Screening for SDOH: Overview of Tools and Resources

Farmworker Health Network

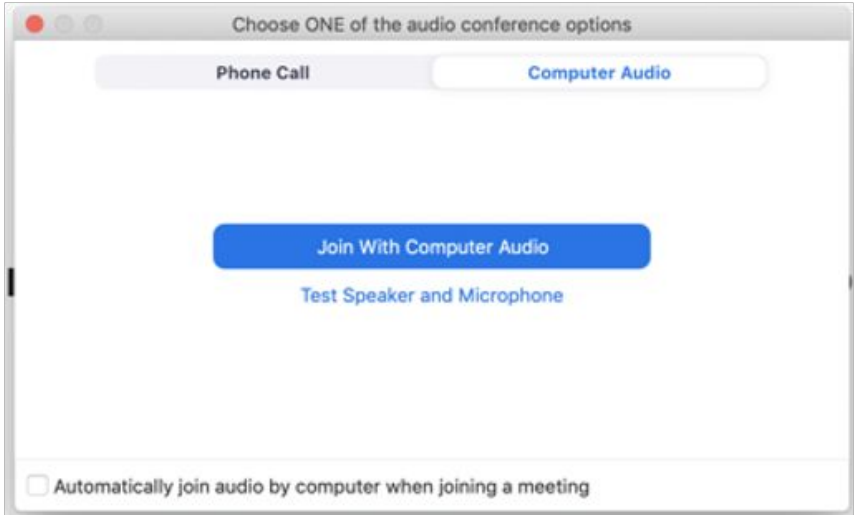
October 26, 2022

Welcome!

Housekeeping Items:

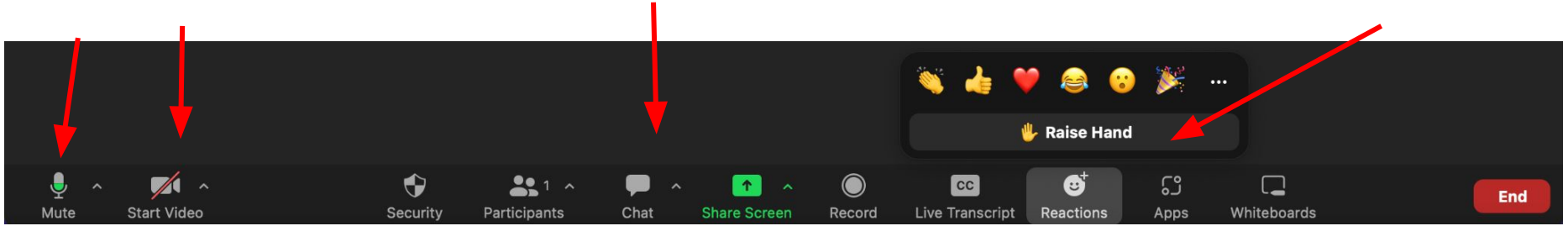
- Webinar will last approximately 1 hour and will be recorded.
- Please move your cell phones away from the device you are using.
- For technical issues, send a chat to the organizer.

ZOOM How-to



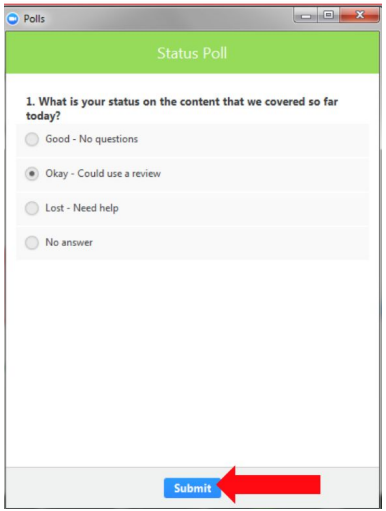
Please mute yourself. Questions are welcomed any time during the webinar, Please raise your hand or send a question in the chat box or the Q & A button. The panelists will be monitoring the chat box throughout the session.
We encourage you to turn on your video, if you are willing and able to do so.
Use chat to send privately to panelists/organizer or the entire audience

- Questions may be addressed during presentation or at Q&A time.
- Any questions that cannot be addressed during the webinar will be responded to via email.



Polls

- There will be a few poll questions that the presenter will ask you to answer. At the designated time, you will see the poll on your screen. Please select a response and the presenter will share poll results after.



