Social Determinants of Health Screening and Referral Project Kickoff Meeting

October 18, 2022

10-11 am

PN QIN OF MASSACHUSETTS

PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

Welcome, Introductions, and Roll Call

Meg Parker, MD, MPH
Academic Chief of Neonatology
UMass Memorial Medical Center

Gaby Cordova Ramos, MD
Assistant Professor of Pediatrics
Boston Medical Center

Welcome!

Introduce yourself!

- Name
- Pronouns
- Hospital
- Role
- One thing you are excited about as we launch this project!

Agenda

Time	Topic
10:00	Welcome and Introductions
10:20	Project Overview
10:35	Timeline and Tasks
10:55	Wrap Up and Next Steps

Picking a time for monthly calls

- Third Wednesday of the month from:
  - 1-2 pm
  - 2-3 pm
  - 3-4 pm

We need to hear from each team- what will work for you?

Project Overview

Meg Parker, MD, MPH

Introductions

- Project management team:
  - Meg Parker, MD, MPH: Clinical Co-Lead
  - Gaby Cordova Ramos, MD: Clinical Co-Lead
  - Aviel: Senior Project Manager
  - Christin Price, MD: PNQIN Administrative Director, DPH
- Hospitals teams:
  - Beverley
  - Lawrence
  - MGH
  - Salem
  - Winchester

Social Determinants of Health

- Social determinants of health (SDH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
  - Healthy People 2030

- SDH screening/referral with a standardized tool is recommended in clinical encounters
  - AAP
  - CMS

SDH Screening and Referral in the NICU

- SDH screening and referral has increased in the out-patient pediatric setting, but has not yet come to scale in the NICU
- National survey study of NICUs- national prevalence of SDH screening/referral using a tool was 23% in 2021 (Cordova Ramos et al, Hospital Pediatrics 2022)

- Common response: “But social workers do that already”
  - Study of 2 NICUs in MA examining the extent that routine assessment of SDH screening occurs demonstrates major areas of improvement (rate 10-80% depending on need)
  - Social workers are typically over worked with a huge array of other tasks

