Harnessing the Power of Outreach and Enabling Services to Address Social Drivers of Health

Wednesday November 8th, 2023
11 AM PDT/ 2 PM EDT
Overview

Purpose

The webinar will provide health center staff on how to screen special and vulnerable populations and using the data to make change.

By the end of this webinar, participants will be able to:

- Participants will identify three new strategies for screening special and vulnerable populations.
- Participants will understand the value of enabling services staff and their impact on clinical patient services as they collect SDOH data.
- Participants will understand the importance of using SDOH data collection in making sustainable changes among their communities.
Agenda

• Welcome and Introductions
• Overview of Social Determinants of Health (SDOH) data collection and Enabling Services Staff role
• Building Capacity to Address SDOH
• Panelist Presentations
• Q&A
• Closing Activity and Evaluation
FACILITATORS

Deanna Canales (She/Her)
Project Manager, HOP

Flor Robertson (She/Her)
Health Strategy Specialist, MHP Salud

Gabrielle Peñaranda (She/Her)
Program Manager, Training and Technical Assistance, AAPCHO

Laureyn Berner-Davis (She/Her)
Director of Implementation Research, NHCHC
MHP Salud

As a HRSA funded National Training and Technical Assistance Partner (NTTAP), MHP Salud has been able to provide training and technical assistance to FQHCs and other organizations looking to build or enhance Community Health Worker (CHW) programs for over 35 years.

We are a national nonprofit organization that implements and runs Community Health Worker (CHW) programs. 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. We serve communities by embracing the strengths and experiences of individuals and families, engaging them to achieve health and wellbeing.

www.mhpsalud.org
MHP Salud
Vision:

We believe everyone deserves to live healthy and resilient lives within their communities
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 Organization
Health equity is at the center of your care. We are here to bring that within reach.

www.outreach-partners.org

Keep up with the latest news from Health Outreach Partners
Sign up for HOP’s mailing list.
About AAPCHO

The Association of Asian Pacific Community Health Organizations (AAPCHO) was formed to create a national voice to advocate for the unique and diverse health needs of AA and NHPI communities and the community health providers that serve their needs.
Mission & Impact

**AAPCHO** is dedicated to promoting **advocacy**, **collaboration**, and **leadership** that improves the health status and access of Asian Americans (AAs), Native Hawaiians (NHs), and Pacific Islanders (PIs) within the United States, the U.S. territories, and the Freely Associated States.
Who is NHCHC?

Grounded in human rights and social justice, the NHCHC mission is to build an equitable, high-quality health care system through training, research, and advocacy in the movement to end homelessness.
Mentimeter Discussion

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OVERVIEW OF SDOH DATA COLLECTION AND ENABLING SERVICES STAFF ROLE
WHAT IS SDOH DATA?

• Social Determinants of Health (SDOH): conditions in the environment where people work, play and live that affect various health and quality of life outcomes and risk (HHS).

• SDOH data is meant to track those conditions (medisolv.com)
  ○ SDOH Data tools include:
    ▪ **PRAPARE:** Protocol for Responding to And Assessing Patient’s Assets, Risks, and Experiences
    ▪ **ICD-10 Z Code & Documentation of SDOH**
    ▪ **CMS Accountable Health Communities and Health-Related Social Needs Screening Tools**
IMPORTANCE OF SDOH DATA COLLECTION

• We can achieve health equity through data collection and create opportunities on how to improve community health.

• In 2022, U.S. health centers serve over 30 million patients.

• Due to the diversity of patients and where they live, it is crucial to recognize the significance of SDOH on patient health and their health outcomes.

• With proactive measures, such as screening and robust data collection, this process will aid in identifying barriers to care and drive meaningful transformation.
Power of Outreach and Enabling Services

Enabling Services Staff include
- Community health workers,
- case managers
- outreach workers

ES staff can assist patients with complex needs.
- Homelessness,
- Public housing sites,
- Agricultural workers and their families,

When ES staff are involved with patients, patients had the likelihood of (NACHC, 2023):
- Enrolling in insurance
- Have a routine check-up
- Have overall satisfaction with care

Recognizing the impact of ES staff and outreach on community health is vital to achieving sustainable change!
Challenges to Collecting SDOH Data Among Enabling Services Staff