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- To receive continuing education credits for this activity, the participant must complete a post-activity evaluation.
- Once successful completion has been verified, each participant will receive a letter and certificate of successful completion that details the number of contact hours that have been awarded.
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FOR QUESTIONS OR ADDITIONAL INFORMATION PLEASE CONTACT:
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Conflict of Interest Disclosure

We have no real or perceived vested interest that relate to this presentation, nor do we have any relationships with pharmaceutical companies, biomedical device manufacturers and/or other corporations whose products or services are related to pertinent therapeutic.

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Migrant Clinicians Network

Migrant Clinicians Network is a national 501(c)3 nonprofit organization that provides support, technical assistance, and professional development to clinicians in community health centers, health departments, and other health care delivery sites.

MCN utilizes

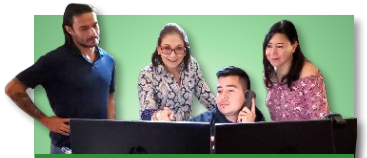
- ✔ online seminars and learning collaboratives,
- ✔ on-the-ground trainings,
- ✔ resource development,
- ✔ and advocacy,

to enable clinicians to provide quality health care, increase health care access, and reduce disparities for people who need ongoing care but are experiencing outside forces that exacerbate their vulnerability.

Our Work

Resource Development

Education



Technical Assistance

Research

Bridge Case Management

Worker Health and Safety

Psychosocial Support for Providers

Evaluation

Advocacy

Peer Networking

CONNECT WITH US!

www.migrantclinician.org

@migrantclinician + TweetMCN + migrantcliniciansnetwork

Farmworker Justice

A nonprofit organization that seeks to empower farmworkers and their families to improve their living and working conditions, immigration status, health, occupational safety, and access to justice.
Using a multi-faceted approach, Farmworker Justice engages in litigation, administrative and legislative advocacy, training and technical assistance, coalition-building, public education, and support for union organizing.

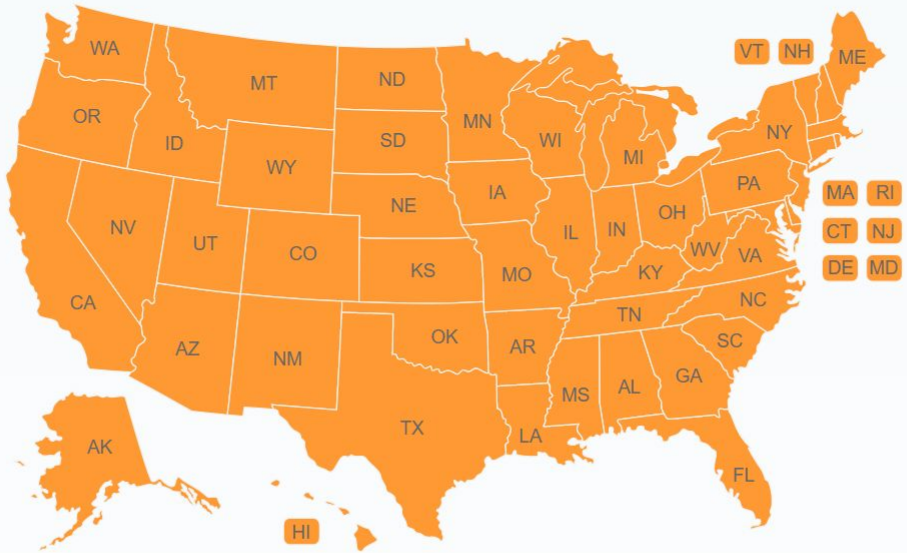
FARMWORKER JUSTICE

Washington, DC
202-293-5420
www.farmworkerjustice.org

Farmworkers' Rights Under State Employment Laws: An Interactive Map

Farmworkers today continue to fight for equal protection under employment and labor laws. This interactive map and database of state laws reveal the discriminatory denial of labor protections in many state laws which contributes to unsafe working conditions, lower wages, and high rates of poverty among farmworkers.

Click on a state and then scroll down to see a summary of state laws affecting farmworkers in that state. Please note that this information does not constitute legal advice – local legal services organizations are listed at the bottom of each state summary if you would like more detailed information or legal guidance. Click on a topic below to see maps of state laws on Workers Compensation, Overtime and Minimum Wages.



Farmworkers and the Climate Crisis

Farmworker Justice's
Environmental Justice Symposium
Summary Report

FARMWORKER JUSTICE

July 2022








MHP Salud

We are a national nonprofit organization that has implemented Community Health Worker (CHW) programs for over 35 years. These programs provide peer health education, increase access to health resources and bring community members closer. MHP Salud also has extensive experience offering health organizations training and technical assistance on CHW programming tailored to their specific needs.

