WELCOME!

• We will begin shortly.
• Please type your name and email into the chat box for attendance.
• Reminder, we will be recording this session.
• Please mute your line upon entering and chat in your comments or questions.
• Vicki Flanagan will monitor the chat box and call on you to unmute yourself.
• If you have trouble connecting, please email karen.g.lee@hitchcock.org

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Enter Activity Code: drPy (Good for this Live Session Only)

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Signing in on-line? http://www.d-h.org/clpd-account

Our presenters have no conflicts of interest to disclose.
NH AIM/ERASE Maternal Mortality Webinar
May 13, 2021 (12 – 1PM)

Operationalizing Screening and Intervention for Social Determinants of Health

Agenda

• Welcome!
  • ERASE-Maternal Mortality (ERASE-MM)
  • NH- Alliance for Innovation in Maternal Health (NH-AIM)
• Screening and providing support to patients with Social Determinants of Health Needs
  • Screening
  • Response
  • New opportunities for reimbursement
• Examples from two New Hampshire maternity care providers
• Discussion: Barriers, facilitators, identified needs, next steps for NH-AIM
Critical Collaborations

- Pregnancy, childbirth, and the year postpartum is a time of transformation for the mother or birthing person, the baby and their family.
- Maternal mortality...is a measure that signals the health and well-being of women, children, and families and the investment in and priority of that health and the systems that produce it.
- The work of the New Hampshire MMRC is to identify and review cases of pregnancy associated death, determine cause(s) and preventability, and generate recommendations for action.

https://www.reviewtoaction.org/
New Hampshire MMRC Recommendations

**Overdose prevention**
- Standardize perinatal education about risk for overdose after pregnancy or any period of abstinence
- Provide naloxone kits and standard education at postpartum discharge for patients with OUD
- Improve treatment access through promotion of 211

**Address social determinants of health**
- Screen for social determinants of health
- Link patients in medical settings to community services
- Enhance outreach to homeless community

---

Why are we talking about the Social Determinants of Health (SDOH)?

Ellen Stickney, RN, BSN, RNC-OB
Perinatal Nurse Coordinator
Maternal Child Health Section

- Many reasons! For example, the rate of Severe Maternal Morbidity is higher among lower Socioeconomic Status (SES*) persons than higher SES persons in New Hampshire. The SDOH are known to differ across SES strata.

- When considering factors such as how lower SES affects prenatal and postpartum visit status, it becomes evident how the SDOH can lead to different health outcomes.

*Defined using Medicaid delivery payer as a proxy for SES since Medicaid is means-tested.
Reduce Substance-Related Maternal Mortality and Severe Maternal Morbidity in NH

Primary Drivers
- Overdose Prevention
  - Access to SUD/ODD Treatment
  - Access to naloxone (Prenatal/pp & hospital DC)

Secondary Drivers
- Social Determinants of Health Addressed
  - Plan of Safe Care implemented for 100% of pp patients with SUD
  - Adopt ACOG postpartum care recommendations
- All Patients Receive Respectful Care
  - Disparities identified based on data and PFAC feedback
  - PFAC recommendations inform practice improvements
  - Opportunities for staff antistigma training promoted by NH-AIM
- Behavioral Health (BH) Needs Addressed
  - Referral network in place for pre/postnatal access to BH services
  - Suicide screening & prevention implemented in OB practice
- MMRC Recommendations Implemented
  - Annual Report Published
  - Implementation team incorporates MMRC recommendations in NH-AIM

Change Concepts
- Universal SBIIT screening & referral
- Develop protocols for OB/GYN naloxone distribution
- Staff training on harm reduction
- Plan of Safe Care initiated in prenatal setting
- Universal screening for social determinants of health
- Increase accuracy of REaL Data
- SMM & perinatal outcomes data disaggregated by PFAC rurality, & payer at State & practice level
- Engage representative Patient & Family Advisors for PFAC
- Implement universal screening for behavioral health needs
- Public health messaging about AWHONN Warning Signs
- Timely identification of cases
- Regular review by multidisciplinary MMRC
- MMRC recommendations driven by data from case review

Timeline
- January-December, 2021
- April 2021
- Ongoing

Current Commentary
Reducing Perinatal Health Disparities by Placing Equity at the Heart of Performance Improvement

Christina Provo, MD, MPH, Fouad Aalshah, MD, Shifra Minzer, MD, and Howard Minkoff, MD

VOL. 137, NO. 3, MARCH 2021
OBSTETRICS & GYNECOLOGY 401
Integrating Social Determinants of Health Screening in Maternity Care: What does best practice look like?

