Scaling Up Social Determinants of Health Interventions

December 10, 2018
12:30-4:00pm

#IHIFORUM
Disclosures

- Sara Bader is an employee of HealthBeGins, LLC.
- The presenters, Sara Bader, Marycatherine Arbour, Baraka Floyd, Samantha Morton, Patsy Hampton, Robert Sege, Elizabeth Beaudin, Gina Burrows, and Billi-Jo Frazier has no other relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Session Objectives

- Describe processes and tools for screening, referral, and tracking social determinants.
- Develop effective relationships with partners, both in and outside the clinical setting, that are crucial for addressing social determinants of health.
- Identify at least three opportunities to spread and scale approaches to help optimize the impact of clinical/community social determinants of health interventions.
Session Faculty

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CEO
MLPB

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HealthBegins

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Director, Population Health
Connecticut Hospital Association

Billie-Jo Frazier, MA
Population Health Coordinator
Connecticut Hospital Association

Elizabeth Beaudin, PhD, RN
Senior Director, Population Health
Connecticut Hospital Association
# Agenda

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<td>support and supervise the CHW</td>
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Before we begin…

Who’s in the room?

- What type of organization are you from?
- What is your role?
- What stage are you at in your work on social determinants of health?
  - in early stages of planning an upstream project
  - close to launching an upstream project
  - currently implementing an upstream project
  - significantly revising an upstream project based on results
  - planning to scale or spread an upstream project
Let’s Discuss Social Determinants
Concrete Strategies

- Connecticut Social Health Initiative
- Community Health Detailing
- Project DULCE
SCALING UP SOCIAL DETERMINANTS OF HEALTH INTERVENTIONS

WE HAVE NO DISCLOSURES

SESSION CODE ML 13
A transformative, multi-year initiative to improve healthcare effectiveness, health outcomes, and population health through integration of social determinants of health into healthcare practice.

STRATEGIC GOAL: Coordinate the collaboration among providers and community-based organizations to address social determinants of health and reduce the disparities that lead to poor clinical outcomes.
What are social determinants of health and why address them?
Statewide assessment
Pilot project: Connecticut Social Health Initiative
Education and advisory group
Scaling up: statewide collaborative
Support and collaboration
Inspiration
AGENDA

- What are social determinants of health and why address them?
- Statewide assessment
- Pilot project: Connecticut Social Health Initiative
- Education and advisory group
- Scaling up: statewide collaborative
- Support and collaboration
- Inspiration
WHAT ARE SOCIAL DETERMINANTS OF HEALTH?

The social determinants of health are:

- Conditions in which people are born, grow, live, work, and age
- Shaped by the distribution of money, power, and resources
- Global, national, and local levels
- Mostly responsible for health inequities
- Unfair and avoidable differences in health status seen within and between countries

World Health Organization
“I diagnosed ‘abdominal pain’ when the real problem was hunger; I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients’ lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether.”

– Laura Gottlieb, MD, San Francisco Chronicle

Source: https://www.sfgate.com/opinion/openforum/article/Funding-healthy-society-helps-cure-health-care-3177542.php
WHAT DETERMINES HEALTH?

Key Determinants of Human Health

- Genetics
- Individual Behavior
- Social Environment
- Physical Environment
- Medical care


COMPARISON OF SOCIAL-TO-HEALTH SPENDING BY NATION

Source: OECD Health Data. (2009)
Life expectancy compared to healthcare spending from 1970 to 2015, in the US and the next 19 most wealthy countries by total GDP.  OurWorldInData.org
Unmet **health-related social needs** may increase the risk of developing chronic conditions, reduce an individual’s ability to manage these conditions, increase healthcare costs, and lead to avoidable healthcare utilization.

Source: https://innovation.cms.gov/initiatives/ahcm
AGENDA

- What are social determinants of health and why address them?
  - **Statewide assessment**
- Pilot project: Connecticut Social Health Initiative
- Education and advisory group
- Scaling up: statewide collaborative
- Support and collaboration
- Inspiration
Conversations
Survey
- 27 out of 27 hospitals responded
- 25 hospitals did not purposefully screen for SDOH
- 2 hospitals did purposefully screen for SDOH
- 6 hospitals that did not purposefully screen for SDOH reported that referrals are sent to a social worker or Case Management for further screening based on mandated high risk questions in the ED
- 3 hospitals screened every ED patient for homelessness
What are social determinants of health and why address them?
- Statewide assessment
- **Pilot project: Connecticut Social Health Initiative**
- Education and advisory group
- Scaling up: statewide collaborative
- Support and collaboration
- Inspiration
Pilot Project

Funded by Connecticut Health Foundation to test process of screening, referral, and follow-up to address SDOH

Project Hospitals
- Bristol Hospital
- Day Kimball Hospital
- MidState Medical Center
- Saint Mary’s Hospital

Who, What, Where, When, How

Project Activities

Planning/preparation
Three month Test
Evaluation

Lessons Learned
- Culture change
- Workflow fit
- Assessment tool questions
AGENDA

- What are social determinants of health and why address them?
- Statewide assessment
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- Support and collaboration
- Inspiration
Education