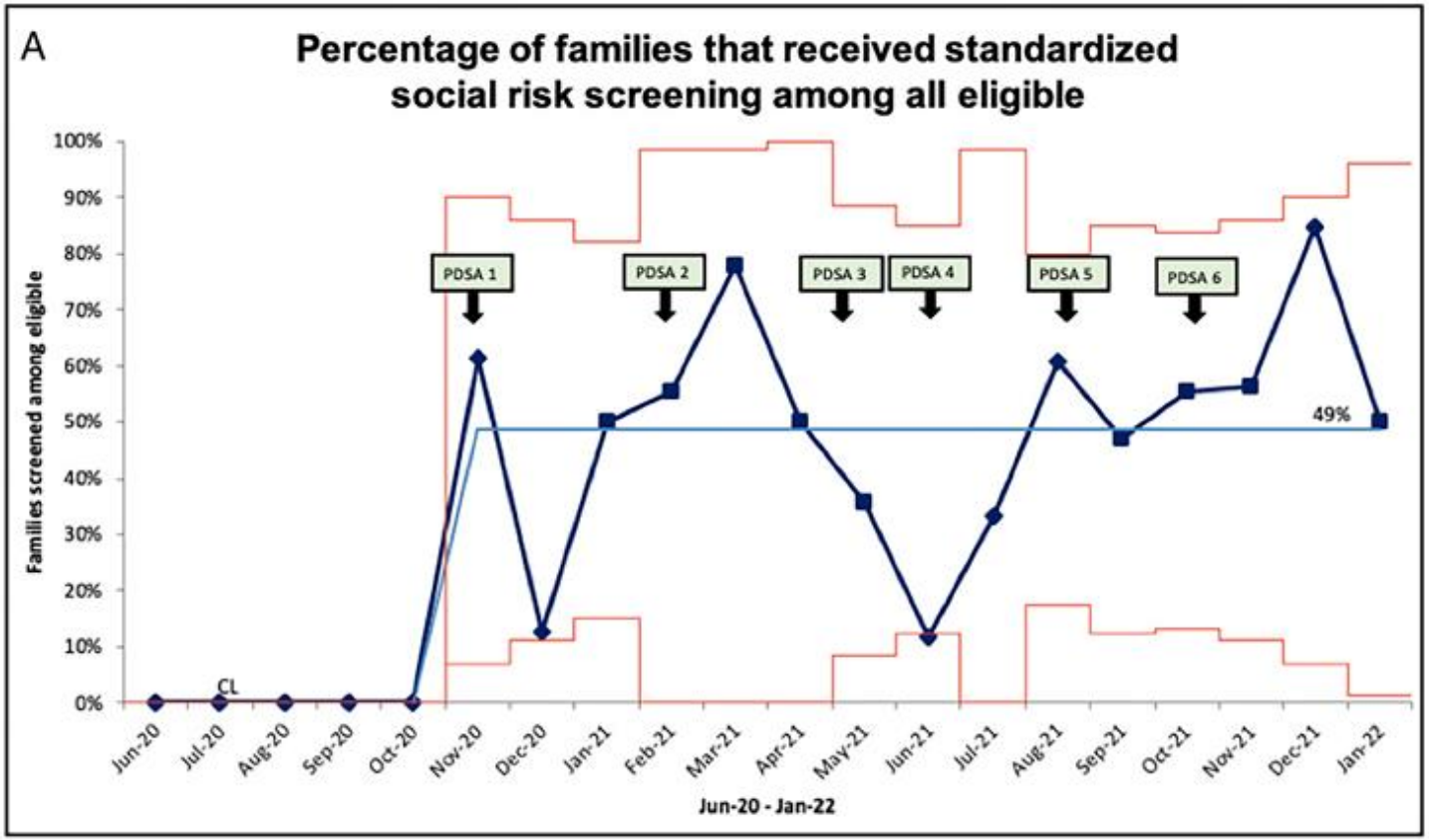
SDH Screening and Referral

- What SDH are we talking about?
  - Housing
  - Food
  - Transportation
