NCFH
National Center for Farmworker Health, Inc.

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To be healthy, information is not enough: The case for SDOH

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About NCFH

A national non-profit organization dedicated to improving the health status of farmworker families through the provision of innovative training, technical assistance, and information services.

Visit our website: **www.ncfh.org**

Objectives

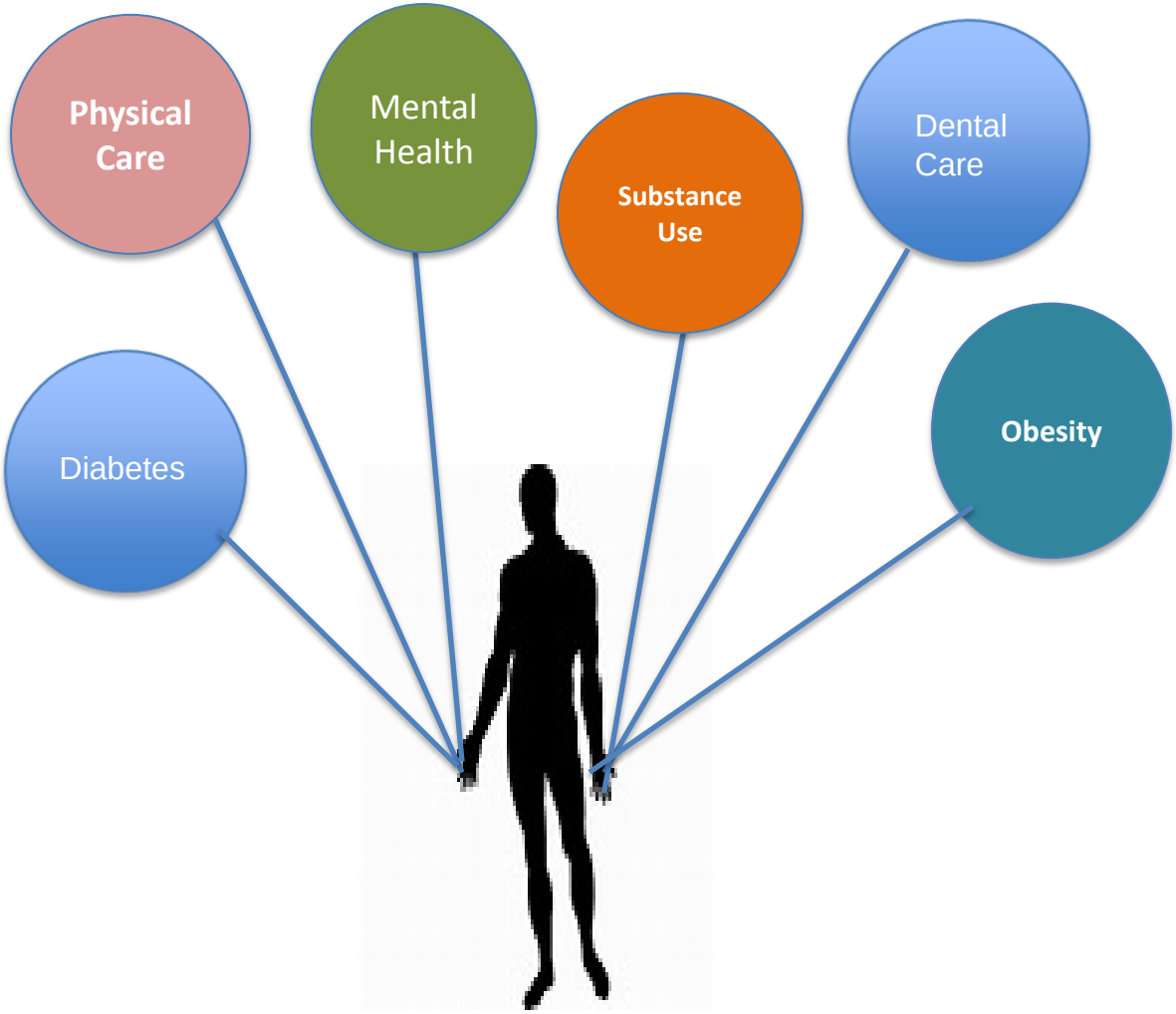
At the end of the presentation, participants will be able to:

- Increase their knowledge about SDOH
- Determine whether or not their health centers are screening and meeting SDOH
- Identify a minimum of two strategies for addressing SDOH for Ag worker patients

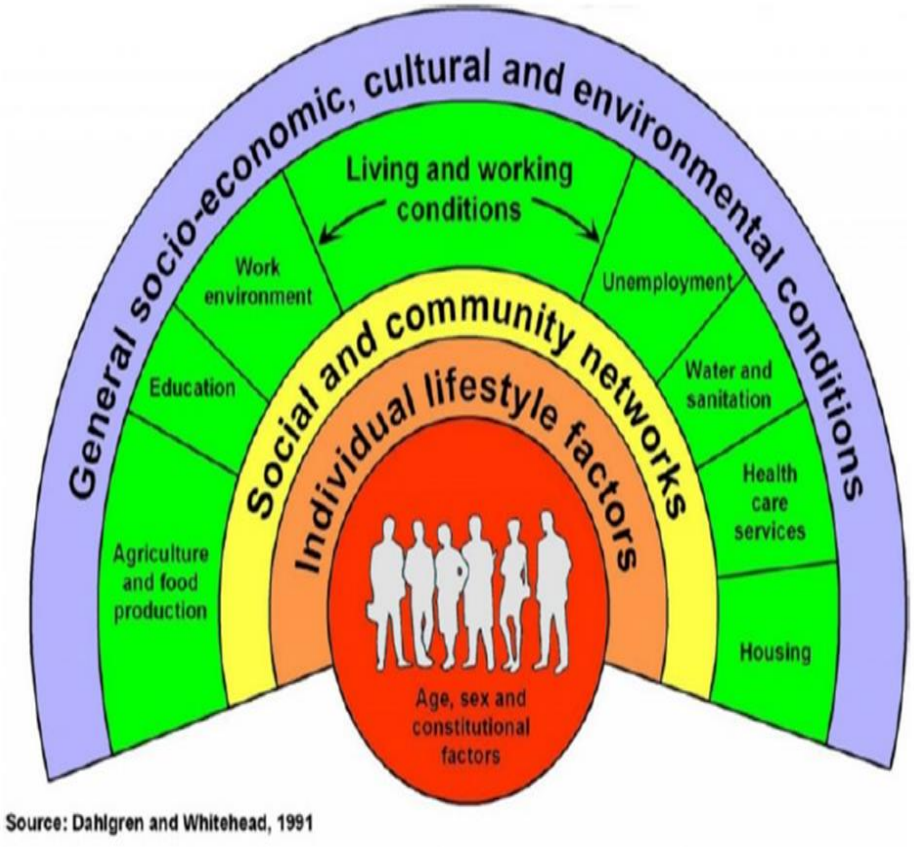
Outline

- Health Care and Health Disparities
- SDOH and their impact
- SDOH screening efforts
- *SDOH Self-Assessment Checklist* and how to use it
- Strategies for addressing SDOH
- Samples of addressing Social Determinants of Health for Pregnant Agricultural Workers (KSFHP)

Health Care Approach



Health Disparities



Source: Dahlgren and Whitehead, 1991

Social Determinants of Health

Conditions in the environments in which people are born, live, learn, work, and age that affect a wide range of health, functioning, and quality-of-life factors and outcomes

MODEL: Instituto Nacional de Salud Publica

Impact of SDOH

Agricultural worker population

Community Health Centers

Impact of Housing as SDOH

Impacts on Populations

- Safety
- Self-esteem
- Hygiene
- Nutrition
- Transportation
- Access to health care
- Access to employment
- Disruption of communication

Figure 1: SDOH for People without Homes
Source: Adopted from HealthyPeople 2020, Social Determinants of Health *Image developed on Piktochart.com

