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Screening for Social Determinants of Health

Resources and Implementation Considerations for Farmworker
Populations

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March 30th, 2022

A photograph of a cactus field, likely a cholla field, with a person wearing a hat and a light-colored shirt in the background. The field is filled with green cholla cacti. The sky is blue with some light clouds.

Learning Objectives

1. Learn key considerations on how to use SDOH data to improve patient care, through steps recommended by the Center for Health Care Strategies .
2. Gather tips and strategies on forming community partnerships to address SDOH barriers and challenges among MSAW populations.
3. Gain access to SDOH screening tools and resources available in NCFH's SDOH Resource Hub.



SDOH Impact 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



Health Care Access & Quality

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

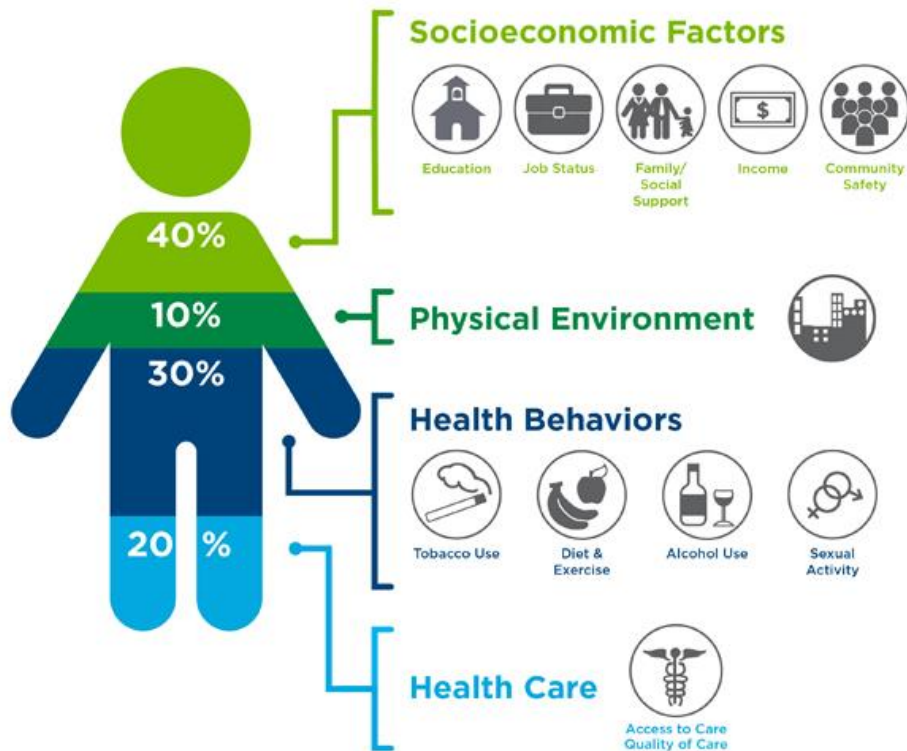
Neighborhood & Built Environment

- Transportation
- Housing
- Food insecurity



SDOH Impact on MSAW Population

What Goes Into Your Health?



Social Determinants of Health affect an array of health outcomes, particularly among low-income and special populations such as Ag workers.

Those with unmet social needs:

- Frequent visits to ER
- Higher “no-shows” to medical appointments
- Less self-control over chronic diseases



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)





**MIGRANT
HEALTH**

**Poll:
What is the importance of screening for
Social Determinants of Health?**



Key Considerations of Implementing Screening Tools

Selecting and implementing SDOH assessment tools

Collecting patient-level information related to SDOH

Creating workflows to track and address patient needs

Identifying community-based social service resources and tracking referrals

Transforming Complex Care (TCC)

National initiative made possible by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies.



Selecting, Adapting, and Adopting Assessment Tools

Factors to adapt or create a screening tool

capacity to address specific needs

availability of local resources/referral network

ease of use within a clinical setting

ability for a tool to capture specific needs that the organization can address

Other considerations:

