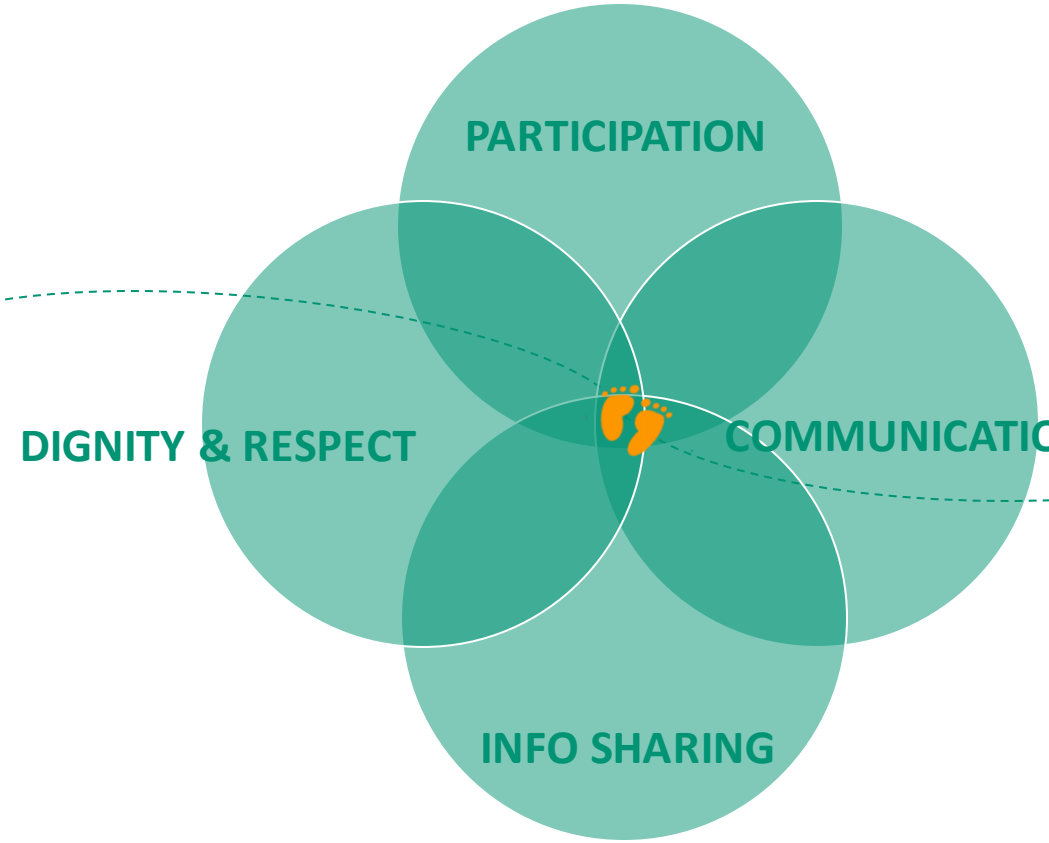
Driver 2:
Health Related Social Needs

Patoula Panagos, MD

PROCESS

OUTCOME

NICU ADMISSION



DC PREPARATION

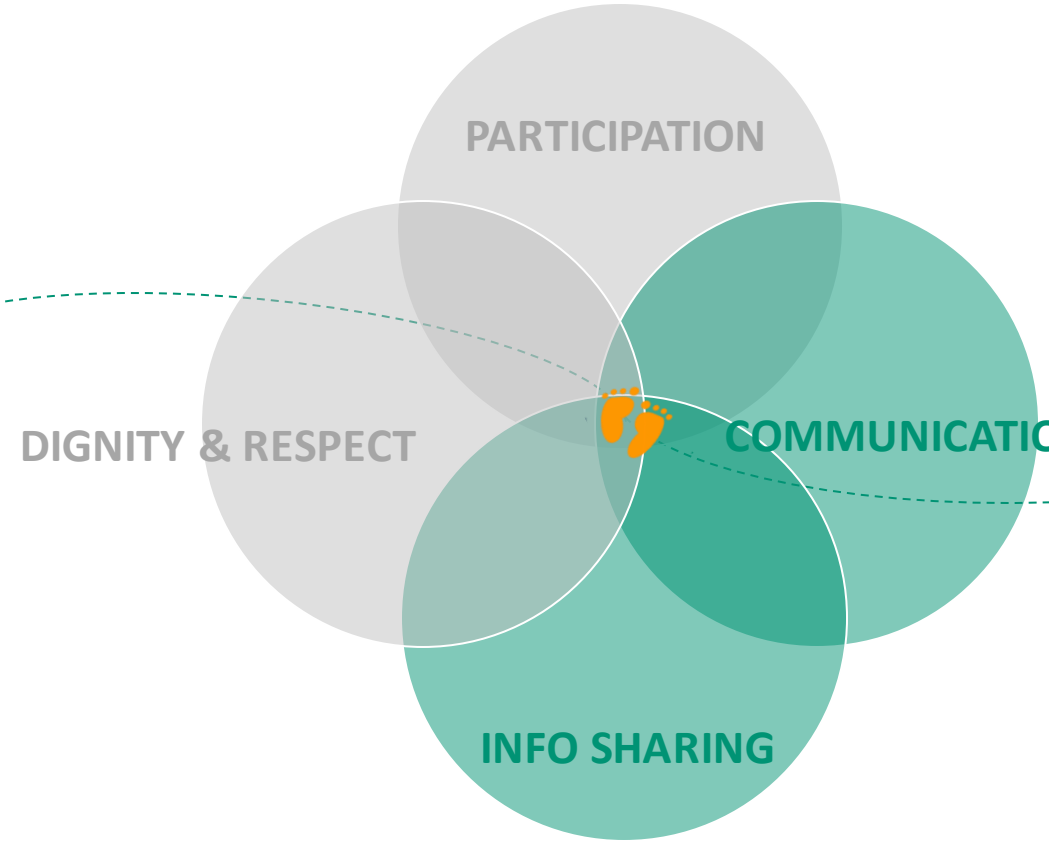
DC READINESS

1. Technical Skills/Knowledge
2. Emotional Comfort
3. Confidence

PROCESS

OUTCOME

NICU ADMISSION



DC PREPARATION

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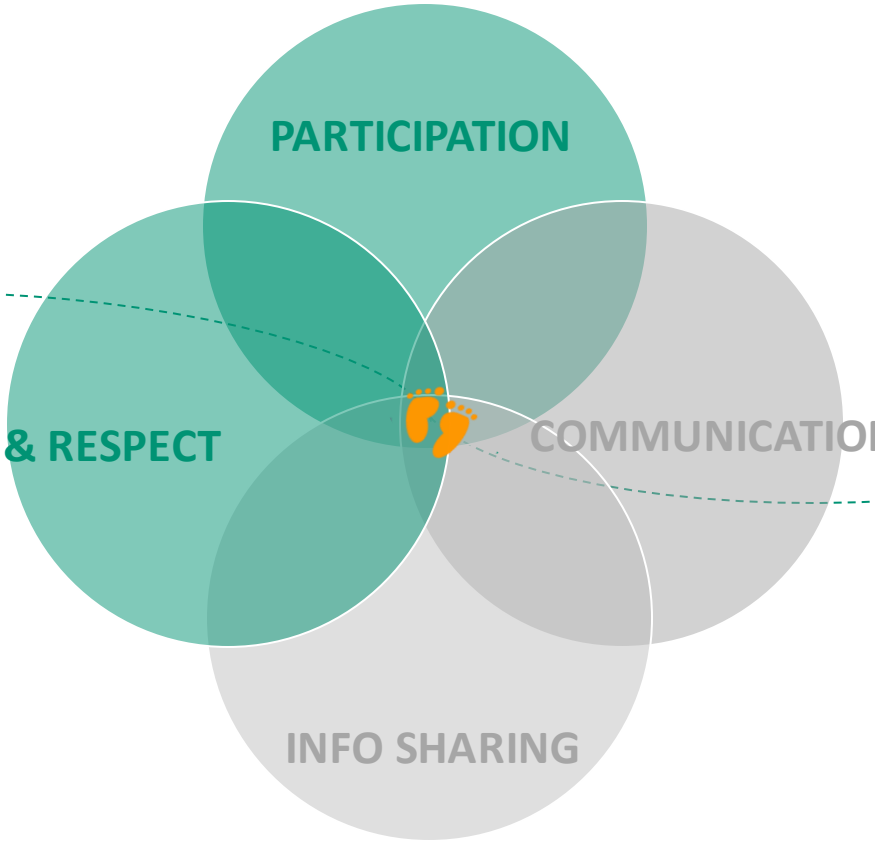

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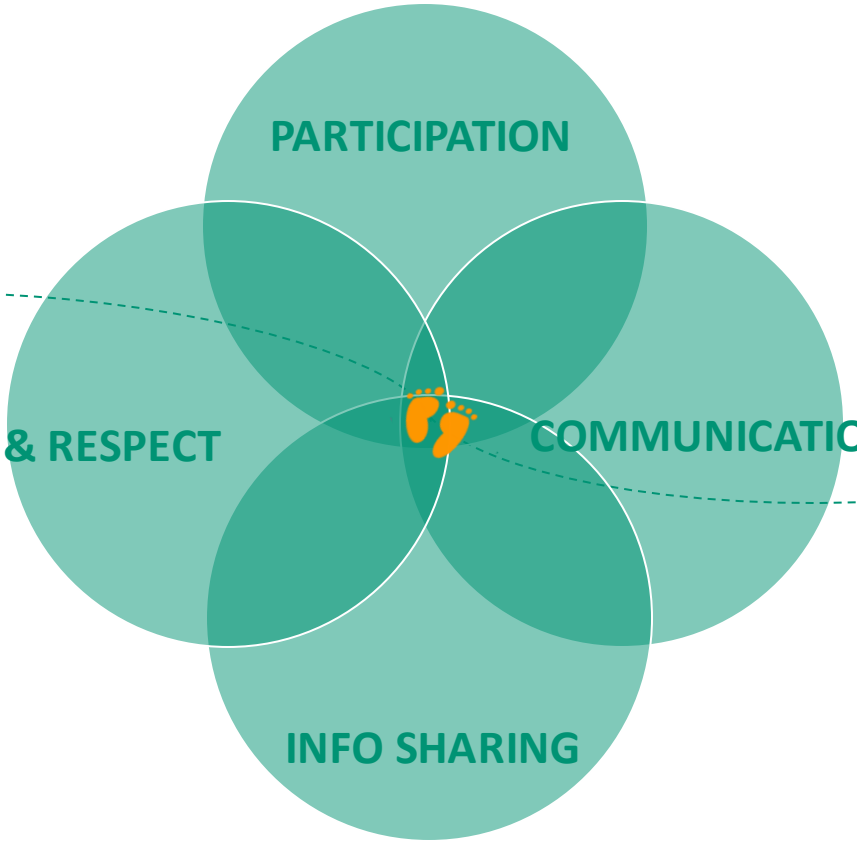

DC PREPARATION

HIGH RISK DISCHARGES

- Active substance use / misuse
- Inadequate prenatal care
- Teenage parents
- Family interpersonal violence
- Housing insecurity
- Food insecurity
- Relationship instability
- Mental health conditions
- Limited socioeconomic resources
- Low health literacy
- Family incarceration
- Transient or migratory families

HOMEWARD BOUND

Primary Key Driver

Health Related Social Needs

Secondary Drivers

- Assess family needs and connect to resources
- Train and commit to dignity and respect in all family interactions

HOMEWARD BOUND

Vision: Integrate family into a "Family Centered" discharge process that encompasses Dignity & Respect, Participation, Communication, and Information Sharing. The process begins on admission, empowering families to collaborate with the clinical interdisciplinary team throughout their baby's transition from NICU admission to discharge home.

Primary Key Driver

Health Related Social Needs

Secondary Drivers

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Family-centered care is a universal component of every driver & activity

HOMEWARD BOUND

Primary Key Driver

Secondary Drivers

Health Related Social Needs

- Assess family needs and connect to resources
- Train and commit to dignity and respect in all family interactions

Health-Related Social Needs (HRSN)

- The varying social needs of people that live in a community and share similar SDOH.

