Screening for Social Determinants of Health: Should We Move Beyond the Hunger Vital Sign?

VCHIP CHAMP Learning Session
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Disclosure

• We have no relevant financial relationships to disclose or conflicts of interest to resolve
• We will discuss no unapproved or off-label pharmaceuticals
Think of a patient encounter of yours where some social factor was impacting health and it changed your management.

Objectives

1. Review the importance and recommendations of screening for social determinants in pediatrics
2. Review tools and processes for expanded SDoH screening
3. Share our experience of screening
Social Determinants of Health:
The economic and social conditions that influence differences in health status
Total Estimated Costs of Food Insecurity and Hunger in the US

• Total Direct and Indirect Costs: 160 Billion
• Estimated Education Costs: 19 Billion
Everyone Recommends Screening
The current state of comprehensive health related social needs (HRSN) screening tools

I’m convinced there is value in screening – what screen should I use?

- There is a lack of validated, multidimensional, comprehensive screening tools for pediatric care professionals.¹
- There has been wide variation in how researchers and health care organizations develop, validate, and implement tools for identifying/addressing patients’ social needs.
- The lack of standardized workflows/screening tools has largely resulted in ad hoc efforts to assess patients’ social needs with varying degrees of success and validation in terms of sensitivity, specificity, or evidence that outcomes are altered.³
- This is currently an area of tremendous flux and study, as we move along the learning curve!

Butler. AMA Forum: Building Blocks for Addressing Social Determinants of Health. JAMA Form. 2017
<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Topics</th>
<th>Questions</th>
<th>Time</th>
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<tbody>
<tr>
<td>Accountable Health Communities Health Related Social Screening</td>
<td>Food insecurity, housing, safety, transportation</td>
<td>10</td>
<td>2 min</td>
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<tr>
<td>SEEK (Safe Environment for Every Kid)</td>
<td>Safety, Food, Parental Depression, Parenting, Substance Use</td>
<td>15</td>
<td>2 min</td>
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<tr>
<td>Health Leads Screening Tool</td>
<td>Financial stress, food insecurity, housing, transportation, safety</td>
<td>10</td>
<td>3 min</td>
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<tr>
<td>IHELLP (Income, Transportation, Housing, Education, Legal Status, Literacy, Personal Safety)</td>
<td>Literacy, Immigration/legal status, literacy, safety, transportation</td>
<td>11-24</td>
<td>5 min</td>
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<tr>
<td>PREPARE (Protocol for Repsonding to and Assessing Patients’ Assets, Risks, and Experiences)</td>
<td>Education, employment, incarceration, financial stress, safety, transportation</td>
<td>17-21</td>
<td>9 min</td>
</tr>
<tr>
<td>We CARE (Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education)</td>
<td>Child Care, Education, Employment, Food insecurity, Housing</td>
<td>10</td>
<td>&lt; 5mi</td>
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Places to find screening tool comparisons: [https://screeningtime.org/star-center/#/screening-tools#top](https://screeningtime.org/star-center/#/screening-tools#top)  
[https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/peds](https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/peds)
Providers often describe:

• Lack of recognized impact or measurable outcomes
• Lack of time
• Lack of professional training
• Lack of familiarity with relevant assessment tools
• Lack of knowledge of relevant community resources
• Will family’s feel it is appropriate?

• Chung, et. al, Current Problems Pediatric Adolescent Health Care, 2016
• Suburban Families’ Experience with Food Insecurity Screening in Primary Care Pediatric Practices. Palakshappa et al. Pediatrics. 2017
Avoiding the Unintended Consequences of Screening for Social Determinants of Health

Key Principles:

1. Ensure patient and family-centered screening for SDoH
2. Emphasize shared decision making
3. Integrate screening with referral and linkage to community-based resources
4. Perform screening within the context of a comprehensive systems approach
5. Use a strength-based approach to support patients and their families
6. Do not limit screening practices based on apparent social status

Garg et al. Avoiding the unintended consequences of Screening for Sdoh. JAMA Network. 2018
2018-19 VCHIP CHAMP Project: Screening for Food Insecurity

Results: Food Insecurity Composite Screening Rates

20 practices chose this topic
Our Experience in Pediatric Primary Care 2016 to Present
How did we choose a SCREENING TOOL?