How much information to collect

Balance number of questions and time

Privacy of SDOH information

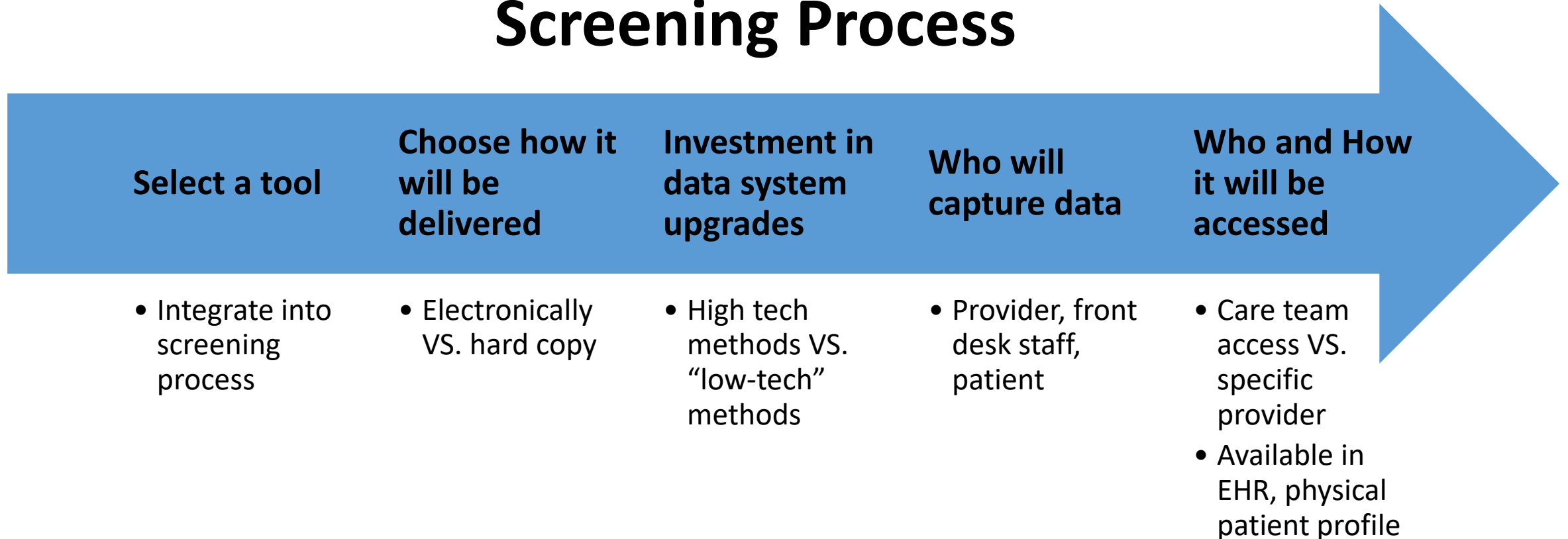
How to share information with other providers and community organizations

[TCC adapted assessment tools](#)



Collecting and Integrating SDOH Information

Screening Process





Creating Workflows to Track Patient Needs

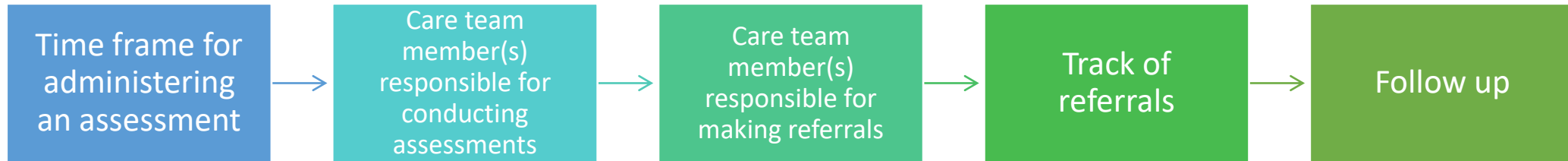


Exhibit 1: VCU Workflow for Administering the Health Leads Social Needs Assessment: Timeline of Typical Relationship between CHW and Patient after Hospitalization

Patient is hospitalized	Week 1: Home visit two days after discharge	Weeks 2-5: Care management	Week 6: Care management and assessment	Weeks 7-12: Care management and reassessment
<ul style="list-style-type: none"> During the morning huddle, new patients are reviewed and assigned to a CHW for the TakeCCARE program CHW contacts patient: <ul style="list-style-type: none"> - Bedside introduction - Schedules a home visit - Administers baseline PAM/VR-12/ social needs assessment Patient is discharged from the hospital 	<ul style="list-style-type: none"> If not conducted at hospital, administer baseline PAM/VR-12/social needs assessment Listen to/document patient's goals, preferences, and cultural/linguistic barriers to care Reinforce and align patient's goals with care plan Assess, identify, and address social needs Provide disease self-management coaching 	<ul style="list-style-type: none"> During weekly home visits: <ul style="list-style-type: none"> - Listen to/document patient's goals, preferences, and cultural/linguistic barriers to care - Reinforce and align patient's goals with care plan - Assess, identify, and address social needs - Provide disease self-management coaching 	<ul style="list-style-type: none"> Administer follow-up PAM/VR-12/social needs assessment if original PAM score is 3 or 4, otherwise, wait until week 12 Made decision on patient's ability to self-manage health Continue to reinforce and align patient's goals with care plan Assess, identify, and address social needs Provide disease self-management coaching 	<ul style="list-style-type: none"> Administer follow-up PAM/VR-12/social needs assessment Continue to reinforce and align patient's goals with care plan Assess, identify, and address social needs Provide disease self-management coaching CHW closes out care management process for patient