- Domains of social needs (prioritized by CMS):
  1. Housing instability
  2. Food insecurity
  3. Transportation problems
  4. Utility help needs
  5. Interpersonal safety

Health-Related Social Needs (HRSN)

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  5. Interpersonal safety*

*High risk infant discharge

***HIGH RISK DISCHARGES**

Active substance use / misuse
Inadequate prenatal care
Teenage parents
Family interpersonal violence*
Housing insecurity*
Food insecurity*
Relationship instability
Mental health conditions
Limited socioeconomic resources*
Low health literacy
Family incarceration
Transient or migratory families

Cause for Action: AAP 2016 Recommendation

Universal Screening for adverse Social Determinants of Health (SDOH) and delivery of referrals for resources for unmet basic needs within Pediatric Care

Where are we?

Current approaches to screening for SDOH and making referrals to appropriate resources are unclear

Parker, et. al, 2021

Only 23% of US level 2 to 4 NICUs reported standardized SDOH screening

Cordova-Ramos, et. al, 2022

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HOMEWARD BOUND

Secondary Drivers

Assess Family Needs and Connect to Resources

Primary Key Driver

Health Related Social Needs

Train and commit to dignity and respect in all family interactions

NICU ADMISSION

PROCESS

PARTICIPATION

DIGNITY & RESPECT

COMMUNICATION

INFO SHARING

DC PREPARATION

OUTCOME

DC READINESS

1. Technical Skills/Knowledge
2. Emotional Comfort
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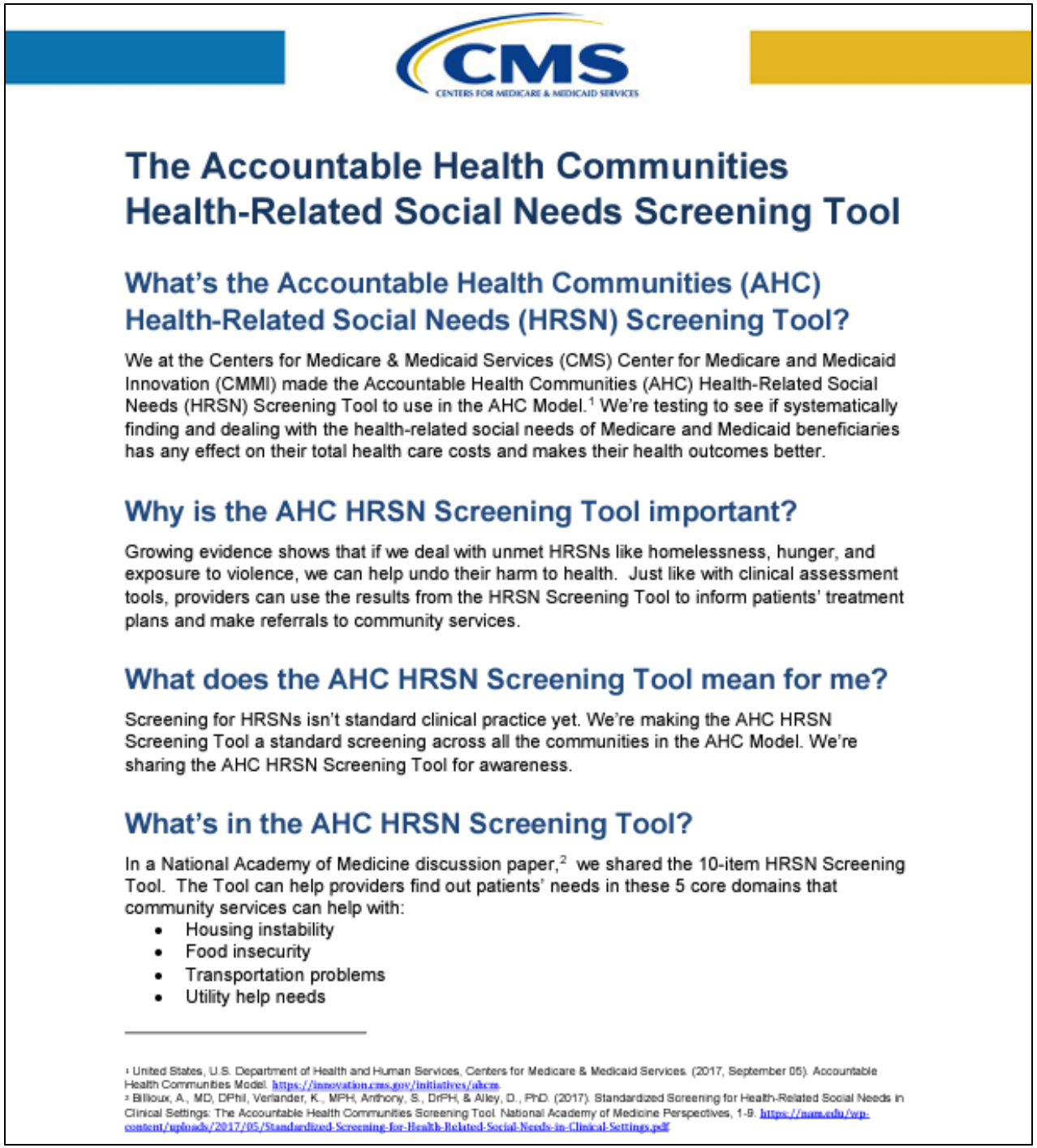
Implement HRSN Assessment

Potentially Better Practices

- **Implement a policy, guideline, or procedure to administer the Health-Related Social Needs (HRSN) Assessment tool**
- **Connect families to resources and referrals**

HRSN Screening Tools & Tips



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

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[1] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.

[2] Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

HRSN Screening Tools & Tips

"I'd like to ask you more about your family and who's helping you already so that we can plan next steps together." Some other open-end questions include:

- Where are you currently living? Is this where you will be living after discharge or will you be moving?
- Who lives in the home with you? Who stays with you regularly? Who visits?
- Are there any family members (e.g., extended family) or other support people who live near you?
- Who are the support people that your family relies on?
- Is there anything that the NICU staff should understand about your family to better serve you?
- Are other children in the family receiving any services or supports? Do they have any unmet needs?
- Who contributes to your family financially and economically? Who helps meet your needs?
- How is your family's health care covered and paid for?

