Screening for Social Determinants of Health

Resources and Implementation Considerations for Farmworker Populations

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March 30th, 2022
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

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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
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

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

<table>
<thead>
<tr>
<th>Patient is hospitalized</th>
<th>Home visit two days after discharge</th>
<th>Weeks 1-5: Care management</th>
<th>Week 6: Care management and assessment</th>
<th>Weeks 7-12: Care management and reassessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not conducted at hospital, administer baseline PAM/VR-12/social needs assessment</td>
<td>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</td>
<td>Administer follow-up PAM/VR-12/social needs assessment if original PAM score is 3 or 4, otherwise, wait until week 12</td>
<td>Made decision on patient’s ability to self-manage health</td>
<td>Continue to reinforce and align patient’s goals with care plan</td>
</tr>
<tr>
<td>CHW contacts patient: - Bedside introduction - Schedules a home visit - Administers baseline PAM/VR-12/social needs assessment</td>
<td>- Assess, identify, and address social needs - Provide disease self-management coaching</td>
<td>Continue to reinforce and align patient’s goals with care plan</td>
<td>Assess, identify, and address social needs</td>
<td>Provide disease self-management coaching</td>
</tr>
</tbody>
</table>
| Patient is discharged from the hospital | - Provide disease self-management coaching | CHW closes out care management process for patient | Provide disease self-management coaching | **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 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

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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
Poll:
What partnerships have your health centers established to address any SDOH factors?
NCFH’s SDOH Resource Hub

provides health centers (HCs):

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

NCFH has created the Social Determinants of Health (SDOH) Resource Hub to increase awareness and knowledge of common causes of health. The Resource Hub provides screening tools, educational materials such as guides, fact sheets, infographics, slides, and other resources related to social factors that affect human health, to assist health centers in screening, documenting, and addressing SDOH factors impacting the migrant population. The Hub also features screening tools and resources shared and discussed with partners from the Migrant Health Information Network (MHN), including data and information on how to assess and reduce health disparities among migrant and seasonal farmworkers.

Social Determinants of Health (SDOH) are conditions in which people are born, live, work, play, and age (i.e., social, economic, and environmental conditions) that shape the health, functioning, and success of individuals and communities. These conditions affect a wide range of health outcomes, including mortality, morbidity, and quality of life.

Resources featured in 5 SDOH domains

Source: CDC

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SDOH Screening Resources

• CHCS Website
• CHCS Implementation Considerations Guide

• Health Leads Website
• Health Leads SDOH Screening Toolkit
Thank you!

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“This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,916,466 with 0 percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.” The percentage financed with nongovernmental sources depends on the project.
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Helpline for Farmworkers and their families

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

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