- Health Begins
- Collaborative Consulting
- Presentations
- Webinar – Connecticut hospital already screening
- Kick-off
  - Bridging Health and Community
  - Montefiore Medical Center

Advisory Group

- Hospitals, Federally Qualified Health Centers, local departments of health, health equity policy experts, healthcare faculty, practitioners, community-based organizations, state agencies
What are social determinants of health and why address them?
Statewide assessment
Pilot project: Connecticut Social Health Initiative
Education and advisory group
Scaling up: statewide collaborative
Support and collaboration
Inspiration
**SCALING UP: STATEWIDE COLLABORATIVE**

**Engaging Leaders, Starting Simply**
- Executive Sponsors
- Collaborative Leaders
- Selection of Unit
- Three domains
- Five questions

**Closing the Loop**
- Technology platform to support collaboration in addressing SDOH
AGENDA

- What are social determinants of health and why address them?
- Statewide assessment
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- Scaling up: statewide collaborative
- Support and collaboration
- Inspiration
Support and collaboration

- Hospitals visits
- Monthly calls
- Education
- Community-based organization connections
AGENDA

- What are social determinants of health and why address them?
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- Support and collaboration
- Inspiration
Powerful inspiration

- Opportunity to join forces to improve health and save lives
- Playbook
- Checklist
- Survey
- CSHI assessment tool, English and Spanish
- CHA assessment tool, English and Spanish
- Sample project flowchart
Concrete Strategies

- Connecticut Social Health Initiative
- Community Health Detailing
- Project DULCE
Community Health Detailing:
A rapid improvement model for clinical-community partnerships seeking to address health-related social needs

SARA BADER, MCD, CPHQ
HEALTHBEGINS
About HealthBegins

We improve care and the social determinants of health by making clinical-community partnerships more effective and efficient.

Our client-partners include Medicaid health plans, large hospitals and healthcare delivery systems, local and national hospital associations, community health centers and self-insured employers. In 2017, HealthBegins was selected to provide technical assistance to CMS Accountable Health Communities model grantees.
Meet Mrs. M
She’s a 46 year old mother of two who also cares for her frail elderly mother.

Her Type II diabetes is poorly controlled (last HbA1c = 8.1). At the end of last month, she nearly fainted at work and was admitted at a local hospital.

The cause of her admission was hypoglycemia (low blood sugar).

Root cause: Food insecurity

Lower-income diabetic adults have a 27% higher rate of hospital admissions at the end of the month due to food insecurity, compared with higher-income diabetics.

Problem Statement

• The need:
  – “We are a community health center and have invested in a number of food resources for our patients, including a partnership with a local urban farm.
  – Despite these investments, our clinicians and care teams haven’t integrated these resources into their work.
  – We need a way to increase the screening and referral rates to address food insecurity.”

• Our solution:
  – A 4-month Upstream QI Campaign for Food Insecurity, powered by Community Health Detailing
Upstream Quality Improvement

Upstream factors
Social factors such as food security, social support, housing stability are associated with better health outcomes.

Quality Improvement
High performing healthcare systems routinely identify opportunities for quality improvement to improve value and outcomes.
## Projects vs Campaigns

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<tr>
<th>Projects</th>
<th>Campaigns</th>
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<td>Usually <strong>one organization</strong> develops, implements, and evaluates a project.</td>
<td>A campaign may be guided by staff, but <strong>members of the community</strong> are directly involved in developing and implementing it – and may evaluate it, too.</td>
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<td>A project usually focuses on <strong>services and/or individual behavior change</strong></td>
<td>A campaign usually focuses on <strong>changes in policies, institutional practices, and/or social norms.</strong></td>
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<td>A project is usually <strong>non-controversial</strong> or only minimally controversial</td>
<td>A campaign is likely to encounter <strong>opposition</strong>, and in a public way, when it challenges the status quo in the community or in institutions</td>
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<td>A small and <strong>finite group</strong> of people are involved in a project from start to finish (e.g. project director, coordinator, trainer, researcher, etc.)</td>
<td>A campaign seeks to <strong>build an ever-expanding number of people</strong> who will participate in this and future campaigns for social determinants and equity</td>
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<td>A project contains <strong>pre-determined and specific goals, objectives, and results</strong> that must be produced during the term of the project.</td>
<td>A campaign has <strong>specific goals</strong> and a <strong>flexible strategy</strong> so it can respond to incidents as they occur in order to further the campaign's goal</td>
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<td>A project must be <strong>accountable to its funder</strong> and the organization’s board.</td>
<td>A campaign must be <strong>accountable to</strong> more than one organization and to <strong>members of a community.</strong></td>
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<td>A project may encourage <strong>dependence</strong> of people in the community on one service organization.</td>
<td>A campaign encourages the <strong>development</strong> of new leaders, skills, and the <strong>empowerment</strong> of members of the community.</td>
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Adapted from Transforming Communities: Technical Assistance and Training Project. Accessed April 20, 2018 [http://www.transformcommunities.org/sites/default/files/project_or_campaign_0.pdf](http://www.transformcommunities.org/sites/default/files/project_or_campaign_0.pdf)
We develop Upstream QI Campaigns with health systems and community partners