Our Programs

We base all of our work on close collaboration with CHWs who improve the health of their communities with health education and activities.

Support Services

We have taken our innovative, outcomes-driven CHW programming to offer you the tools to make it work in your system, with your providers, and for your population.

Who are CHWs?

A Community Health Worker is a trusted member of the community who empowers their peers through education and connections to health and social resources.

To Learn More, Visit Us!
www.mhpsalud.org

National Center for Farmworker Health

The **National Center for Farmworker Health** is a private, not-for-profit organization located in Buda, Texas, whose mission is "To improve the health of farmworker families".

- Population specific data resources and technical assistance
- Workforce development and training
- Health education resources and program development
- Board Governance training
- Program Management

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

Governance Tools

Board Tools, Resources & Templates

Health Outreach Partners

www.outreach-partners.org

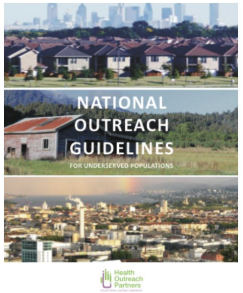
WE SUPPORT HEALTH OUTREACH PROGRAMS by providing training, consultation, and timely resources.

OUR MISSION IS TO BUILD STRONG, EFFECTIVE, AND SUSTAINABLE HEALTH OUTREACH MODELS by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable and underserved populations.

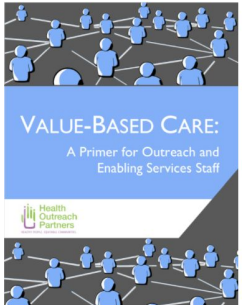
WE SERVE Community Health Centers, Primary Care Associations, and Safety-net Health Organizations

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

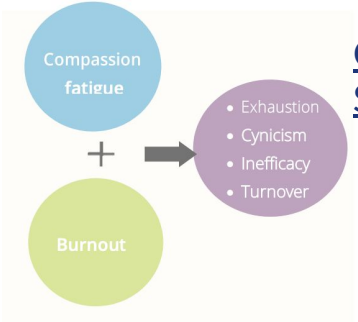
Our Work



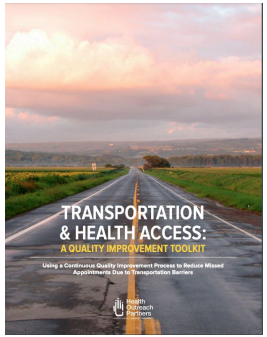
[National Outreach Guidelines]



[Value Based Care]



[Organizational Self-Care]

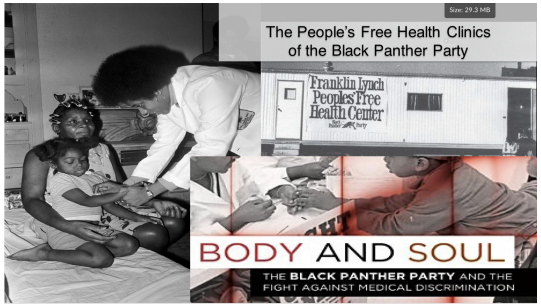


[Transportation and Health Access: A quality improvement toolkit]

OUTREACH BUSINESS VALUE CALCULATORS

[Outreach Business Value]

[Health Equity Starter Kit]



[Structural Competency Curriculum]

Learning Objectives

By the end of this webinar, participants will:

- Gain knowledge about SDOH factors that impact vulnerable populations including Migrant, Seasonal, and Agricultural Workers (MSAWs).
- Better understand how to identify and screen for specific SDOH factors.
- Gain access to SDOH screening tools and additional resources.