- Staff buy-in
- Staffing
- Cultural appropriateness
- Reimbursement issues
- Navigating SDOH
- SDOH Analysis
- Capacity to Respond
What are some challenges your health center/staff faces in collecting SDOH data?
Mentimeter Discussion

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BUILDING CAPACITY TO ADDRESS SDOH
Building Capacity To Act on Data and Respond

Source: PRAPARE Implementation and Action Toolkit p. 74
https://prapare.org/prapare-toolkit/
Responding In-House and/or Through Partnerships

Create Services In-House
- PEOPLE: Develop staffing models to respond to social determinants
- PROCESS: Develop resources to support staff in addressing social determinant needs at point of care
- TECHNOLOGY: Develop ways to track non-clinical services provided

Form Coalitions with Community Partners and Advocate for Policy and Environmental Changes
- PEOPLE: Build and staff a resource desk and community resource guides
- PROCESS: Build and sustain effective community partnerships
- TECHNOLOGY: Track referrals to non-clinical services and measure intervention impact

Raise Awareness to Strengthen Staff, Patient, and Partner Knowledge of Social Determinants
- PEOPLE: Deliver skills training on how to discuss social determinants (e.g., empathic inquiry)
- PROCESS: Create opportunities for staff and leadership to message the value of addressing social determinants
- TECHNOLOGY: Begin collecting data on social determinants in your EHR

Partner with Community-Based Organizations and Leaders
- PEOPLE: Set up volunteer programs at your organization for community volunteers
- PROCESS: Focus public health/grant funds to support partnership development with local community organizations
- TECHNOLOGY: Develop an electronic referral system or resource guide

Source: PRAPARE Implementation and Action Toolkit p. 75
https://prapare.org/prapare-toolkit/
Building Internal Capacity: Key Takeaways

Start with the Data
Let the Needs of Your Population Guide You

Identify Strategic Opportunities
Go Where the Resources Are

**Resources**

**PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences**

- National, standardized social determinant of health assessment tool developed and founded by AAPCHO, NACHC, and Oregon PCA
- Built into EHR and meant to be patient-centered
- Most common SDOH screening tool used by CHCs and Medicaid managed care organizations

**Enabling Services Accountability Project**

- Standardized codification system to document enabling services provided
- ESDC Toolkit and past trainings developed by AAPCHO, HOP, and NHCHC
Building External Capacity Through Partnership

Housing Providers, Continuums of Care, Housing Authority

Farmers Markets, Food Pantries, Soup Kitchens, Shelters, Schools

City/County Departments, Rideshares, Insurance

Community Development Organizations, After School Programs, City Planning

Legal Aid, Court Systems, Social Action Organizations, Police Department
Building External Capacity Through Partnership

Referrals

Care Coordination

Full Service Integration

Co-Location
Panelists

David Li
Social Impact and Policy Officer
Chinese American Service League

Monica Calderon, BMS, CCHW, CHWI
Resource Specialist
MHP Salud

Melisa Laelan
Chief Executive Officer/Founder
Arkansas Coalition of Marshallese
Please add questions to the chat as we go!
David Li

Social Impact & Policy Officer at the Chinese American Service League (CASL), a community-based social services organization located in Chicago’s Chinatown neighborhood.
HEALTH EQUITY @CASL

- Who we are
- What we’re doing
- My role
SDOH @CASL

- Why SDOH?
- Who cares?
- What matters?
- How to evaluate?
- Why now? (When)
SDOH as a referral system

• How to triage care more effectively?
• Piloting referrals following PRAPARE
• Promising outcomes
Thank you!

Feel free to keep in touch, ask questions, collaborate

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To learn more about CASL, please visit www.caslservice.org
Monica Calderon, BMS, CCHW, CHWI

Resource Specialist at MHP Salud

Certified Community Health Worker (CHW) and Certified Community Health Worker Instructor (CCHWI)
Applying CHW Lived Experiences

CHW lived experiences can help support Community Health Workers target social determinants of health and health disparities, impacting health outcomes.
Virtual CHW Support group/ Grupo de Apoyo Virtual

Recognizing the strengths of CHWs

Grupo de Apoyo Virtual COVID-19 de Promotores de Salud realizado en ESPAÑOL
CHW Dual Education tool

Diabetes and Oral Care

Diabetes combined with oral health can be challenging for Migrant Seasonal Agricultural Workers (MSAWs) to treat and manage. Common barriers MSAWs face in accessing health and dental care are cultural challenges, poverty, migration, political considerations, and work environments.¹

What is oral health?

