

WHAT IT TAKES TO ADDRESS ADVERSE SDOH IN THE NICU

Gaby Cordova Ramos, MD

January 2024

ADVERSE SDOH ARE COMMON AMONG FAMILIES OF PRETERM CHILDREN

N=24,026; US Children 0-3 years, 2016-2019

	Term	Preterm		
	≥ 37 weeks & >2500 g	1500 -2500 g	<1500 g	P-value
Weighted %	93.4%	5.1%	1.5%	
Race/ethnicity				
NHW	55.5%	46.8%	39.0%	0.04
NHB	9.8%	13.2%	18.9%	
Hispanic	22.2%	23.6%	20.5%	
Low income (<200% FPL)	38.6%	44.1%	47.1%	0.04
Social risks in past year				
Food insufficiency	28.5%	28.3%	41.5%	0.02
Financial hardship (covering food/housing)	18.8%	19.6%	40.5%	<0.001
Difficulty paying bills	14.0%	17.9%	47.9%	<0.001

ADVERSE SDOH ARE ASSOCIATED WITH WORSE CHILD HEALTH OUTCOMES

- Material hardships such as **housing instability, food and energy insecurity** have been shown to increase a child's risk for **poorer health, medical conditions, and hospitalizations.**
- In the preterm population, household food insufficiency, financial hardship and difficulty paying bills are associated with **worse overall health, more ER visits, forgone health care.**

Cordova-Ramos et al. Journal of Perinatology 2022

Sandel et al. Pediatrics 2018

Fuller et al. Acad Pediatrics 2019

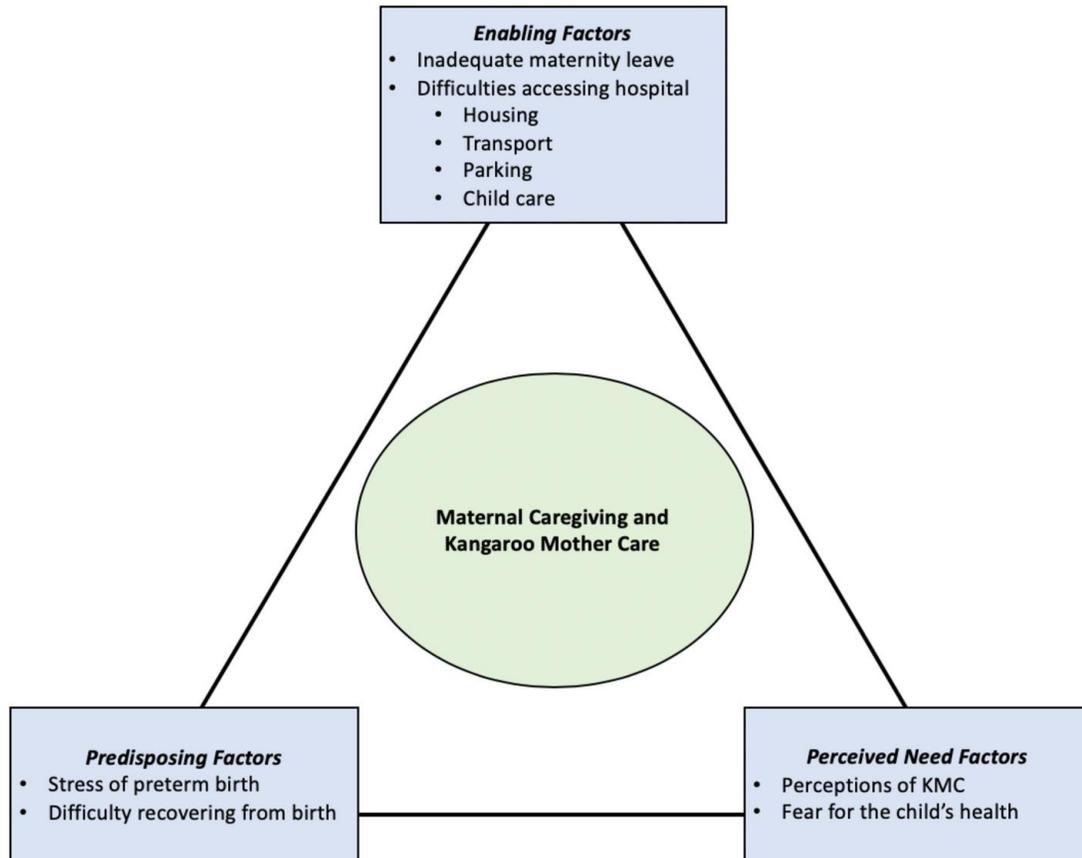
ADVERSE SDOH ARE BARRIERS TO EVIDENCE-BASED PRACTICES IN THE NICU: BREASTFEEDING

“During the time we were in the hospital we were barely making enough money because I was not working. There is so much you have to pay for, the parking every day, the food, **it’s all so expensive**. We fell behind on the rent. I was so **sad and stressed** that **I couldn’t make any milk** for my baby.”

“Transportation was stressful because I couldn’t drive because of the C-Section. I was in a lot of pain and had a lot of swelling, I had to wait to get a ride, but **I wasn’t able to get a ride all the time** to take **my milk** to the NICU and it eventually **dried out**.”

Cordova-Ramos et al. In preparation

ADVERSE SDOH ARE BARRIERS TO EVIDENCE-BASED PRACTICES IN THE NICU: KANGAROO CARE



Lewis et al. BMC Pregnancy and Childbirth 2019

ADDRESSING SDOH IN THE CLINICAL SETTING IS A PRIORITY

- Professional organizations endorse screening and referral for SDOH in clinical settings
 - National Academy of Medicine
 - American Academy of Pediatrics
 - Centers for Medicaid and Medicare Services
 - Joint Commission



Recommendation: Universally screen for social risks/needs and facilitate connections with community resources during patient encounters

SUMMARY OF REGULATORY REQUIREMENTS

Joint Commission	Centers for Medicare and Medicaid Services (CMS)
<p>The medical record contains information about the patient's health-related social needs (HRSNs)</p> <p>At a minimum, this includes:</p> <ul style="list-style-type: none">• Difficulty paying for prescriptions or medical bills• Food insecurity• Housing insecurity• Interpersonal safety	<p>Screening for Social Drivers of Health: This measure assesses whether a hospital implements screening for all patients who are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.</p> <p>To report on this measure hospitals will provide:</p> <ol style="list-style-type: none">1. The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for the five HRSNs; and2. The total number of patients who are admitted to the hospital who are 18 years or older at time of admission