  - Energy/heat
  - Employment
  - Education
  - Childcare

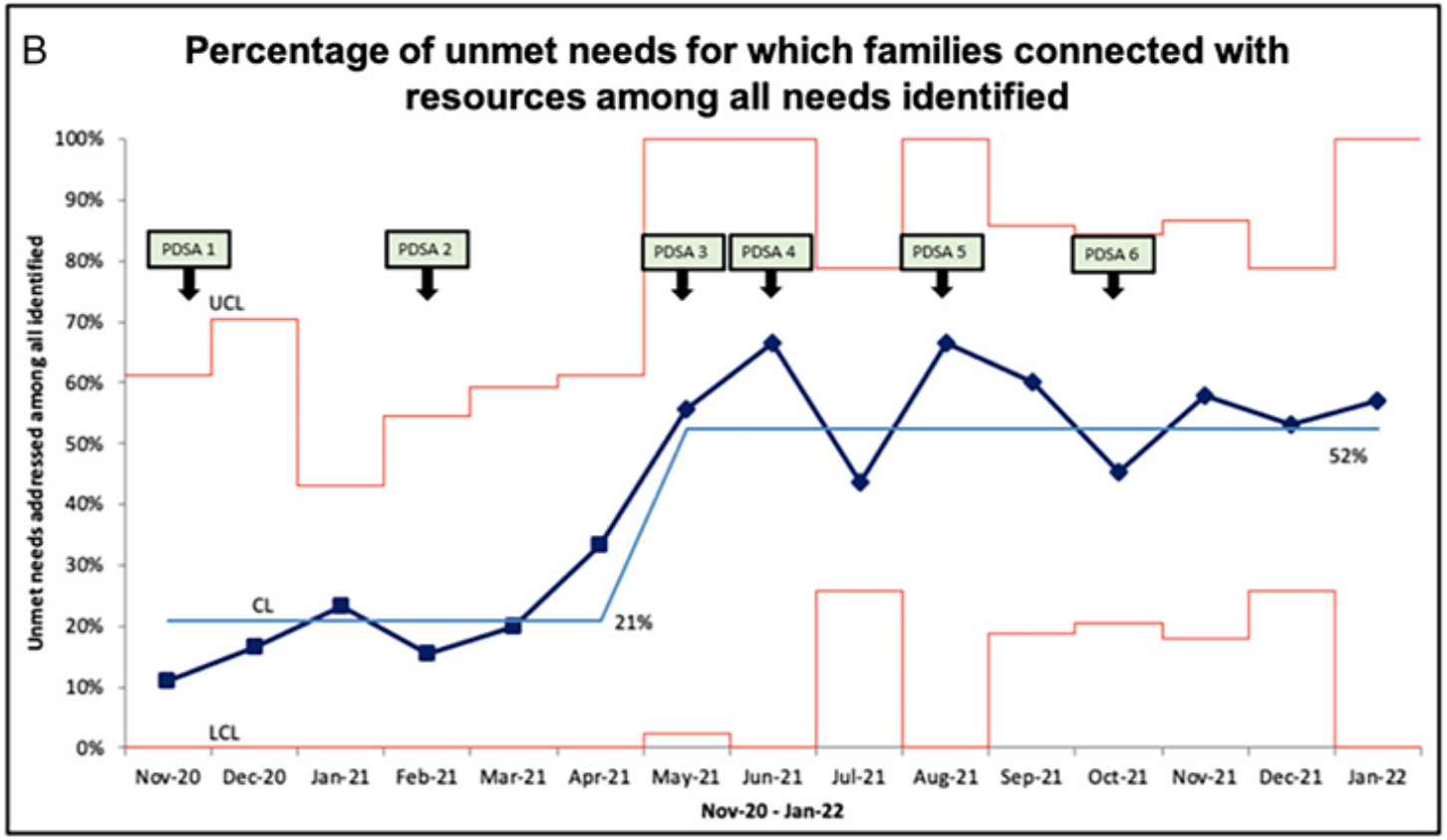
How did we get to this point? Why now?