Identify Community Resources and Close the Referral Loop

Create an inventory of a community available resources

Identify the social service assets and gaps within the community

Help patients understand their benefits

Establish relationships with “non-traditional” partner organizations

National and Local Social Services Applications:

- [1Degree](#), San Francisco, California
- [Aunt Bertha \(Findhelp\)](#), Austin, Texas
- [Healthify](#), New York
- [Health Leads Reach](#), Boston, Massachusetts
- [Purple Binder](#), Chicago, Illinois
- [NowPow](#), Chicago, Illinois



Partnerships to address SDOH

Salud Family HC:

Salud Family Health Centers was recognized for its service delivery adaptations in their mobile health units.

These adaptations minimized exposure and has allowed for continued outreach and access to services for the Ag worker population

Sun River Health:

Sun River Health was recognized for its service adaptations since the start of the pandemic. Their transportation team added prevention procedures, improved infection control, and allowed for continued transportation services to those patients in most need.

[COVID-19 Safety Measures video for Mobile Clinics](#)



[COVID-19 Safety Measures video for Patient Transportation](#)





**MIGRANT
HEALTH**

Poll:

What partnerships have your health centers established to address any SDOH factors?



NCFH's SDOH Resource Hub

[NCFH SDOH Resource Hub](#)

provides health centers (HCs):

- Access to available screening tools
- Educational materials
 - Guides
 - Fact sheets
 - Infographics
 - Videos
 - Other resources

SOCIAL DETERMINANTS OF HEALTH RESOURCE HUB

NCFH has created the Social Determinants of Health (SDOH) Resource Hub to increase awareness and knowledge of commonly used screening tools and to identify the SDOH factors that impact the Migratory and Seasonal Agricultural Worker (MSAW) population across the country.

The SDOH Resource Hub provides health centers (HCs) access to available screening tools, educational materials such as guides, fact sheets, infographics, videos and other resources related to the social factors that affect people's health, to assist staff efforts in screening, documenting, and addressing SDOH factors impacting the MSAW population. This Hub also features screening tools and resources shared and discussed with participant HCs from NCFH's IAC Plus Learning Collaborative (IAC PLUS LC), a HRSA supported collaboration intended to increase knowledge about SDOH factors impacting the health care, access, and health status of the MSAW population.

Social Determinants of Health (SDOH) 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 (Healthy People, 2030).

Watch this video, [Social Determinants of Health - an Introduction](#), for more information about SDOH factors that impact population health outcomes.



Source: CDC

Resources featured in 5 SDOH domains



SDOH Screening Resources



- [CHCS Website](#)
- [CHCS Implementation Considerations Guide](#)



- [Health Leads Website](#)
- [Health Leads SDOH Screening Toolkit](#)

Thank you!

