

Social Determinants of Health Screening and Referral Project April Meeting

April 26, 2023

3-4 pm



Welcome, Introductions, and Roll Call

Gaby Cordova Ramos, MD

Assistant Professor of Pediatrics

Boston Medical Center

Welcome!

Please chat your name and hospital into the chat box

Zoom Group Chat

From Me to [Everyone](#):
Aviel Peaceman, Boston Medical Center

To: [Everyone](#) ⌵ ⋮

Type message here...

Agenda

Time	Topic
2:00	Welcome and Introductions
2:05	Reflections on the PNQIN Summit
2:15	Barriers to data entry discussion
2:25	Integration of screening and referral using QI methods
2:50	Team check ins
2:55	Wrap Up and Next Steps

Reflections on the PNQIN Summit

Gaby Cordova Ramos, MD

Thoughts on the PNQIN Summit

- What worked well?
- What could have worked better?
- Any reflections for the “neonatal track” for future summits?
- If you didn't attend, could you please share why for future planning

Integration of screening and referral using QI methods

Gaby Cordova Ramos, MD

PNQIN SDOH NICU Key Driver Diagram Year 1

Overall project goal:

Improve connection to community resources that address adverse SDH among parents of NICU infants in MA

Specific AIMS:

Among 5 safety-net NICUs in MA by September 2023

- 1) Increase screening of eligible families with a standardized tool for SDOH by 30% of baseline.
- 2) Increase delivery of a referral to families that indicate an adverse SDOH and desire help by 30% of baseline
- 3) Achieve aims 1 and 2 without disparities by maternal race/ethnicity and language status

QI Balancing Measure Goals

-parental decline of completion of the screening tool

Drivers

Lack of an easily accessible standardized SDOH screening tool

Lack of awareness of community resources by NICU teams

Lack of unit-wide approach to integrate SDOH screening and referral into routine workflow

Change Concepts

Select a SDOH screening tool

Adapt SDOH screening tool to NICU context

Integrate SDOH screener into EMR

Review the community resources available and share with team

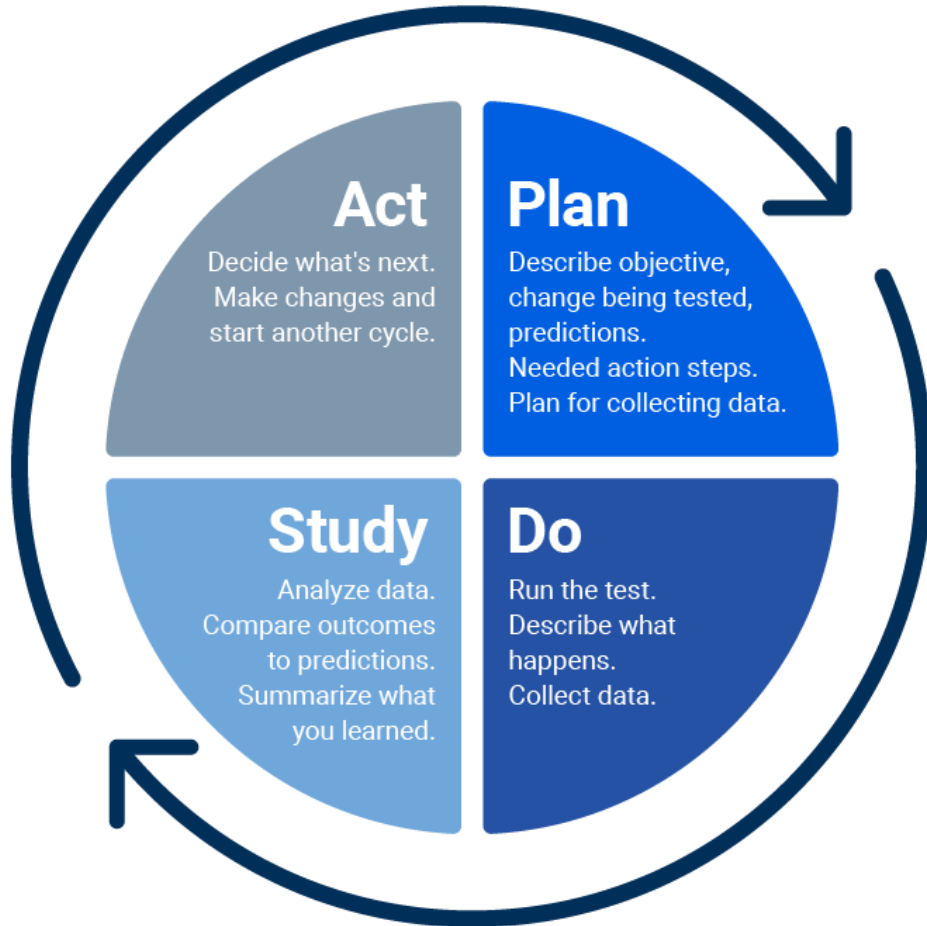
Develop, maintain and train staff in use of a resource guide