- PNQIN (NeoQIC) Family Engagement and Social Disparities multi-site QI project
  - 2020 to present
  - About 10-15 level 2 and 3 SCNs/NICUs participating
  - 4 major drivers
    - 1 driver is on “social supports for families”
  - A major “win” of our first 2 years was the introduction of a SDH screening/referral program in the BMC NICU

SDH Screening and Referral in the BMC NICU



SDH Screening and Referral in the BMC NICU



How did you get to this point?

- CDC had an RFA for perinatal quality collaboratives (PQCs) in the spring of 2022.
  - Typically last 5 years
  - MA has received these twice in the past and they serve as a major funder of our work
  - Specific emphasis on health equity

- Meg and Gaby developed the idea to build off our past experience with the family engagement project and focus specifically on implementation of an SDH screening/referral
- Note that there is a maternal based project focused on equity as well
- We were funded! Grant start 9/30/2022

Project Purpose

- Goals:
  1) Identify and address adverse SDH in the neonatal setting;
  2) Implement the PNQIN Maternal Equity Safety Bundle measures to reduce overall severe maternal morbidity (SMM) and to close the Black-White gap in SMM.

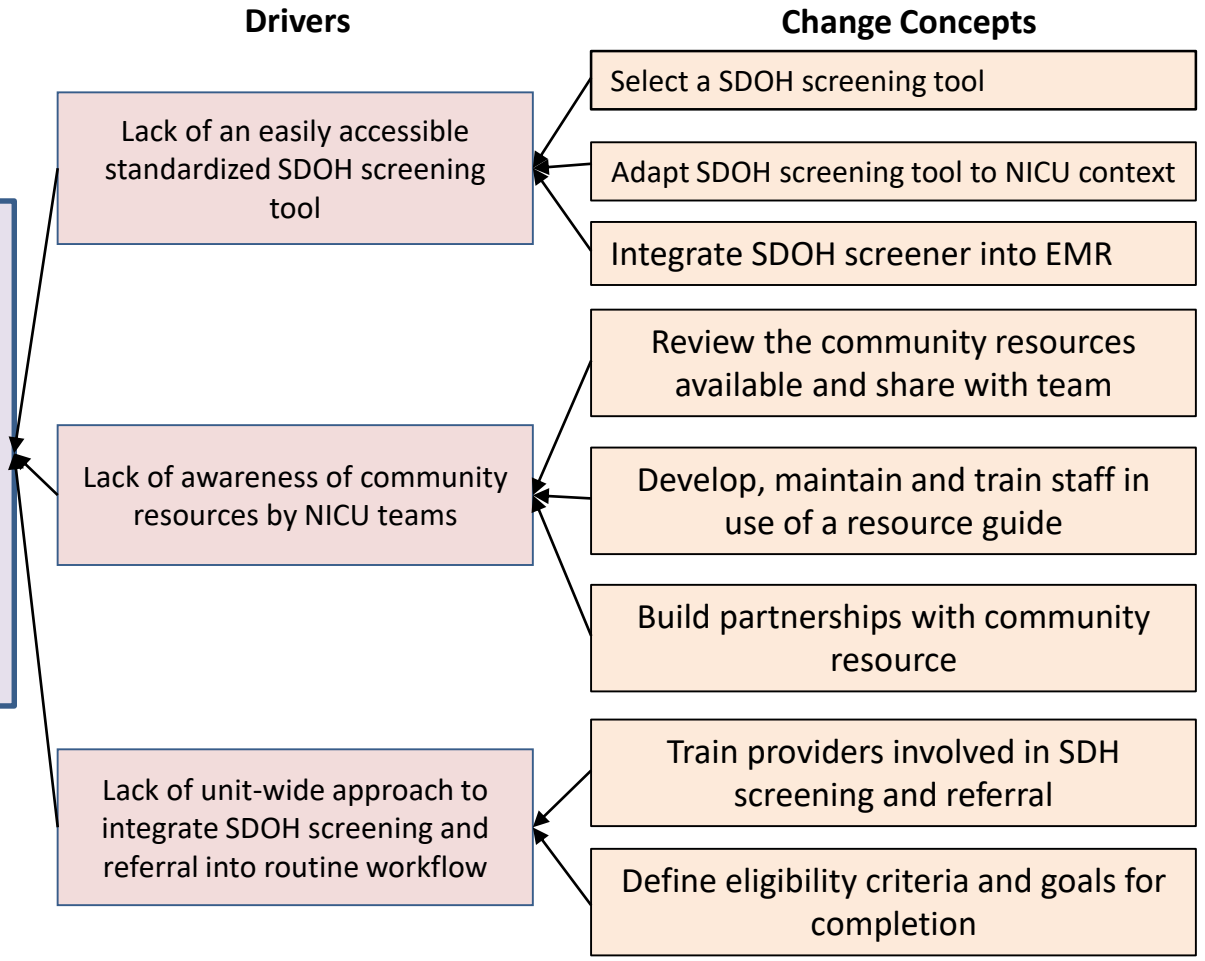
PNQIN NICU SDH Project: Key Driver Diagram, Year 2

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

Specific AIMS:
Among NICUs in MA by Sept. 2027:

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



Broad Timeline

- In the first year, we are targeted five NICUs for the SDH project and five maternity hospitals for the equity bundle implementation project
- We plan to expand to all birth hospitals within five years.
- By September 2027, we plan to integrate standardized SDH screening in **>80% of NICU/SCNs** and **>50% of prenatal clinics** associated with birth centers in MA.
  - Another critical goal is to achieve no inequity by race/ethnicity or language in SDH screening/referral
  - In year 1, we are on track with this goal.

