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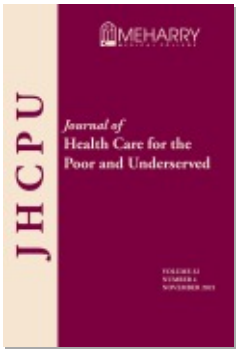

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Abstract: In this Report from the Field, we reflect on the first six months of the 2018 implementation of a screener aimed at identifying and addressing social determinants of health (SDH) at Pediatric Associates, an outpatient clinic in East Harlem, New York City. We share descriptive statistics and reflect on lessons learned.

Key words: Social determinants of health, Pediatrics, Screening, East Harlem.

Background

Addressing social determinants of health (SDH), the social and environmental factors that affect a person's health, is critical for effective health care.[1,2] This is especially true in pediatric health care and in underserved settings.[3–9] Routine primary care visits provide an opportunity to screen for social needs and connect families with appropriate resources.[3,10] Various SDH screening tools and referral systems have already been integrated into practice protocols.[11–15] However, which screening questions to ask, how to ask them, and how to integrate them into clinic flow remains complex and must be tailored to each community.

In this report, we describe the preliminary stages of developing and implementing a screening tool for SDH (the "screener") at a pediatric clinic in New York City (NYC).

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Our goal was to reliably and effectively integrate SDH screening questions into clinic flow without over-burdening medical providers or staff, and to standardize the referral process. With a screening program in place, we expect that our clinic will better identify and address the complex concerns that affect health. This project remains a work in progress.

Context and Rationale

Pediatric Associates. Pediatric Associates (PA) is a pediatric outpatient clinic affiliated with Mount Sinai Hospital. Located in East Harlem, NYC, the clinic serves a diverse pediatric population (age 0–21 years) that is 51% Hispanic, 40% African American, and 9% mixed race/other race (internal data.) Most patients (90%) are insured by Medicaid. While the majority of patients reside in and around East Harlem, patients also come from neighboring communities and the other four NYC boroughs.

The East Harlem community is a neighborhood impacted by decades of systemic racism, whose residents face substantial structural barriers to health care access. East Harlem has the highest concentration of public housing in NYC, and 46.5% of children live in poverty.[16] Furthermore, East Harlem ranks in the lowest third of NYC neighborhoods with respect to home health and safety indicators, including mold, cockroaches, peeling paint, and maintenance deficiencies.[17] There are high rates of obesity, smoking, diabetes, and asthma.[16]

Establishing the need for a comprehensive SDH screening program. Prior to program implementation, clinic physicians referred patients to social workers when unmet social concerns were noted. However, identification of these concerns was not routine or uniform. To address this gap, we integrated questions related to food insecurity into the electronic medical record (EMR). However, chart analysis revealed that providers were not asking these questions consistently. This was likely due to time constraints and/or reluctance to refer to unfamiliar resources, as has been found in other clinics.[10] In order to better identify patients with social needs, we designed a pilot program to enhance screening for a broad range of SDH.

Process

Development of screening questions. Screening questions (Box 1) were developed with input from faculty and staff in the Departments of Pediatrics, Environmental Medicine and Public Health, and Population Health Science and Policy. Many questions were adapted from SDH screening tools currently used in the United States, including HealthLeads and Hager's two-question food insecurity survey (Hunger Vital Signs).[12,18] Focus groups were conducted with providers and caretakers in the early stages of screener development, and screening questions were modified in response to feedback. We received approval from the Icahn School of Medicine at Mount Sinai Institutional Review Board.

Establishing referrals to community resources. Before piloting the screener, it was critical to identify resources to address each reported need. The Director of Advocacy and Community Pediatrics training and clinic social workers provided expertise on

Box 1.

SOCIAL DETERMINANTS OF HEALTH (SDH) SCREENING QUESTIONS USED IN THE PEDIATRIC ASSOCIATES CLINIC IN EAST HARLEM

SDH	Screening Questions[a]	Source
Food Insecurity[b]	1. Within the past 12 months we 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 money to buy more	Hunger Vital Signs[16]
Home environmental concerns[c]	3. Think about where you live, do you have any of these common problems? (check all that apply) Water Leaks, Mold, Roaches, Mice, Rats	Adapted from Accountable Health Communities Core Health-Related Social Needs Screening[21]
Tobacco Smoke	4. Does anyone who lives in your home or who cares for your child smoke tobacco? 5. Do you and your child ever smell tobacco smoke in your home that drifts in from a neighbor?	Adapted from AAP Clinical Practice Policy[22]
Healthcare and Insurance	6. In the last 6 months, was there a time when you or someone in your household needed to see a doctor but could not because of cost or problems with insurance like Medicaid?	Adapted from BRFSS Questionnaire[24] with guidance from REAP[d]
Housing and Homelessness	7. Are you worried that in the next 2 months, you may not have stable housing?	Health Leads[12]
Child Education	8. Do you have concerns about your child's learning or school performance?	Adapted from PEDS Developmental Screening Tool[23]
Adult Literacy	9. Do you have concerns about your reading or literacy skills?	Developed by the screening team