Build partnerships with community resource

Train providers involved in SDH screening and referral

Define eligibility criteria and goals for completion

QI approach

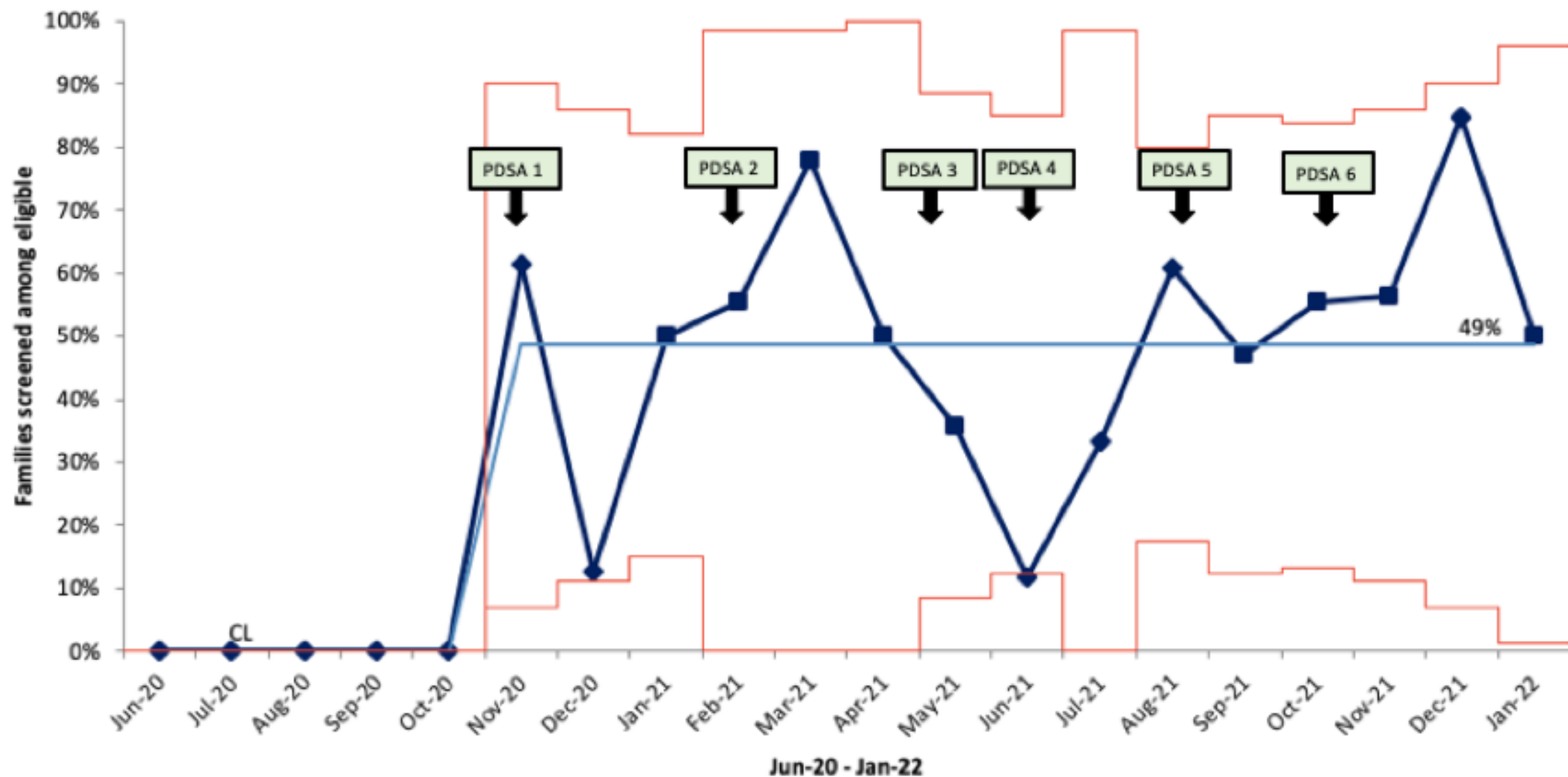


- **General Principles:**

- Start small! Just a few families can be a PDSA
- One or more change concepts may be tested as part of one PDSA cycle
- **STUDY** as you **DO**

