Social Determinants of Health Screening and Referral Project Kickoff Meeting

October 19, 2022

3-4 pm

PN QIN OF MASSACHUSETTS
PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

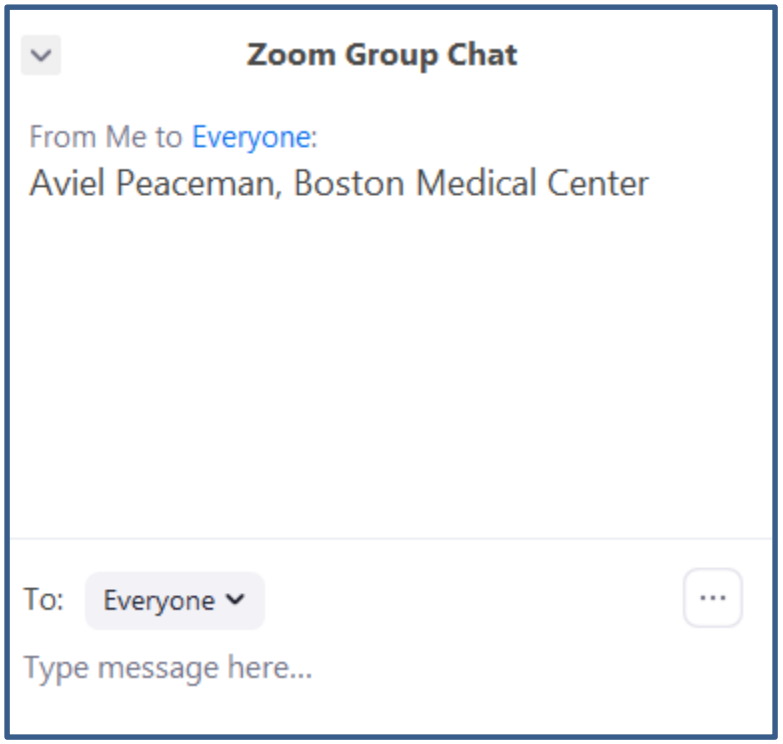
Welcome, Introductions, and Roll Call

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

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

Welcome!

Please chat your name and hospital into the chat box



Agenda

Time	Topic
2:00	Welcome and Introductions
2:20	Project Overview
2:35	Timeline and Tasks
2:55	Wrap Up and Next Steps

Project Overview

Meg Parker, MD, MPH

Introductions

- Project management team:
  - Meg, Gaby, Aviel, and Kevin
  - DPH Oversight
- Hospitals teams:
  - Baystate
  - BMC
  - Lowell
  - Tufts
  - UMass

Social Determinants of Health

- Social determinants of health (SDOH) 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