CMS measures are optional for 2023 and **mandatory for 2024**

NICU THRIVE PILOT: IMPLEMENTATION OF SDOH SCREENING AND REFERRAL IN THE BMC NICU



- Setting:
 - Level 3 NICU, academic, urban, safety net hospital.
 - ~2800 annual births, 22 NICU beds
 - ~70% public insurance, ~50% non-Hispanic Black, ~25% Hispanic, ~15% non-Hispanic White
 - 1.0 FTE social work coverage for the NICU, labor and delivery and post-partum area (one person)
 - All families in NICU receive SW consult

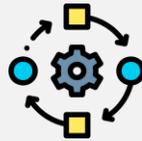
BMC NICU THRIVE



Selection and adaptation of screening tool to fit NICU context



Stakeholder input for screening/referral processes



Implementation of standardized screening and referral



Outcomes measurement and continued improvement

SCREENING TOOL SELECTION AND ADAPTATION

Possible Domains	CMS Mandate	NICU Relevance	Our Recommendation

THRIVE: ORIGINAL TOOL

- Developed for adults and widely used in outpatient settings
- Already integrated in health system EHR

Assessment of social risks

Assessment of social needs



Place Patient Sticker Here

Thrive Screening

Please fill this form out and bring it to the exam room. You don't have to answer these questions but your answers will help us take better care of you. Thank you!

Please circle your answers:

	Do you currently live in a shelter or have no steady place to sleep at night?	Yes / No
	Do you think you are at risk of becoming homeless?	Yes / No
	Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true / Sometimes true / Never true
	Within the past 12 months, you worried whether your food would run out before you got money to buy more.	Often true / Sometimes true / Never true
	Is this an emergency, do you need food for tonight?	Yes / No
	Do you have trouble paying for medicines?	Yes / No
	Do you have trouble getting transportation to medical appointments?	Yes / No
	Do you have trouble paying your heating or electricity bill?	Yes / No
	Do you have trouble taking care of a child, family member or friend?	Yes / No
	Are you currently unemployed and looking for a job?	Yes / No
	Are you interested in more education?	Yes / No

Would you like help connecting to resources? Please circle below.

Housing / Shelter	Food	Paying for Medicines	Transportation to medical appointments	Utilities	Child care / Daycare	Care for Elder or disabled	Job Search / Training	Education

THRIVE: ORIGINAL TOOL

- Things that did not quite fit the NICU context...

 **Do you have trouble paying for medicines?**

 **Do you have trouble getting transportation to medical appointments?**

 **Are you currently unemployed and looking for a job?**

 **Are you interested in more education?**



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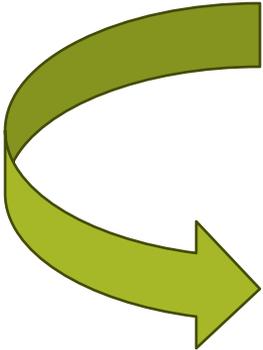
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ADAPTATION PROCEDURES/ STAKEHOLDER INPUT

- 2 focus groups with diverse families (one in English, one in Spanish) to ask them about questions
- 4 bi-monthly meetings with NICU multidisciplinary team (social worker, case manager, nursing director, bedside nurse champion, physician champion) to iteratively adapt questions for NICU context
- BMC team tested the revised tool with families at bedside

THRIVE ADAPTATION



Do you have trouble getting transportation for medical appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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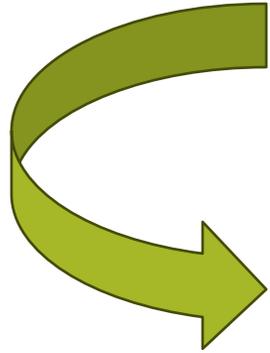


Do you need support getting transportation to or from the NICU? (Examples: paying for parking, getting a taxi ride, shuttle services)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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“Offer support vs asking about trouble”

“Match to the resources you can offer”

THRIVE ADAPTATION



Are you currently unemployed and looking for a job?

- Yes
 No

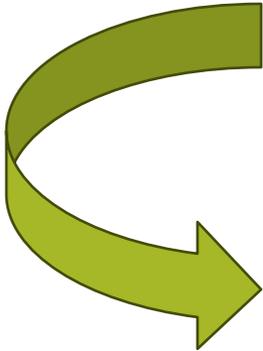


Do you need support looking for a job or job training for you or anyone in your house?

- Yes
 No

“I would keep. But this question may be more pertinent for the non-birthing parent at this time”

THRIVE ADAPTATION



Are you interested in more education?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you need support getting more education for you or anyone in your house? (Examples: obtaining GED, English as second language classes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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“Need examples of resources. Many families are interested in ESL classes.”

“Offer support and target the household.”

THRIVE: ADAPTED FOR NICU

Disclosure statement



Verbal prompt: *The goal of our team is to provide the best possible care to both babies and families. For that, I would like to tell you about our THRIVE program. It is a few questions that cover areas such as housing, food, and other needs that many parents in the NICU have. Some questions may not apply to you but we ask them to all families. You may answer all questions, some, or none at all if you prefer. Our team will do its best to help you find resources and services you may be eligible for.*

	Do you need support with housing? (Examples: emergency shelter, eviction prevention, rent help, housing application)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the past 12 months, you worried whether your food would run out before you got money to buy more.	<input type="checkbox"/> Often true <input type="checkbox"/> Sometimes true <input type="checkbox"/> Never true
	Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	<input type="checkbox"/> Often true <input type="checkbox"/> Sometimes true <input type="checkbox"/> Never true
	Do you need support with food? (Examples: apply for SNAP, WIC, referral to food pantry)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you need food for tonight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you need support with: Getting transportation to or from the NICU (Examples: paying for parking, or getting a taxi ride, shuttle services).	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Paying your heating or electricity bills (Examples: community organizations, state programs)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Finding childcare for other children at home (Examples: daycare, afterschool programs)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Looking for a job or job training for you or anyone in your house	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Getting more education for you or anyone in your house (Examples: obtaining GED, English as second language classes)	<input type="checkbox"/> Yes <input type="checkbox"/> No



For any "yes" can we refer you to free or low-cost programs?