Notes:
[a]When caretakers answered "Yes" to any screener question, further questions were asked to identify appropriate resources for referrals and determine eligibility for those referrals.
[b]A positive response (often true, sometimes true) to one or both food insecurity questions qualifies a family for a referral.
[c]Endorsing any one (or more) home environmental concerns qualifies for follow up questions to determine if they are eligible for an in-home asthma intervention.
[d]Resource Entitlement and Advocacy Program (REAP): assists Mount Sinai families with health insurance, medical bills, and entitlements.

the development of social service referrals. The efficacy and reliability of these referrals depends on mutually beneficial, long-term relationships with trusted community-based organizations (CBOs). We applied for and received grant funding from the United Hospital Fund (UHF) and the New York Community Trust (NYCT) to promote clinical-community partnerships. Under these grants, we had two key CBO partners in East Harlem, the New York Common Pantry (NYCP), and LSA Family Health Service (formerly known as Little Sisters of the Assumption Family Health Service), with whom we met quarterly to analyze referral patterns, provide feedback on referrals made, and streamline the referral process.

LSA Family Health Service provides social services including family support programs, home environmental assessments, and a food pantry. The partnership between PA and LSA was built on over 20 years of experience working together. New York Common Pantry is a CBO that addresses food insecurity with services such as a choice pantry, hot meals, and assistance with enrollment in entitlement programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP). Both LSA and NYCP are trusted institutions within East Harlem; their staff is knowledgeable and well-integrated into the community.

Referrals to hotlines and public programs were included when quality and reliability were determined to be excellent based on prior experiences with our team, who verified the referral sources were functional and helpful for families. In addition, we continued to check in regularly with referral organizations via telephone and email throughout project implementation. This was particularly important for referral services in boroughs outside Manhattan with which we were less familiar.

In addition, the team developed paper-based educational materials, which were reviewed by content experts in each subject area and available in English and Spanish. An expanded list of resources offered is in Box 2.

Screening protocol. The team recruited and trained personnel (medical, public health, and college students) to screen families and become content experts. Team members approached caretakers in private patient rooms while families waited for the physician. The team member explained the purpose of the screener; the caretaker could decline to answer any or all questions. Each screening session took two to five minutes, depending on the needs identified. Families were provided resources if they screened positive for a social need; an example of this process is provided in Figure 1. If complex or multiple needs were identified, families were given the option of meeting with a social worker.

First Six Months of Program Implementation

To evaluate our progress, de-identified data was analyzed using SAS software, version 9.4 (SAS Institute Inc., Cary, NC, USA, 2018). In the first six months of implementation (February–July 2018), 300 families were screened, and 58.7% screened positive for at least one unmet need. An average of 1.4 social needs were identified per family. The most commonly identified needs were home environmental concerns (mold and/or pests) (40.0%), tobacco exposure (from caregiver smoking or drift between apartments)

Box 2.

RESOURCES OFFERED TO PEDIATRIC ASSOCIATES FAMILIES WITH A SOCIAL NEED IDENTIFIED USING THE SOCIAL DETERMINANTS OF HEALTH (SDH) SCREENING TOOL

SDH	Resources offered if family screens positive
Food Insecurity	*Local food pantry referral:*[a] LSA Family Health Service: https://littlesistersfamily.org/ New York Common Pantry: http://nycommonpantry.org/
	Information on community food resources: List of food pantries by borough
Home Environment: Pests and Mold	*Referral for an in-home asthma intervention:*[b] AirNYC: www.air-nyc.org LSA Family Health Service: https://littlesistersfamily.org/
	Resource centers: Pediatric Environmental Health Specialty Unit (PEHSU): www.pehsu.net National Pesticide Information Center (NPIC): http://npic.orst.edu/
	Educational materials: Prescriptions for Prevention: www.nyscheck.org/rx
Housing and Homelessness	*Referral to social work:* Referral made to clinic social worker as appropriate
	Information on community resources: HomeBase: A program of Homeless Services within the New York City Department of Social Services: www1.nyc.gov/site/hra/help/homebase.page Mount Sinai Medical-Legal Partnership
Insurance and Medical Care	*Referral to social work:* Resource Entitlement and Advocacy Program (REAP): assists with health insurance, medical bills, entitlements
	Information on community resources: Lists of free clinics for the uninsured by borough
Tobacco Smoke	*Hotline and resource center:* New York State Smoking Quit Line: www.nysmokefree.com
Secondhand Smoke	*Resource center:* Pediatric Environmental Health Specialty Unit (PEHSU): www.pehsu.net
	Educational materials: Prescriptions for Prevention: www.nyscheck.org/rx New York City Department of Health and Mental Hygiene: www1.nyc.gov/site/doh/health/health-topics/smoking-smoke-free-housing.page