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

SoDH 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

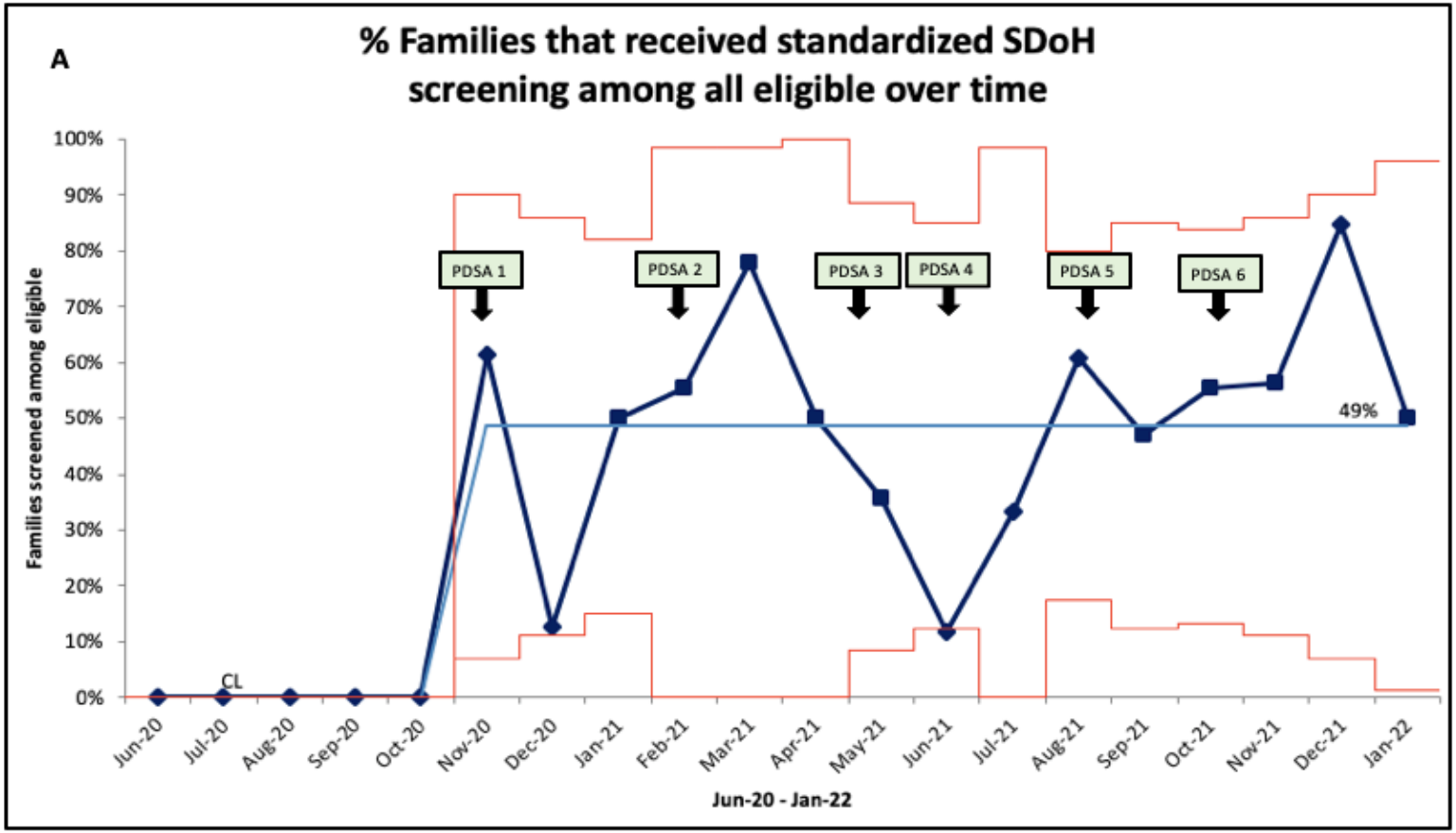
SDH Screening and Referral

- 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



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

What is in the grant: Project Purpose

- Goals:
  1) Identify and address adverse SDoH 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.

What is in the grant: Broad Timeline

- In the first year, we are targeting these five NICUs for the SDoH 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 SDoH 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 SDoH screening/referral.

One Timeline and Tasks for our 5 Pilot Teams

Why did we choose these 5 sites for year 1?

- Large proportion of low-income families with need for SDH referrals
- Range of geography
- Combo of level 2 and 3 and NICU size
- Range of discharge home vs. transfer to level 2

What do sites get?

- Tufts, Lowell, and Baystate will receive ~$10,000
- BMC and UMass slightly less to accommodate Gaby and Meg's roles
- This can be used for what you need to execute the project
  - Data abstraction
  - Project management
  - Tool integration to EMR
  - Stipends for families
  - Any need for families
- Funds are for 09/30/22-09/29/23

1 year Timeline

Activity	Oct. 22	Nov. 22	Dec. 22	Jan. 23	Feb. 23	Mar . 23	Apr. 23	Jun. 23	Jul. 23	Aug. 23	Sep. 23
Engage 5 NICUs serving predominately low-income families to integrate routine SDoH screening and referral	X										
Support facilities with QI infrastructure to initiate screening and referral for SDoH for NICU families											
Build and strengthen data systems to improve identification and documentation of inequities											
Engage patients/ communities in QI initiatives											
Facilitate cross-sector partnerships between perinatal providers and organizations that provide resources in unmet needs											
Dissemination of findings at local, state, and regional level											

Next Steps for Sites- 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

Next Steps for Sites- Garner Leadership Buy In

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

Next Step for Teams- Data Collection Plans

- We plan to leverage our data collection system for the PNQIN Family Engagement and Social Disparities project
- Data is housed at BMC
- Benefits
  - Many of our team have already gone through the DUA process
    - Master NeoQIC agreement and individual project scope of work
  - We already have data collected on nearly all the measures that we need for this project (demographics, basic info on medical morbidities, disposition, and SDH)
  - Some sites have already been collecting data
- Limitation/Challenges
  - This data set includes other aspects of our family engagement project too
    - Ex- communication with families, discharge planning, hands on care

Data Collection Plans continued

- Plan going forward:
- We will give our teams participating in the SDH screening/referral project two options:
  - **Option #1:** Collect data on only the SDH screening/referral plus demographics and basic info
  - **Option #2:** Collect data on all family engagement measures
- Please let us know soon what you would like (ideally **end of October**), so that we can set up the REDCAP database to accommodate

Eligibility Criteria for Data Collection

- Any baby hospitalized for at least 2 weeks; and
  - No restrictions on parental visitation throughout the duration of the hospitalization
  - For level II hospitals, we have reduced the LOS to 7 days

Activities

Oct-Nov 2022

1. Identify NICU champion and form multidisciplinary team (social worker/navigator, physician, nurse, **family partner**).
2. Complete DUA and decide on who will do the data collection
3. Identify who you will work with for integration of screening tool into EMR.
4. Attend webinar on screening tool selection and developing resource guide.
5. Select your screening tool

Activities

2023

1. Develop driver diagram with your team.
2. Integrate SDOH screening tool into EMR.
3. Develop resource guide and translate into multiple languages
4. Train staff in use of tool and resource guide
5. Complete PDSA cycles and attend coaching sessions for feedback

Wrap Up and Next Steps

Next Steps for Hospital Teams

- DUAs:
  - Keep working on your IRB/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
- We will be meeting monthly as a leadership group!

Upcoming Events

Update to the date for the fall conference:

- Fall in person summit for the Family Engagement Collaborative on **December 5th from 9-3** at the Conference Center at Waltham Woods!!!!
- We are thrilled to have Mary Coughlin, MS, NNP, RNC-E as our keynote speaker!
  - Mary is the President & Founder of Caring Essentials Collaborative, LLC
  - She will speak to us about providing trauma informed care in the NICU
- We will send out a registration link in a follow up email

Any Comments, Reflections, or Questions?

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

We enjoy working with all of you on this journey to improve family engagement with NICU families across MA