NCFH
National Center for Farmworker Health, Inc.
1770 967 FM | Buda, TX
www.ncfh.org

Screening for Social Determinants of Health

Resources and Implementation Considerations for Farmworker Populations

Alexis Laboy, MPHE, MPH, CHES®
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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

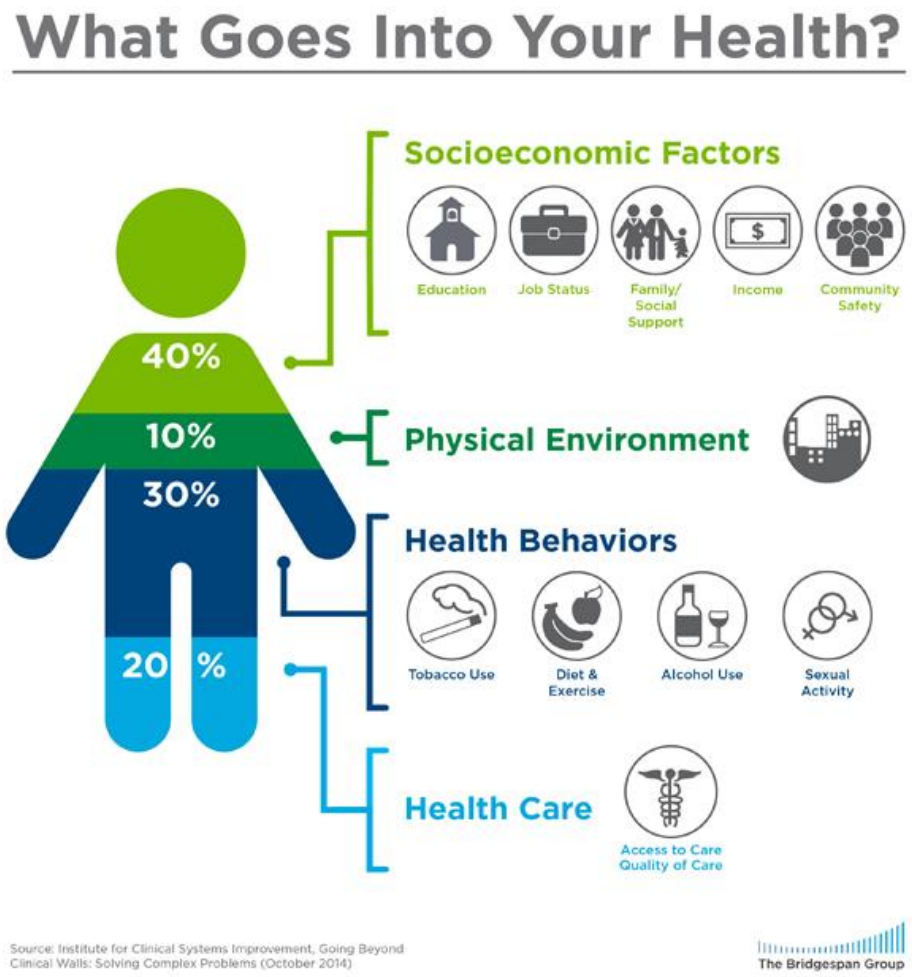
Economic Stability
- Poverty
- Lack of employment benefits

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



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

Recognizing SDOH influence on health outcomes → Development of innovative strategies → Address patients’ social needs