- **Screening**
  - Universal screening
  - Validated tools

- **Providing support/referrals**
  - Case management
    - Nursing
    - Community Health Workers/Resource Specialists
    - Social workers

- **Documentation**
  - For team-based care
  - For reimbursement/sustainability

**NH-AIM Baseline Hospital Survey Results**
How are New Hampshire’s Maternity Care hospitals screening patients for Social Determinants of Health?

- We screen all patients: 71.4% (Validated instrument not used for screening)
- We screen some patients: 28.6% (Validated instrument used for screening)

Which Social Determinants of Health Are Included in Screening?

- Need for spoken language interpretation
- Difficulty reading
- Prior military service
- Justice system involvement
- Intimate partner violence
- Social support
- Employment
- Transportation access
- Food security
- Housing security
- We do not screen for SDOH

Percent Screened
# Tools for SDOH Screening

<table>
<thead>
<tr>
<th>Tool</th>
<th>Implementation</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRAPARE</td>
<td>Implementation Toolkit</td>
<td><a href="https://www.nachc.org/research-and-data/prapare/">https://www.nachc.org/research-and-data/prapare/</a></td>
</tr>
<tr>
<td>PRAPARE Implementation Toolkit</td>
<td>Webinar trainings</td>
<td>Available in 26 languages</td>
</tr>
<tr>
<td>PRAPARE Implementation Toolkit</td>
<td>Webinar trainings</td>
<td>Available in 26 languages</td>
</tr>
<tr>
<td>Health Leads Recommended Tool</td>
<td>Implementation Toolkit</td>
<td><a href="https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/">https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/</a></td>
</tr>
</tbody>
</table>

---

**What questions are in PRAPARE?**

<table>
<thead>
<tr>
<th>Core</th>
<th>Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Race*</td>
<td>1. Incarceration History</td>
</tr>
<tr>
<td>2. Ethnicity*</td>
<td>3. Domestic Violence</td>
</tr>
<tr>
<td>3. Veteran Status*</td>
<td>2. Safety</td>
</tr>
<tr>
<td>4. Farmworker Status*</td>
<td>4. Refugee Status</td>
</tr>
<tr>
<td>5. English Proficiency*</td>
<td><strong>Optional Granular</strong></td>
</tr>
<tr>
<td>6. Income*</td>
<td>1. Employment: How many hours worked per week</td>
</tr>
<tr>
<td>7. Insurance*</td>
<td>3. Insurance: Do you get insurance through your job?</td>
</tr>
<tr>
<td>8. Neighborhood*</td>
<td>2. Employment: # of jobs worked</td>
</tr>
<tr>
<td>9. Housing Status*</td>
<td>4. Social Support: Who is your support network?</td>
</tr>
</tbody>
</table>

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

[https://www.nachc.org/research-and-data/prapare/](https://www.nachc.org/research-and-data/prapare/)
Health Leads Social Needs Screening Tool

- Available in English and Spanish
- Implementation Toolkit: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

Coding and Reimbursement for Addressing SDOH

Additional reimbursement is available with 2021 E/M changes
- New Code Selection Criteria emphasize complexity of medical decision making
- “Diagnosis or treatment significantly limited by social determinant of health” added as criteria for Moderate Risk of Complications and/or Morbidity or Mortality of Patient Management (99214)

Documentation must include
- History: briefly describe problem faced by patient (ex: “unable to get labs drawn due to transportation issues”)
- Visit diagnosis (ex: Lack of Access Transportation Z91.89)
- Brief description of intervention (ex: patient met with RN to discuss Medicaid transportation)
Example Z-Codes

Social Determinants recognized as contributing to level of medical decision making:

- Food insecurity
- Housing instability
- Access to education
- Literacy level
- Discrimination
- Incarceration or other justice involvement
- Access to health care services
- Exposure to violence
- Access to transportation