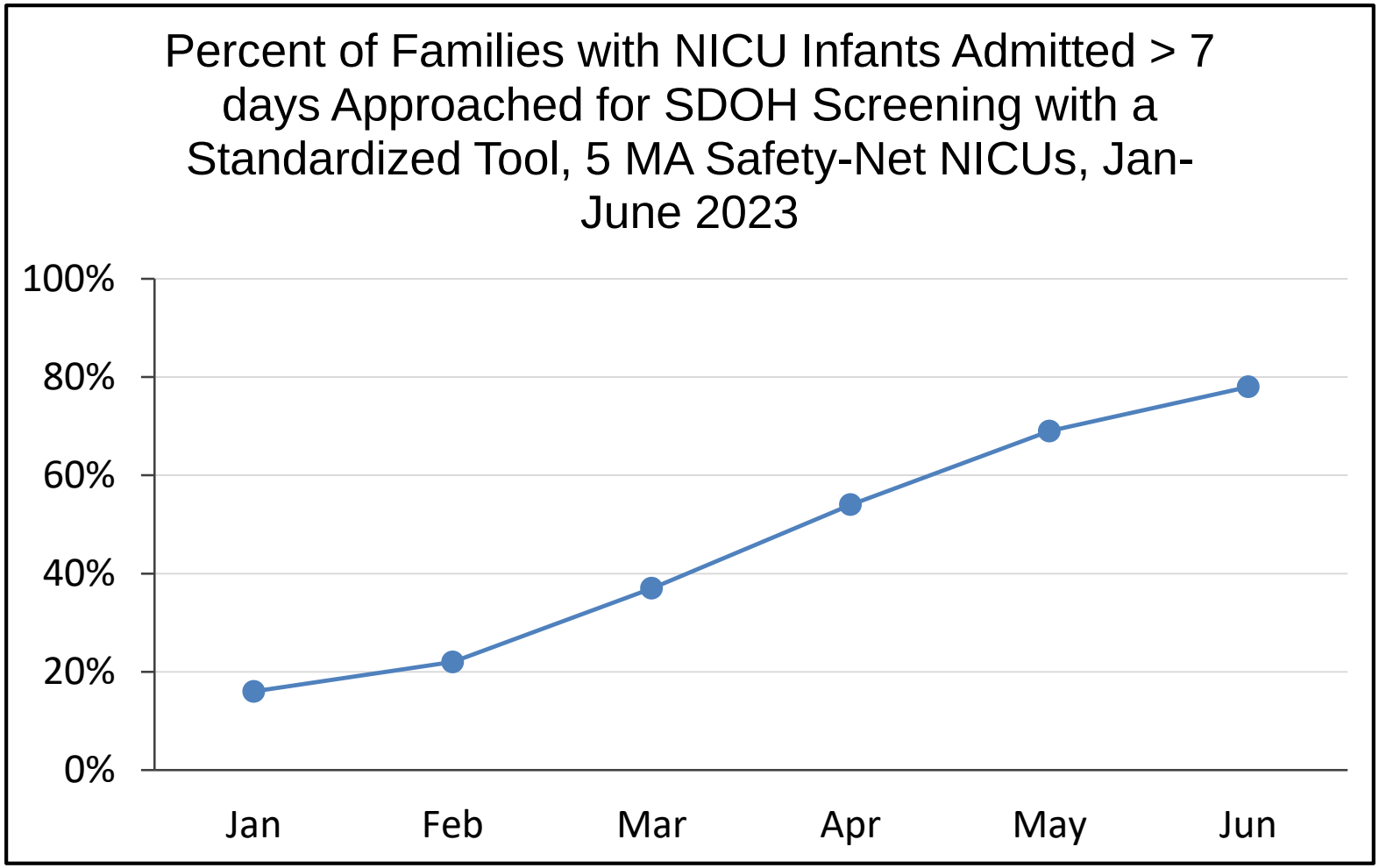
Why did we choose these five sites for year 2?

- Your excitement for this work!
- Range of geography across our state
- Combo of level 2 and 3 and NICU size
- Range of hospital systems involved (BI-Lahey, MGH-Salem, Tufts affiliates- Lawrence)

Year I Highlights

- We built the data collection tool in REDCap
- Teams conducted the following activities:
  - Tool selection
  - Integration into the EMR (or found a workaround)
  - Created a resource guide with local resources for referral
- All 5 teams are entering data
- Great collaboration on monthly calls

Collaborative Wide Data



Activities and Expectations

The big picture tasks for next year

1) Create multi-disciplinary team, address data regulatory requirements (Oct-Nov)
2) Choose social risks/needs screening tool and adapt to NICU context (Nov-Dec)
3) Integrate tool into EHR
4) Build community resource guide and partnership with community organizations (Dec-Feb)
5) Implement screening into NICU work flow using QI approach (Feb-Sept)
6) Track data over time (start with babies born Jan 2024)

Project Funds

- Each team will receive $7500 for the year to put towards things like:
  - Engaging a student to do data entry
  - Materials for families
  - Transportation: Uber health, public transit, parking, etc.
  - Stipends to families for participating on your QI team
  - Any other needs for families
- Start thinking through a plan for spending your funds now to ensure you can use it up during the grant period (10/1/23-9/30/24)

Build your Multi-Disciplinary Team

- Assemble your team!
  - Physicians
  - Nurses (bedside and leadership)
  - Social workers
  - Case managers
  - Any child life or family support people
  - Family members
- Need to meet with your team regularly
  - We suggest monthly meetings

Leadership and stakeholder buy in!