YR3 Poll

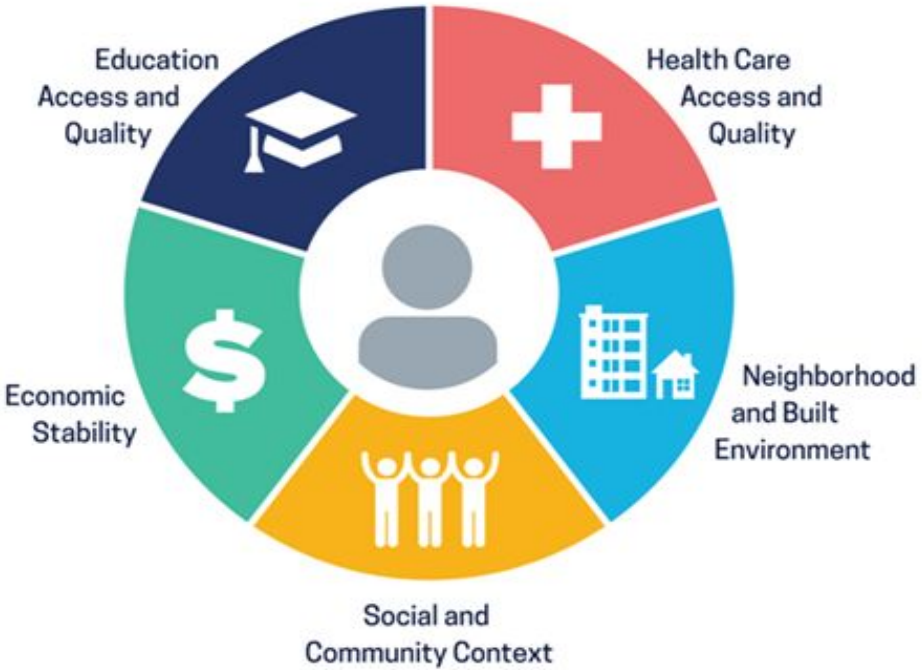
Did you participate in either the FHN Year 1 or 2 Screening for SDOH Learning Collaborative?

- Yes
- No

Social Determinants Of Health 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.



Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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.

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

Schmalzried H & Fleming Fallon L. (2012). Reducing barriers associated with delivering health care to migratory agricultural workers. https://www.rrh.org.au/journal/article/2088
Kozhimannil KB & Hennings-Smith C. (2018). Racism and health in rural America. https://muse.jhu.edu/article/686951/summary
Hacker K, Anies M, Folb B & Zallman L. (2015). Barriers to health care for undocumented immigrants: A literature review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4634824/
Portes A & Fernandez Kelly P. (2012). Life on the edge: Immigrants confront the American health system. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3622255 /

SDOH Impact on MSAW Population

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

Schmalzried H & Fleming Fallon L. (2012). Reducing barriers associated with delivering health care to migratory agricultural workers. https://www.rrh.org.au/journal/article/2088
Kozhimannil KB & Hennings-Smith C. (2018). Racism and health in rural America. https://muse.jhu.edu/article/686951/summary
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Portes A & Fernandez Kelly P. (2012). Life on the edge: Immigrants confront the American health system. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3622255 /

Additional SDOH factors from COVID

- Increase risk for illness/health conditions
- Challenges to quarantine (family household, employers)
- Limited transportation to access healthcare services and COVID tests/vaccines
- Added food insecurity
- Lack of childcare/ school exposure
- Lack of adequate education and nutrition programs for children
- Lack and/or limited access to technology and digital literacy
- Lack of access to linguistically and culturally appropriate information
- Mental Health impact (increased stress, anxiety, depression)

Schmalzried H & Fleming Fallon L. (2012). Reducing barriers associated with delivering health care to migratory agricultural workers. https://www.rrh.org.au/journal/article/2088
Kozhimannil KB & Hennings-Smith C. (2018). Racism and health in rural America. https://muse.jhu.edu/article/686951/summary
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Portes A & Fernandez Kelly P. (2012). Life on the edge: Immigrants confront the American health system. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3622255 /