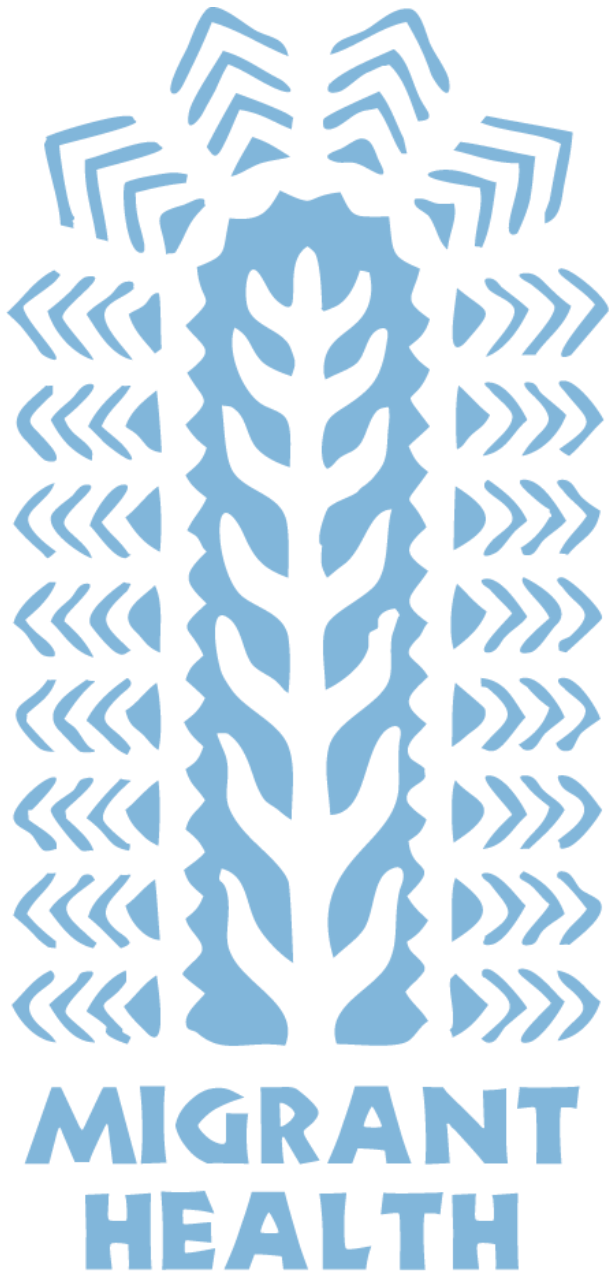
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Session Evaluation



A screenshot of the Whova app interface. The top navigation bar is dark blue with the Whova logo and user information. Below it, a blue header displays the event title "Midwest Stream Forum for Agricultural Worker Health" and location "Austin, TX (View map) Mar 28 - 30, 2022". A left sidebar contains navigation options like Home, Agenda, Sessions, Speakers, Attendees, Community, Messages, Photos, Leaderboard, Feedback to Whova, Organizer Tips, and About Whova. The main content area shows a session titled "Social Determinants of Health..." with a "Show Agenda" button. The session details include the date "Wed, Mar 30, 2022", time "10:15 AM - 11:30 AM", location "Capitol Ballroom F - H", and "1 Attending". There are buttons for "Add to My Agenda", "Like session", and "Rate Session". A speaker profile for Alexis Laboy is shown below. On the right, there are tabs for "Q&A", "Polls", "Chat", and "Communi", and a "Questions" section with "Filter by" and "Sort by" options. At the bottom right, there are two blue buttons: "View as Attendee" and "Ask a question".

Please complete the post-session evaluation through your Whova app.

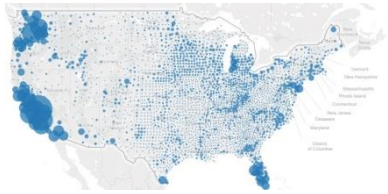
1. Search for this session: *“Screening for Social Determinants of Health: Resources and Implementation Considerations for Farmworker Populations”*.
2. Press *“Rate Session”*
3. Complete Evaluation Survey

Please, indicate if you prefer a hard copy evaluation sheet.



National Center for Farmworker Health

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[Fact Sheets & Research](#)



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[Resource Hubs](#)
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[Digital Stories](#)



[Patient Education Materials](#)

Governance/ Workforce Training



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Governance Tools

[Board Tools, Resources & Templates](#)



NCFH Additional Resources



Una Voz Para La Salud
Call for Health

1 (800) 377-9968

1 (737) 414-5121 WhatsApp

<http://www.ncfh.org/callforhealth.html>

Helpline for Farmworkers and their families

- Connects Farmworkers to healthcare and social services
- Assists with limited financial resources for health services



Farmworker Health Network

Farmworker Health Network

- Farmworker Justice <http://www.farmworkerjustice.org>
- Health Outreach Partners <http://www.outreach-partners.org>
- MHP Salud <http://www.mhpsalud.org>
- Migrant Clinicians Network <http://www.migrantclinician.org>
- National Association of Community Health Center <http://www.nachc.com>





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- Dedicated to improving the health status of Ag worker families: providing info services, training/technical assistance & a variety of products to health centers, organizations, universities, researchers, & other Ag worker health advocates nationwide.
- The National Center for Farmworker Health proactively supports the work of health centers and the empowerment of

National Center for Farmworker Health, Inc. added an event.
58m

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