Yes
 No

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Targets the household

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Targets the household

Asks for **social risks** and social needs

	Do you need support with housing? (Examples: emergency shelter, eviction prevention, rent help, housing application)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Targets the household

Asks for social risks and **social needs**

	Do you need support with housing? (Examples: emergency shelter, eviction prevention, rent help, housing application)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Targets the household

Asks for social risks and social needs

Gives examples of what assistance may look like

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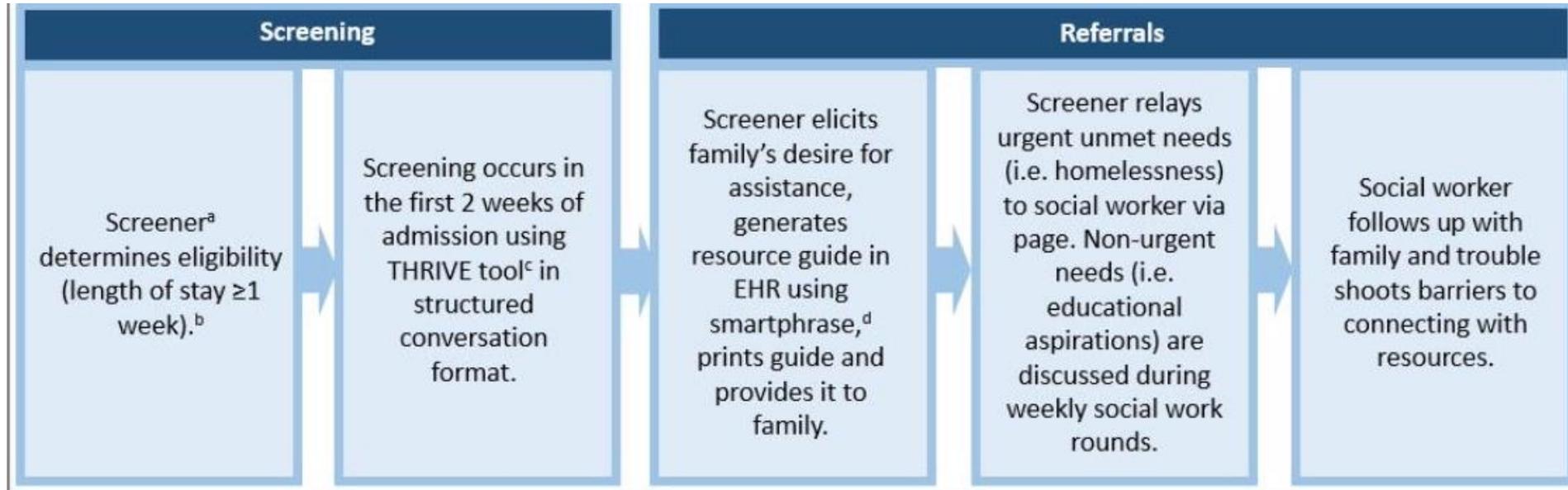
LESSONS LEARNED

There is no evidence that any social screening tools are better than others. Tools can be adapted to fit your NICU. Prioritize pragmatic characteristics (e.g. brief, relevant to NICU families, regulatory requirements).

At minimum, consider screening for food insecurity, housing instability, utilities and transportation difficulties. If screening for education needs, include ESL classes.

IMPLEMENTATION OF STANDARDIZED SDOH SCREENING AND REFERRAL

GENERAL PROCEDURES



THE KEY ROLE OF NICU SOCIAL WORKERS

- **Social workers:**
- Care for an array of highly complex issues of NICU families, such as mental health, domestic violence, family structure, and substance use.
- Promote family well-being through assessment, advocacy and support.
- Typically see the vast majority of families admitted.

Standardized social screening tools DO NOT EVER replace the role of social workers in the NICU

- The use of a standardized screening tool can help social workers streamline the assessment and support planning process.

RESOURCE GUIDE DEVELOPMENT

- Step 1** Leverage any existing resources
- Step 2** Use search engines to look up any new resources
- Step 3** Call community resources to assess fit for NICU families and build partnerships
- Step 4** Make choices about optimal community resources
- Step 5** Develop information sheets and translate into multiple languages
- Step 6** Iteration and maintenance

SOME HELPFUL RESOURCES

- Community resource aggregators
 - Find Help: <https://www.findhelp.org/>
 - AAFP Neighborhood Navigator: <https://navigator.aafp.org/>
- Local public health departments
- Hospital social workers/family navigators
- Community action agencies:
 - <https://communityactionpartnership.com/find-a-cap/>
- Non-profit and faith-based organizations (e.g., Catholic Charities)
- 2-1-1 help line (availability varies by state)
- Benefits.gov

EXAMPLE RESOURCE GUIDE MULTI-DOMAIN

BOSTON MEDICAL CENTER NICU– COMMUNITY RESOURCE GUIDE

	MASSTRIVE	The MA Community Resource Directory allows you to quickly find services in your neighborhood to help with housing, health, food, goods, transit, financial supports, childcare, social supports, education, work, and legal supports. You can search the site in >100 different languages on your phone, tablet or computer. https://massthive.org/
	Massachusetts 211	Need Help Fast? Get the answers you need through this free, confidential, multilingual state resource by phone or online. Dial 2-1-1 https://mass211.org/
	ABCD Boston	Action Boston Community Development has multiple programs to support community members with housing, rent, food, utilities, childcare, education, employment, essentials, immigration, financial and tax assistance. 617-348-6329 www.bostonabcd.org For direct assistance call [name and contact] (Mon-Fri 9am-5pm) and please say you were referred by the BMC NICU.
	HomeStart, Inc.	Works to end homelessness by assisting individuals with preventing homelessness, housing searches, finding housing resources, and stabilization. Main Line 617-542-0350, Eviction Prevention Hotline 857-415-2900 https://www.homestart.org/
	Metro Housing Boston	Provides up-to-date information on affordable open listings and offers housing search advice and workshops. They also provide homelessness / eviction prevention services and housing vouchers application support. 617-859-0400
	Housing and Community Development	Department of Housing and Community Development (DHCD) provides affordable housing options, financial assistance, and other support to MA communities. 617-573-1100 TTY 617-573-1140 https://www.mass.gov/orgs/housing-and-community-development
	Project Bread Food Source Hotline	Hotline counselors refer callers to food resources in their community as well as provides information about school meals, summer meal sites for kids, elder meals programs, and the Supplemental Nutrition Assistance Program (SNAP) application support. 1-800-645-8333 available Monday-Friday 8:00am to 7:00pm, Saturday 10:00am to 2:00pm
	Health Care Transportation	Ask your nurse about the parking program and the Uber Health Program in the BMC NICU. If you live in East Boston, ask about the shuttle service to and from East Boston.
	JVS Boston Immigrant & Refugee Center	Free career advancement and job center that offers flexible programs for obtaining high school diploma, English as a second language, preparation for college, job search assistance, career counseling, resume building and more. It also offers special services for immigrant families through their Immigrant & Refugee Center. jvs-boston.org 617-399-3131 To book an appointment fill out this brief questionnaire and learn about the programs you may be eligible for!
	MA Substance Use HelpLine	The Helpline provides free and confidential statewide, public resource for finding substance use treatment and recovery services. Caring trained specialists will help you understand your options for treatment. 800-327-5050 https://helplinema.org/
	Domestic Violence Hotline	The Domestic Violence Hotline has highly trained expert advocates available 24/7 for anyone experiencing domestic violence or seeking resources or information for themselves or a loved one. 800-799-7233 https://www.thehotline.org/

“Wrap around” resources

Warm hand-offs (from CBO partners)

Place holder for QR code

Resources beyond screening

EXAMPLE
RESOURCE
GUIDE
SINGLE
DOMAIN

How to use this
guide section

Boston Medical Center HEALTH SYSTEM

THRIVE Housing Resources

Please be aware that after you submit an application for resources, there will be a wait time before you hear back.