Oral health is taking good care of your teeth, gums, and, overall, your mouth. Good oral health allows us to smile, speak, and chew without any discomfort or problems.

Oral hygiene and good blood sugar control are the best ways to manage both diabetes and oral health care. Part of your oral care plan is to keep your blood sugar low. Both diabetes and oral health problems are linked to high blood sugar. When blood sugar is poorly managed, it increases the risk of oral health problems developing. This happens because uncontrolled diabetes weakens white blood cells. White blood cells are the body’s main defense against bacterial infections that can occur in the mouth.²

Common oral health problems associated with diabetes:

- Slow Healing Injuries
- Dry Mouth / Thirsty
- Change in Taste and Flavor

Gum Abscesses
Mouth Ulcers
Tooth Decay / Tooth Loss
Fungal Infections / Oral Thrush³

How can I practice good oral health?

- Keep Blood Sugar Under Control
- Check your Mouth Regularly
- Brush and Floss Twice Daily
- Avoid Smoking
- Clean Dentures Once a Day
- See Your Dentist Every 6-12 Months
- Talk to Your Doctor and Dentist about your Oral Health²

By learning how people with diabetes can practice good oral hygiene habits, the risk for infection from periodontal disease (gum disease), tooth loss, and other oral complications can be greatly reduced.

For more about diabetes care and other health and wellness resources, visit us at mhpsalud.org

References:

NIHSA Disclaimer
This publication is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $10,750,000 with 100 percent financed with non-governmental 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 US Government. For more information, please visit www.HRSA.gov.

mhpsalud.org
CHW voice focused blogs/newsletters

La Esperanza Summer 2023 Edition
La Esperanza (Hope) is a bilingual newsletter dedicated to the work of Community Health Workers across the country. MHP Salud, collaborators and CHWs themselves write articles specifically for and about their work.

Emerging Issues among MSAW Populations
Migrant Seasonal Agricultural Workers (MSAWs) are defined as seasonal farmworkers who travel to perform farm work and cannot return to their permanent residence within the same day.

Continue
CHW Preventive Health tools

Preventive Care Checklist

Chronic Disease Management Tool
Melisa Laelan

Chief Executive Officer and Founder of Arkansas Coalition of Marshallese, a not-for-profit organization based in Springdale, AR that is a Marshallese-operated organization and focuses on health, leadership, education, and culture.
ARKANSAS COALITION OF MARSHALLESE

To empower the Marshallese community through a culturally sensitive approach to Education, Leadership, Policy and Holistic Services

Presenter: Melisa Laelan
Chief Executive Officer
IT’S A VILLAGE

- Our vision is to create a Thriving Community through initiatives that are designed to empower and uplift the community.

- Marshallese is the largest COFA migrant group living outside of the Islands. In Arkansas, the population of the Marshallese community is accounted for 12,172 in 2020 Census. Majority are working for the poultry industry and considered essential workers.

- Over 40 churches and the culture is very much alive and rich. Traditional leaders and faith-based organizations are very important in outreach and connecting to the people.

- One-Stop-Shop is set up as a wrap-around service provider. The needs of the community are major drivers in the programs that we run. Based on the concept of Designed By Us For Us, we can directly address other social determinants that contribute to health disparity. We received around 4800-7000 visits a year.

*Immigration Services
*Driver License Education
*Healthcare Insurance Enrollment
*Notary Services
*Marshallese Cultural/History Education
*Youth Apprenticeship
*Pacific Islander Diabetes Prevention Program
*TB Outreach/Education
*Vaccine Equity Program
*Enra Food Pantry
*Anti-Hate Programs
*Natural Disaster Resiliency/Relief Program
10-15% are Program Enrollments
SNAP, Health Insurance (including Medicaid & Medicare and other Federal/State programs.

