness appointment
- Follow-up with patients at end of visit and/or next visit

CHW Responsibilities

CHWs have a **unique skillset** that allows them to meet patients where they are. These skills include:

- Ensuring confidentiality
- Building trust
- Facilitating patient engagement
- Providing follow-up care/referrals

Source: The Community Health Worker Core Consensus (C3) Project. Retrieved from: https://www.c3project.org/

Follow-up Care

Given the **CHW role in providing education and resources**, follow-up care/referral is often another aspect of the SDOH screening process where CHWs are key.

For example, CHWs can:

- Provide health education to patients during this visit
- Schedule a follow-up visit and transportation
- Facilitate virtual care/telehealth
- Give immediate resources to address health disparities (i.e. food)

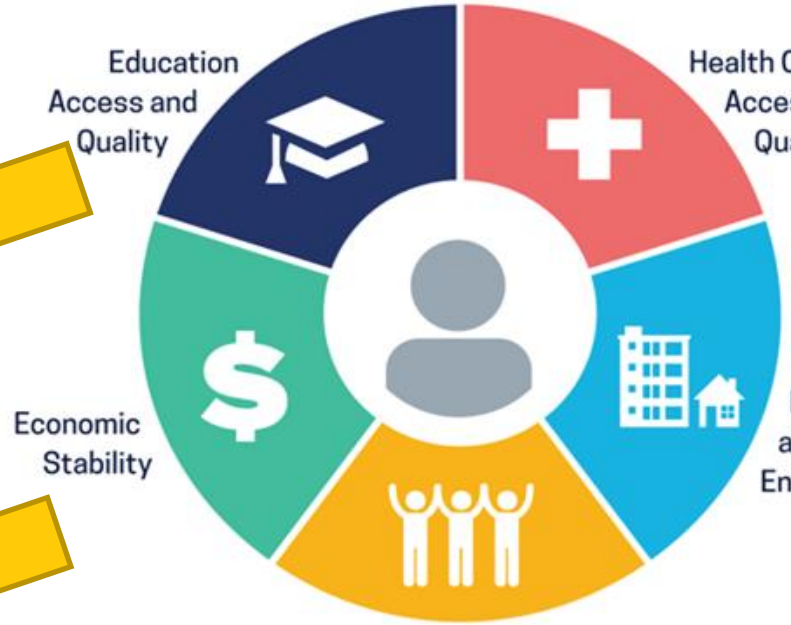
Addressing SDOH Gap

SDOH screening tools are used to **identify** the non-medical needs of patients (i.e. housing) that impact their overall health; and to **address** these needs through follow-up care, education, resources, referrals, or programming.

For example, if CHWs discover their migrant farmworker patients all lack transportation services, the clinic may:

- Provide clinic-facilitated transportation
- Administer care via mobile clinics onsite
- Give patients bus, Lyft/Uber, or taxi vouchers
- Develop strong virtual care outreach

CHW Role in SDOH Screening and Care



Providing information in an educationally-equitable manner

Connecting patient(s) with health services or referrals

Giving patients vouchers or other resources

Facilitating care via mobile units

Collecting SDOH data in language of patient(s)

Source: Adapted from "Healthy People 2030", U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

Social Determinants of Health Screening Tools Showcase

NCFH

NCFH

The **National Center for Farmworker Health** is a private, not-for-profit corporation located in Buda, Texas, whose mission is "To improve the health of farmworker families."

Programs, products, and services in support of our mission, include:

- Population specific resources and technical assistance
- Governance development and training
- Program management
- Staff development and training
- Health education resources and program development

IAC Plus Learning Collaborative

Increase Access to Care Plus Learning Collaborative

The Increase Access to Care Plus learning collaborative will be addressing social determinants of health (SDOH) in order to increase access to care for the MSAW population in effectively identifying and documenting for SDOH to enhance service delivery. Learning sessions will provide a comprehensive overview of SDOH factors; discuss available SDOH tools and resources and how to integrate them into your work; and address SDOH factors have been impacted by COVID-19. Contact Alexis Laboy for more information.