- Need to have buy in from medical and nursing leadership, AND social worker

Data Use Agreements

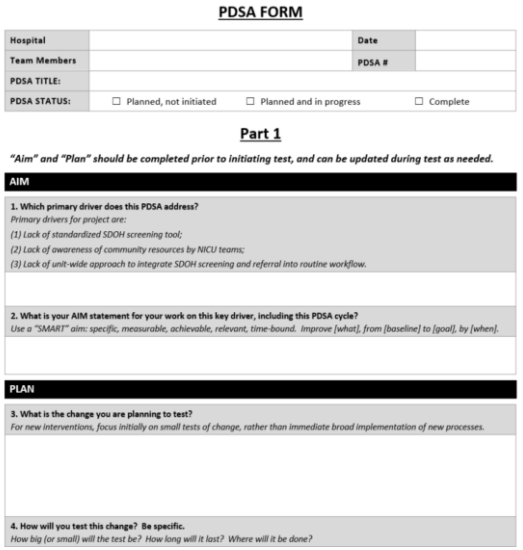
- We've been in touch with all teams about completing a DUA and SOW in order to enter data in REDCap for this project.
- Baseline data entry will begin for infants born in Jan. 2024 (or earlier if your DUA and SOW are in place!)

Data Collection

- REDCap database housed at BMC
  - Once your DUA/SOW are in place, Aviel will give your team access to REDCap
- Eligibility criteria: Any baby hospitalized for at least 1 weeks; and
  - No restrictions on parental visitation throughout the duration of the hospitalization

Plan Do Study Act (PDSA) Cycles and Homework Forms

- Each month we will have you complete a brief form (~5 min.) in REDCap to update us on your progress
- Once you begin to integrate the screening tool into your NICU, you will also conduct PDSA cycles
- These can be submitted to us directly through the homework form in REDCap
  - We will review and provide timely feedback to each team



PDSA FORM

Hospital		Date	
Team Members		PDSA #	
PDSA TITLE:			
PDSA STATUS:	☐ Planned, not initiated ☐ Planned and in progress ☐ Complete		

Part 1

"Aim" and "Plan" should be completed prior to initiating test, and can be updated during test as needed.

AIM

1. Which primary driver does this PDSA address?
Primary drivers for project are:
(1) Lack of standardized SDOH screening tool;
(2) Lack of awareness of community resources by NICU teams;
(3) Lack of unit-wide approach to integrate SDOH screening and referral into routine workflow.

2. What is your AIM statement for your work on this key driver, including this PDSA cycle?
Use a "SMART" aim: specific, measurable, achievable, relevant, time-bound. Improve [what], from [baseline] to [goal], by [when].

PLAN

3. What is the change you are planning to test?
For new interventions, focus initially on small tests of change, rather than immediate broad implementation of new processes.

4. How will you test this change? Be specific.
How big (or small) will the test be? How long will it last? Where will it be done?

Wrap Up and Next Steps

Aviel Peaceman, MPH

Next Steps for Hospital Teams

- DUAs:
  - Keep working on your DUA submission process.
  - Reach out with questions- we're here to help!
- Team roster- send us a spreadsheet with the names and email addresses of the people on your local hospital team

PNQIN Fall Summit

The Road to Equity: Creating System Change to Address Perinatal Mental Health and Improve Access to Care

- Date: Monday, December 11, 2023 from 8:00-4:30
- Location: Four Points by Sheraton, Norwood, MA
- Register here: https://pnqinma.org/event/pnqin-fall-2023-summit/
- Neonatal highlights:
  - Keynote speaker, Cindy Liu, PhD on addressing parental mental health in the NICU
  - Family testimonial- Jessica Arnold will speak to us about her 22 day NICU stay and subsequent bereavement experience and how it ignited a spark to create the EMA Project to support other families
  - Baystate will present on their work for this project over the last year.

Any Comments, Reflections, or Questions?

Thank you!
We look forward to seeing you again on the next webinar!