Objective 1: Identify food-insecure patients by increasing screening rate

Objective 2: Improve quality of care by improving provider knowledge about care of food-insecure patients

Objective 3: Reduce risks by referring food-insecure patients to resources

Example: Food Insecurity Upstream QI Campaign objectives at Hayward Wellness Center
Community Health Detailing is a tool to help achieve Upstream QI Campaign goals

But first.... What is detailing?
“Detailing” = An educational approach that brings content to clinicians and care teams

To be effective, detailing must be:

- Easy to understand
- Sensitive to needs & priorities
- Helpful with new information/skills
- In-person and brief
- Repeated over time
Example: Academics have used detailing to lower average daily hypertensive drug costs

- **Objective**: to evaluate the economic impact of group academic detailing for hypertension in a large HMO

- **Design**: Retrospective cost analysis of a randomized controlled trial
  - Used process data to derive intervention costs
  - Used administrative pharmacy records to generate prescribing costs

- **Primary outcome**: Average daily hypertensive drug costs

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<th>Change in daily drug costs, $</th>
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<td>Year 1</td>
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<tr>
<td>Individual AD</td>
<td>-0.06 (p=.176)</td>
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<tr>
<td>Group AD</td>
<td>0 (p=.998)</td>
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Example: The New York City Department of Health has used detailing to lower high-dose opioid prescribing

Target community → 12.4% decrease.

Control community → 7.3% decrease.

Significantly different, using difference-in-difference analysis
We adapted detailing to tap into the power of community organizations to optimize health.

We call it Community Health Detailing™

- **Pharmaceutical Detailing**
  - **Goal:** Change prescriber behavior to increase sales of drugs.
  - Sales reps were known as "detailmen" because of role promoting "details" about particular drugs in one-on-one meetings with doctors.

- **Academic Detailing** - Pioneered by Dr. Jeffrey Avorn, Harvard
  - **Goal:** Change prescribing behavior to be consistent with medical evidence, promote safety and choice of cost-effective medications.

- **Public Health Detailing** – Adapted by Dr. Tom Frieden, NYC Dept of Health
  - **Goal:** Promote essential preventive and disease management practices in high mortality areas in New York City.

- **Community Health Detailing** – Adapted by HealthBegins
  - **Goal:** Engage community-based organizations and residents to promote disease management as well as clinical and community preventive practices that impact health and social outcomes for individuals and communities with high levels of health-related social needs (social determinants of health).
How is Community Health Detailing different from other detailing models? (e.g. pharmaceutical, academic, or public health detailing)

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<th>A focus on SDOH and equity</th>
<th>We recruit educators from the community</th>
<th>We don’t just educate clinicians, we educate communities</th>
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| • While CHD can be used to educate learners on a variety of health topics, we focus on SDOH.  
  • We train educators, aka “detailers”, to understand the latest science on SDOH and equity and their relationship to health and healthcare. | • As a educational intervention model, detailing has often focused on changing behaviors of clinicians in clinic settings.  
  • In CHD, the model can be extended to change knowledge and practice behaviors among service providers in the community, such as social service providers, CBO staff, and faith-based organizations. | • Other detailing models recruit and rely on educators who have technical expertise and pedigrees (MDs, nurses, pharmacists, etc).  
  • We recruit educators with “community expertise” i.e. staff CBOs and/or people from the community who have lived experience with health-related social needs. |
Community Health Detailing™

Original demonstration: High school students from south central LA trained UCLA doctors to address health-related social needs

Step 1: Over 100 students learned about social determinants of health and how to detail

Step 2: The students mapped over 500 health-related social resources and built a local “Yelp for Health”
Community Health Detailing™ demo:
High school students from south central LA trained UCLA doctors to address health-related social needs

Step 3. The students detailed UCLA MDs

Results
- Clinicians reported nearly 3x increase in confidence to address patients’ housing and other social needs
- Students reported 3x increase in efficacy and confidence to address health-related social needs
Upstream QI Campaign Food Insecurity screening and referral workflow  
(developed at Hayward Wellness Center)

Patient comes in

MA screens for food insecurity during vitals using Hunger Vital Sign

Screen positive

No

Yes

MA documents “not food insecure” in EHR

MA fills out Help Desk Rx and gives to provider

PCP

• Assesses level of food insecurity
• Adjusts care plan
• Provides patient with **Produce Rx AND Help Desk Rx**
• Refers adult, non-pregnant, diabetic patients with A1C > 9 to clinical pharmacist
• Considers referral to relevant group medical visits

Farm provides access to fresh and healthy food and opportunity to build healthy habits

Health Advocates provide customized resources for patient and follow up

Clinical pharmacist provides education and support

DOH groups provide education and support
Customized campaign roadmap to address food insecurity

1. Ask
Use the Hunger Vital Sign to screen for food insecurity

2. Assess
Clinicians should assess the level of food insecurity and adjust care based on level and patient condition

3. Refer
Refer all patients with food insecurity to:
- Help Desk with Help Desk Rx
- Dig Deep Farms with Food Rx
- Relevant group medical visits
- Refer all adult, nonpregnant diabetics with A1c ≥ 9 to a clinical pharmacist
Campaign Overview: Whole clinic activity