Benefits from participating in this learning collaborative include:

- Increase knowledge of SDOH priority topics
- Increase self-efficacy to screen, document, and address SDOH barriers
- Be able to create and evaluate SDOH assessment tools
- Seek new funding opportunities to improve and expand SDOH health services at your health center

IAC Plus Learning Collaborative

The EveryONE Project by the American Academy of Family Physicians (AAFP):

1. Guide to Social Screening
2. Social Needs Screening Tool
3. Neighborhood Navigator
4. Action Plan

PREPARE by the National Association of Community Health Centers (NACHC)

- Screening Tool (Available in 26 languages)
- Implementation and Action Toolkit

IAC Plus Learning Collaborative

Centers for Medicare & Medicaid Services (CMS)

- AHC Screening tool (Available in English)

NCFH

- Self Assessment tool (Available in English)
- Patient SDOH Screening Tool & Action Plan (Available in English)
- **IAC PLUS SDOH Checklist**
- **Customizable SDOH Screening tool**

IAC Plus Learning Collaborative

Main challenges:

- Inaccessibility to appointments (Transportation)
- Poor Health literacy
- Access to healthy food
- Exposure to mold, lead, lack of social distancing (Substandard housing)
- Language barriers
- Fear of seeking care (Immigration status)
- Exposure to hazards
- Cultural barriers

Main successes:

- Improvement in Telehealth services
- Assistance filing paperwork
- Development of programs for health literacy
- Partnerships with public and private organizations
- Promotores programs connected to communities
- Mobile unit programs
- Partnerships with schools and colleges
- Community events on health rights

SDOH Discussion

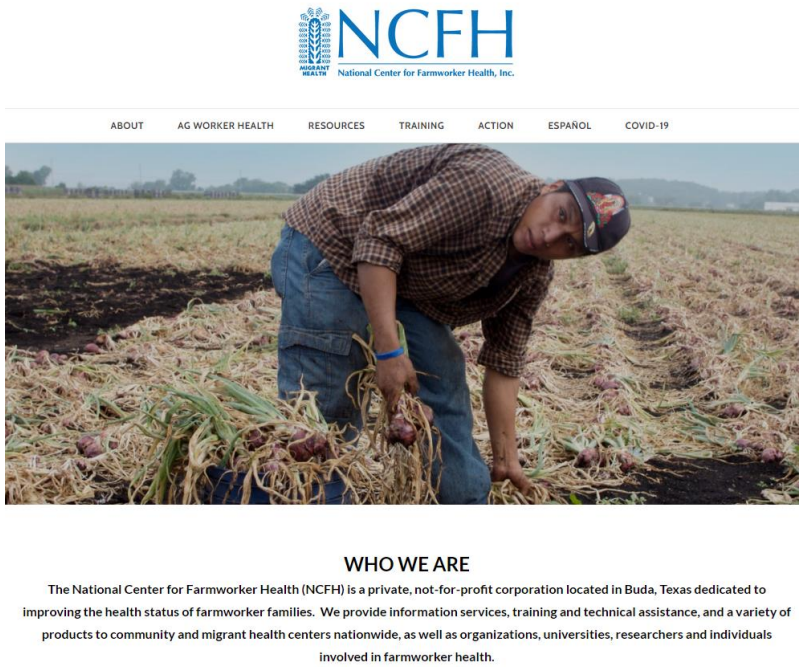
- Jam Board Discussion

SDOH Specific Resources

- Language Competency Checklist
- Language Access Services Assessment and Planning Tool
- Implementing a Language Access Program
- SDOH Self-Assessment Tool
- Patient SDOH Screening Tool
- FHN 2019 SDOH Webinar series

NCFH Resources

- NCFH Website (www.ncfh.org)
  - Patient Education Materials
  - Diabetes Resource Hub
  - Digital Stories
  - Call For Health
  - Fact Sheets and Research
  - Health Center ToolBox
  - Learning Collaboratives
  - Trainings
  - Archived Webinars
  - COVID webpage



Ag Worker Access Campaign

A national initiative to increase the number of Migratory & Seasonal Agricultural Workers & their families served in Community and Migrant Health Centers.

http://www.ncfh.org/ag-worker-access.html

Thank you!

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NCFHTX

National Center For Farmworker Health (NCFH)

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Questions?

Thank you for coming to the SDOH Panel session!