Metro Housing Boston Residential Assistance for Families in Transition (RAFT)

☎ Phone: 617-859-0400

✉ info@metrohousingboston.org

🔗 [bit.ly link](#)

Location & Hours: 1411 Tremont Street, Boston, MA 02120-3401;

M–F, 8:45 a.m. – 5 p.m.

Eligibility: A household's income must be at or below 50 percent area median income (AMI) and must currently be experiencing a housing crisis. Households are made up of any of the following: individuals, families with older children, couples without children, unaccompanied youth, and households of any size.

Boston Medical Center (BMC) Living Well at Home

☎ Phone: 617-414-1642

✉ Kip.Langello@bmc.org

🔗 [bit.ly link](#)

Location & Hours: 850 Harrison Avenue, Boston, MA 02118

4th Floor, Room 45-18, Yawkey Center; M–F, 8 a.m. – 5 p.m.

Eligibility: Must be at risk of losing housing.

HomeStart Eviction Prevention

☎ Phone: 857-415-2900

✉ homestart@homestart.org

🔗 [bit.ly link](#)

Location & Hours: 105 Chauncy Street, Suite 502, Boston, MA 02111;

M–F, 9 a.m. – 12 p.m. & 1 p.m. – 4:45 p.m.

Eligibility: Must be at risk of losing housing.

Place
holder for
QR code

How to Use This Guide

You're getting this guide because you recently completed the THRIVE screening about needs that can affect how you live and stay healthy.

Tips for Using This Guide to Get Help in Your Community

- 🕒 Look through the guide to find resources related to the area where you need assistance.
- 📄 Check the contact info of the places you decided to reach out to.
- 🗣️ Speak up and share your thoughts; it's okay to ask for help when you need it.
- 📅 Keep any letters or communication you receive and be aware of deadlines.
- 🔄 Keep trying — sometimes it takes multiple tries to find the right help.

We want to make sure you can find support for your needs by using this guide. You are not alone. If you have any questions or need more help, your healthcare team is here for you and trusts you to live a good life!

Additional Helpful Resources

- Call 2-1-1 to get connected to resources available in your community.
- Search Massthive.org to find free or low-cost services in your area.
- For help related to violence or abuse call Domestic Violence Hotline 1-800-799-7233 (thehotline.org) or contact Massachusetts Office for Victim Assistance (MOVA) 1-844-878-6682 (mass.gov/orgs/askmova)
- Contact BMC Patient Financial services at 617-414-6155 for questions about health insurance or medical bills.

Getting certain types of benefits could impact your current benefits or eligibility for future benefits. When applying for benefits, always ask about what the impact might be; there is no risk to you for asking.

EXAMPLE
RESOURCE
GUIDE
SINGLE
DOMAIN

Additional helpful
resources

Boston Medical Center HEALTH SYSTEM

THRIVE Housing Resources

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🔗 [bit.ly link](#)

Location & Hours: 1411 Tremont Street, Boston, MA 02120-3401;

M–F, 8:45 a.m. – 5 p.m.

Eligibility: A household's income must be at or below 50 percent area median income (AMI) and must currently be experiencing a housing crisis. Households are made up of any of the following: individuals, families with older children, couples without children, unaccompanied youth, and households of any size.

Boston Medical Center (BMC) Living Well at Home

☎ Phone: 617-414-1642

✉ Kip.Langello@bmc.org

🔗 [bit.ly link](#)

Location & Hours: 850 Harrison Avenue, Boston, MA 02118

4th Floor, Room 45-18, Yawkey Center; M–F, 8 a.m. – 5 p.m.

Eligibility: Must be at risk of losing housing.

HomeStart Eviction Prevention

☎ Phone: 857-415-2900

✉ homestart@homestart.org

🔗 [bit.ly link](#)

Location & Hours: 105 Chauncy Street, Suite 502, Boston, MA 02111;

M–F, 9 a.m. – 12 p.m. & 1 p.m. – 4:45 p.m.

Eligibility: Must be at risk of losing housing.

Place
holder for
QR code

How to Use This Guide

You're getting this guide because you recently completed the THRIVE screening about needs that can affect how you live and stay healthy.

Tips for Using This Guide to Get Help in Your Community

- 🕒 Look through the guide to find resources related to the area where you need assistance.
- 📄 Check the contact info of the places you decided to reach out to.
- 🗣️ Speak up and share your thoughts; it's okay to ask for help when you need it.
- 📅 Keep any letters or communication you receive and be aware of deadlines.
- 🔄 Keep trying — sometimes it takes multiple tries to find the right help.

We want to make sure you can find support for your needs by using this guide. You are not alone. If you have any questions or need more help, your healthcare team is here for you and trusts you to live a good life!

Additional Helpful Resources

- Call 2-1-1 to get connected to resources available in your community.
- Search Massthive.org to find free or low-cost services in your area.
- For help related to violence or abuse call Domestic Violence Hotline 1-800-799-7233 (thehotline.org) or contact Massachusetts Office for Victim Assistance (MOVA) 1-844-878-6682 (mass.gov/orgs/askmova)
- Contact BMC Patient Financial services at 617-414-6155 for questions about health insurance or medical bills.

Getting certain types of benefits could impact your current benefits or eligibility for future benefits. When applying for benefits, always ask about what the impact might be; there is no risk to you for asking.

IMPLEMENTATION CONSIDERATIONS

Family-centered

Foster trust, empathy, autonomy, dignity and respect. Minimize stigma.

**Efficient
workflow**

Minimize time/ documentation burden. Increase staff comfort, knowledge and skills.

WHAT FAMILIES HAVE TOLD US MATTER TO THEM



Untold worries and fears

- Negative lived experiences with social services
- Disclosing needs = “failing at parenting”
- Fear of intervention by a child protective services and losing custody of their children
- Frustration at the prospect of disclosing sensitive information without getting help

Let's review some implementation strategies that may address this...

IMPLEMENTATION STRATEGIES: “HOW TO”

Involve families / advisory boards

- Engage and include families **throughout** implementation efforts.
- Solicit and incorporate family feedback often.

Identify and prepare champions

- A champion actively encourages team to meet goals, overcomes resistance, orients new staff.