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

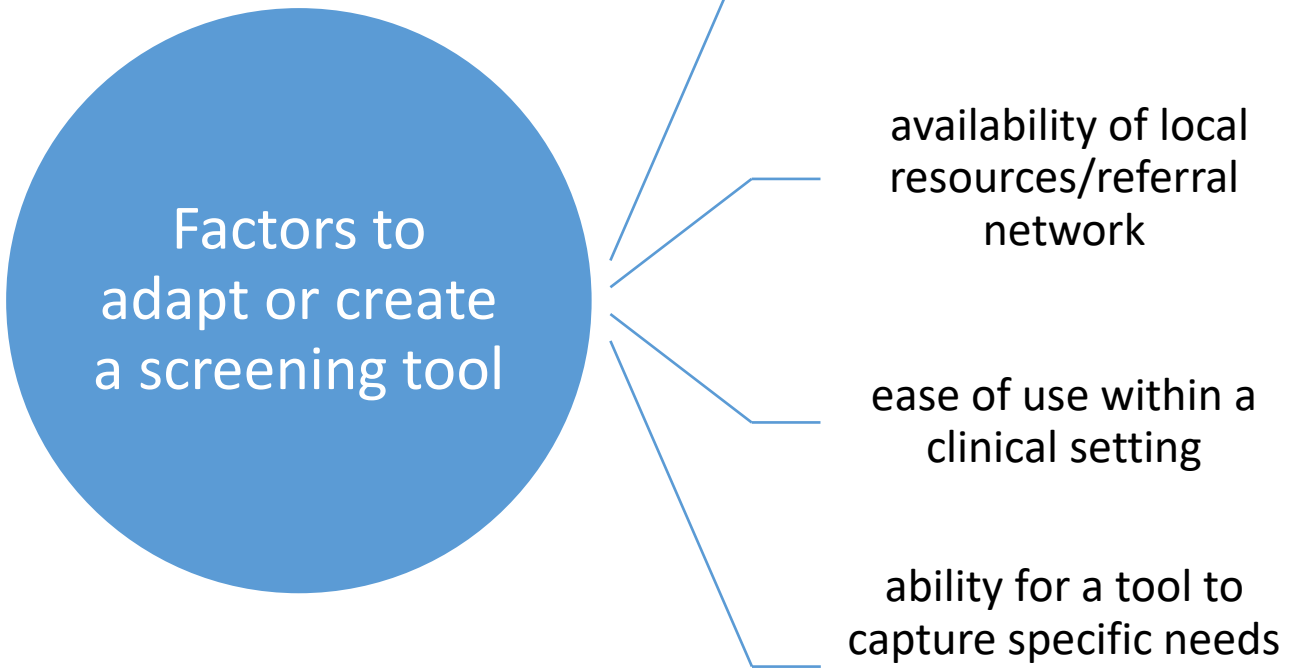
Key Considerations of Implementing Screening Tools

- 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



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

Select a tool	Choose how it will be delivered	Investment in data system upgrades	Who will capture data	Who and How it will be accessed
• Integrate into screening process	• Electronically VS. hard copy	• High tech methods VS. “low-tech” methods	• Provider, front desk staff, patient	• Care team access VS. specific provider • Available in EHR, physical patient profile

Creating Workflows to Track Patient Needs

Time frame for administering an assessment → Care team member(s) responsible for conducting assessments → Care team member(s) responsible for making referrals → Track of referrals → Follow up

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
■ During the morning huddle, new patients are reviewed and assigned to a CHW for the TakeCCARE program ■ CHW contacts patient: - Bedside introduction - Schedules a home visit - Administers baseline PAM/VR-12/ social needs assessment ■ Patient is discharged from the hospital	■ 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	■ During weekly home visits: - 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	■ 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	■ 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

Source: Advancing innovations in health care delivery for low-income Americans | www.chcs.org