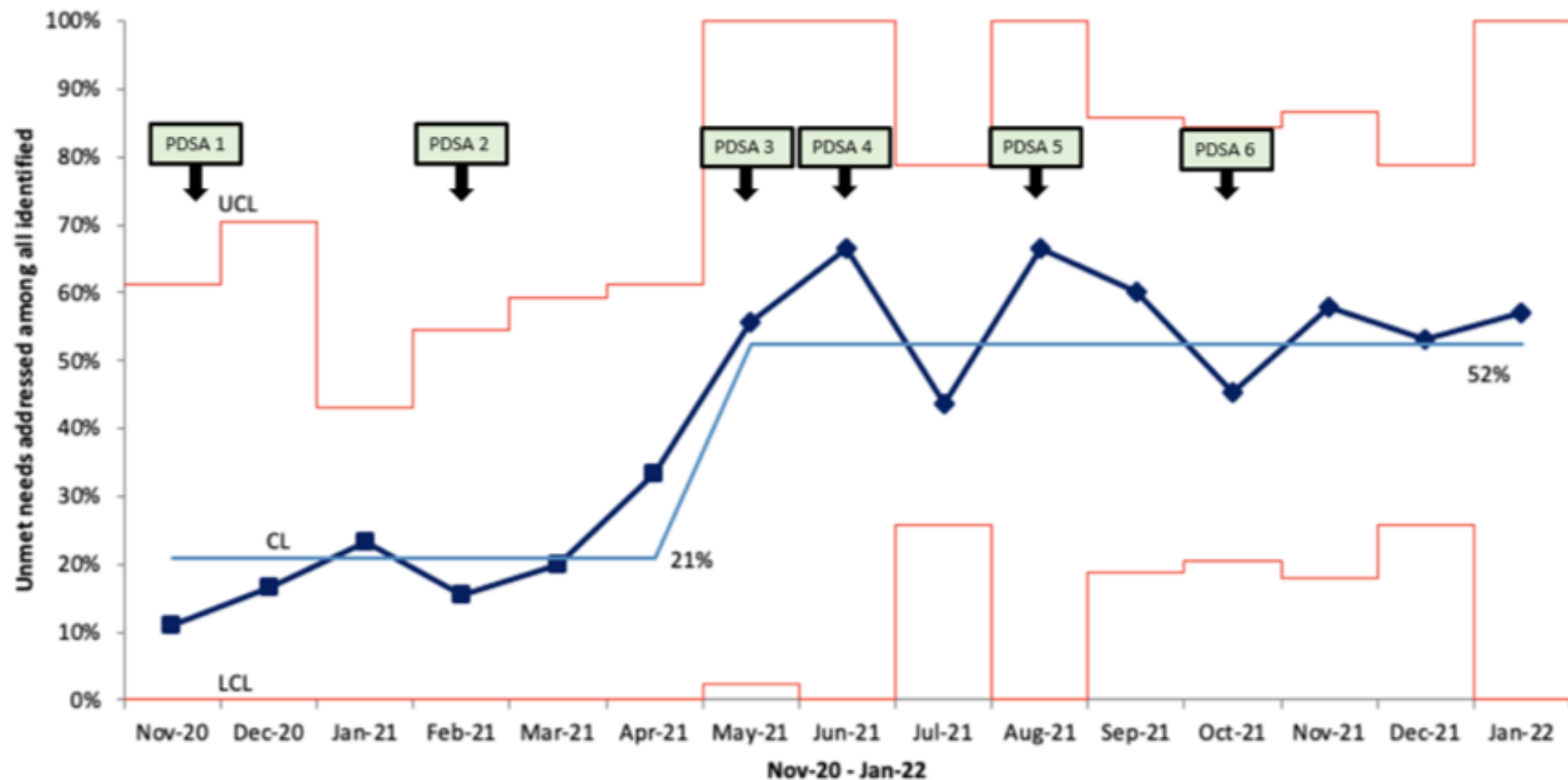
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Percentage of families that received standardized social risk screening among all eligible

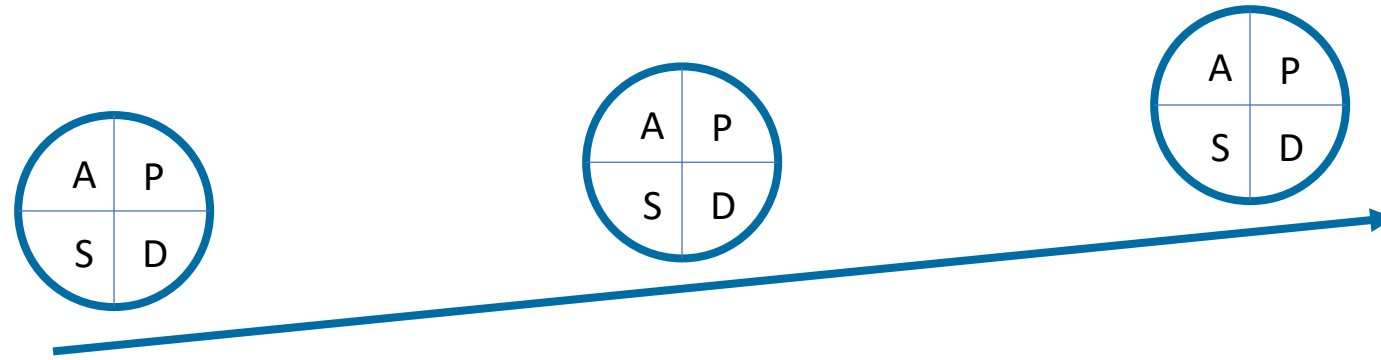


Percentage of unmet needs for which families connected with resources among all needs identified

B



PDSA cycles



Cycle 1 (Nov 2020)

P: Distribution, approach and timing of screening

D: Co-created intro script. Trained 6 nurses to screen, provide referral, document in EPIC (goal within 2 weeks), discuss in SW rounds

S: Feasible, appropriate but difficult to reach screening targets during times of high census and acuity.