Table 12. Family and home needs assessment content.

FAMILY AND HOME NEEDS ASSESSMENT CONTENT	
RECOMMENDATIONS	**SUPPORTING REFERENCES**
FAMILY LIVING ARRANGEMENT ASSESSMENT	
Assess where the family is currently living and where they will be living after discharge. Ascertain if there are special considerations related to location that could affect discharge planning (e.g., rural setting or limited local resources).	[3, 6, 16, 27]
HOME SUPPLIES ASSESSMENT	
Prior to discharge, confirm the family has the supplies and equipment they will need to provide care for their infant at home. This includes, at minimum, confirming they have a food, diapers, crib/bassinette, safe sleep environment, and a car seat for the infant.	[3, 4]
HOME ASSESSMENT	
The home assessment should confirm secure housing for the family and gauge basic essentials such as safe/adequate water, electricity, heat, cooling, smoke/carbon monoxide detectors, and if needed space for medical equipment. When appropriate, ask about the physical space in which the family will be living to make sure it can accommodate appropriate home medical equipment.	[3, 16, 27]
TRANSPORTATION ASSESSMENT	
Determine if the family has any problems with transportation that would adversely affect their ability to attend medical follow-up appointments. With the family's permission, communicate this with community providers. Offer information on medical transportation.	[2, 3, 9, 16, 27]
CHILD CARE NEEDS	
Explore with the family their plan for child care after discharge from the NICU. Help them communicate their babies' needs with caregivers.	[2, 3, 9, 16, 27]
NUTRITION ASSISTANCE	
Determine if families meet criteria for social programs including Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP) (formerly referred to as food stamps), Supplemental Social Security Income (SSI), SSI Disability, etc.	[2]
SOCIAL SUPPORT NEEDS	
Evaluate what social supports the family has in place (or anticipates will be in place) at discharge as well as what supports they may still need. Also, ask how the family feels about the receiving social supports.	[2, 3, 9, 16, 27]
FAMILY COPING STYLE	
Learn about the family's coping habits and styles. Offer supportive resources.	
PARENTAL MENTAL HEALTH	
Assess parents for mental health complications in the NICU and incorporate the results into the discharge planning, This is especially important for those with a known history of mental health issues, including postpartum depression (typical and atypical), anxiety, and post-traumatic stress.	[2, 3, 6, 9, 14, 15]
Request a mental health assessment if there is concern about the parents' bonding or attachment with the infant. This should be informed by parent report and based on the observed behavior. Provide parent-infant mental health support.	[9]
SOCIAL OR SAFETY CONCERNS	
Develop safety plans in collaboration with the family when there are social and/or safety concerns.	[2]
Assessment of the family should include screening for interpersonal violence and parental substance misuse.	[2]

The Association of Social Factors and Time Spent in the NICU for Mothers of Very Preterm Infants

Socioeconomic Status	Mothers with an annual household income of over $100,000 were 5.68x more likely than those with an income below $50,000 (CI: 1.77-18.19)
Travel Time	Mothers with a travel time of less than 30 minutes were 7.85x more likely than those with a travel time of more than an hour (CI: 2.81-21.96)
Presence of other dependents	Mothers with no other children in the household were 3.15x more likely than those with other children (CI: 1.39-7.11)

Social Factors that contributed to more time spent with the baby in the NICU include:

Bourque, et. al, 2021

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HRSN Screening: Implementation

- Design process to achieve HRSN screenings on infants in the NICU.

- Process considerations:

  - Retrieve HRSN screening from Maternity unit to ensure that positive screenings for adverse social needs are translated into the infants chart.

  - If the screening is not completed for mother, then ensure that a HRSN screening is completed during the infants stay in the NICU.

  - Repeat screening if HRSN change during NICU stay.

HRSN Screening: Referrals

- Adapt a care plan for families that screen positive for HRSN.

- Provide the applicable resources and referrals.
  - Ensure a family centered transition to home
  - Prevent a delayed discharge transition to home

- Practice Shared Decision-Making with the family to promote completion of referral process.

Link Patients to Available Community Services

- Connect with Health Start Coalition
- Resource Directory for your community
- Review quarterly