- **10/2/17 Campaign launch**
- **9/20 Provider training #1**
- **1/31/18 Campaign end**
- **10/2/17 Campaign launch**
- **Dec Provider training #2**
- **Jan Provider training #3**
Campaign Overview: Example of individual detailer activity

For each visit with care team, detailer should:
- Schedule visit
- Prepare for the visit
- Complete the visit
- Take post visit notes and/or follow up based on conversation
Stages of a detailing visit

- **Introduction**: Sets the tone of the visit, introduces detailer, conveys purpose and importance using personal story.
- **Needs Assessment**: Open ended questions to understand the clinician, his/her practice, beliefs, and concerns to be able to tailor the visit to address that clinician’s specific situation and needs.
- **Key Messages**: limited number of specific practice recommendations that are compelling and evidence based, to bring about behavioral change.
- **Objection Handling**: For each key message, detailer will identify the potential barriers and enablers that might be useful in addressing those barriers.
- **Summary and Close**: An overview of the key messages that the clinician agreed to and asking the clinician to implement some of the key messages/practice recommendations.
Stages of a detailing visit

- **Introduction**: Sets the tone of the visit, introduces detailer, conveys purpose and importance using personal story.

- **Needs Assessment**: Open ended questions to understand the clinician, his/her practice, beliefs, and concerns to be able to tailor the visit to address that clinician’s specific situation and needs.

- **Key Messages**: Limited number of specific practice recommendations that are compelling and evidence based, to bring about behavioral change.

- **Objection Handling**: For each key message, detailer will identify the potential barriers and enablers that might be useful in addressing those barriers.

- **Summary and Close**: An overview of the key messages that the clinician agreed to and asking the clinician to implement some of the key messages/practice recommendations.
Key Message 1: 
ASK with Hunger Vital Sign™

Screening for Food Insecurity

1. Within the past 12 months, we worried whether our food would run out before we got money to buy more. (Yes or No)

2. Within the past 12 months, the food we bought just didn't last, and we didn't have money to get more. (Yes or No)

Although an affirmative response to both questions increases the likelihood of food insecurity existing in the household, an affirmative response to only 1 question is often an indication of food insecurity and should prompt additional questioning. 
Key Message 2: ASSESS level of food insecurity

PCP to ask patient:
1. Has anyone in your household experienced hunger because food ran out or didn’t last long enough?
   a. Adults
   b. Children
   c. Both
2. What kind of food does your household eat?
   a. Healthy, minimal change in quality from when food-secure
   b. Nutrient-poor
   c. Severe lack of nutrition

Levels of Household Food Insecurity
- Low: No hunger in household, concerns about budget lead to changes in buying and managing food
- Medium: Adults report hunger, while children are shielded, diets poor in nutrients
- High: Adults and children experience hunger due to severe cuts in food intake, severe lack of nutrition
Key Message 3: REFER to resources

- Based on workflow, all patients who screen positive should receive:
  - Help Desk Rx and Produce Rx
  - Provider should consider referral to relevant group medical visits
  - If adult diabetic with A1C $\geq 9$, then referral to clinical pharmacist.
- National Hunger Hotline at 1-866-3-Hungry or 1-877-8-Hambre
- Diabetes Self-Management programs
Action kit snapshots – Pocket Guide

- **Audience:** care team members being detailed
- **Use:** Detailers will use to communicate key messages to care team

- **Goal:** to provide succinct pocket guide for care team members to refer to
Action kit snapshots – Clinical tool poster

- **Audience:** care team
- **Use:** To be hung in areas where visible to care team members
- **Goal:** to remind care team of steps and actions for addressing food insecurity

**Food INSECURITY**
Ask your patients about it

**STEP ONE**
**ASK**
Ask your patients to answer the following questions:

1. Within the past 12 months we were worried whether our food would run out before we got money to buy more.
2. Within the past 12 months, the food we bought just didn’t last and we didn’t have the money to buy more.

**SOURCE:** Hunger Vital Signs™

**STEP TWO**
**ASSESS**
Levels of Household Food Insecurity

- **LOW RISK**
  - No hunger in household
  - Concerns about budget lead to changes in buying and managing food

- **MEDIUM RISK**
  - Adults report hunger, while children are shielded
  - Diets poor in nutrients

- **HIGH RISK**
  - Adults and children experience hunger due to severe cuts in food intake
  - Severe lack of nutrition

**STEP THREE**
**REFER**
1. Refer patients to the Food as Medicine program
2. Refer patients to the Help Desk for local resources
3. Refer patients to relevant group medical visits
4. Visit www.FeedingAmerica.org for more info

LEARN MORE AT HEALTHBEGINS.ORG
Action kit snapshots – Patient flyer

- **Audience:** patients
  - Developed at a 6th grade reading level
- **Use:** To be hung in areas where visible to patients or can be printed as a flyer
- **Goal:** to introduce concept of food insecurity to patients and encourage them to get information for themselves
Evaluating Success