A: Expand screeners pool. Facilitate EHR documentation.

Cycle 2 (Feb 2021)

P: Expand screeners pool. Facilitate EHR documentation.

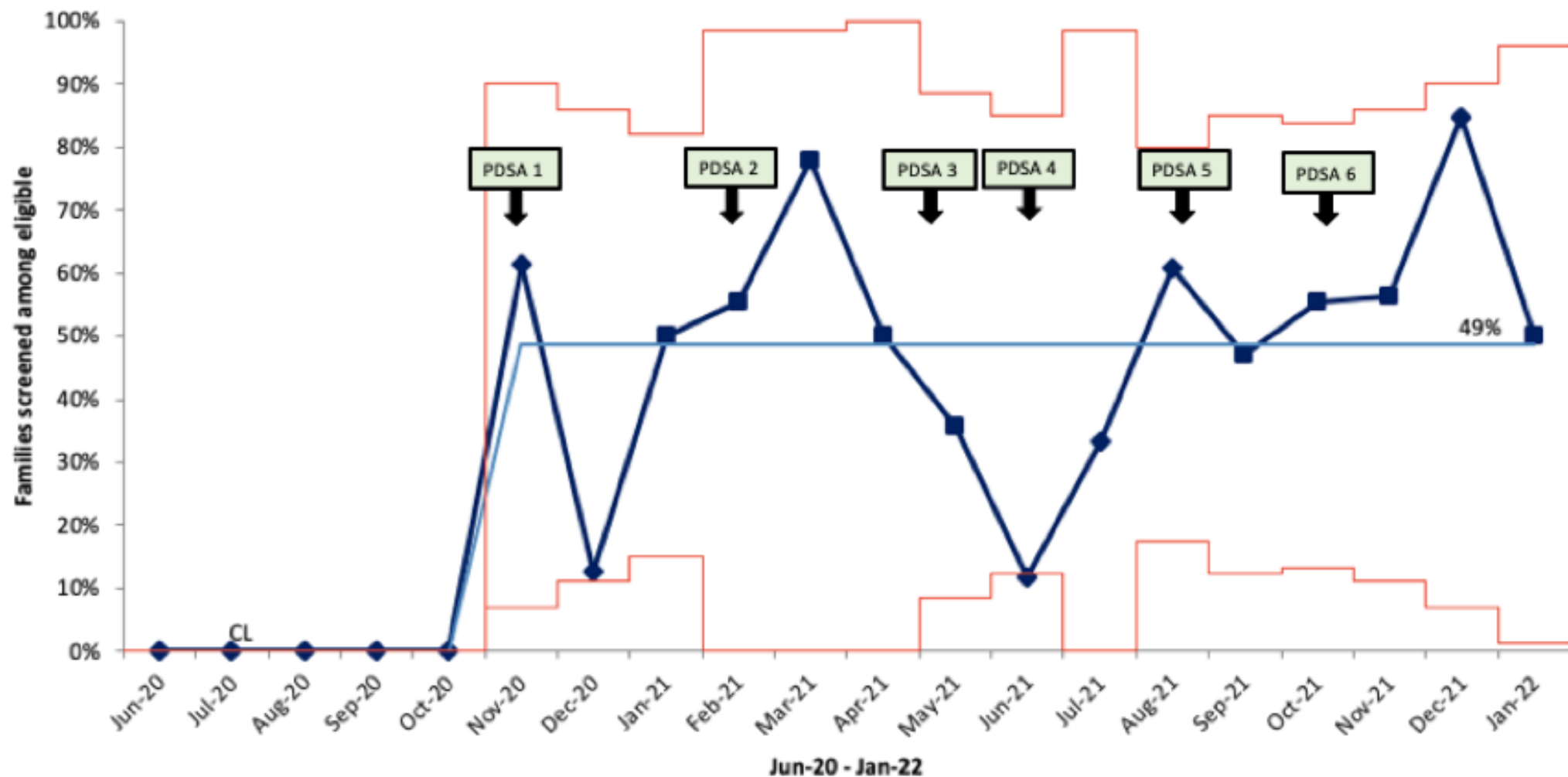
D: Train residents to perform screening and referral. Step-by-step instructions for EHR documentation in nurses' station.

S: Training of residents involved huge time investment and wasn't feasible due to frequent turnover.

A: Abandon residents as screeners.