Linkages to Services & Resources Recommendations

Florida Healthy Start
Florida Association of Healthy Start Coalitions

findhelp

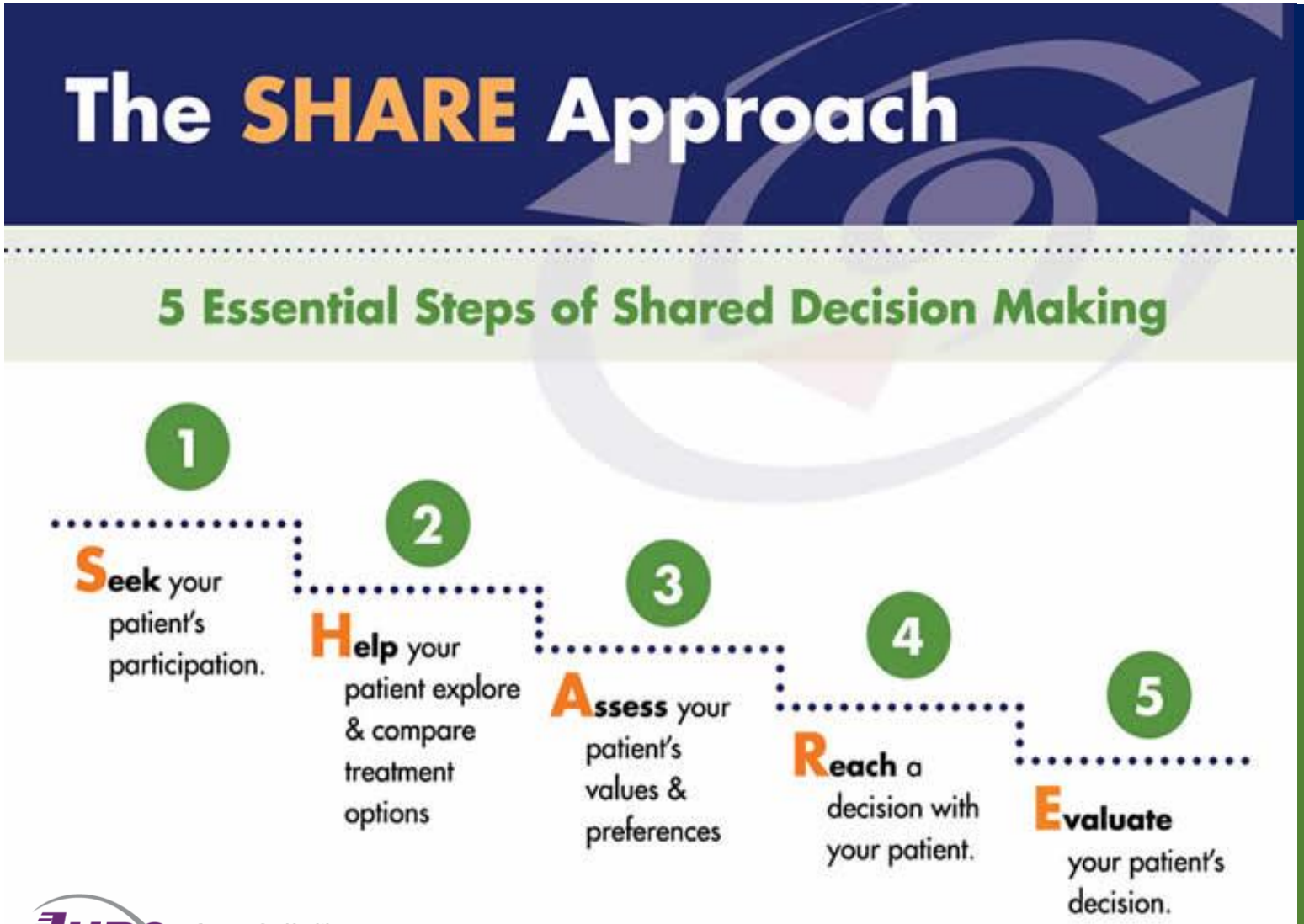
UNITE US

Others?

***Live toolbox**

FPQC

Promote completion of the referral process



Improvement:

1. Quality of care delivered
2. Patient satisfaction
3. Patient care experience
4. Patient adherence to treatment recommendations

HOMEWARD BOUND

Secondary Drivers

Assess family needs and connect to resources

Primary Key Driver

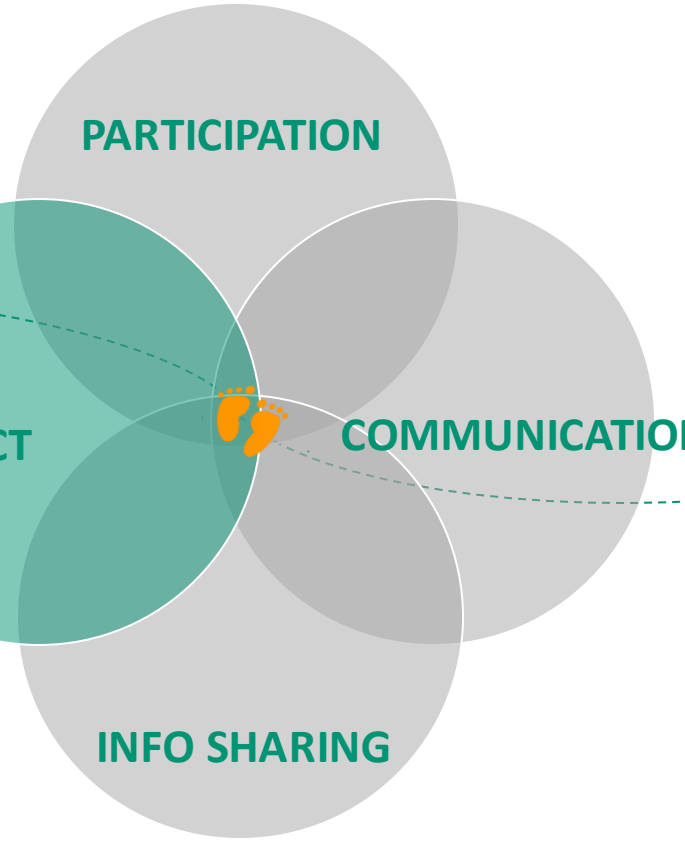
Health Related Social Needs

Train and commit to dignity and respect in all family interaction

PROCESS

OUTCOME

NICU ADMISSION



DC PREPARATION

DC READINESS

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Smith et al. (2022) Recommendations: Respect toward NICU Families