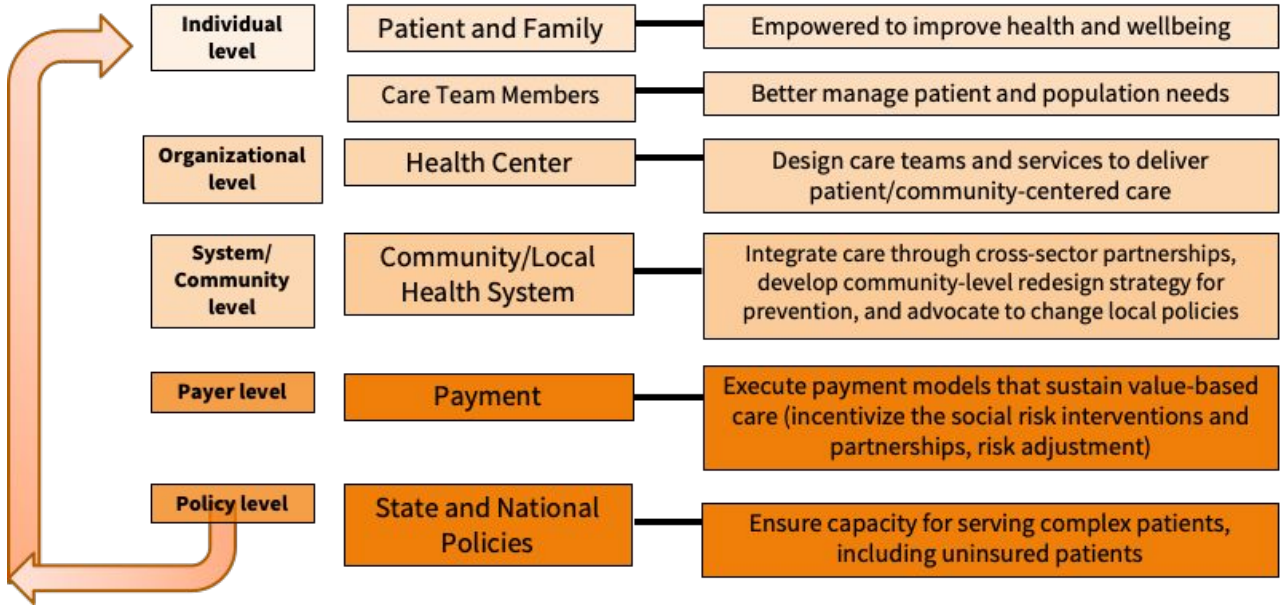
Addressing SDOH Gap

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:

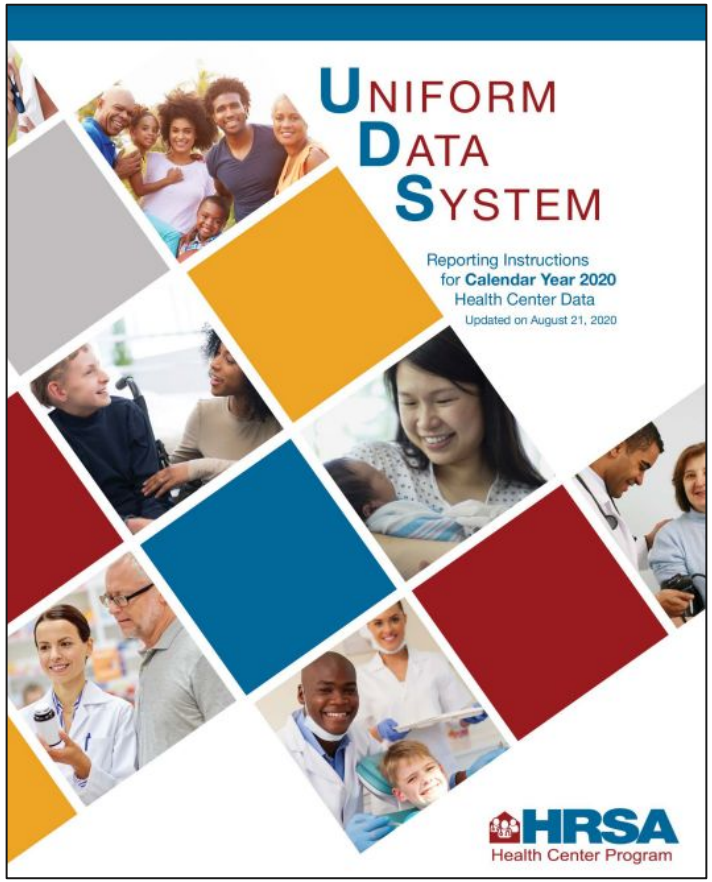
- Provide clinic-facilitated transportation
- Administer care via mobile clinics onsite
- Give patients bus, Lyft/Uber, or taxi vouchers
- Develop strong virtual care outreach

Why collect SDOH data?



PRAPARE

Source: PRAPARE, National Association of Community Health Centers, In., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Retrieved from https://www.nachc.org/research-and-data/prapare/toolkit/



Appendix D: Health Center Health Information Technology (HIT) Capabilities

Question 11: *Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?*

Question 12: *Which standardized screener(s) for social risk factors, if any, do you use?* (Select all that apply.)

UDS 2020: Health Center HIT Capabilities

11. Health center data collection on individual patients' social risk factors

- **~69% of health centers reported that they collect data on individual patients' social risk factors, outside the data reportable in the UDS.**
- ~25% of health centers are in the planning stages to collect this information.