Over the past 3 years:

• Initially started using the “SEEK”

• Participated in a task force with Family Med, Adult Med, and inpatient to use CMS 10 tool

• Included the PHQ-2 to screen for parental mental health

• Patient advisory group reviewed and recommended changes
• Decided on Annual Screening at health supervision (well child) visits
• Started with ages 2-12 years. Why?
  • Weren’t sure which younger visits to choose? Also more paperwork (Edinburgh depression screen, ASQ)
  • Weren’t ready to tackle screening parents of adolescents
• Expanded to all ages ~ 1 year later
  • Screen at 2-4wk, 1 year, and 2 year visits and annually after that.
• Screening process involved the whole office integrated into our “normal” flow
  • Paper screening tool given to parents at check-in
  • MA/LPN enters results into the computer
  • Clinician reviews results with the family
**Process Flow Map: Food Insecurity or Social Determinant of Health (SDoH) Screening**

**Patient for HS visit annually from birth on**
- SDOH screening tool given to parent by front desk
- LPN/CCA collects SDOH screening tool and enters into Epic
- MD/NP reviews SDOH results

**Positive Screen?**
- Yes: MD/NP Discusses importance of SDoH and normalizes.
  - Ask: “Would you like help with this?”
  - Yes: MD/NP offers intervention to family (Shared Decision-Making conversation; Use Resource Handout)
    - Discuss importance of SDoH and normalize screen
    - Discuss family strengths
    - Resource handout (if they want it)
    - MD/NP documents intervention in SDOH flowsheet and note
    - Add to Problem List
  - No: MD/NP Discusses importance of SDoH and normalizes.

- No: Visit per usual
  - Discuss importance of SDoH and normalize screen
  - Discuss family strengths

**Screen Results?**
- Positive in 1 domain
- Globally Positive

**MD/NP offers intervention to family (Shared Decision-Making conversation; Use Resource Handout)**
1. Social Work consult
2. Help Me Grow/211 referral
3. Specific resource referral

- Place CHT order in EPIC
- Web-based or phone referral
- Direct family there (resource handout)
Patient for HS visit annually from birth on

SDOH screening tool given to parent by front desk

LPN/CCA collects SDOH screening tool and enters into Epic

MD/NP reviews SDOH results

Positive Screen?

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MD/NP Discusses importance of SDoH and normalizes.

Ask: "Would you like help with this?"

• Discuss importance of SDoH and normalize screen
• Discuss family strengths
• Resource hand out (if they want it)

No

Screen Results?

Positive in 1 domain

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Globally Positive

Visit per usual

• Discuss importance of SDoH and normalize screen
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Screen Results?

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Add to Problem List

Place CHT order in EPIC

Web-based or phone referral

Direct family there (resource handout)
What is Resilience?
The ability to return to being healthy and hopeful after bad things happen.

Resilient Families:
- Have resilient parents who solve problems, build relationships with other adults, and seek help when necessary.
- Create social connections with family, neighbors, schools, church and community.
- Meet basic needs such as safe housing, nutritious food, clothes, health care and education. Can access services and supports during hard times.
- Understand how children grow, and how to encourage healthy development.
- Help children manage their emotions and communicate their feelings and needs. Family members listen to one another and respond with patience.

Tips for Building Resilience in Kids:
- Make eye contact.
- Simply notice what your child is doing.
- Manage your own emotions, breathe.
- Play simple back and forth games like catch, counting or alphabet games, I-Spy.
- Keep a sense of humor.
Food Resources

WIC (Women, Infants, Children)
Burlington: 1-888-253-8803/1-802-863-7323
- For income eligible women, new mothers, infants, and children up to age 5
- Kids on Medicaid/Dr. Dynasaur automatically qualify

Vermont Food Help: Hunger Free Vermont
1-800-479-6151
- Benefits specialists to help
- Hours and requirements vary for each location.

Help preparing meals on a budget?
- WIC Nutritionists
- Hunger Free Vermont Learning Kitchen
  1-800-479-6151
- Vermont Expanded Food & Nutrition Education Program
  802-668-2311

Mental Health Services

24 hour, 365 day services
First Call for Chittenden County—24 hour crisis line.
802-488-7777

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

Crisis Text Line
Text 741741 when in crisis

Economic Services

211/Help Me Grow
Call 211 or text your zip code to 898211.
Person-to-person assistance is available 24/7.

Economic Services
Call 1-800-479-6151
- 3SquaresVT (Food Stamps)
- Emergency and Fuel Assistance
- Reach Up

CVOEO—Champlain Valley Office of Economic Opportunity
802-863-6248
255 South Champlain St, Burlington
- Housing and Emergency Assistance
- Food Shelves
- Tax Preparation
  Hours: Monday - Saturday 5:00pm-6:00pm

Personal Safety

Domestic and Sexual Violence Support—
STEPS To End Domestic Violence
24 hour hotline
802-688-1996
www.Stepsvt.org

Hope Works
Sexual Violence Support
802-863-1236
800-499-7273
www.Hopeworksvt.org

Safe Space
working to end physical, sexual, and emotional violence in the lives of lesbian, gay, bisexual, transgender, queer, and HIV-affected (LGBTQH) people: www.pridesentryvt.org/services
local: 802-863-3003
toll free: 866-888-7941

Food Pantries/Free Meals

For the most up-to-date sites and times throughout Vermont, contact:

211/Help Me Grow
Call 211 or text your zip code to 898211.
Person-to-person assistance is available 24/7

Burlington
Chittenden Emergency Food Shelf
228 North Winooski Ave, Burlington
802-658-7939

Old North End Community Dinner
Salvation Army
We used QI tools and measured

SMART Aim (2018 Quality Metric):
To screen for food insecurity (using the Hunger Vital Sign embedded in the CMS Accountable Health questions) at 50 percent of health supervision visits for children aged 2 to 12 years by September 30th, 2018.