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

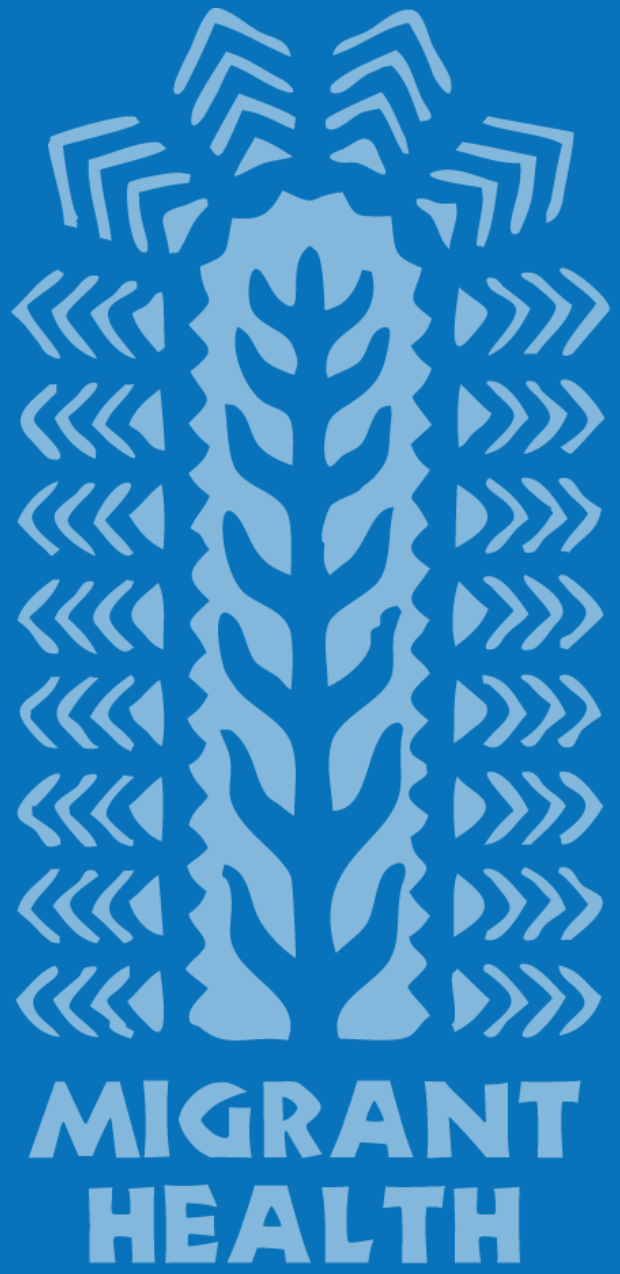
Partnerships to address SDOH

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

COVID-19 Safety Measures video for Mobile Clinics

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 Patient Transportation



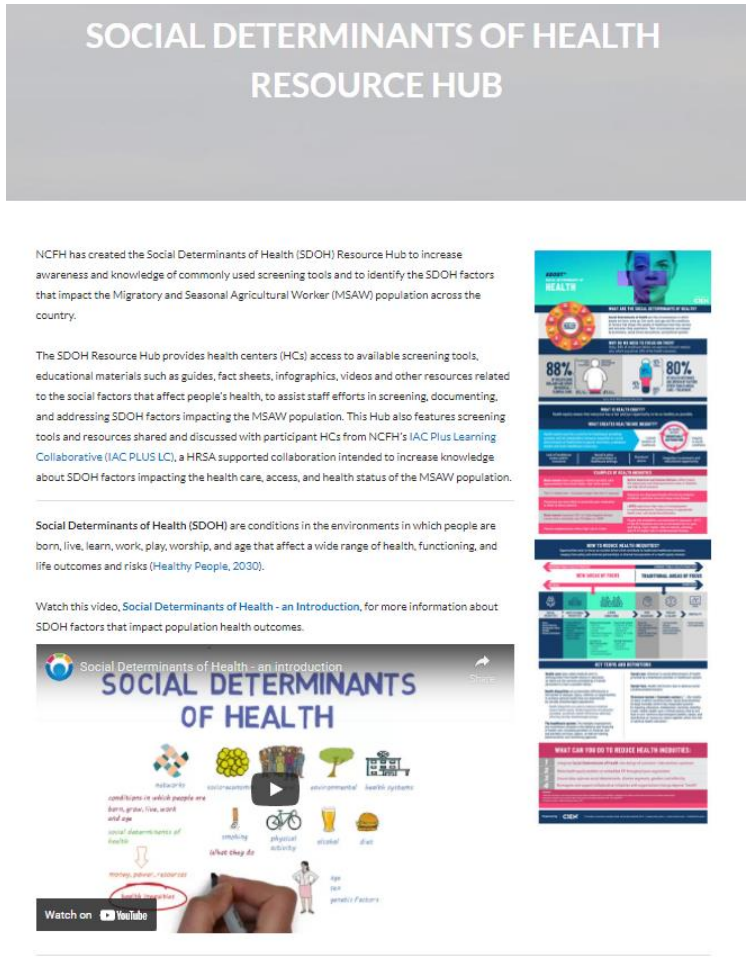
Poll:

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



Source: CDC

Resources featured in 5 SDOH domains

SDOH Screening Resources

Center for Health Care Strategies
Better care where it's needed most

- CHCS Website
- CHCS Implementation Considerations Guide

Health Leads

- Health Leads Website
- Health Leads SDOH Screening Toolkit

Thank you!