- **Process metrics**
  - Change in patterns of care: # patients screened, # referrals, pamphlets handed out, # resource visits by patients
  - Level of engagement of detailers with care teams: # visits, # minutes/visit, barriers identified, commitments attained

- **Outcomes metrics**
  - Change in clinician’s knowledge, attitude, self-efficacy / confidence, behavior
  - Patient outcomes: change in % with food insecurity and respective change in A1c levels
Results of the Hayward Upstream Quality Improvement Campaign

We dramatically improved care for food-insecure patients within 4 months

1. **Objective 1:** Identify food-insecure patients by increasing screening rates from 0% (with Hunger Vital Sign) to 80%

2. **Objective 2:** Improve provider knowledge and confidence regarding care of food-insecure patients (from ~40% to 80%)

3. **Objective 3:** Refer 80% of food-insecure patients to resources

   3a: Refer at least 90% of adult diabetics with A1c > 9 to clinical pharmacist

92% of uncontrolled diabetics referred to clinical pharmacist
Thank you!

Sara Bader, MCD, CPHQ
Senior Manager, Upstream Quality Improvement
HealthBegins

sara@healthbegins.org
Concrete Strategies

- Connecticut Social Health Initiative
- Community Health Detailing
- Project DULCE
Scaling up SDoH Interventions

Project DULCE: Developmental Understanding and Legal Collaboration for Everyone

MaryCatherine Arbour, Baraka Floyd, Samantha Morton, Robert Sege
DULCE’S Intention

Improve health and well-being by transforming the way that families experience the delivery of supports and services from the moment their children are born through the collaborative effort of pediatric, legal, and early childhood system builders.
First six months of infant’s life are uniquely challenging for families

Peripartum depression extremely common
highest risk timeframe for child abuse and neglect
What is DULCE?

• **Universal** pediatrics-based intervention available to families with infants 0-6 months

• Primary care sites bolster family strengths through **6-month partnerships with families** that include:
  – Structured coaching for parents on infant development milestones
  – Proactively detecting and addressing negative SDOH (bolstering family access to Concrete Supports is a *Strengthening Families™* protective factor)

• Key intervention actors:
  • **Highly structured cross-sector interdisciplinary team** that meets weekly
  • **Dedicated Family Specialist** trained and supported by:
    • **Legal partnerships** that strengthen families’ ability to secure concrete supports
    • **Brazelton Touchpoints** training and reflective mentorship to promote knowledge of parenting and child development and to strengthen collaborative parent, child and provider relationships
DULCE: Evidence

Randomized controlled trial conducted at Boston Medical Center (Pediatrics) in 2010-12 showed:

Improved preventive care:
  - RHC visits & immunizations,
  - fewer ED visits,
  - Retention at clinic

Increased access to concrete supports:
  - utilities,
  - food,
  - cash supports

Randomized controlled trial conducted at Boston Medical Center (Pediatrics) in 2010-12 showed:

**Improved preventive care:**
- RHC visits & immunizations,
- fewer ED visits,
- Retention at clinic

**Increased access to concrete supports:**
- utilities,
- food,
- cash supports

In 2015, a DULCE national demonstration project launched in 5 counties in 3 states (CA, FL, VT). For more information: www.dulcenational.org
DULC E leverages the strengths of 3 sectors

Health
- Universal reach
- Longitudinal relationships with families
- Well-versed in the use of standard protocols to improve quality of care

Early Childhood
- Accountable to communities and families
- Immersed in community resources & connections
- Able to drive evidence-informed practices and programs
- Organized to influence policy and practice

Legal
- Well-versed in family rights and system responsibilities
- Professional orientation toward problem-solving and advocacy
- Policy lens and expertise
DULCE: The Intervention

• First 4 well-child visits: screening for maternal depression and barriers to concrete supports, Touchpoints-informed focus on the baby’s developing temperament, personality, anticipatory guidance and related parent coaching.

• 6-month visit: wrap-up to the intervention, transition plan to assure ongoing support within the family-centered medical home & early childhood system

• Weekly interdisciplinary Case Review assures all positive screens are addressed on ongoing basis.

• Leveraging of legal partnerships throughout to help families overcome barriers to concrete supports (including rapid response representation)

• Continuous Quality Improvement to monitor implementation and allow date-based adaptation to local environments
By the infant’s 6 month visit, families will

*Receive all Bright Futures™ recommended routine healthcare visits on time*
- 75% of children get all RHC visits on time
- 80% of expected RHC visits occur on time

*receive high-quality, family-centered RHC visits*
- in 95% of RHC visits the FS will use Touchpoints principles

*connect to supports during the intervention & beyond***
- 90% of families who screen positive for barriers to concrete supports will access supports that they want and for which they are eligible
- 75% of families with mental health or IPV needs receive support
## DULCE Screens for and Addresses Many SDoH

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<th>DULCE Core Screens</th>
<th>DULCE Optional Screeners</th>
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<td>Food Insecurity</td>
<td>Smoking</td>
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<td>Intimate Partner Violence</td>
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<td>Maternal Depression</td>
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</table>
SMART Aim:
By the infant’s 6 month visit, families will

*Receive all Bright Futures™ recommended routine healthcare visits on time*
-75% of children get all RHC visits on time
-80% of expected RHC visits occur on time