IMPLEMENTATION STRATEGIES: “HOW TO”

Disclosure statements

- Key elements
 - **Universal:** explain that this is done with all families and why
 - **Confidential:** assure confidentiality and explain how data may be used
 - **Voluntary:** provide opportunity to skip questions or decline screening
 - **Set expectations:** Explain lag time (e.g. waitlists) for some resources.

IMPLEMENTATION STRATEGIES: “HOW TO”

Staff training

- **Scenario 1: Social worker conducts screening and referral**
 - ❑ **All-staff educational sessions:** Even when screening is conducted by social worker, all NICU staff should be trained in the importance of understanding and addressing social risks/needs in the NICU.
- **Scenario 2: Staff other than social worker conducts screening and referral**
 - ❑ Training in **empathic inquiry** and **trauma informed care**
 - ❑ **Dynamic role play** to boost confidence/comfort with screening/referral

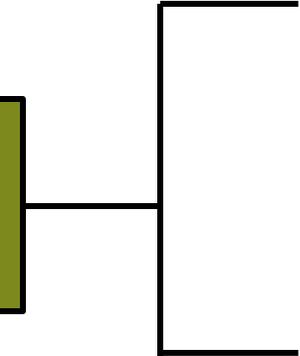
IMPLEMENTATION STRATEGIES: “HOW TO”

Iterative tests of change (PDSAs)

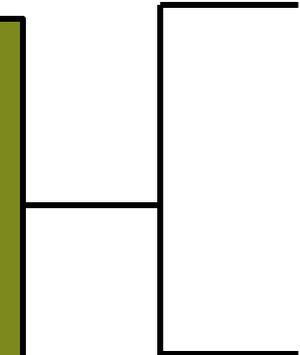
- Test change by planning, doing, observing results, and acting on what is learned.
- Include the multidisciplinary team and family input throughout.
- Start by testing in small scale.

PDSA EXAMPLES

Integrate screening into workflow



Improve resource guide



Improve quality of referrals through community partnerships

PDSA Cycles ^a	
#1	Training of 6 champion nurses to perform universal screening, provide 1-page resource guide to families, and document in EHR
#2	Training of residents to perform screening/referral
#3	Availability of step-by-step instructions for EHR documentation in nurses' station
	Training of all beside nurses to perform screening/referral
	Revision of resource guide based on family feedback
#4	Webinars on community resources by agency representatives
	Partnership with community organization #1
#5	Created "THRIVE station" with resource guides readily available (printed) and "resource cheat sheet"
	Launched Parking and Uber Health Program
#6	Partnership with community organization #2

PDSA #7

- ❑ Health Accelerator Boston Medical Center- \$100,000 (3/22-8/23)
PI Cordova-Ramos

- ❑ Pilot implementation project of a **dual peer lactation consultant and SDH navigator**
 - 1) Breastfeeding mother, trilingual! (English, Spanish, and Haitian Creole)
 - 2) Supported mothers as peer lactation counselor with CLC training
 - 2) Supported families as an SDH family navigator
 - Conducted SDH screener and connected families with resources

IMPLEMENTATION STRATEGIES: "HOW TO"

EHR integration

Screening documentation

Referral documentation

The screenshot displays the Epic EHR interface for a patient named ERIKA C. The main window is titled "Chart Review" and shows a comprehensive overview of the patient's health. On the left, a sidebar contains patient information such as "Needs Interpreter: Haitian Creole", "Bed: Y4N11-01", and "Code: FULL". The central area is divided into several sections: "Health Maintenance" (None), "THRIVE- Social Determinants of Health" (listing risks for Housing, Medications, Utilities, Employment, Food, Transportation, Caregiving Burden, and Education), "Medical History" (1 item), and "Significant History/Details" (Smoking, Smokeless Tobacco, Alcohol, Preferred Language). On the right, there are sections for "Most Recent Behavioral Scores from encounters over the past 365 days" (No data recorded), "Last 3yr" (No visits), "Family History" (1 item), and "Family Comments" (None). Arrows from the external text boxes point to the "THRIVE- Social Determinants of Health" section, the "Medical History" section, and the patient information sidebar.

IMPLEMENTATION STRATEGIES: "HOW TO"

EHR integration

Social Determinants of Health Screening

Time taken: 9/29/2023 1131 Responsible

Show Row Info Show Last Filed Value Show Details

+ Add Group + Add Row

▼ Patient did not answer

Select reason why patient did not answer screening: Declined to answer Unable to answer due to clinical status Language barrier

Person who completed the screener: Patient Parent/Caregiver

▼ Patient's Language (Reading)

Language for patient instructions English Spanish Portuguese Haitian Creole Vietnamese Arabic

▼ FOOD

In the past 12 months, did the food you bought just didn't last and you didn't have money to get more? Often true Sometimes true Never true Patient declined to answer

Within the last 12 months, were you worried whether your food would run out before you got money to buy more? Often true Sometimes true Never true Patient declined to answer

Social risks

THRIVE: Please check the resources you want help with

Housing Food Medications Transportation Utilities Caregiving (child)

Employment Education

Social needs

IMPLEMENTATION STRATEGIES: “HOW TO”

EHR integration

Not Screened

♥ THRIVE- Social Determinants of Health ↗

Housing Not on file	Food Not on file
Medications Not on file	Transportation Not on file
Utilities Not on file	Caregiving Burden Not on file
Social Support Not on file	Employment Not on file
Education Not on file	

Screened

♥ THRIVE- Social Determinants of Health ↗

Housing Sep 19, 2023: Low Risk	Food Sep 19, 2023: Low Risk
Medications Sep 19, 2023: Low Risk	Transportation Sep 19, 2023: High Risk
Utilities Sep 19, 2023: Low Risk	Caregiving Burden Sep 19, 2023: High Risk
Social Support Sep 19, 2023: Not on file	Employment Sep 19, 2023: Low Risk
Education Sep 19, 2023: High Risk	

IMPLEMENTATION STRATEGIES: “HOW TO”

Audit and feedback

- ❑ Collect and summarize data and present it back to the team (not just the QI team but the NICU staff in general).
- ❑ Data on referral outcomes and patient testimonials can be particularly powerful means to increase buy-in.

IMPLEMENTATION STRATEGIES: “HOW TO”

Build partnerships

- Build partnerships with community-based organizations and social service agencies.
- This will make it easier to know which agencies welcome social risk-related referrals.
- Partners may:
 - Provide point personnel for warm hand-offs
 - Feedback on outcome of referrals
 - Advise to streamline referral procedures (e.g. eligibility screens, links to book intake appointments online.)
 - Train staff (e.g. navigators) on applications/ documentation gathering, timelines to counsel families.