Alexis Laboy
laboy@ncfh.org
512-312-5461

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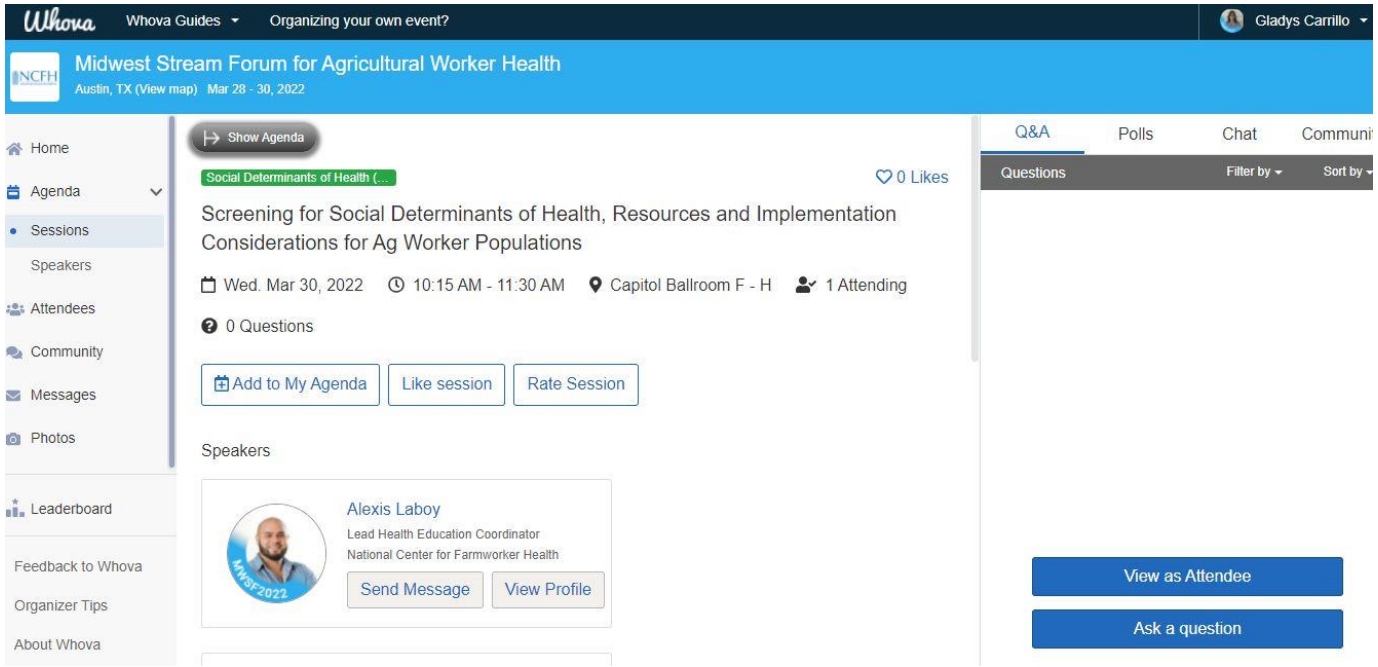
Session Evaluation



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2. Press "Rate Session"
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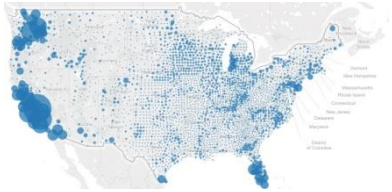
Please, indicate if you prefer a hard copy evaluation sheet.

National Center for Farmworker Health

Population Specific



Population Estimation

Fact Sheets & Research

Health Center Learning Collaboratives

Health Education/Patient Education Resources

Resource Hubs
Diabetes
Mental Health
SDOH

Digital Stories

Patient Education Materials

Governance/ Workforce Training

Health Center ToolBox

Archived Webinars

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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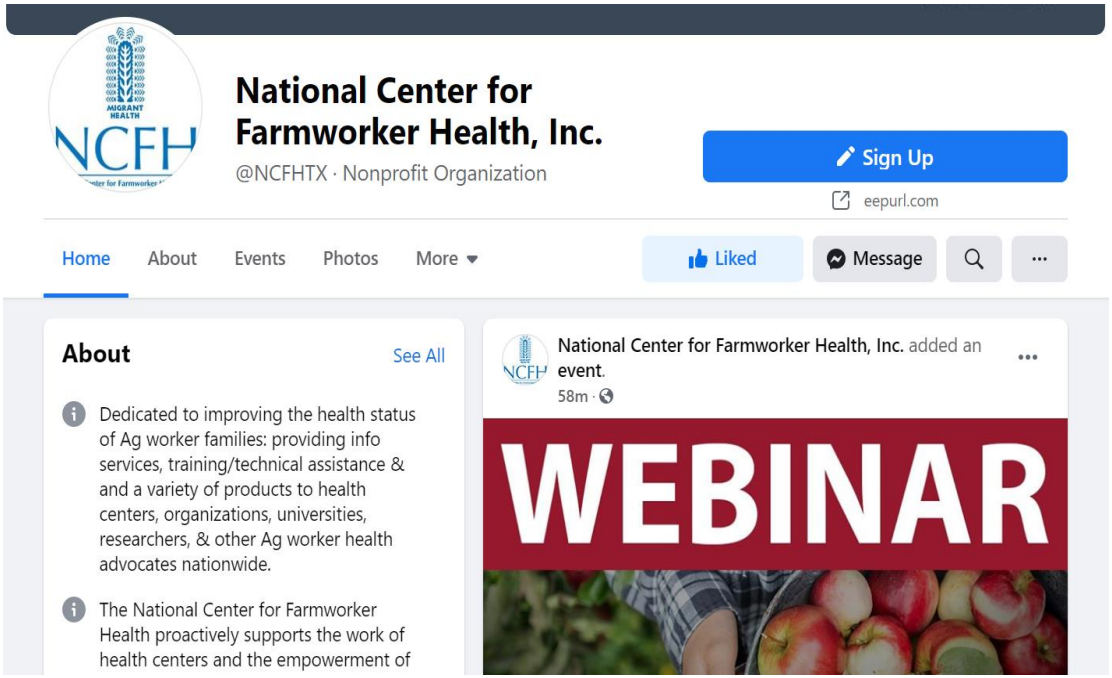

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