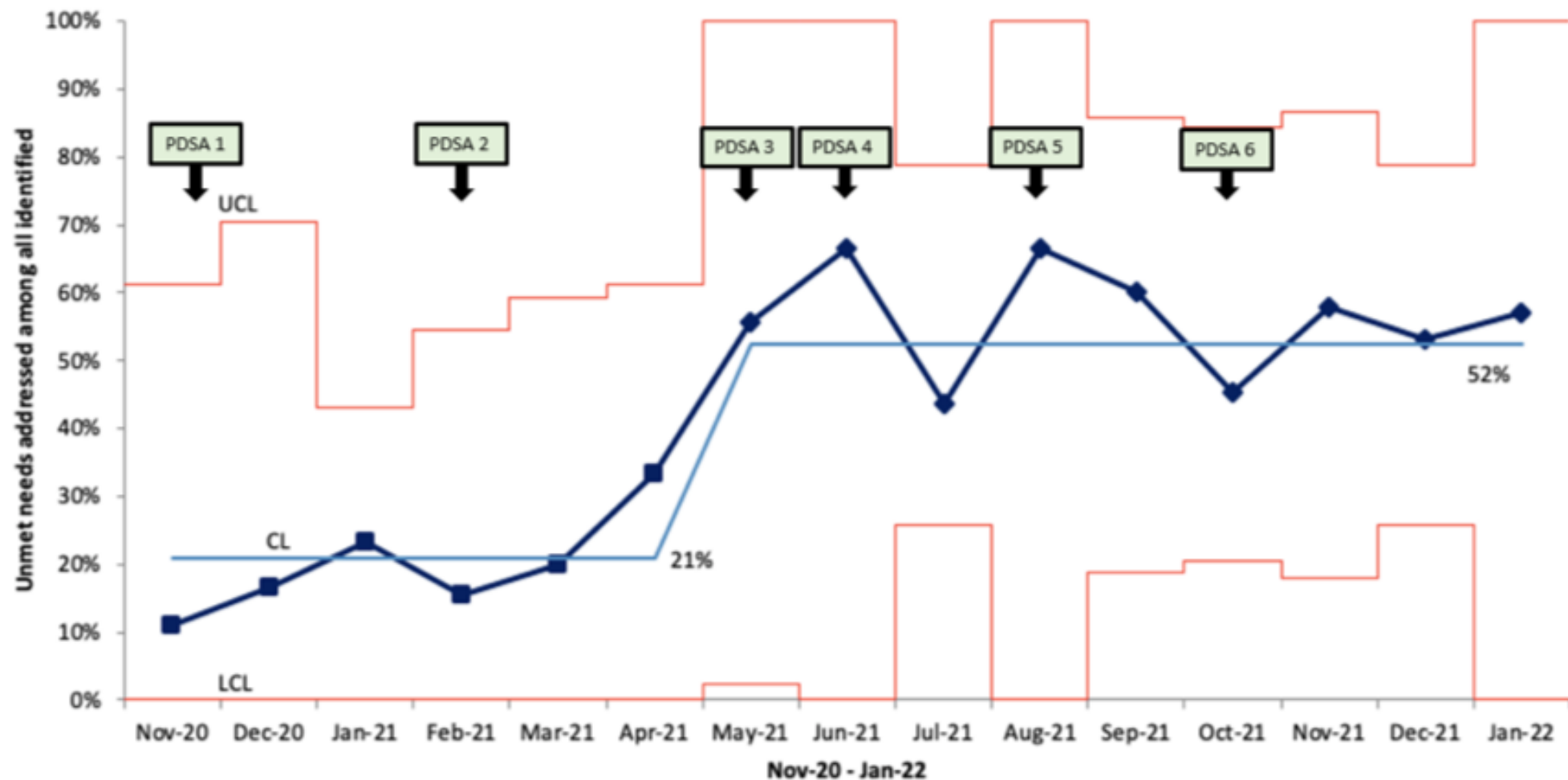
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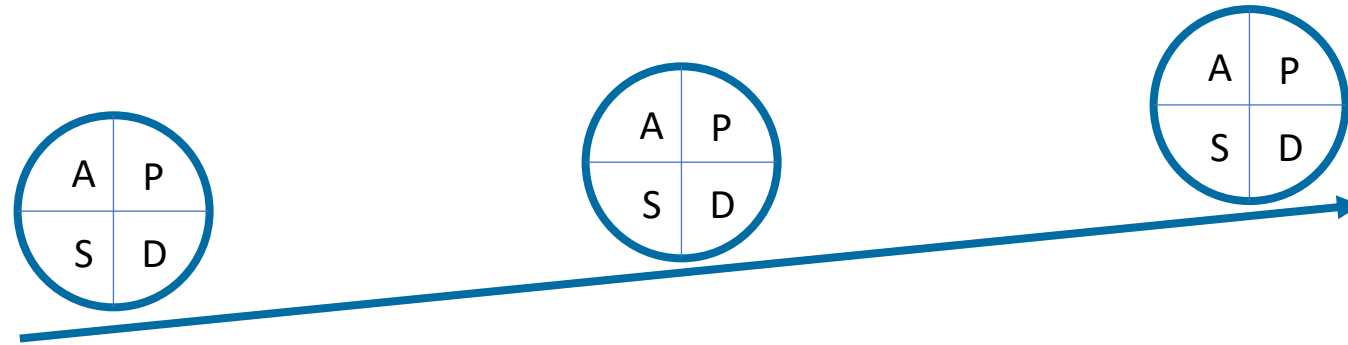


Percentage of unmet needs for which families connected with resources among all needs identified

B



PDSA cycles



Cycle 3 (March 2021)

P: Increase screeners capacity. Increase awareness of intervention.