12. Standardized screeners for social risk factors used by health centers	
Accountable Health Communities Screening Tools	8.03%
Upstreaming Risk Screening Tool and Guide	1.06%
iHelp	0.42%
Recommend Social and Behavioral Domains for EHRs	9.19%
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	**52.69%**
Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)	6.55%
WellRx	0.74%
Health Leads Screening Toolkit	2.11%
Other	23.86%

https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=EHR&year=2021

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PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

- PRAPARE (developed by NACHC, AAPCHO, Oregon PCA, and Institute for Alternative Future) is an evidence-based, national standardized patient risk assessment protocol designed to help health centers and other providers collect the data needed to assess and act on their patients' SDOH[1].
- According to the 2020 UDS 52.7% health centers reported using PRAPARE compared to only 34.4% in 2019.

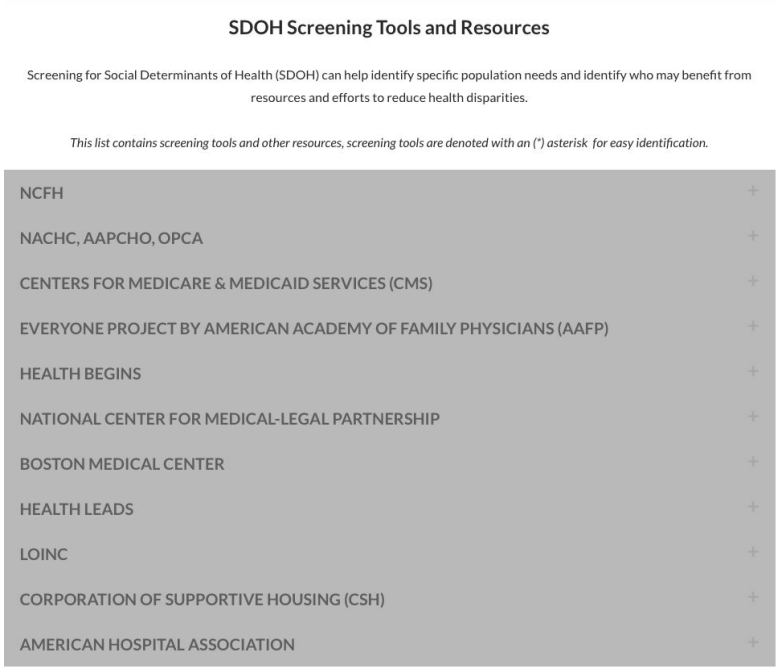
PRAPARE Core Measures	
Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/Neighborhood	Social & Emotional Support
PRAPARE Optional Measures	
Incarceration History	Domestic Violence
Refugee Status	Intimate Partner Violence

1. NACHC, AAPCHO (2020). PRAPARE. Accessed at: https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020

Image Source: N (2016). PREPARE. Accessed at https://prapare.org/the-prapare-screening-tool/

PRO TIP: PRAPARE is available for FREE to health centers along with training and technical assistance on how to start using the tool.
For more information visit: www.prapare.org

SDOH Screening Tools



SDOH Screening Tools and Resources

Screening for Social Determinants of Health (SDOH) can help identify specific population needs and identify who may benefit from resources and efforts to reduce health disparities.

This list contains screening tools and other resources, screening tools are denoted with an (*) asterisk for easy identification.

- NCFH +
- NACHC, AAPCHO, OPCA +
- CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) +
- EVERYONE PROJECT BY AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) +
- HEALTH BEGINS +
- NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP +
- BOSTON MEDICAL CENTER +
- HEALTH LEADS +
- LOINC +
- CORPORATION OF SUPPORTIVE HOUSING (CSH) +
- AMERICAN HOSPITAL ASSOCIATION +

NACHC, AAPCHO, and OPCA:

- Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) Assessment Tool
- PRAPARE Readiness Assessment Tool

NCFH:

- Patient SDOH Screening Tool
- SDOH Self-Assessment Tool
- Increase Access to Care (IAC) PLUS SDOH Customizable Screening Tool

SDOH Screening Tools

Centers for Medicare & Medicaid Services (CMS):

- Accountable Health Communities Screening Tool

EveryONE Project by American Academy of Family Physicians (AAFP):

- Social Needs Screening Tool

Health Begins:

- Upstream Risks Screening Tool & Guide

National Center for Medical-Legal Partnership:

- Income, Housing, Education, Legal Status, Literacy, Personal Safety (IHELLP) Social History Questions

Boston Medical Center:

- WE CARE Survey

Health Leads:

- Social Needs Screening Toolkit

LOINC:

- WellRx Questionnaire

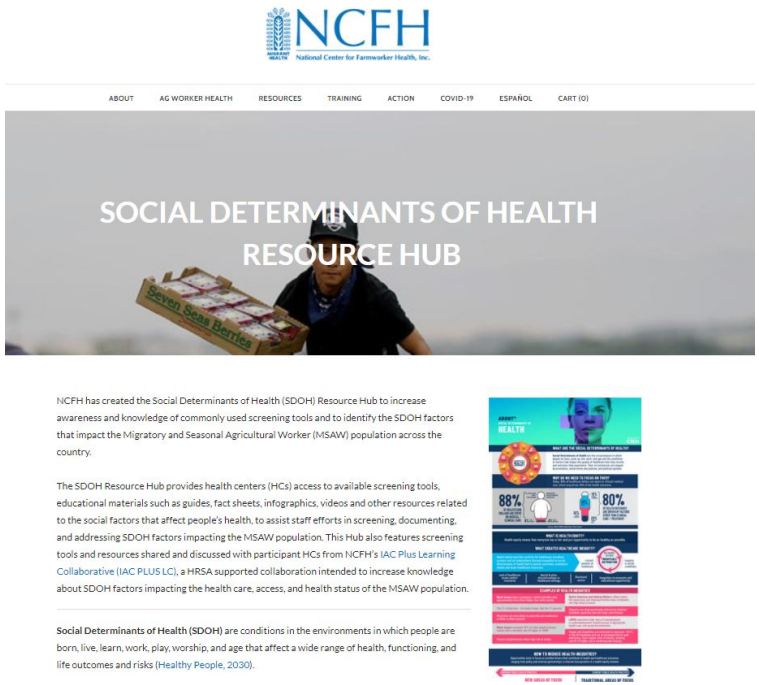
Corporation of Supportive Housing (CSH):

- Data Integration Best Practices for Health Centers & Homeless Services

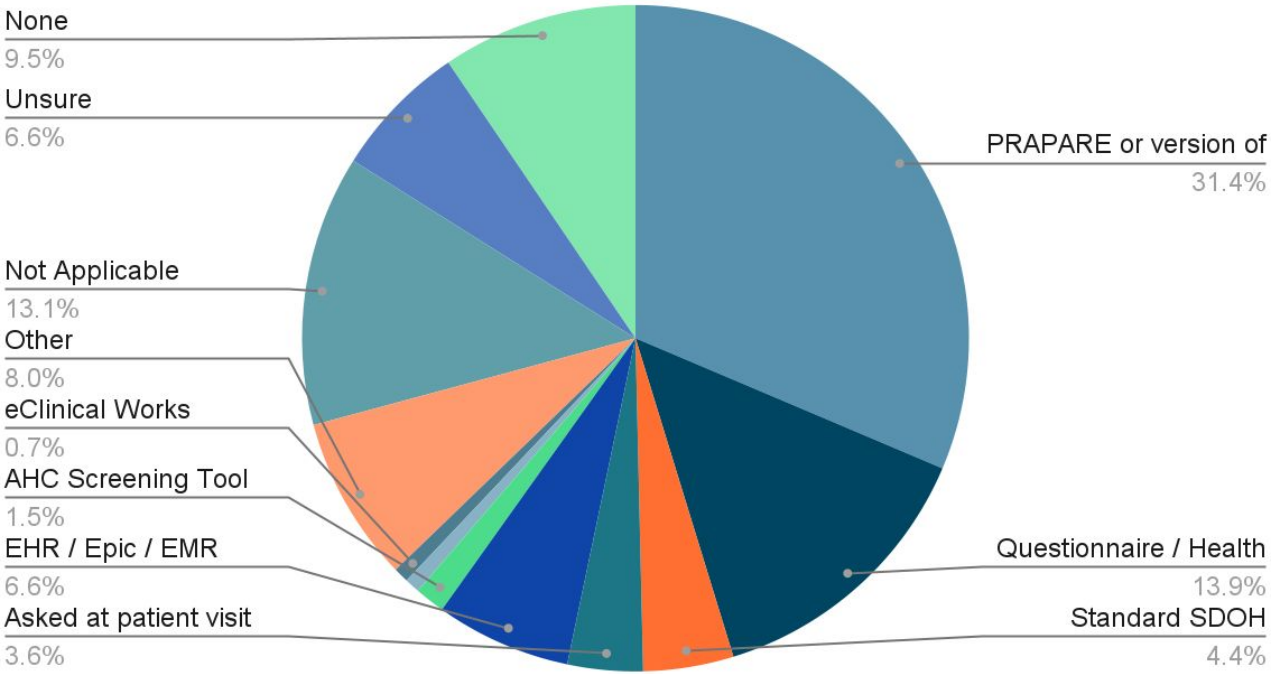
American Hospital Association:

- Screening for Social Needs: Guiding Care Teams to Engage Patients

SDOH Resource Hub



Which SDOH Screening Tool do you use at your HC?