(*continued on p. 2272*)

Box 2. (*continued*)

SDH	Resources offered if family screens positive
Learning and School Performance	*Social work:* Referral made to clinic social worker as appropriate for assistance with evaluation and referral to appropriate educational services *Information on community resources:* Early Intervention (EI) New York City Committee on Preschool Education (CPSE) New York City Committee on Special Education (CSE)
Parent Literacy	*Information on community resources:* List of free adult education and English as a Second Language (ESL) classes by borough

Notes
[a]Local food pantries also assist families with enrollment in government entitlement programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Supplement Nutrition Assistance Program (SNAP).
[b]Eligibility criteria for in-home asthma interventions varies among home visit organizations.

(29.3%) and food insecurity (20.6%) (Table 1). Per our protocol, 100% of families with an identified need were offered referrals to CBOs or other resources. In 80.3% of cases, those with an identified need accepted the referral or resources offered (Table 1).

Lessons Learned

In our study, we identified many families with unmet social needs, and the majority were receptive to receiving help to address those needs. Below, we highlight four principles that have guided our project, and may serve clinics initiating similar screening programs.

I. Community-based organizations (CBOs) as partners. Community-based organizations with proven success often have the most credibility within communities. They are intimately acquainted with community concerns, and are therefore the best agents to address complex issues affecting health.[19] We designed the program to leverage our existing relationships with CBOs, only including CBOs as referrals if: a) they had a proven track record and b) we had well-defined means of communication with them.

Being able to communicate with CBO partners is critical to solving problems in real time and ensuring families can access services. When families presented with pressing needs, we could ensure their issues were addressed in a timely manner through same-day appointments, emergency food packages, and other interventions.

II. Adapting to the context of a busy clinic. We knew the screener would not work if it negatively affected clinic flow. Early input from providers was integral to ensuring seamless integration. Specific decisions made to best meet the needs of providers included:

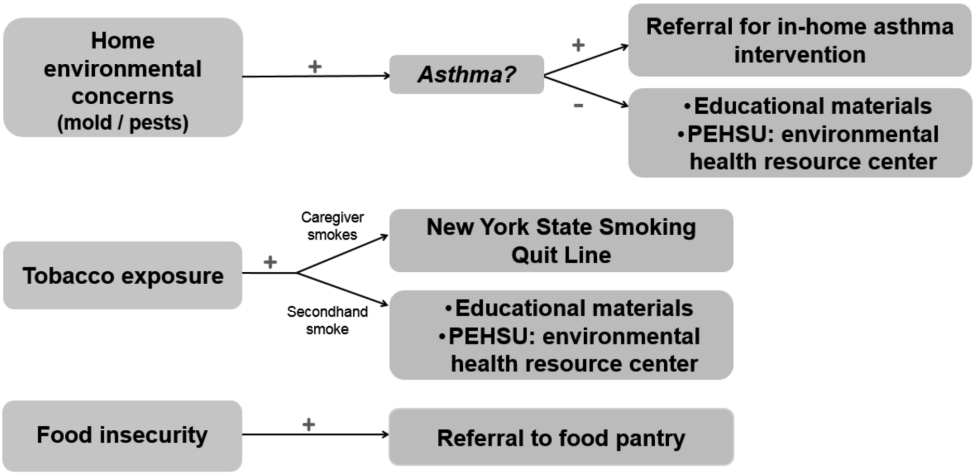

Figure 1. Referral algorithms for the three most common social needs as identified by the Social Determinants of Health (SDH) screening tool during the first six months of implementation at Pediatric Associates.
Note:
PEHSU = Pediatric Health Specialty Unit

- Asking screening questions during "down time" while patients were waiting for the physician; offering to pause if interrupted by a physician
- Educating providers about the program through formal presentations and informal conversations
- Exploring technology options to streamline the program, including use of tablets for screening and integration of results into the EMR

III. Ongoing feedback and quality improvement. Though we based our protocol on a literature review of current SDH screening practices and models, our screener had to be fine-tuned to meet the unique needs of our clinic's structure, patient population, and eligibility requirements of referral organizations. With ongoing feedback, we modified both the screening process and our offerings. Key areas of quality improvement included:

- Reflective and critical assessments of resources, with input from families, social workers, providers, and CBOs:
  - Prioritizing quality and clarity of resources over breadth of information; for example, making printed materials concise and using infographics
  - Ensuring educational materials were evidence-based and appropriate for low-literacy and Spanish-speaking audiences
  - Regularly speaking with CBO partners to maintain relationships and stay up to date on services provided
  - Seeking feedback from caretakers and adding screening questions and resources to address additional needs caretakers identified; for example, we added a screening question and created resources on childcare options after families inquired about that issue

Table 1.

