Strategies for Applying SDH Research Findings to Practice and Service Delivery

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In the U.S., children are the **poorest** segment of the population.

Child Poverty is Everywhere.

1 IN 5 CHILDREN LIVES IN POVERTY
Poor children experience worse health across their life course.

Poverty is one of the most significant non-communicable diseases children are suffering from today.

Courtesy of Dr. Benard Dreyer
Abraham Jacobi (1830-1919)

- Father of Pediatrics
- Motivated by issues of social justice
- Fought to ensure clean water and decent housing for poor urban children

“It is not enough to work at the individual bedside at the hospital.”
Bright Futures

- *Guidelines for Health Supervision* (1994): importance of viewing the child in the context of the family & community

- *Children’s Health Charter*: guiding principles
  - “Every child and adolescent deserves satisfactory housing, good nutrition, a quality education, an adequate family income, a supportive social network, and access to community resources.

- “The charter states unequivocally the explicit connection between a wide range of social determinants and the health of children and youth”
AAP Recommendations on SDH Screening

POICY STATEMENT  Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Poverty and Child Health in the United States
COUNCIL ON COMMUNITY PEDIATRICS
AAP Recommendations

- Screen for risk factors within social determinants of health during patient encounters.
- Either brief written screener or verbally ask family member questions about basic needs.
- As patient-centered medical homes develop, care coordinators may connect families in poverty with resources.

Percent of Pediatricians Who Routinely Screen

- Child Care: 41.5%
- Parental Mental Health: 29.0%
- Transportation: 29.0%
- Food Insecurity: 20.3%
- Housing Insecurity: 20.5%
- Utilities: 15.4%

p < 0.001

Readiness for Screening

p <0.001

Barriers for Pediatricians
Barriers for Pediatricians

- Time
- Lack of professional training
- Unsure of effectiveness
- Negatively impact therapeutic alliance
- Lack of knowledge of community resources
- Reimbursement
WE CARE Project

Funded by: The Commonwealth Fund
Methods

- **Study Design**: Cluster randomized controlled trial (RCT)
- **Setting**: 8 health centers (CHCs) in Boston
- **Randomization Unit** = CHCs
Participants

- Mothers of infants between ages of birth and 6 months presented for WCC visit
Intervention: **WE CARE 2.0**

- **4 Components:**
  1) Survey Instrument
  2) Family Resource Book
  3) Provider Training
  4) Follow-up
Component 1: WE CARE Survey

- Completed prior to WCC visits
- Self-report
- Screened for 6 basic needs
Six Basic Needs

- Childcare
- Education (< high school)
- Employment
- Food security
- Household heat
- Housing
Component 2: Family Resource Book

- Contained 1 page tear-out information sheets for each basic need
- Lists 2-4 community resources and contact information
- Available in all exam rooms
Control Conditions

- Standard of Care at 4 CHCs
Unmet Basic Needs at Baseline

Of all mothers (n=336):

- 90% ≥ 1 need
- 68% ≥ 2 needs
- 39% ≥ 3 needs
Referrals Received at WCC Visit

% Received Referral

WE CARE: 70%
Control: 7%

P < .001
Enrollment in Resources at f/u

% Received Referral

WE CARE: 39%
Control: 24%
P<.05
# Enrollment in Resources

<table>
<thead>
<tr>
<th>Resources</th>
<th>WE CARE (n=136)</th>
<th>Control (n=135)</th>
<th>aOR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any new resource</td>
<td>39%</td>
<td>24%</td>
<td>1.6 (1.1-2.5)</td>
</tr>
<tr>
<td>Childcare</td>
<td>15%</td>
<td>7%</td>
<td>3.3 (1.1-9.3)</td>
</tr>
<tr>
<td>Food assistance</td>
<td>11%</td>
<td>9%</td>
<td>0.8 (0.4-1.7)</td>
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<tr>
<td>GED degree</td>
<td>2%</td>
<td>1%</td>
<td>2.0 (0.5-8.8)</td>
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<tr>
<td>Employment/job training</td>
<td>8%</td>
<td>2%</td>
<td>7.9 (1.3-49.7)</td>
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<tr>
<td>Fuel assistance</td>
<td>7%</td>
<td>1%</td>
<td>11.1 (1.6-75.4)</td>
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<tr>
<td>Homeless shelter</td>
<td>2%</td>
<td>5%</td>
<td>0.3 (0.1-0.7)</td>
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<tr>
<td>Rental assistance</td>
<td>4%</td>
<td>7%</td>
<td>0.7 (0.3-1.3)</td>
</tr>
</tbody>
</table>

Adjusted for race, marital status, and maternal employment

Adjusted ICC ≤0.001
Translating Research into Practice

- Estimated **17 years** to incorporate research findings into practice
- “Research-practice” gap
- Often, interventions are not replicated in the *real world* setting
- But **WE CARE** is different (right?)....
Implement WE CARE in 3 health centers
All politics is local.

(Tip O'Neill)
“Translating research into practice is local.”

- Clinic culture
- **Buy in** from clinic leadership and staff
- Health policy issues:
  - MA Medicaid value-based payment system in 2018
  - BMC now an ACO- mandated to screen for homelessness and SDH as a quality measure
- SDH remedies are **outside of medicine** and rely on a fragile safety net system that varies by community
How Much Adaptation is Okay?

- Adaptation is necessary to meet the local needs of the patients and fit within the clinical care model
- But how much is too much?
WE CARE Core Components (we think?)

- Self-report screener **readable**- 3rd grade level
- **Screening questions focused on specific needs** – e.g., GED vs higher education
- **One screening question** for each social need
- Capturing patients’ desire for help via **Stages of Change** (do you want help with this? Yes, no, maybe later)
- An **actionable step** for providing parents with need with community resource information sheets
Guiding Principles for SDH Screening

- Ensure screening is Family-Centered
- **Integrate** Screening with Referrals and Linkage to Community-based Resources
- **Shared Decision Making**
- Use a **Strength-based Approach**
- Do **not** Limit Screening Practices on Apparent Social Status