TEST 1: Started using a paper interval screener with questions at HS visits 2 years – 12 years

TEST 2: Developed some dot-phrases we can use to document results

TEST 3: Changed to standardized 10 question screener that was built into the EHR
Had the CCA/LPN’s start entering this data into the EHR.

TEST 4: Expanded screening to include the 2-4wk visit and the 12 month visit and annually after that

TEST 5: Created on handout we can use as a communication tool for families

TEST 6: Held “lunch and learns” to improve our knowledge of community partners

PDSA Ramp

We used QI tools and measured
How have we done? Percentage of well child visits completing screening

Screening for Social Determinants of Health

Goal = 80%

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Percentage of patients aged 0-18 years screened annually for social determinants of health at their well child visit

- Burlington
- Williston
- Total Clinic
How have we done? Percentage of positive Screens

Monthly Percentage of Positive Screens by Domain from Social Determinants of Health Screening
9/2019 - 8/2020
Family Provider and CCA/LPN Team

Accessible, Continuous, Comprehensive, Coordinated, Family-centered, Compassionate, Culturally effective

Mental Health Needs: Logan Hegg, PsyD Rebecca Ruid, PhD

Children with Complex Medical Care Coordination Needs: Krissa Jamieson, RN Kristy Trask, RN (chronic/terminal conditions)

Children with Special Health Needs Social Work: DOH 802-863-7338

Developmental Behavioral Pediatrics: Elizabeth Forbes, MD Kathy Workman, PhD Susan Meyer, LICSW Nora Sabo, MSW

Asthma: Beth Kranz, RN

Mental Health, Psychosocial & Socio-economic Care Coordination: Kate Cappleman Sinz, LICSW

PNAC/New American Social Work Care Coordination: Cathy Kelley, LICSW

Psychiatry Partners: *VCCYF/ Autism Assessment Clinic *CHCB Pediatric Consultation

Accessible, Continuous, Comprehensive, Coordinated, Family-centered, Compassionate, Culturally effective
Thank you for answering these questions. This is important for your health.

1. What supports do you currently have (WIC, 3Squares)? Who currently helps you with this?
2. Would you like support around this?
Lessons Learned

• Families are not surprised and generally accept doing this screening
• The more we have these conversations the more natural it gets
• There is a lot more that having the ”right” screening tool
  • The nuances of “how” you ask matter a lot
• It is a shared decision-making conversation
  • Ask about current supports and family wishes
• We still can’t ”fix” all the positive screens
• We are still trying to improve our connections with community partners
• Covid has up-ended our paper-based screening process
New American families

- **More obvious barriers:** language, cultural practices/beliefs/preferences, many large/extended families

- **Less obvious:** access issues caused by low literacy, lack of familiarity with resources, transportation issues, stigma, fluctuations in income

- **COVID-related:** challenges created by unemployment (decreased 3Squares benefits, increased rent, fluctuating equation)

- **Systems issues:** ongoing barriers reflecting lack of education/refusal to adapt service provision, systemic bias/discrimination/racism

- **Consider:** community-based resources, including programs serving this population (USCRI-VT, AALV), mutual aid programs (Winooski Mutual Aid), school-based assistance, Family Room and other organizations which have stepped up to fill in gaps
Everyone Eats:

- Partnership with Skinny Pancake, Intervale Center, Vermont Community Foundation and High Meadows Fund
- Provides nutrition meals; source of income for restaurants, farms and food producers
- Frozen meals for families screening positive for food insecurity and negatively impacted by Covid

Electronic referral connection with Feeding Chittenden and 211

- With Children’s Hospital, applied for grant funding
- Easier referral to sources of support
- Connect with online grocery ordering program for food insecure families
In Conclusion

• Screening for social determinants of health (besides the HVS) can be done
• The tools we have are imperfect and this will continue to evolve
• Remember the strengthening families paradigm
  • We can help connect families to concrete support in times of stress
  • We can help families identify areas of strength and help families cope
  • We can do this in a family-centered way without judgement that respects families decision making

Thank you for all the work you are doing to care for patients and families!
Healthcare and Community partnerships in Minnesota

It’s hard to be healthy when you are hungry.

The Food Shelf @ HCMC
References

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• Chung, et. al, Current Problems Pediatric Adolescent Health Care, 2016

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Return to Main Webinar Space

Click the link in the Chat (or email/agenda) to return to the main webinar space

When prompted, select “Yes” to leave the main webinar room and join the breakout session

Up Next

**Wrap-Up** (for General Learning Session)
**Presenters:** Wendy Davis, MD, FAAP and Breena Holmes, MD, FAAP

**MOC QI Project Orientation and Overview**
**Presenters:** Stan Weinberger, MD, FAAP and Chris Pellegrino, MS, ASQ CMQO/E