Direct Services: 40%-60% of our visits are to the ENRA food pantry. Access to Food/Nutrition Program is limited

PROGRAMS AND IMPACTS

Immigration Services (120 individuals)
Border Trip (I-94 Form)
Passport Renewal/Replacement
2017 - 2022
Arkansas Coalition of Marshallese
IMPACT REPORT

915 Participants Enrolled
533 Completed Program Participants
332 Reduced Risk of Diabetes
10,399 lbs Total Site Weight Loss
4,047,921 Total Physical Activity Minutes (PAM)

The Arkansas Coalition of Marshallese (ACOM) is an organization based in Springdale, Arkansas and aims to empower the Marshallese community through culturally-sensitive programs via education, leadership, and policy advocacy. Northwest Arkansas is home to the largest Marshallese population (31,000 individuals) in the continental United States. In 2017, health screenings conducted by the University of Arkansas for Medical Sciences found 41 percent of Marshallese had diabetes.

ACOM delivers the Pacific Islander Diabetes Prevention Program (PI-DPP) to promote community-wide positive lifestyle changes. Of the 1,124 screened and eligible for PI-DPP, 688 were at risk for diabetes per the risk test and 466 had pre-diabetes or a history of gestational diabetes mellitus (GDM) per the blood test.

PI-DPP is a year-long, evidence-based lifestyle change program and holds the highest level of achievement: CDC Full Recognition. Success of completion of the program can CUT A PERSON’S RISK for developing type 2 DM by 58% (71% for people over the age of 50) and can reduce risk of non-communicable diseases such as heart disease, cancer, and stroke. Per DPP success standards, participants aim for 5% body weight loss, 150 weekly PAMs, and lower AIC values.

ACOM IMPACT

62% Completed Program Participants Reduced their Risk*
349 min Average PAM per week per participant
354 vs 429 Months 1-3 vs 7-9 Average PAMs
298 Lost 5% Body Weight
13 lbs Average Weight lost**
6.63% Average % Body Weight loss **
34 Reduced 4% Weight + 150 PAMs

885 Total Classes Delivered
4 Certified Coaches*

I don’t just go exercise for my health, but also for the fun of it. Finally, I thought about it. Maybe I should consider taking these classes provided to our Zumbe class.

I started studying it and saw the need for it, so I continued to study. Then I started seeing results. It really motivated me and my friends especially when I shared what I learned during my classes. I saw a lot of changes.

I used to weigh 180 lbs, and it shouldn’t be that weight because of my height. Now, I have dropped to 160 lbs and it motivates me to continue. Make sure I eat what they provide me in class, exercise, then when I take a glance, my weight decreases to 140 lbs. *

- Melina (PI-DPP Participant)

“Testimonials

When I first joined, I was 2 lbs away from 200 lbs. I joined 3 years ago.

I went through a lot of illnesses before coming to this program, diabetes, and other sicknesses. I really was weak. After I joined this program, I see a lot of changes with me. I see that I am doing better and I’m not sick anymore.

This program is very important to everyone. After joining this program, I made sure I eat healthy and workout all the time. I see results now. My weight went down to 172 lbs from 198 lbs. *

- Julie P. (PI-DPP Participant)

Community Garden (2021)
ACOM’s Food Pantry supplies participants with healthy and accessible foods (above).

Support Activities

Walk-a-thons, Zumba Classes, Stretching, and Hula are offered free of charge to all participants to promote physical activity.

ACOM was formed through a partnership between the American Pacific Community Health Organizers (APCHO) and the Pacific Islander Center for Primary Care Excellence (PICPE) as a proposal to be the first in the Diabetes Detection and Prevention (DDP) Public grant to scale the CDC National Diabetes Prevention Program in under-served areas.

*Satisfaction of participants who reduced their weight.
**Satisfaction of participants who reduced their body weight.

*Certified coaches who taught a class.
QUESTIONS

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Panelist Q&A
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PLEASE COMPLETE OUR POST-WEBINAR SURVEY!

https://tinyurl.com/2ewvwd5m
Attention Health Center Staff and Executives: Share your Voice on Training and Technical Assistance (TTA) Needs

Help HRSA/BPHC and their training entities understand YOUR:

- Health Center Role and Location
- Specific TTA Needs
- Preferred Ways to Receive and Participate in Training
- Priority TTA Topics

Please take a few moments to provide your ideas for health center TTA needs to HRSA/BPHC’s 22 National Training and Technical Assistance Partners (NTTAPs).

Use the below link or above QR code to access a quick list of questions for your response. This will take no longer than 15 minutes!

https://www.healthcenterinfo.org/training-and-technical-assistance-needs-assessment/
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