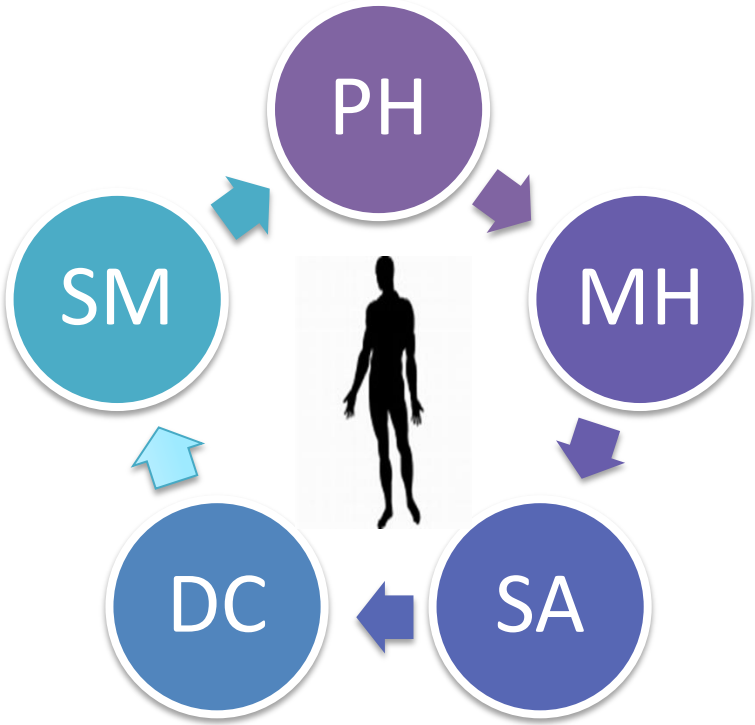
Health Care for the Homeless 2016

Impact of Housing as SDOH

Impacts on Health Centers

- Decrease number of people served
- Increase no-show rate
- Decrease productivity
- Increase cost
- Increase difficulty in reaching population
- Increase cost of outreach
- Increase communication difficulties
- Increase difficulty in providing continuity of care
- Increase possibility of poor outcome
- Increase health center liability
- Difficulty reaching target performance improvement in clinical and financial measures
- Loss of potential quality awards
- Loss negotiating power with insurance companies

Comprehensive Approach to Health Care and Health Equity



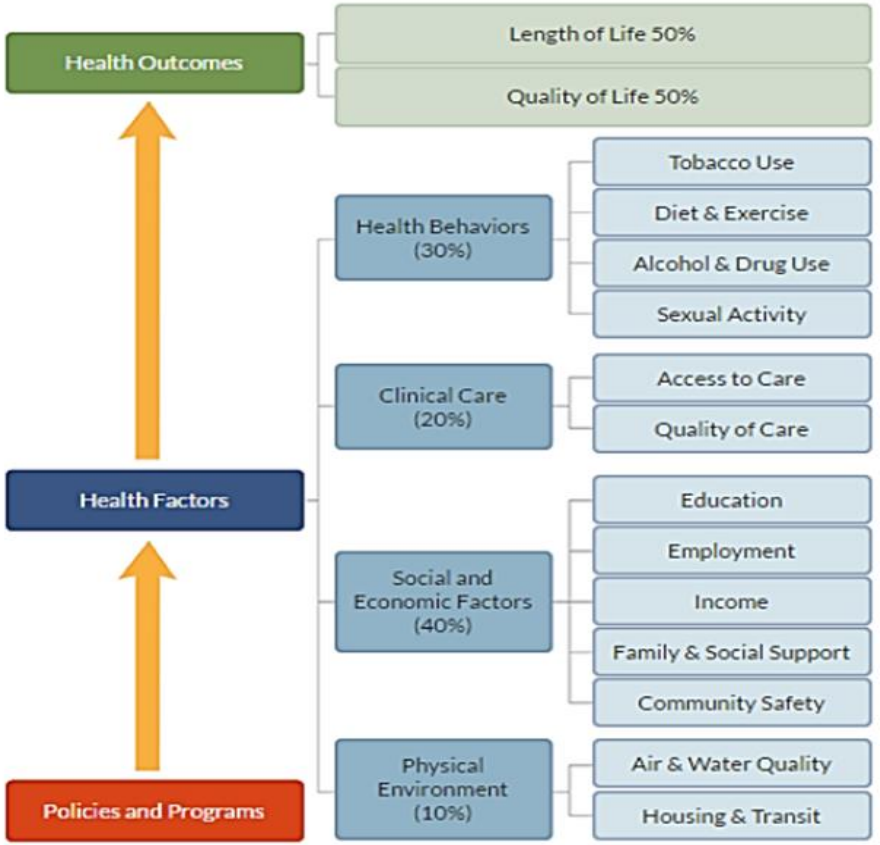


Figure 2: County Health Model of Population Health
County Health Rankings model 2014 UWPHI