*receive high-quality, family-centered RHC visits*
-in 95% of RHC visits the FS will use Touchpoints principles

*connect to supports during the intervention & beyond***
-90% of families who screen positive for barriers to concrete supports will access supports that they want and for which they are eligible
-75% of families with mental health or IPV needs receive support

**Primary Drivers**

**Primary Driver 1.** Infants and their families receive comprehensive primary care enriched by FS engagement during and between RHC visits

**Primary Driver 2.** Systematic identification of family strengths through strategies to promote families protective factors

**Primary Driver 3.** Systematic identification of social determinants of health (including concrete supports needs and mental health/IPV needs) and family-led problem-solving to access benefits, services, and legal protections

**Primary Driver 4.** Interdisciplinary team that a) conducts weekly case review and ongoing collaboration to inform care and b) includes a legal advocate, MH lead and early childhood system representative along with FS, clinic champion, clinic DULCE lead

**Primary Driver 5.** Clinical care for infants is embedded in the local early childhood system to meet families needs and to inform EC system of opportunities, gaps, barriers.

**Primary Driver 6.** Families as partners in DULCE design and implementation

**Primary Driver 7.** Continuous quality improvement: data-driven adaptation to improve DULCE implementation and outcomes for children, families, and interdisciplinary partners.
SCREENING Q. #3: Within the past 12 months, you worried that your food would run out before you got money to buy more; or, SCREENING Q. #4: ...the food you bought just didn't last and you didn't have money to get more.

Are you or your family hungry today?

Yes: Follow clinic protocol for offering family a snack, then re-engage with process map.

No: Orient family to landscape of food bank/pantry resources.

Would you like to learn about eligibility for SNAP and/or WIC?

Yes: Do you currently receive SNAP ("Food Stamps") and/or WIC?

Yes: Are you concerned the SNAP or WIC benefits may be reduced or stopped?

Yes: Consult with Legal Partner about family's legal risks, rights, and remedies.

No: Convey legal information to family (and if Legal Partner authorizes, offer safe hand-off for legal intake interview).

No: Initiate eligibility assessment for WIC, SNAP and/or other financial supports. Follow local site protocol for whether this assessment happens via: (1) FS; or (2) safe hand-off to best available community-based resource.

FS conducts assessment: If complex, consult with LP about assessment (e.g. concerns about immigration consequences).

Community-based resource conducts assessment:

Determine (or confirm with community resource) eligibility status:

Not Eligible: Prioritize concern at Case Review; get guidance from DULCE team on problem-solving strategies; support as appropriate; track outcome.

Eligible: Would you like to apply?

Yes: Support family to prepare application(s) and/or communicate updates to account(s); track outcome.

No: Respect family's decision; re-engage at later time.

Would you like to learn about other financial supports that can bolster a food budget?

Yes: Would you like help updating your SNAP and/or WIC account?

No: Respect family's decision; re-engage at later time.

No: orient family to landscape of food bank/pantry resources.

Is SNAP and/or WIC aware that you have a new baby?
The Children's Clinic - Percent families screened

The Children's Clinic - Percent families w positive screen

Food Insecurity Screening

**KEY**
- Monthly percentage
- N families (see definitions below)*
- Average
- Goal % screens completed (95%)
- Goal % families using resource(s)(90%)

**Black axis**: scale for red squares & line

**Blue axis**: scale for green dotted line

**Blue axis**: scale for blue diamonds
FOOD INSECURITY: The Children’s Clinic Percent
pos. families eligible and interested using resource(s)

Families with pos. screen using/receiving resources

All families with positive screen:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Discussed</th>
<th>Interested in info</th>
<th>Eligible</th>
<th>Interested in applying*</th>
<th>applied</th>
<th>using/receiving</th>
<th>disrupted</th>
<th>using again</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>SNAP</td>
<td>23</td>
<td>15</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Food bank</td>
<td>23</td>
<td>15</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Sibling supports</td>
<td>23</td>
<td>15</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Informal supports</td>
<td>30</td>
<td>15</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

*PATIENT IDS FOR THOSE INTERESTED IN APPLYING

WIC 91000800672 91000800672
SNAP 91000800672 91000800672
Food bank 91000800672 91000800672
Sibling supports 91000800672 91000800672
Informal supports 91000800672 91000800672
Other 91000800672 91000800672

PATIENT IDS FOR THOSE APPLIED BUT NOT USING

WIC 91000781114 91000781114
SNAP 91000781114 91000781114
Food bank 91000781114 91000781114
Sibling supports 91000781114 91000781114
Informal supports 91000781114 91000781114
Other 91000781114 91000781114
RESULTS TO DATE
DULCE identifies mental health needs AND links families to supports

All Sites - Mental Health (IPV & MD) – Screening Summary

Total DULCE families to date = 758

- 93% (705)
- Goal Percent Resource Provided (75%)
- 75% (21)
- Goal Percent Screens Completed (95%)
- 89% (673)
- Maternal depression
  - 14% (95)

Intimate partner violence

- 4% (28)
- Percent of Screens Completed
- Percent of Positive
- Percent Resources Provided
RESULTS TO DATE