D: Training all bedside nurses to perform screening/referral. Review of THRIVE results on bedside rounds.

S: Rounds prompted discussion of barriers to caregiver presence and ways to support family. Variable levels of comfort among bedside nurses.

A: Maintain. Additional 1:1 trainings and internal facilitation. Focus on primary patients only.

Cycle 4 (June 2021)

P: Improve referrals and buy-in. Data sharing.

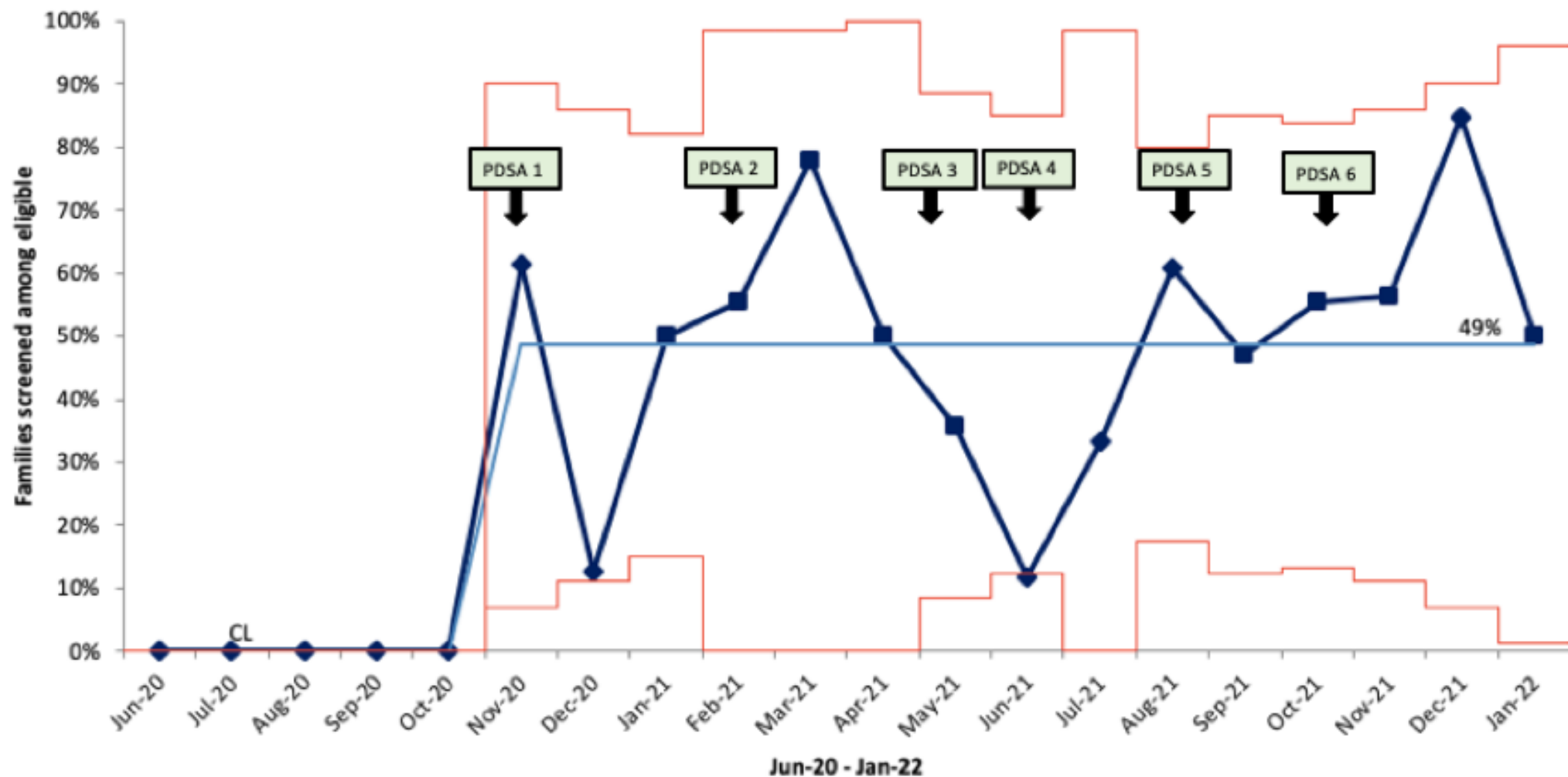
D: Revision of resource guide based on family feedback. Webinars by community agency representatives. Partnership with CBO #1.

S: Increased shared knowledge among NICU staff of available hospital and community resources. Increased nurses buy-in.

A: Maintain and highlight success stories in NICU board.