FACT SHEET: SOCIAL DETERMINANTS OF HEALTH
National Health Care for the Homeless Council 2016

Promote Health Equity

HRSA : Promote Health Equity

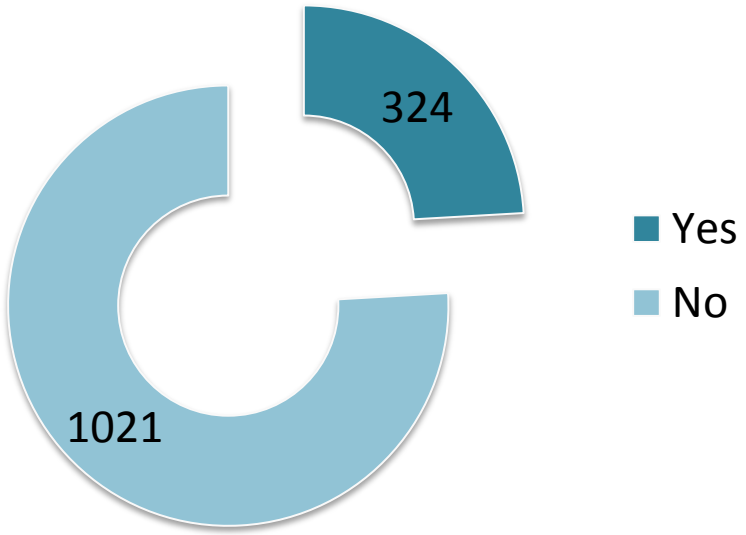
Increase the number of health centers *providing services or engaged in partnerships* that **address** social determinants of health (SDOH), such as housing, education, employment, transportation, and food security.

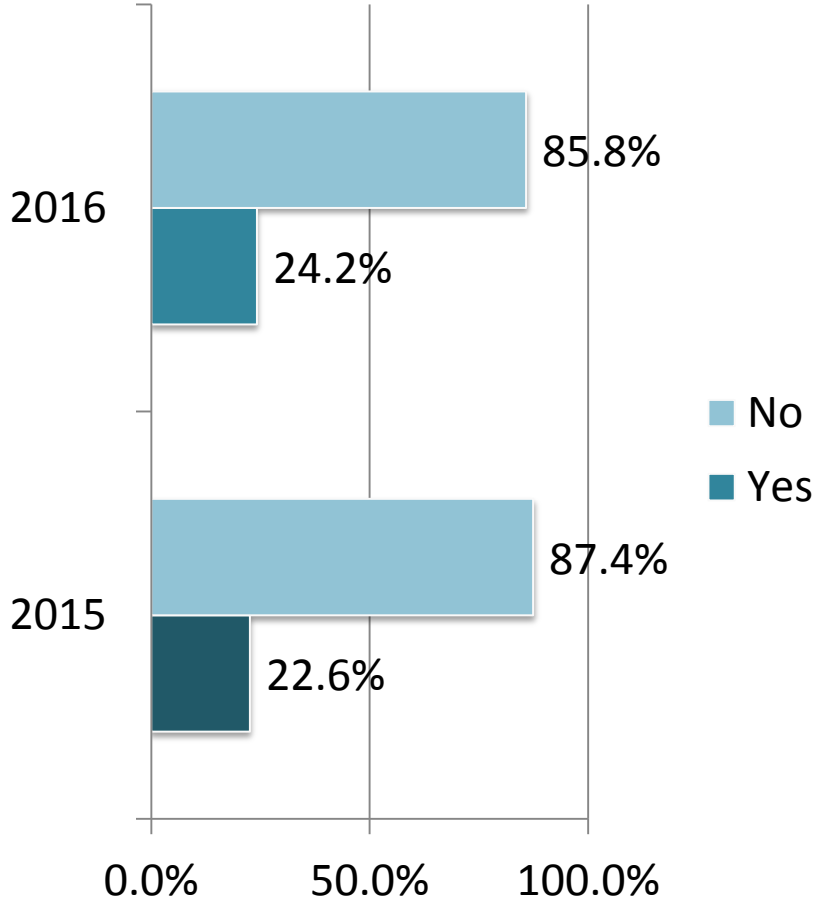
All NCAs working with CHCs to help them address SDOH