Integrating SDOH Screening in Maternity Care Practice

Two examples from New Hampshire
Addressing SDOH at Amoskeag Health

GABI Teed, BSW, CRSW
Amoskeag Health
Manchester, NH
# Patient Centered Medical Home Model – Integrated Care

## Demographics
- 15,000 + Patients
- 65 Languages
- In-house interpreters for 10 languages
- Most insurances accepted and sliding scale option

## Services Offered
- Primary Care
- Pediatrics
- OBGYN
- Eye Clinic
- Behavioral Health
- MAT
- Podiatry
- Nutrition
- Case Management
- Family Support Programs
- Early Supports and Services

## Case/ Care Management

### Tools Used
- CCSA – ages 18+
- Family Risk Assessment – ages 0-17
- Verbal inquiry

### When
- Assessments conducted at least annually at intake and at time of annual physical exam
- Verbal inquiry conducted by care providers at Patient appointments

### Follow-up
- Assessed by CHW who then makes referrals / warm hand-offs made
- Providers and CHW refer to Case Managers if more support needed
Comprehensive Core Standardized Assessment (CCSA) Domains

- Demographic
- Medical
- Substance Use (SBIRT)
- Housing
- Family and Support Services
- Education
- Legal
- Depression
- Risk Assessment
- Functional Status
- Pediatric Developmental Screening

SDOH Resources

**In-House**
- Extensive food pantry
- Eye clinic
- Diaper Pantry
- Transportation Assistance
- Medication Assistance
- Language support
- Medicaid Enrollment Coordinators
- Barrier Reduction Funds for PSUD

**Community**
- Food Pantries
- NH Legal Assistance
- DHHS
- Waypoint
- Easter Seals
- Elliot Hospital
- Recovery Community
- Etc....
Partnering for Prevention

Improving Effective Screening and Right Care for Psychosocial Needs in Pregnancy
Background

National guidelines, including those of the US Preventive Services Taskforce (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG), recommend screening pregnant patients for social risk factors including housing, depression, substance use, and exposure to violence. The prevalence of these problems, which confer significant health risk to parents and children, is widespread.

Justin Lerra hugged his girlfriend, Sarah, who was pregnant, as he turned himself in to the Manchester, N.H., fire station to get treatment for his opioid addiction. She had insisted he get treatment or she would
# The Roadmap

**SCREENING**

**SHARED DECISION-MAKING**

**RIGHT CARE**

**TEAM ENGAGEMENT**

## Prenatal Psychosocial Health Assessment

Prenatal psychosocial problems may be associated with unfavorable postpartum outcomes. The questions on this form are suggested ways of inquiring about psychosocial health. Issues of high concern to the women or caregiver usually indicate a need for additional support or services. When issues of some concern are identified follow-up and/or referral should be considered. Please consider the sensitivity of this information before sharing it with other caregivers.

### Prenatal Factors

<table>
<thead>
<tr>
<th>MATERNAL FACTORS</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>First prenatal visit in third trimester? (check records)</td>
<td></td>
</tr>
<tr>
<td>What is the reason that you did not start prenatal care sooner?</td>
<td></td>
</tr>
<tr>
<td>Prenatal education (refusal or quit) (C/4)</td>
<td></td>
</tr>
<tr>
<td>What are your plans for prenatal classes?</td>
<td></td>
</tr>
<tr>
<td>What is your reason for not attending/quitting prenatal classes?</td>
<td></td>
</tr>
<tr>
<td>Feelings toward pregnancy after 20 weeks (C/4,W)</td>
<td></td>
</tr>
<tr>
<td>How do you feel when you first found out you were pregnant?</td>
<td></td>
</tr>
<tr>
<td>How do you feel about it now?</td>
<td></td>
</tr>
<tr>
<td>Relationship with parents in childhood (C/4)</td>
<td></td>
</tr>
<tr>
<td>How did you get along with your mother? Your father?</td>
<td></td>
</tr>
<tr>
<td>Did you feel loved by your mother? Your father?</td>
<td></td>
</tr>
<tr>
<td>Self esteem (C/4, W)</td>
<td></td>
</tr>
<tr>
<td>What concerns do you have about becoming/being a mother?</td>
<td></td>
</tr>
<tr>
<td>What sort of mother do you think you’ll be?</td>
<td></td>
</tr>
<tr>
<td>History:</td>
<td></td>
</tr>
</tbody>
</table>