COMMUNITY PARTNERSHIPS

Collaboration with navigators in outpatient pediatrics



Individualized contact
for families
Weekly huddles to
follow up on referrals



BMC NICU intake
link for families for
needs assessment and
to set up
appointment
Quarterly feedback



VitalVillage
BELONG • LEARN • ENGAGE • TRANSFORM
NETWORKS

Abundance app
Post-discharge BF
support

Accountability

IMPLEMENTATION STRATEGIES: “HOW TO”

Access new funding

- ❑ Data collected can be leveraged to support implementation efforts and improve or create new resources for families.
- ❑ Huge impact on staff buy-in!



LESSONS LEARNED

Screening and referral processes should fit NICU context while prioritizing the tenets of family-centered care (respect, autonomy, cultural sensitivity, and shared decision-making).

Common implementation facilitators: standardizing procedures to normalize screening, frequent and transparent communication with families and staff, ongoing education and training.

OUTCOMES MEASUREMENT

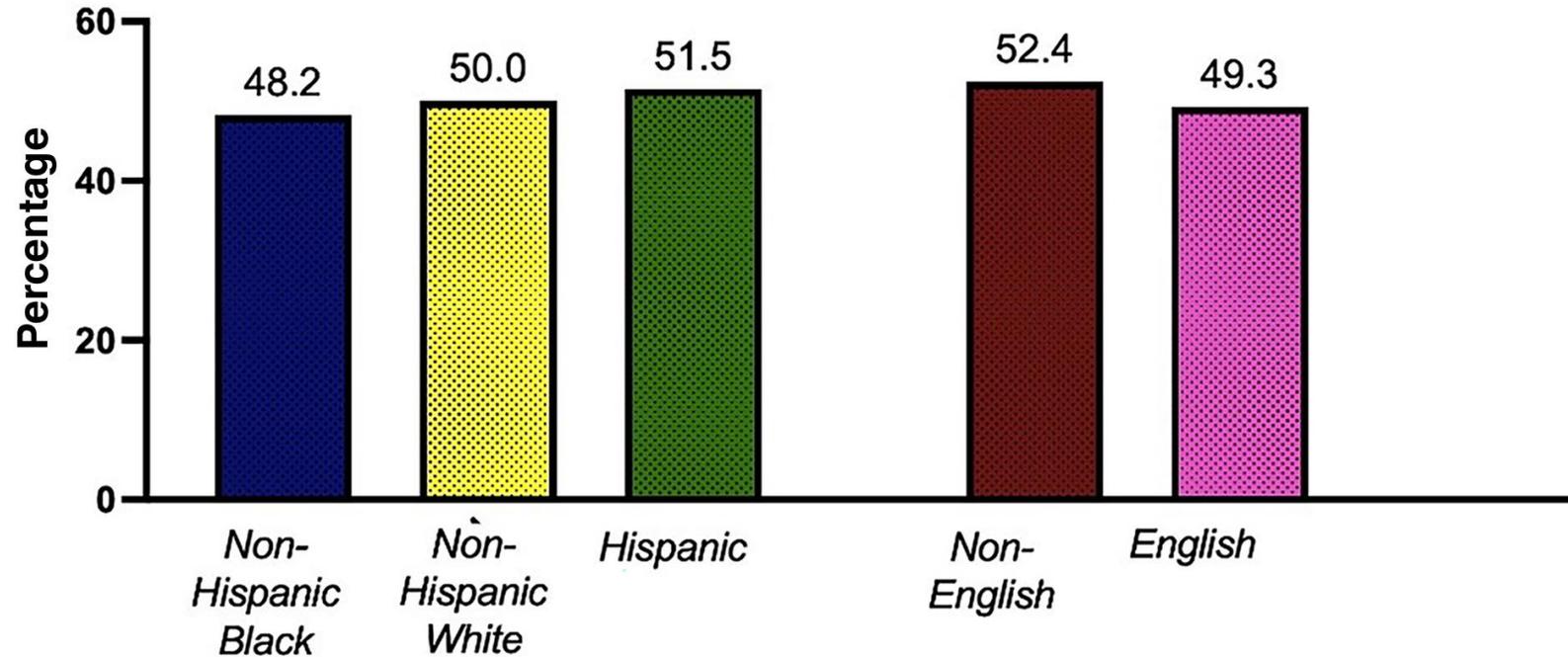
IMPLEMENTATION OUTCOMES

Outcome	Definition	Mode of data collection
Feasibility	Ability of the model to be implemented as designed and barriers to program implementation	<ul style="list-style-type: none"> • Feasibility of Intervention Measure (FIM) • Semi-structured interviews with stakeholders*
Acceptability	Perceptions of value of the model to stakeholders	<ul style="list-style-type: none"> • Acceptability of Intervention Measure (AIM) • Semi-structured interviews with stakeholders*
Penetration	THRIVE screening was conducted, referrals were placed and contact with community organization was initiated.	<ul style="list-style-type: none"> • Chart review of THRIVE flowsheet and THRIVE directory as well as notes from social worker
Equity	Equal access to THRIVE screening and referrals	<ul style="list-style-type: none"> • Stratification of penetration outcomes by race/ethnicity and language (English vs. not English).