CHCs Offering SDOH Interventions

Source: A Basic Analysis of SDOH Interventions. Capital Link 2018

Offering 1+SDOH Interventions N=1,341 CHCs





Levering SDOH

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

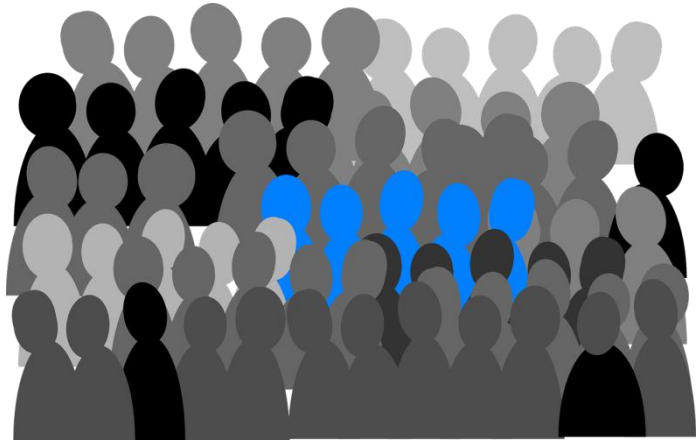
THE HENRY J. KAISER FAMILY FOUNDATION

"A health center is leveraging the social determinants of health (SDHO) when it moves beyond providing health care to address the built environment or social and economic conditions that affect health and wellbeing."
Source: Institute for Alternative Future.

Addressing the factors that cause some people to be healthy or unhealthy (SDOH) Contributes to create a world in which everyone has an equal chance to live a long, healthy life (Health Equity)
Source: "The ABC of Social Determinants of Health" by Instituto Nacional de Salud- SDH-Net