DULCE identifies concrete supports needs & links families to supports

All Sites – Concrete Supports - Summary

<table>
<thead>
<tr>
<th>Support</th>
<th>Goal Percent</th>
<th>Percent Screens</th>
<th>Percent Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95%</td>
<td>97% (732)</td>
<td>94% (709)</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>96%</td>
<td>95% (722)</td>
<td>92% (300)</td>
</tr>
<tr>
<td>Income supports</td>
<td>96%</td>
<td>96% (726)</td>
<td>96% (724)</td>
</tr>
<tr>
<td>Housing insecurity</td>
<td>79%</td>
<td>79% (78)</td>
<td>86% (37)</td>
</tr>
<tr>
<td>Housing health &amp; safety</td>
<td>88%</td>
<td>88% (23)</td>
<td>89% (17)</td>
</tr>
<tr>
<td>Employment</td>
<td>56%</td>
<td>56% (61)</td>
<td></td>
</tr>
</tbody>
</table>

Total DULCE families to date = 758

Percent of Screens Completed

Percent of Positive

Percent Resources Provided
• American Academy of Pediatrics (AAP) Policy on *Poverty and Child Health* recommends that pediatricians screen for poverty and provide resources to address it.

• AAP Bright Futures *Fourth Edition (2017)* has new priorities!
  • Highlights parents concerns and SDOH as priorities at EVERY routine visit
  • Strengths based approaches
  • Maternal depression screening 4 times in 6 months

> “This is why I became a pediatrician: to address the things that really matter for families and children. Through DULCE, I can.”

Dr. Sam Singer, Highland Hospital Pediatric Clinic
Oakland, CA
The Key to Executing these Principles:
Weekly interdisciplinary case review

“Make a commitment to weekly case conference -- it is the heartbeat of Project DULCE”

Leslie Larsen, Nurse Practitioner and DULCE team lead
October, 2018

Interdisciplinary team that a) conducts weekly case review and ongoing collaboration to inform care and b) includes a legal advocate, MH lead and early childhood system representative along with FS, clinic champion, clinic DULCE lead
Scaling Up Social Determinants

- Steps to Implementing Social Needs Screening
- Handling Objections
- Interdisciplinary Case Review to monitor, support and supervise the CHW
Steps to Implementing Social Needs Screening
Break!

2:30 p.m. – 3:00 p.m.
Scaling Up Social Determinants

- Steps to Implementing Social Needs Screening
- Handling Objections
- Interdisciplinary Case Review to monitor, support and supervise the CHW
Handling Objections
Objections generally fall into 4 categories:

1. **Stops**: A disagreement with your key messages and rejection of your call to action.
2. **Stalls**: A deferral of decision on your call to action.
3. **On the fence**: An indication that the clinician is open to your position, but just not completely convinced.
4. **Indifference**: A general lack of interest.
Role Play!

Directions:

1. Pair off into teams of 2
2. Assign one person to be the clinician, one person the detailer
3. Scenario: The detailer is teaching the Clinician the “Ask, Assess, Refer” workflow for food insecurity screening.
4. Clinician: Pick a type of objection
5. Detailer: Deliver your key message (Ask, Assess, Refer) in response to the objection
How did that go?
Steps for handling objections:
1. Keep a positive attitude and avoid argument
2. Ask questions to clarify your understanding of the objection and your understanding of clinician’s needs and attitudes.
3. Restate the objection to signal that you are being attentive to the clinician’s concerns, and to confirm that you understand them and have identified the true barrier.
4. Consider whether you are prepared to address the objection then and there, or if you need more information and time to do so. It is ok to say, “let me find out and get back to you.”
5. Respond to the objection, utilizing probing skills and relevant key messages, features/benefits and enablers.
6. Gain confirmation that you addressed the objection successfully.
Handling Objections

Four categories of objections:
1. Stops
2. Stalls
3. On the Fence
4. Indifference

**Stops:** A disagreement with your key messages and rejection of your call to action.
- Based on misunderstandings, skepticism, valid drawback
- Ask clarifying questions to better understand the concern
- **Misunderstandings and skepticism are the easiest to address → provide credible data for your position.**
- Valid concerns about drawbacks can arise out of weighing the facts differently, and should be addressed through acknowledging the concern and framing in the bigger picture where the benefits are worth the costs

**Objection**

“I don’t think approach patients will want to tell us such personal info.”

**How to handle**

“Dr. X, you’re not alone in being skeptical of patients’ willingness to disclose food insecurity.

Data shows that patients are more willing than we might expect. Three peer-reviewed studies have examined patient acceptability. In one study, 80% reported that they either welcomed or did not mind at all inquiries about social needs.”
Handling Objections

Stalls: A deferral of decision on your call to action, or avoidance of making decisions
- Difficult because it keeps you from knowing the learner’s true thinking
- Ask direct questions.
- Depending on what you uncover, you may need to handle a true barrier

Four categories of objections:
1. Stops
2. Stalls
3. On the Fence
4. Indifference

Objection: "We have a staff meeting next week and we will discuss the situation and make a decision."