SDOH Implementation

PRAPARE

Source: PRAPARE, National Association of Community Health Centers, In., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. Retrieved from https://www.nachc.org/research-and-data/prapare/toolkit/

What needs improvement?

Challenges:

- Limited staff capacity/staffing shortages
- Fear, mistrust, and shame around answering screening questions
- Need more institutional buy-in to implement larger-scale SDOH screening
- In some areas, even if they do screen for SDOH, there are few resources to refer patients to (eg, public housing)
- Often need many appointments to address SDOH; patients may come infrequently
- COVID-19 pandemic continued exacerbating SDOH

What works well?

Successes:

- Trusted bilingual community health workers/outreach staff conducting screenings
- Integrating screenings into the intake process
- Integrating SDOH screening and services/incentives (eg, screenings with food giveaways)
- Community partnerships with organizations who can accommodate referrals

Best Practices

Food Insecurity	Housing Insecurity	Transportation Barriers

• 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
	• 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
		• 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

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

Q&A Discussion

We will now address your questions!

Webinar Evaluation

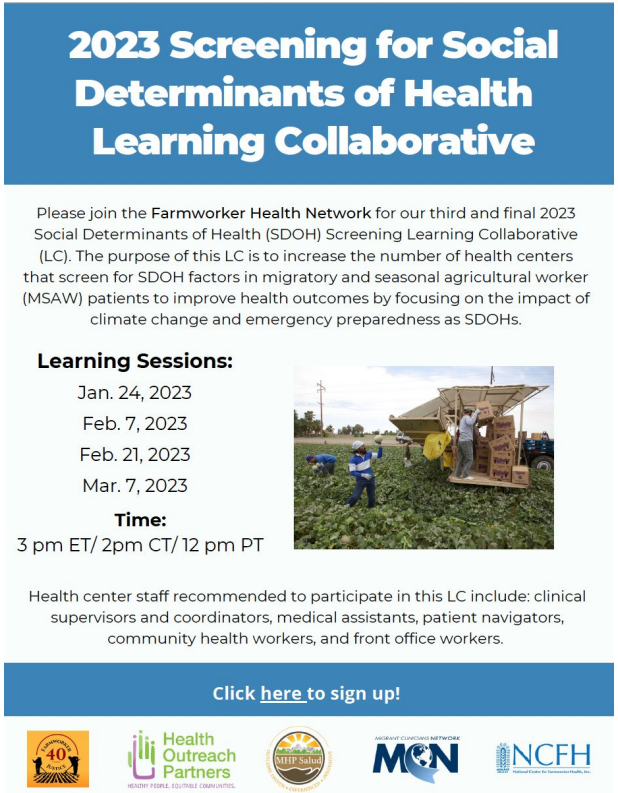
Please remember to submit the evaluation.
Submission is required if you would like to receive a Certificate of Attendance or a Certificate of Continuing Nursing Education.

You can access the evaluation by scanning the QR code, clicking on the link provided in the chat, or wait until the session is closed and the evaluation will automatically open in a new window. **Thank you!**

YR3 Screening for SDOH LC

Year three will build upon ***years one and two*** to integrate health center best practices on screening for and addressing SDOH factors that impact the Migratory and Seasonal Agricultural Worker (MSAW) population by focusing on the impact of climate change and emergency preparedness as SDOHs. The link below will be provided in the chat

Link:
https://us02web.zoom.us/meeting/register/tZEkdOisrz8iG9T7meHPO57BDbrdLdXRsC05



SDOH Poll

If you were to participate in this LC, what SDOH factor would you want to address? (Please choose top three).

- Climate change
- Natural disasters
- Transportation
- Housing
- Mental health
- Food insecurity
- Language
- Digital literacy
- Telemedicine/Telehealth

References:

- Ag Worker Access Campaign. Retrieved from http://www.ncfh.org/ag-worker-access.html
- Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health.
- 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.
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Thank you all for the excellent work and for being a part of our day. We appreciate you all. We appreciate you all and look forward to seeing you all in our next learning collaboratives.

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