*Green Form*
### Need Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>PDSA 1 N=9</th>
<th>PDSA 2 N=18</th>
<th>PDSA 3 N=23</th>
<th>PDSA 4 N=28</th>
<th>Total N=78</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
<td>13</td>
<td>15</td>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>Substance Use</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Violence</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Patients With At Least 1</td>
<td>3</td>
<td>14</td>
<td>16</td>
<td>17</td>
<td>50</td>
</tr>
</tbody>
</table>

### Social Support Worksheet

#### My Options
- **Centering Pregnancy**: Group-based prenatal care in Bronx. Interaction with other families, information and support. Not having reliable transportation. Tell your provider you want to enroll, attend your groups online.
- **Healthy Starts Referral**: Provides peer and clinician support in your home. Help for parenting, access to needed services and homes. Some people don't want a visit in their home, but actually really need and are willing to talk. Call the referral form and wait for a call from "Healthy Start, Healthy Families, Community Health Steward." Ask your provider to refer you and then take a call with scheduling to see if they can provide that.
- **Prenatal Wellness Program Referral**: On call with a clinician, our health navigator. To receive counseling and learn coping strategies. phone call you need from your health provider appointment.
- **Monadnock Center for Violence Prevention**: A group of advocates for a healthy people in need. People can help if you are experiencing domestic violence, sexual violence, sexual assault, or other problems. Sometimes people are wondering if you need to be able to say it. They want to be able to do it. They say it. Call the criminal justice system, 911. Homeless services, 1-888-21-1-800 (1-888-22-1-800) if you need to be able to say it. They say it. No need to be able to say it. They say it. Talk to your health provider.
- **Mothers in Recovery**: Hudson Medical Center's treatment program for mothers with substance use disorders. You can get medication-assisted treatment, prenatal care, and recovery care all in one place. If you are already established with another program and don't want to transfer. Call the office-based treatment at call the office-based treatment at 800-800-800.
- **The Doorway**: Helps girls and women with substance use disorders. Referral is available for 24/7 and Monday through Sunday. Call the office-based treatment at 800-800-800.
- **Childbirth Classes**: Classes for birth, breastfeeding, and baby care. Information, discussion, meetings, and families. Call 800-800-800. Nearest clinic and call it.
- **Southwest Community Services**: Help with housing, food, heat, transportation, job assistance. Once a month for help with local resources. Need to have a phone. Not accepts cash, and phone services.

### Circle Your Choices

**Centering Pregnancy**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

**Healthy Starts Referral**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

**Prenatal Wellness Program Referral**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

**Monadnock Center for Violence Prevention**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

**Mothers in Recovery**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

**The Doorway**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

**Childbirth Classes**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

**Southwest Community Services**: Not Interested | 1 | 2 | 3 | 4 | 5 | Very Interested

I have my own plan. Please Describe:

My goal for this pregnancy:
Patient Satisfaction Survey

Mean % Survey Score

Value
Median
Goal

Chart Area

Housing
Depression
Substance Use
Violence & Trauma
Team Engagement
<table>
<thead>
<tr>
<th>Date</th>
<th>Actual Date</th>
<th>Communication Type</th>
<th>Objective of Communication</th>
<th>Medium</th>
<th>Frequency</th>
<th>Planned</th>
<th>Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/29/20</td>
<td>12/29/20</td>
<td>Kickoff Meeting</td>
<td>Describe project and secure buy-in through description of the problem</td>
<td>Zoom</td>
<td>Once</td>
<td>12: CMC Clinic personnel, patient rep, and community rep named in the team plan.</td>
<td></td>
</tr>
<tr>
<td>1/12/20</td>
<td>Implementation Start Meeting</td>
<td>Debrief the Interview and SDM tool, and tracking process. Discuss next steps and patient surveys.</td>
<td>Zoom</td>
<td>Once</td>
<td>12: CMC Clinic personnel, patient rep, and community rep named in the team plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/11/20</td>
<td>First Weekly Email</td>
<td>Update, Data Sharing, Goals for the Cycle</td>
<td>Email</td>
<td>Weekly</td>
<td>To all team members with read receipts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/18/20</td>
<td>Provider Zoom Huddle</td>
<td>Process clarification, feedback on implementation during the pilot.</td>
<td>Zoom</td>
<td>Once</td>
<td>6: Clinical staff with direct patient care responsibilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/2/21</td>
<td>All Team Meeting</td>
<td>Report out of PDSA data and planning for future cycles</td>
<td>WebEx</td>
<td>upw</td>
<td>12: CMC Clinic personnel, patient rep, and community rep named in the team plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/21</td>
<td>PDI SDM Email Engagement</td>
<td>Educate providers about TD's' connection with shared decision-making in order to increase engagement.</td>
<td>Email</td>
<td>Once</td>
<td>All providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/2/21</td>
<td>Provider Zoom Huddle</td>
<td>Process clarification, feedback on implementation during the pilot.</td>
<td>Zoom</td>
<td>Once</td>
<td>6: Clinical staff with direct patient care responsibilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/5/21</td>
<td>Meeting with lead MA</td>
<td>Discussing project timeline and shared decision-making</td>
<td>In Person</td>
<td>Once</td>
<td>Improvishly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team Survey Likert Scores</th>
<th>PDSA 1</th>
<th>PDSA 2</th>
<th>PDSA 3</th>
<th>PDSA 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=4</td>
<td>N=4</td>
<td>N=8</td>
<td>N=10</td>
<td>N=26</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>Median</td>
<td>Range</td>
<td>Mean</td>
<td>Median</td>
<td>Range</td>
</tr>
<tr>
<td>How would you describe our team efficacy?</td>
<td>3.75</td>
<td>3.5</td>
<td>3-5</td>
<td>3.75</td>
<td>4</td>
</tr>
<tr>
<td>Which statement best describes our staff's understanding of their roles and responsibilities?</td>
<td>4.25</td>
<td>4</td>
<td>4-5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>How would you describe the way our team communicates clinical information to our patients?</td>
<td>4</td>
<td>4</td>
<td>3-5</td>
<td>2.8</td>
<td>2.5</td>
</tr>
<tr>
<td>This project did not increase my workload.</td>
<td>3.5</td>
<td>3.5</td>
<td>2-5</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>How much do you know about community resources for housing?</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>How much do you know about community resources for intimate partner violence?</td>
<td>2.75</td>
<td>2.5</td>
<td>2-4</td>
<td>3.2</td>
<td>4</td>
</tr>
<tr>
<td>How much do you know about community resources for substance use?</td>
<td>3</td>
<td>3</td>
<td>2-4</td>
<td>4.25</td>
<td>4</td>
</tr>
<tr>
<td>How much do you know about community resources for depression?</td>
<td>2.75</td>
<td>2.5</td>
<td>2-4</td>
<td>4.5</td>
<td>4.5</td>
</tr>
</tbody>
</table>
Sustain Plan

Right Now

• Continue social needs screening by confidential provider interview.
• Continue with right care bundles
• Continue SDM
• Continue to strengthen community partnerships

Near Future

• Move SDM to an electronic format
• Increase prenatal care coordination (maintain a case log)
• Reexamine prenatal intake process

“Health equity is achieved when every person has the opportunity to “attain full health potential” and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

• How will we know what barriers our patients face unless we ask?

https://www.cdc.gov/chronicdisease/healthequity/index.htm
“Equity will never be fully addressed until performance-improvement committees, the designated performance watchdogs in departments of obstetrics and gynecology, accept equity as a key component of their charge...”

“No organization or department can be credited with attaining high quality if any particular group is left behind, and if all groups are recipients of equally substandard care there is no quality”
Upcoming:

NH AIM/ERASE Maternal Mortality Webinar
July 15, 2021 (12 – 1PM)

Integrated Practice

To Receive CME/CNE Credit for today’s session, Text 603-346-4334
Enter Activity Code: drPy (Good for this Live Session Only)
Need help? clpd.support@hitchcock.org
Signing in on-line? http://www.d-h.org/clpd-account

CHI Resources:
This is available through the POSC website it was compiled so that practices would have a resource:
Check out the Pregnant and Parenting Services and Supports link and map.
SAVE THE DATE

June 10, 2021

NNEPQIN Virtual Spring Meeting

Let’s stay in touch....

Victoria.A.Flanagan@Hitchcock.org
daisy.j.goodman@hitchcock.org