How NOT to handle
Accepting the stall: "Ok, I will follow up on Monday"

How to handle
Probing for better understanding: "Based on the information we discussed today, what will your recommendation be at the meeting?"
Handling Objections

Four categories of objections:
1. Stops
2. Stalls
3. On the Fence
4. Indifference

**On the fence:** An indication that the clinician is open to your position, but just not completely convinced.
- Ask open-ended questions to better understand what benefit is missing for them. What would be convincing?
- Offer information, benefits related to the concern.
- Confirm resolution of issue

**Objection**

“\[Objection\]

**How to handle**

“\[How to handle\]

“I understand how your approach could be useful, but I am worried we won’t be able to implement it.”

“What part of the implementation do you think will be the most difficult?

Is there a different approach that can still help us address patient’s food insecurity?”
Handling Objections

Four categories of objections:
1. Stops
2. Stalls
3. On the Fence
4. Indifference

**Indifference:** A general lack of interest.
- Acknowledge the clinician’s point of view.
- Request permission to probe.
- Use closed-ended probes to create awareness of a need.
- Confirm recognition of the need.
- Show how the need can be met

"Ok but I have a lot of other things to worry about."

"Have you had patients who have had a really difficult time getting their diabetes under control even thought it seemed they were taking their meds? Would it have been helpful to have a tool to find out more information about their self management and coping behaviors?"
Role Play – Again!

Directions (again!)
1. Pair off into teams of 2
2. Assign one person to be the clinician, one person the detailer
3. Scenario: The detailer is teaching the Clinician the “Ask, Assess, Refer” workflow for food insecurity screening.
4. Clinician: Pick a type of objection
5. Detailer: Deliver your key message (Ask, Assess, Refer) in response to the objection
How did that go?
Scaling Up Social Determinants

- Steps to Implementing Social Needs Screening
- Handling Objections
- Interdisciplinary Case Review to monitor, support and supervise the CHW
Aligning the Team for Successful SDOH Problem-Solving with Families: The DULCE Interdisciplinary Case Review
Setting the [Case Review] Table

1. What is a case review?

2. What is the DULCE Interdisciplinary Case Review?

3. Time for some cross-sector knowledge transfer! A Concrete Supports Quiz

4. DULCE Case Review – A Case Study
What is a case review?

Members of a transdisciplinary team cross professional discipline boundaries to **achieve service integration by consulting... one another**. They do not abandon their discipline, but blend specific skills with other team members to focus on achieving integrated outcomes...team members accept and build upon each other’s knowledge and skill.

(Pletcher & Younggren 2013) (emphasis added)
What is the DULCE Interdisciplinary Case Review?

- Weekly 60-90 min. meeting

- Attended consistently by:
  - Family Specialist (CHW-equivalent)
  - Mental Health Lead
  - Legal Partner
  - Early Childhood System rep
  - Pediatrician or NP
  - Clinic Administrator

- To inform quality care for DULCE families, including:
- Assuring all positive screens for Maternal Depression, IPV, or barriers to Concrete Supports are addressed promptly and on ongoing basis
Purpose

- Systematizing team-based SDOH problem-solving
  - Quality assurance – no DULCE families with barriers to concrete supports “fall through the cracks”
  - Support for the Family Specialist (CHW-equivalent)
  - Discipline-specific issue-spotting and problem-solving action items
Key Features

- Shared cross-sector structure and process
- Issue-spotting
- Shared reflective practice
  - Mental Health lead engages reflective practice to FS
  - Reflective practice extends to other team dyads and relationships and optimally informs broader DULCE team culture
- “Role Release”
- Holding Tension
Capacity-building and Knowledge Transfer via DULCE Interdisciplinary Case Review . . .

A Concrete Supports Quiz!
Multiple Choice

As a practical matter, as long as you’re income-eligible and meet other eligibility requirements, you’ll start receiving the following benefits within a matter of days or weeks:

A. SNAP (food stamps)

B. TANF (welfare)

C. Federally subsidized housing (public, Section 8, etc.)

D. A & B
True or False?

Addiction is considered a qualifying disability for SSI/SSDI.
False
True or False?

An immigrant placed into deportation proceedings is constitutionally entitled to a lawyer free of charge.
False
True or False?

A child who is in the U.S. on a visitor visa can automatically extend that visa if they get very sick and need intensive medical care here.
False
Rosa is a single mom with a 3 month-old and a 6 year old. Since her partner left, Rosa can’t afford the rent. For years she’s complained to the landlord about the leaky roof and resulting mold.

Now she is 3 months behind in the rent. Yesterday, the landlord left her a voicemail telling her to leave by the end of the week. He said he’s owed the rent, and he’s tired of listening to screaming children, anyway.
Practice: How can DULCE support Rosa?
Part 1 of 2

Rosa is cutting back on groceries because she’s worried about catching up on rent. Her older child has a special diet due to multiple food allergies.

Rosa knows her kids may be eligible for SNAP but is afraid to apply.

Her ex applied for a green card for her a few years back but now he’s gone. It was a hard relationship so she’s relieved he’s out of the picture, but Rosa is worried about what this means for her immigration status.
Thank you!
What are you going to do by next Tuesday?
Thank you!