IMPLEMENTATION OUTCOMES

Equity

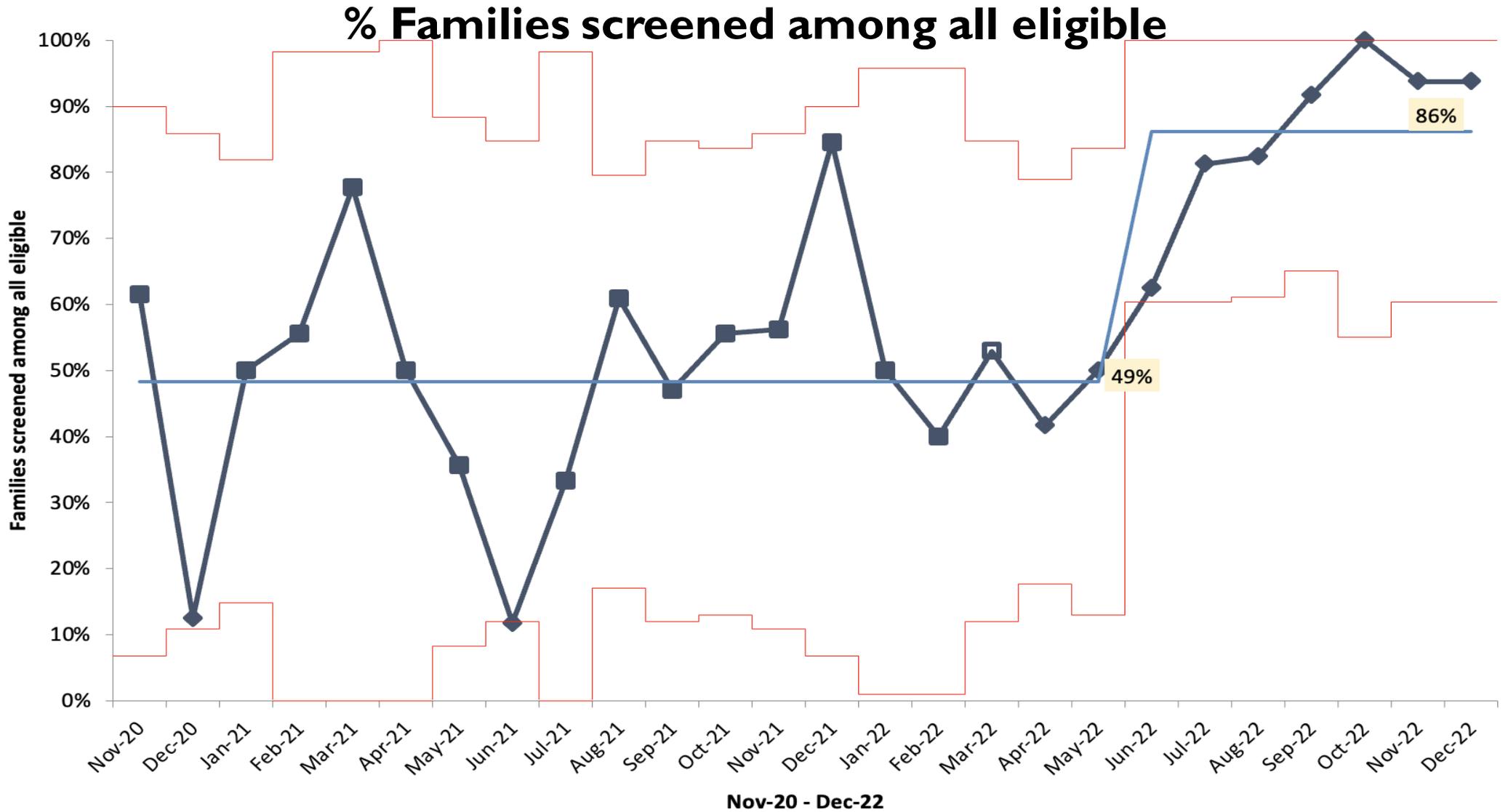
Percentage of families screened by race/ethnicity and primary language



QUALITATIVE COMPONENT

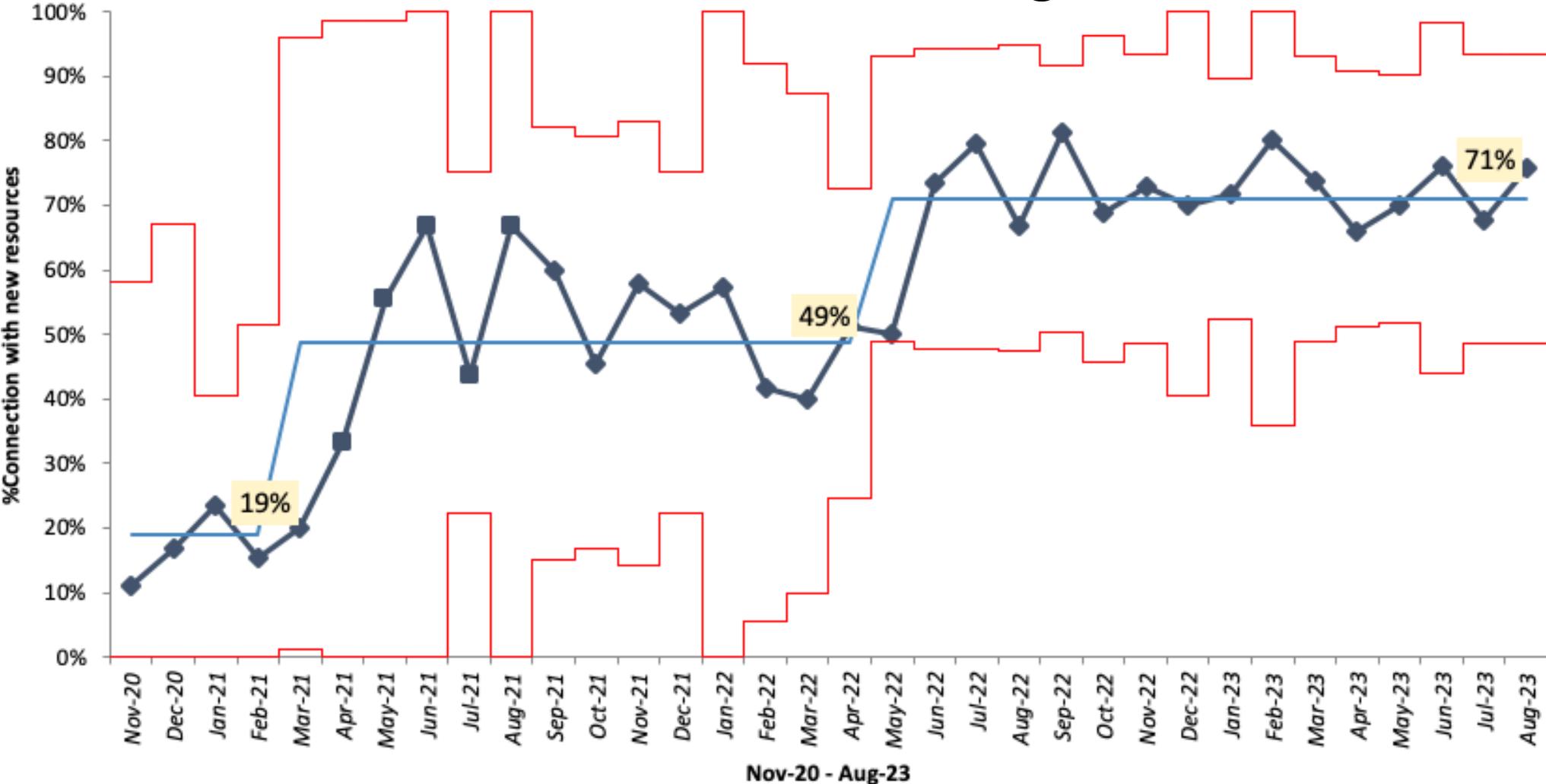
I have been to other parts of the hospital where they give you the paper to fill out and you never talk about it with anyone. It's like checking the box I think for some places. But in the NICU, the way they did it, I mean, they explain it to you and they personally follow up on the help you got. So, it was perfect.