Efforts to Address SDOH at CHCs

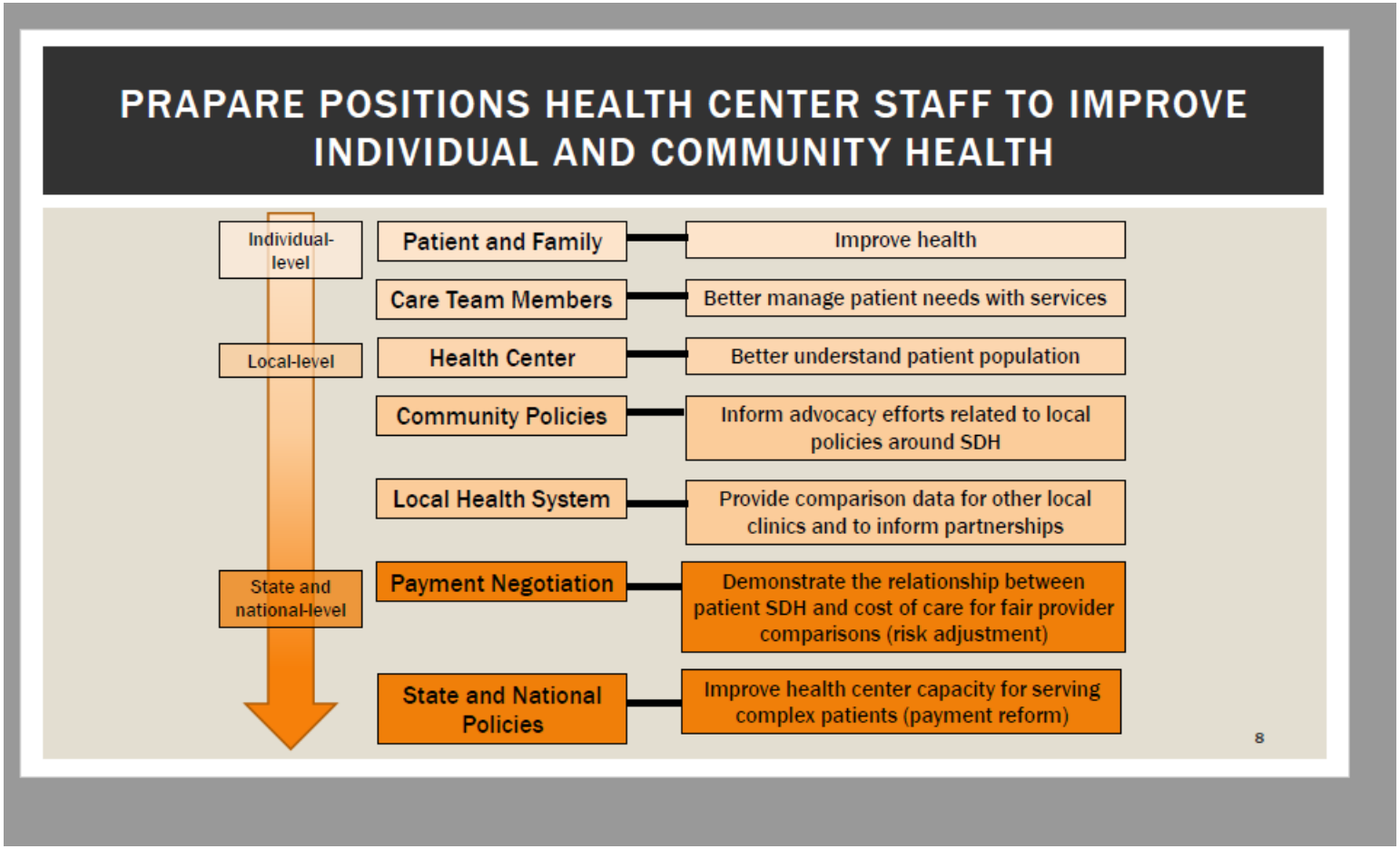
Specific Disease Groups



All Health Center Patients

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

PRAPARE


PRAPARE POSITIONS HEALTH CENTER STAFF TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH
Individual-level
Local-level
State and national-level
Patient and Family
Improve health
Care Team Members
Better manage patient needs with services
Health Center
Better understand patient population
Community Policies
Inform advocacy efforts related to local policies around SDH
Local Health System
Provide comparison data for other local clinics and to inform partnerships
Payment Negotiation
Demonstrate the relationship between patient SDH and cost of care for fair provider comparisons (risk adjustment)
State and National Policies
Improve health center capacity for serving complex patients (payment reform)
8

Individual Activity

Social Determinants of Health Self-Assessment Tool

Health Center: **Assessment Date:**

Instructions: Please read each of the following questions and select the response(s) that most accurately reflect your health center's work addressing Social Determinants of Health (SDOH).

1. Is your health center screening Ag Workers for the following SDOH? Please mark all that apply.

Social Determinant of Health	Yes	No
a. Agricultural Worker Status	☐	☐
b. Race & Ethnicity	☐	☐
c. Language Preference or Limited English Proficiency	☐	☐
d. Sex & Gender Identity	☐	☐
e. Food Security (e.g. Access to food, etc.)	☐	☐
f. Personal Safety (e.g. Interfamily Violence, etc.)	☐	☐
g. Housing Situation	☐	☐
h. Neighborhood Safety	☐	☐
i. Utilities (e.g. Access to water, electricity, etc.)	☐	☐
j. Employment	☐	☐
k. Income	☐	☐
l. Transportation Access	☐	☐
m. Communication Challenges (i.e. Visually impaired or hard of hearing)	☐	☐
n. Health Insurance	☐	☐
o. Social Connections	☐	☐
p. Child Care	☐	☐
q. Education	☐	☐
r. Health Literacy	☐	☐
s. Legal Assistance	☐	☐
t. Other:	☐	☐

2. What tool or tools are you using?

- ☐ Own tool
- ☐ IHELLP: National Center for Medical-Legal Partnership
- ☐ FACE Poverty: American Academy of Pediatrics
- ☐ Health Related Social Needs by Clinical Settings: National Academy of Medicine
- ☐ Social Needs Screening Toolkit: Health Leads, Inc.
- ☐ PRAPARE: National Association of Community Health Centers
- ☐ None or Other (Please specified)_____

2.1 Are you satisfied with the current the tool or tools?

- ☐ Yes
- ☐ No (If No, consider exploring other tools)

3. Is the Screening tool part of the electronic health record?

- ☐ Yes
- ☐ No (If No, how are screening results made available to health providers at the time of the visit?)