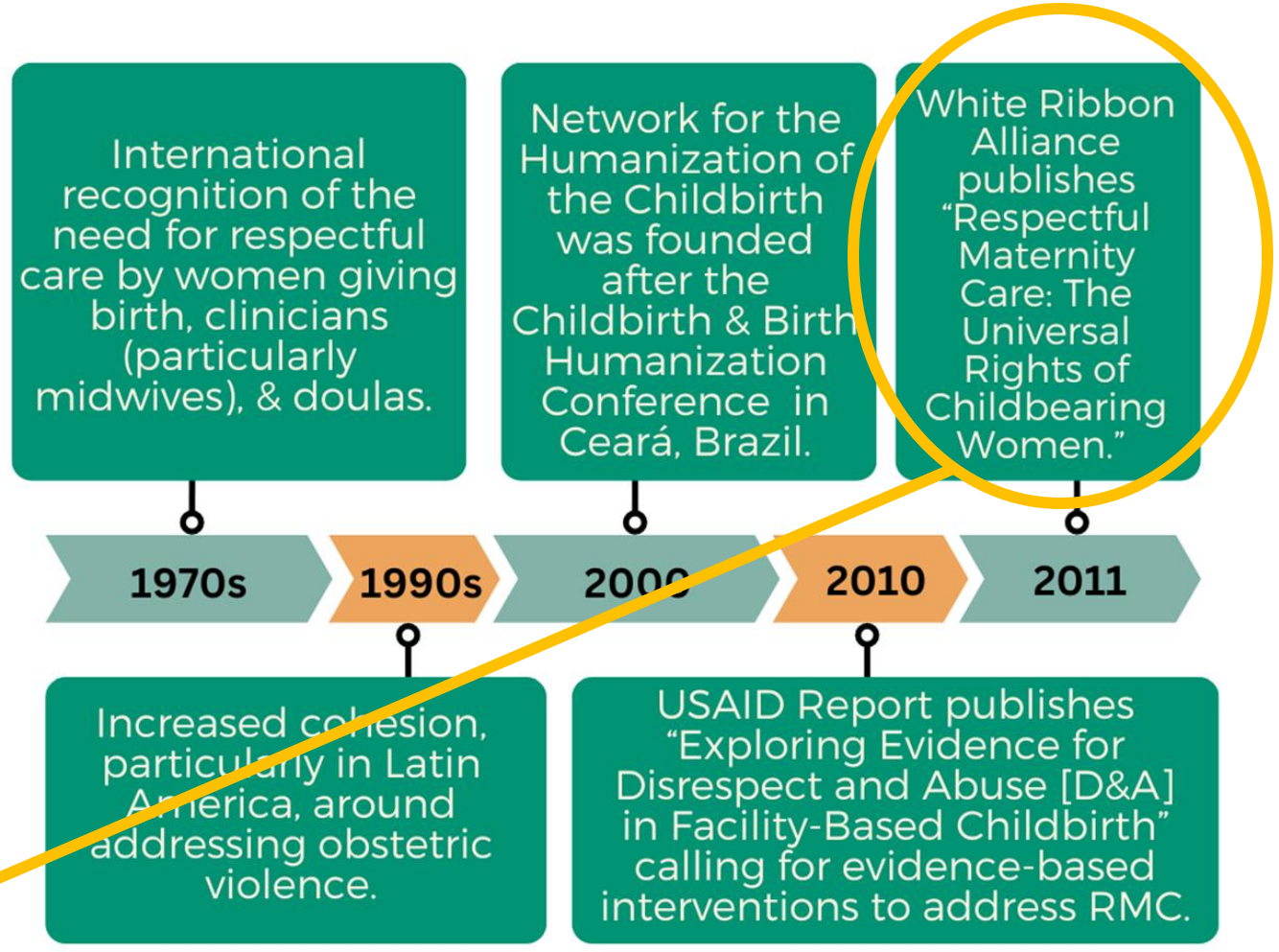
"The person doing the assessment needs to be aware of their own explicit and implicit biases and respect the family's right to disclose or not disclose information during the assessment process".

"If they are going to provide ethical care, staff should be aware of their own explicit and implicit biases and try to minimize their influence on the family and home assessment process".

Smith et al., 2022

Expanding Respectful Maternity Care to Include Newborns

A timeline of Respectful Care: 1970s to Present



In October 2019, the Global Respectful Maternal Care Council, convened by the White Ribbon Alliance, launched Respectful Maternal Care Charter: the universal rights of women and newborns. Added additional language about shared needs of dyad, and included newborn-specific elements.

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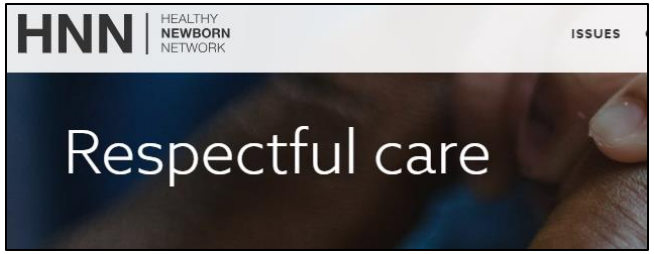
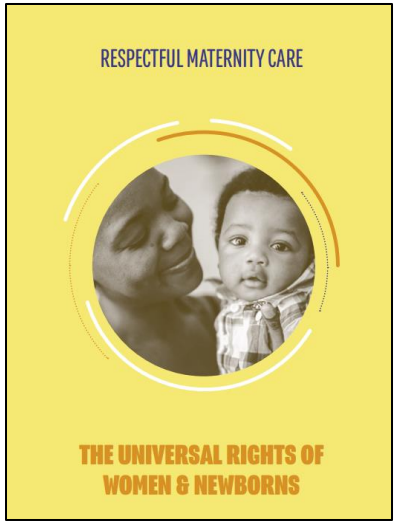
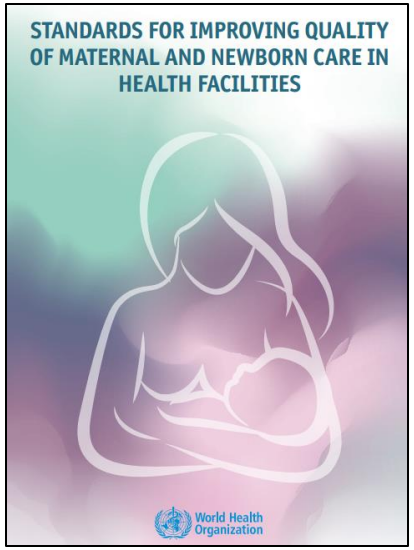
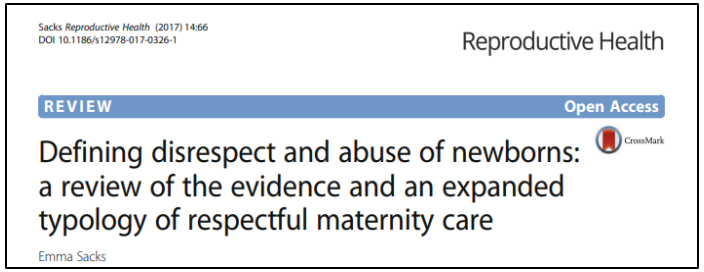
Respectful Maternity Care→ Including Newborns

RMC is founded on the premise that women should not be mistreated in childbirth. In recent years, this definition continues to expand to include newborns.





