Welcome to the SDOH Panel

2021 Virtual Forum for Migrant and Community Health

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Speakers of SDOH Panel

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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.

SDOH can be grouped into 5 domains:

- Education: Access and Quality
- Health Care: Access and Quality
- Economic Stability
- Neighborhood and Built Environment
- Social and Community Context

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

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

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 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 question

5. Are you worried about losing your housing?
   - Yes
   - No
   - I choose not to answer this question

6. What address do you live at?
   - Street:
   - City, State, Zip code:

7. Money & Resources
   - Less than high school degree
   - High school diploma or GED
   - More than high school
   - I choose not to answer this question

8. What is your current work situation?
   - Unemployed
   - Part-time or temporary work
   - Full-time work
   - Otherwise unemployed but not seeking work (e.g., student, retired, disabled, unpaid primary care giver)

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Why collect standardized SDOH data?

**Individual level**
- Patient and Family: Empowered to improve health and wellbeing
- Care Team Members: Better manage patient and population needs

**Organizational level**
- Health Center: Design care teams and services to deliver patient/community-centered care

**System/Community level**
- Community/Local Health System: Integrate care through cross-sector partnerships, develop community-level redesign strategy for prevention, and advocate to change local policies

**Payer level**
- Payment: Execute payment models that sustain value-based care (incentivize the social risk interventions and partnerships, risk adjustment)

**Policy level**
- State and National Policies: Ensure capacity for serving complex patients, including uninsured patients

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

<table>
<thead>
<tr>
<th>Who</th>
<th>Where</th>
<th>When</th>
<th>How</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical staff (patient navigator, community health workers)</td>
<td>In waiting room or in staff office</td>
<td>Before of after provider visit</td>
<td>Administered PRAPARE with patients who would be waiting 30+ mins for provider</td>
<td>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 patient’s ability and motivation to respond to their situation.</td>
</tr>
<tr>
<td>Nursing staff and/or MAs</td>
<td>In exam room</td>
<td>Before provider enters exam room</td>
<td>Administered it after vitals and reason for visit. Provider reviews PRAPARE data and refers to case manager</td>
<td>Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info.</td>
</tr>
<tr>
<td>Care Coordinators</td>
<td>In office of care coordinator</td>
<td>When Completing chart reviews and administering Health Risk Assessments</td>
<td>Administered PRAPARE in conjunction with Health Risk Assessments</td>
<td>Allows care coordinators to address similar issues in real time that may arise from both PRAPARE and HRA.</td>
</tr>
<tr>
<td>Any staff (from Front Desk Staff to Providers)</td>
<td>No wrong door approach</td>
<td>No wrong door approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Self-Assessment</td>
<td>At home, in waiting room, etc.</td>
<td>Before visit with provider</td>
<td>Self-administered using email, mobile, tablets, kiosks, etc.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

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.

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

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

- Collecting SDOH data in language of patient(s)
- Connecting patient(s) with health services or referrals
- Facilitating care via mobile units
- Providing information in an educationally-equitable manner
- Giving patients vouchers or other resources

Social Determinants of Health Screening Tools Showcase

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
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**
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

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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

We Care.
We serve America’s Ag Workers.
Thank you!
Questions?
Thank you for coming to the SDOH Panel session!