EFFECTIVENESS OUTCOME



EFFECTIVENESS OUTCOME

% Connection with new resources among all needs identified



LESSONS LEARNED

Be thoughtful about data collection and track outcomes by race/ethnicity and primary language. Assess for and address inequities in implementation.

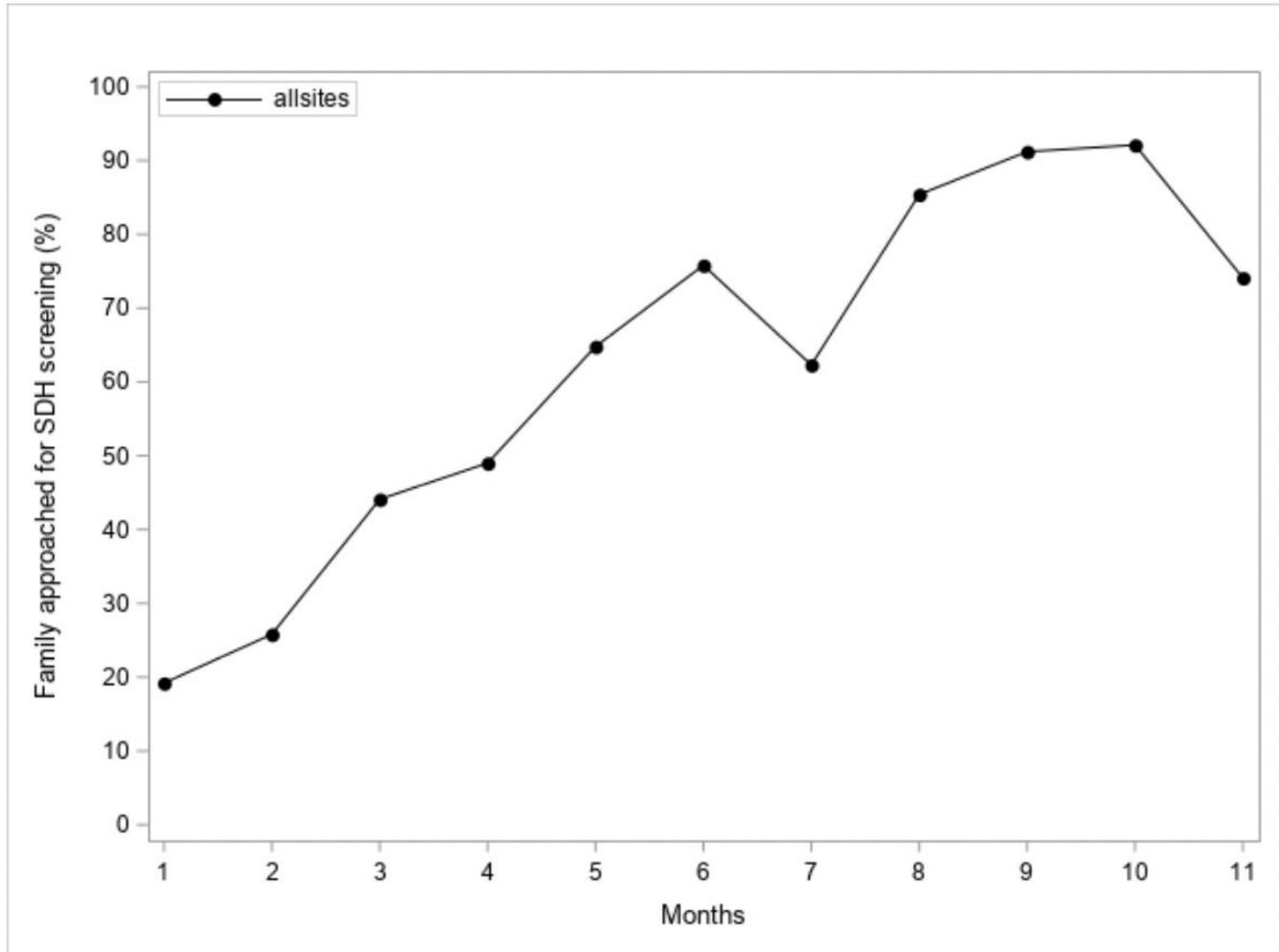
SUSTAINABILITY

- ❑ Hospital leadership increased social work FTE for mother and baby units
- ❑ Peer counselor/ social navigator role made permanent and incorporated into hospital value-based care program budget
- ❑ Ongoing cost-effectiveness comparison of two modalities of transportation support for NICU families

NEXT STEPS

- ❑ Dissemination of practices across level 2-4 NICUs in MA
 - ❑ 5-year CDC grant (PI Hafsadou, co-PIs Parker/ Cordova-Ramos)
 - ❑ Year 1: 5 hospitals
 - ❑ Year 2: 7 hospitals – ongoing team trainings

NEXT STEPS



NEXT STEPS

❑ Dissemination of lessons learned

Practical modules on Vermont Oxford Network platform

<https://public.vtoxford.org/health-equity/>

Module 1: Introduction to Social Determinants of Health in the NICU Setting

The screenshot shows a video player interface. At the top, there is a black header bar with a globe icon, the text "SDOH Screening - Module 1: Introduction ...", a clock icon, and a share icon. Below the header, the video title "Module 1: Introduction to Social Determinants of Health in the NICU Setting" is displayed in blue. A red play button icon is centered over the video area. Below the title, the names of the presenters are listed: "Gaby Cordova Ramos, MD; Assistant Professor of Pediatrics, [unclear] Center" and "Meg Parker, MD, MPH; Professor of Pediatrics, UMass Chan School of Medicine". To the right of the text is a circular logo with a scale of justice and the word "EQUITY". At the bottom of the video area, the "VON Vermont Oxford NETWORK" logo is visible. Below the video area, there is a black bar with the text "Mirar en" followed by the YouTube logo and the word "YouTube".

CONCLUSIONS

Standardized SDOH screening and referral can be effectively integrated in the NICU to **augment capacity** to address adverse SDOH

Interventions targeting individual behavior are important but attention should be given to creating an **enabling environment and addressing structural barriers** to the target behavior.

OUR SHARED RESPONSIBILITY TO PRACTICE SOCIAL MEDICINE



“This is not my responsibility. I am a [physician, nurse, respiratory therapist, pharmacist, nutritionist, or other allied health professional]. This is a social problem, something to be addressed and solved by government and society at large, not by me or other health professionals. Let someone else take this on.”

“Even if I accept that this is my responsibility, there is nothing I can do about it. I already have my hands full providing the technical aspects of bedside care.”

Health professionals, families and communities as partners to meet the social as well as medical needs of infants and families.