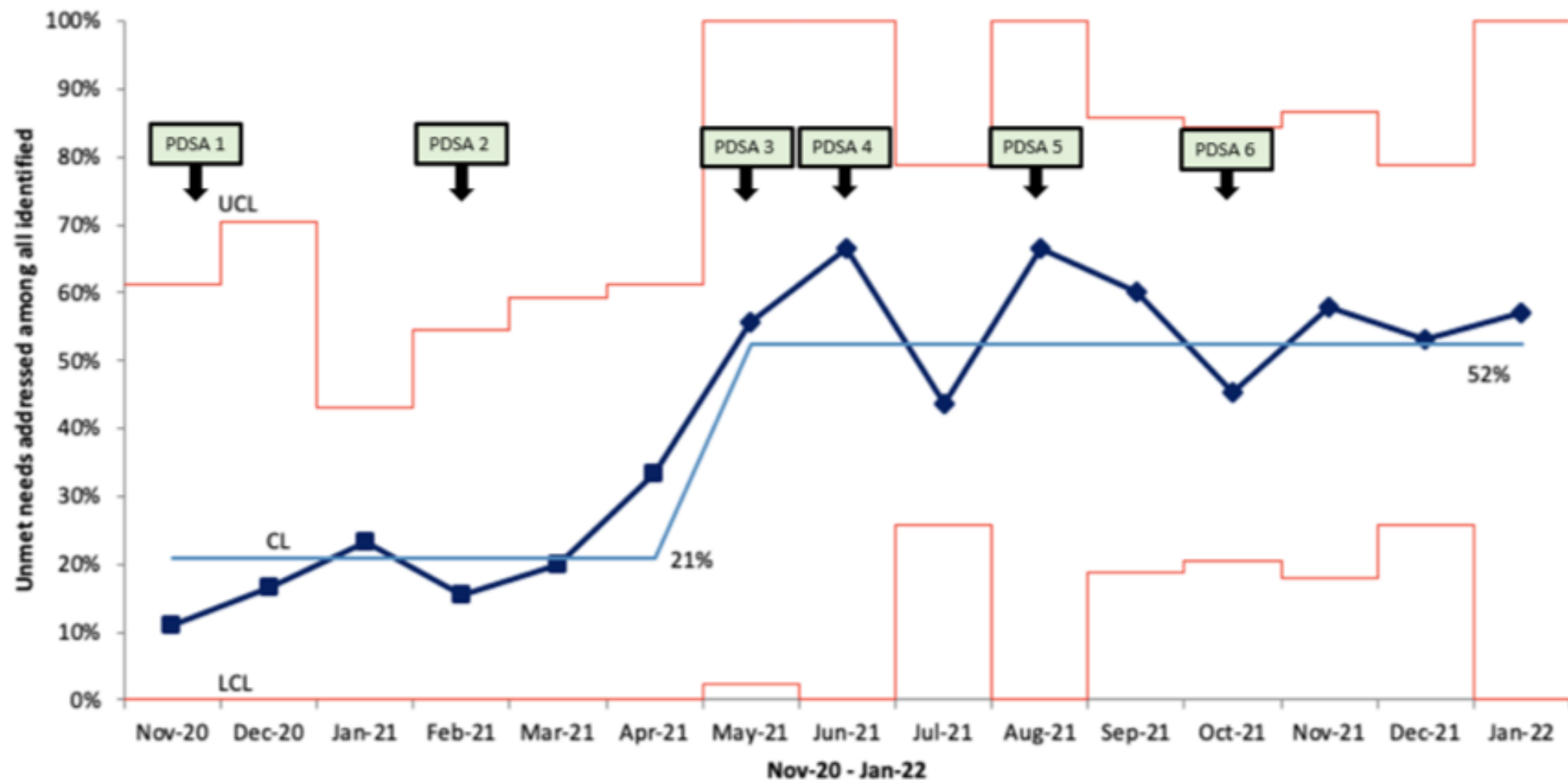
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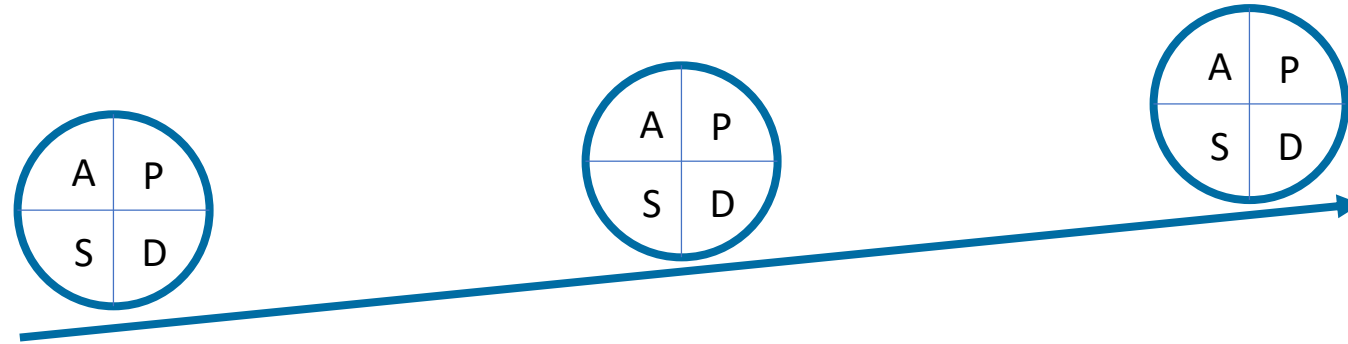


Percentage of unmet needs for which families connected with resources among all needs identified

B



PDSA cycles



Cycle 5 (August 2021)

P: Reduce burden of screening/referral processes.