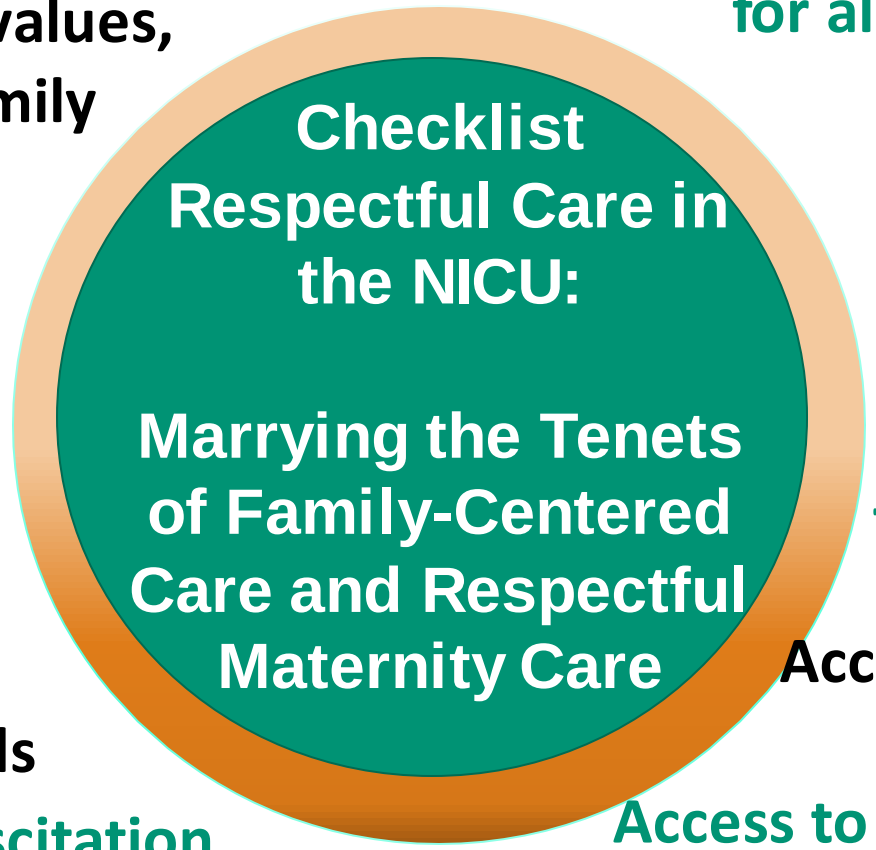




Available Trainings with RMC Component

- VON: Health Equity and Follow Through Programs
- ACOG: Respectful Care eModules
- AWHONN: Respectful Care Implementation Toolkit (RMC-IT)
- ICM: Respect Workshops: A Toolkit
- Perinatal Quality Institute: Speak UP
- March of Dimes: Awareness to Action
- FPQC: QI Initiatives

National Perinatal Information Center (NPIC)



Shared Decision-Making

A home transition plan that respects and incorporates the culture, values, and lived experience of the family