4. Who at your health center is tasked with conducting the SDOH screening?

- ☐ Outreach Workers or health promotors
- ☐ Registration Personnel
- ☐ Nurse Aides or Patient Care Technicians
- ☐ Case Managers
- ☐ LPNs or Registered Nurses
- ☐ Other:_____

5. Who reviews or uses the results of the screening tools?

- ☐ Health Care Providers
- ☐ Case Managers
- ☐ Social Workers
- ☐ Nurses
- ☐ Other:_____

6. How are those results utilized? (Check all that apply)

- ☐ To update the health center needs assessment
- ☐ To inform what services are needed and can be internally provided
- ☐ To refer patient to needed services
- ☐ To inform work plans for community collaborations
- ☐ For reporting purposes
- ☐ Other:_____

7. What strategies are you using to address identified SDOH among agricultural workers? (Check all that apply)

- ☐ We address some of those needs directly (e.g. transportation, interpretation, etc.)
- ☐ We have contracts with third parties for some services (e.g. transportation, interpretation, etc.)
- ☐ We have individual referral agreements with local organizations
- ☐ We are part of a community coalition of local providers working to address SDOH
- ☐ We arrange and case manage all SDOH referrals
- ☐ We have a directory of services and distribute them to our patients
- ☐ We have no established collaborations specifically to address SDOH
- ☐ We have no formal plan to address SDOH
- ☐ We are in the process of developing our SDOH Plan

8. Are SDOH directly addressed by your health center evaluated to identify improvement opportunities?

- ☐ Yes
- ☐ No (If No, consider evaluating the strategy)

9. Are SDOH addressed by your contractors (e.g. interpretation services) monitored for quality?

- ☐ Yes
- ☐ No (If No, consider establishing a monitoring process)

10. Are SDOH directly addressed by formal or informal referral agreements case managed to assess patients' access to needed services?

- ☐ Yes
- ☐ No (If No, consider establishing a referral and follow-up process)

11. Are you aware of other community agencies providing SDOH not currently addressed by your health center?

- ☐ Yes (If Yes, consider making a list and explore possibilities for collaboration)
- ☐ No (If No, consider conducting an asset mapping to identify potential partners)

12. If you already have a plan or are in the process of developing one, what elements (e.g. screening, utilization of results, follow-up, collaboration, etc.) will need to be modified or need to be included in your SDOH plan? List all that apply

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Addressing Social Determinants of Health

- Use a self- assessment tool
  - Find out what is being done at your CHC
  - Who is collecting and using the data?
  - What data is already being collected and how it is used?
- Select patient screening tool
- Plan screening strategies
- Plan how to address SDOH

Group Work: Strategies

- Housing/Housing stability
- Migration patterns/Mobility
- Food and water security
- Employment and opportunities
- Income/poverty status
- Prevailing burden of disease
- Transportation
- Health Care Accessibility
- Education
- Early Childhood Development and Afterschool Programs
- Description of a typical family unit
- Language and culture
- Working Conditions- Environmental risk factors
- Safety
- Prevention, intervention and care management

Strategies for Addressing SDOH

- Provide services directly
- Form a SDOH community coalition
- Create a SDOH-based directory of services
- Establish formal referral agreements
- Establish informal contact with key people and organizations with common goals
- Create a CHC formal case management program and f/u SDOH referrals

Resources

- The ABC of Social Determinants of Health - SDH-Net

  http://www.sdh-net.eu

- Healthy People 2020: healthypeople.gov
- World Health Organization:

  http://www.who.int/social_determinants/en/

- PRAPERE: http://nachc.org/research-and-data/prapare/
- National Center for Farmworker Health: *Special Population SDOH Checklist* http://www.ncfh.org/performance-management--

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Thank you!

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