D: Created “THRIVE station” with resource guides readily available (printed) and “resource cheat sheet.” launched parking and Uber Health Program.

S: Launching a new resource increased buy-in and uptake. High family satisfaction with transportation program.

A: Maintain.

Cycle 6 (October 2021)

P: Improve referrals and buy-in.

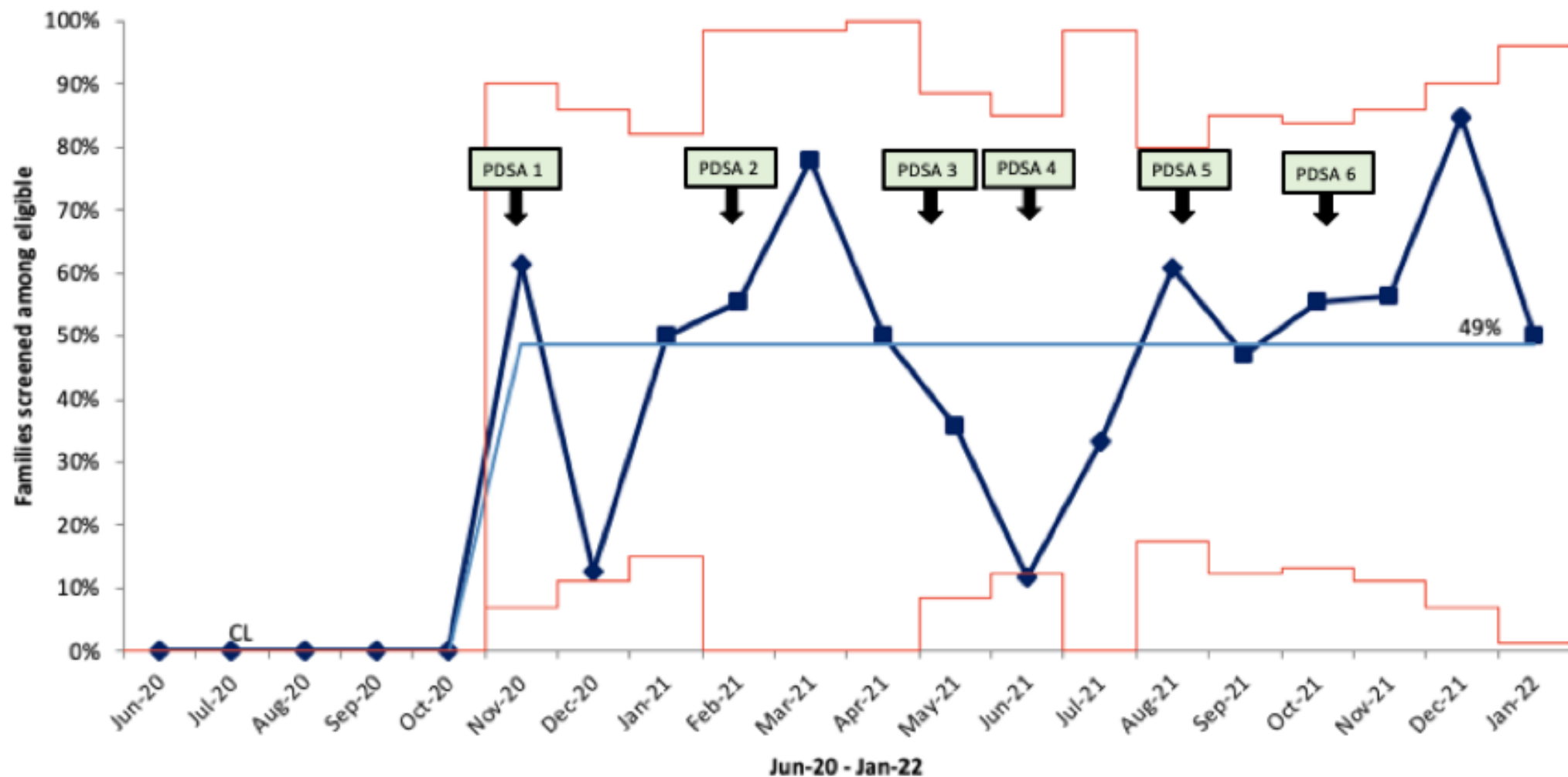
D: Partnership with CBO #2.

S: Launching a new resource increased buy-in and uptake.

A: Maintain.

A

Percentage of families that received standardized social risk screening among all eligible



Percentage of unmet needs for which families connected with resources among all needs identified

B