Centering the baby and family for all care and decisions

Dignity and autonomy

Equity in access to lactation support and donor milk

Informed consent

Equitable access to pain management

Assessment of nutrition

Trauma Informed Care

Assessment of transportation availability

Access to Postpartum doulas

Assessment of childcare needs

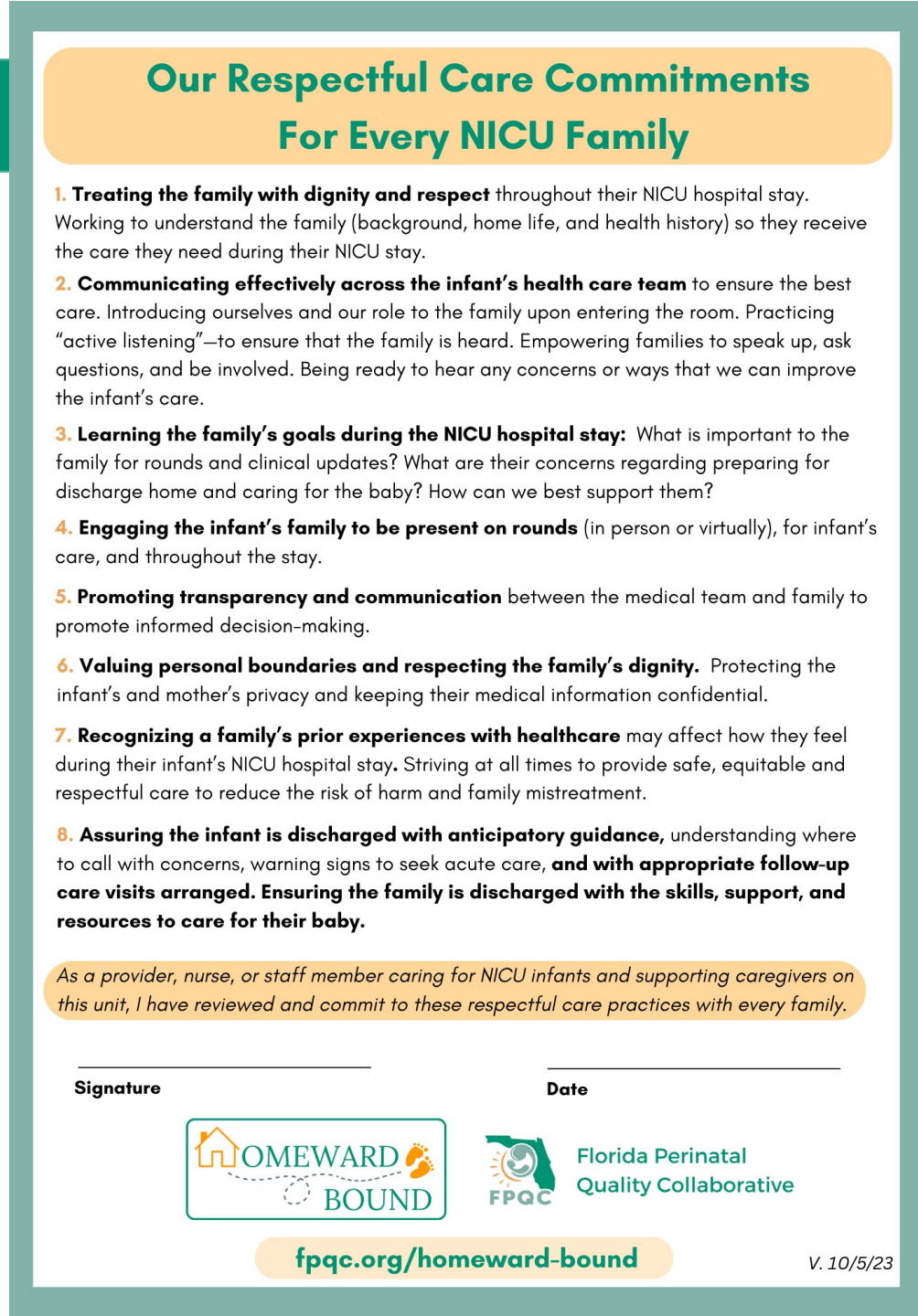
Parental presence during resuscitation

Access to Community Health Workers

24-hour access to baby

Commitment to Respectful Care for NICU Families

- Adapted from the RMC Commitment from FPQC Mother-Focused Care Initiative
- Incorporates Family-Centered Care with special sensitivity to SDOH/HRSN
- Lists actionable strategies to improve respectful care for NICU families
- Teams are able to adapt for their facilities
- Opportunity to serve as a standard orientation of new team member onboarding



Our Respectful Care Commitments For Every NICU Family

1. **Treating the family with dignity and respect** throughout their NICU hospital stay. Working to understand the family (background, home life, and health history) so they receive the care they need during their NICU stay.
2. **Communicating effectively across the infant's health care team** to ensure the best care. Introducing ourselves and our role to the family upon entering the room. Practicing "active listening"—to ensure that the family is heard. Empowering families to speak up, ask questions, and be involved. Being ready to hear any concerns or ways that we can improve the infant's care.
3. **Learning the family's goals during the NICU hospital stay:** What is important to the family for rounds and clinical updates? What are their concerns regarding preparing for discharge home and caring for the baby? How can we best support them?
4. **Engaging the infant's family to be present on rounds** (in person or virtually), for infant's care, and throughout the stay.
5. **Promoting transparency and communication** between the medical team and family to promote informed decision-making.
6. **Valuing personal boundaries and respecting the family's dignity.** Protecting the infant's and mother's privacy and keeping their medical information confidential.
7. **Recognizing a family's prior experiences with healthcare** may affect how they feel during their infant's NICU hospital stay**.** Striving at all times to provide safe, equitable and respectful care to reduce the risk of harm and family mistreatment.
8. **Assuring the infant is discharged with anticipatory guidance,** understanding where to call with concerns, warning signs to seek acute care, **and with appropriate follow-up care visits arranged. Ensuring the family is discharged with the skills, support, and resources to care for their baby.**

As a provider, nurse, or staff member caring for NICU infants and supporting caregivers on this unit, I have reviewed and commit to these respectful care practices with every family.

Signature _____ **Date** _____

HOMEWARD BOUND

Florida Perinatal Quality Collaborative

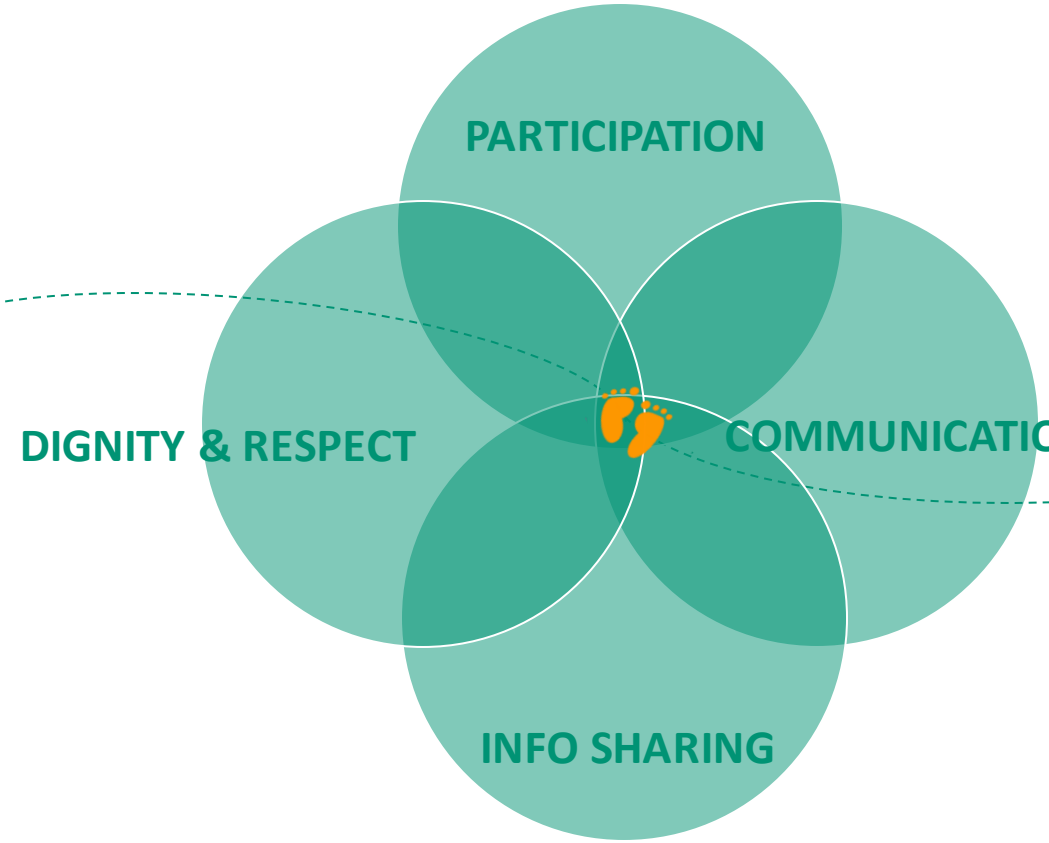
fpqc.org/homeward-bound

V. 10/5/23

PROCESS

OUTCOME

NICU ADMISSION



DC PREPARATION

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Thank you

Questions & Discussion