CARETAKER RESPONSES TO SOCIAL DETERMINANTS OF HEALTH (SDH) SCREENING TOOL AT PEDIATRIC ASSOCIATES CLINIC IN EAST HARLEM DURING THE FIRST SIX MONTHS OF IMPLEMENTATION FEBRUARY TO JULY 2018 (N=300)[a]

SDH	Families who screened positive n (%)	Families with positive screen interested in a referral[b] n (%)
Any home environmental concern	120 (40.0%)	88 (73.3%)
Mold	29 (9.7%)	N/A
Pests (cockroach and/or rodent)	99 (33.0%)	N/A
Any smoke exposure	83 (29.3%)	45 (54.8%)
Smoker in home	32 (11.2%)	10 (32.3%)
Secondhand tobacco smoke	65 (22.7%)	41 (64.0%)
Food Insecurity	61 (20.6%)	49 (87.5%)
Learning/School Concerns	34 (12.8%)	19 (55.9%)
Adult Literacy	34 (12.2%)	27 (79.4%)
Insurance and Healthcare Access Needs	27 (9.5%)	19 (70.3%)
Housing and Homelessness Risk	20 (7.2%)	16 (84.2%)
One or more of any of the above	193 (64.3%)	155 (80.3%)
Average number of SDH identified per caretaker: 1.4		

Note:
[a]Data from 300 families surveyed used. For each SDH, the total number of respondents may not equal 300 if survey was not completed in full.
[b]These values represent the total number of caretakers interested in a referral out of the total number of caretakers that screened positive for a given SDH, as referrals were only offered to those who screened positive.

- Developing quality assurance measures (in progress):
  - Initiating a pilot study to assess barriers to referral completion for food insecurity
  - Brainstorming new modalities for offering referrals and resources electronically through text message or email in addition to paper-based referrals
- Leveraging technology to track referrals and maintain updated information in the EMR (in progress)
  - Using secure electronic data platforms to screen, refer, and track referral outcomes

IV. Sustaining and making innovations through trainee participation. The engagement of multidisciplinary trainees, including undergraduate, medical, and graduate students was critical to the sustainability of the program. Their participation as interns or paid study personnel increased program capacity and enabled program growth and

innovation. We were able to recruit trainees because of the clinic's affiliation with a large academic medical center. As students proved integral to the screening process, we then reached out to local universities and recruited students beyond the Mount Sinai network. Their participation aligns with the growing recognition of the importance of incorporating SDH into health curricula.[20]

Conclusions and Future Directions

Social determinants of health play an integral role in pediatric health, and identifying social needs is critical, especially in underserved settings. The process of integrating an SDH screener required multiple iterations of the screener itself, its mode of delivery, associated referral protocols, and ongoing feedback from those involved. The project's success was dependent on pre-existing relationships with CBOs and enhanced by the participation of student trainees. The relevance of our screener has been confirmed by our preliminary data, which show high rates of social needs and acceptance of resources offered.

At the same time, we recognize the importance of continually adapting the screener. We plan to further incorporate caretaker input through additional focus groups, and we will use that information to inform what questions best identify need and what resources best serve our population. For example, we continue to grapple with how we ask families about literacy concerns. Although we know caretaker literacy is important for family health, there are few validated screening questions addressing broader literacy concerns beyond health literacy. We continue to explore options for improving our literacy screening questions and related resources to meet identified needs. We also continually assess how to optimally collect high-quality data, and as an example, we are now collecting data on how many families decline to participate in the survey.

We are currently in the process of integrating the screening questions into the EMR as part of an institution-wide commitment to integrate SDH into patient care. The screener will be linked to a web-based platform that makes direct referrals to CBOs, allowing providers to get direct feedback on referrals and facilitating better communication between health care teams and CBOs. Our next steps also include undertaking a follow-up survey to solicit feedback on resources provided, as well as a longitudinal study that will assess the impact of our program on broader child health outcomes.

A note from the authors: Of note, this SDH screener was first implemented in 2018. The data described in this report was collected February-July 2018 and analyzed shortly thereafter. We acknowledge that the multifaceted challenges of the COVID-19 pandemic, the impact of racism and the murder of George Floyd, amongst other crucial factors shaping the past few years, have drastically changed the landscape of social determinants of health in outpatient pediatrics. In particular, patients in our clinic and others have faced unprecedented social barriers to health care and other critical services, and we have adapted to meet their needs. We hope this report provides a useful framework for initial screener implementation. In future work, we look forward to sharing the ways we have modified and expanded our screener in the context of the COVID-19 pandemic.

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