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MCH Innovations Database Practice Summary & Implementation Guidance

Maimonides Pediatric Primary Care

The Building Resilience in Children, Families, Infants and Toddlers (BRIC FIT) initiative addresses a critical need for early childhood emotional and behavioral health within the pediatric medical home by using integrated mental health care in conjunction with a comprehensive social needs screening and referral program to address psychosocial needs for our most vulnerable families with children ages zero to five.



Location

Brooklyn, NY



Topic Area

Health Screening/Promotion,
Mental Health, Access to
Health Care



Setting

Urban Academic Pediatric
Primary Care



Population Focus

CYSHCN, Prenatal/Infant
Health



NPM

Medical Home



Date Added

January 2022

Contact Information

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Section 1: Practice Summary

PRACTICE DESCRIPTION

The Building Resilience in Children, Families, Infants and Toddlers (BRIC FIT) initiative addresses a critical need for early childhood mental health services within the pediatric medical home at the Maimonides Children's Hospital by using collaborative care to address psychosocial needs for our most vulnerable families with children ages zero to five. Using an evidence-based model of care to identify families of children 0-5 years of age with behavioral or developmental concerns, or Social Determinants of Health (SDH) risk factors, BRIC FIT delivers integrated early childhood mental health care, and parent education and support as a part of pediatric primary care visits. The BRIC FIT program's core intervention focuses on building parenting skills and resilience through an attachment and trauma informed lens, and is augmented by systematic screening for social determinants of health and direct linkages to health promoting community-based organizations.

Maimonides Medical Center is a specialty care teaching hospital in Brooklyn that serves the ethnically and socioeconomically diverse communities of the borough, as well as a large immigrant population. Poverty, child abuse and neglect, neighborhood violence, and domestic violence are highly prevalent in many communities in Brooklyn, and are likely to be among the adverse childhood experiences (ACE) experienced by children participating in the BRIC FIT program. The prevalence of exposure to ACE and SDH in Brooklyn children leading to long-term negative health effects, coupled with the fragmented system of care and lack of trained professionals competent to address these problems within primary care settings, highlights the need for the care innovations inherent in the BRIC FIT program. To address the myriad psychosocial risk factors that our families are challenged with, we have sought to provide integrated mental health services in our pediatric primary care clinics, along with linkages to community-based supports that address ACEs and SDH. Brooklyn is comprised of approximately 2.6 million people, of which about 200,000 are children under the age of 5. It is estimated that 32% of children under the age of 5 are living below the poverty level in Brooklyn as compared to 23.6% in NYS and in the United States. Due to the large number of socioeconomic risk factors present in the community, 41% of children in Brooklyn are living in homes receiving public assistance such as SSI, cash public assistance, or food stamps/SNAP benefits, compared to 28% in NYS. In a needs assessment completed in 2019 of families attending pediatric primary care at Maimonides, we found that more than half of the 166 patients surveyed wanted help with resources to; access nutritious foods, help children do better in school, and help finding early childhood enrichment programs. And more than a third of the patients answered wanting helping for housing, legal support, literacy and mental health.

We serve over 12,000 patients between the ages of birth and twenty-one. Our patients come from a diverse background, speaking more than 35 languages, and representing multiple ethnicities (Figures 1-3 in appendix).

Goals:

Goal 1: Implement Universal Screening In Primary Care and Subspecialty Clinic Settings

Objective: Train Pediatricians on use of SDH screening tools during well child visits- this was completed by April 2019 for attendings and by October 2019 for Residents

Objective 2: Train Pediatricians and clinic staff on use of validated developmental screening, ACEs, postpartum depression – this was completed January 2020

Objective 3: Provide ongoing support detailing to pediatric clinic staff to improve screening rates through monthly meetings- this is ongoing

Objective 4: Screen 80% of patients annually for SDH, and based on developmental stage for developmental screeners- Our screening rate is 52-73% depending on the clinical site.



Goal 2: Systematize Recruitment and Enrollment of Eligible Families with Children age 0-5 into BRIC FIT Program

Objective 1: Become a site affiliate with HealthySteps National- Completed January 2020

Objective 2: Develop Brochures to be distributed to families of eligible patients- completed but due to COVID19 not currently implemented

Objective 3: Develop and Implement Referral and Scheduling System for patients- In progress- patients are generally referred to our HealthySteps Specialist via our electronic medical record, or in person, and appointments can either be scheduled by front desk clerks or by Dr. Cuno herself.

Goal 3: Implement Early Childhood Development and Mental Health Program

Objective 1: Train BRIC FIT psychologist in HealthySteps Model of integrated child development care- completed January 2020

Goal 4: Train Primary Care Providers and Pediatric Residents in Evidence-Based Practice Related to Early Childhood Mental Health, Community Based Referrals, and Principles of Trauma Informed Care

- February 2020 and July 2020 Lecture to pediatric residents on the Introduction to Infant Mental Health and Newborn Brain Development July 2020 and February 2021- Social Determinants of Health lecture to pediatric residents
- One pediatric resident each month is paired with our healthy steps specialist as a part of their behavior and development rotation and shadows her with patients.
- June 2020- Medical student elective with SUNY Downstate on the use of telemedicine to screen for social and behavioral health needs

Goal 5: Develop Coordinated System of Referrals and Communication with Community-Based Organizations Providing Complementary Mental Health and Social Services

- Semi-annual advisory board breakfast with 11 Community organizations
- Developed closed loop communication with 5 of these organizations who are able to provide feedback on patients we refer if there are issues that arise with communication, ability to enroll etc. These organizations include: WIC lactation services, NYLAG medical legal partnership, JCCA Health Home Care Coordination and Arab American Family Support Services Food Stamp Enrollment

HealthySteps (www.healthysteps.org) is an evidence-based model that utilizes principles of early childhood development, attachment theory, and toxic stress to support a curriculum and interventions to promote positive parenting and healthy parent-child relationships. This model is the backbone of our integrated early childhood behavior and development approach. As an official cite, we are supported with training and implementation guidance.

The SDH screening tools we will utilize have been validated and carefully chosen to suit the needs of our diverse population based on a needs assessment completed 6 months before implementation with over 200 patients. More specifically, we modified the WE CARE survey, a parent completed screening tool that was adapted from the Bright Futures Pediatric Intake Form. The modifications made include expanding the number of questions to meet the domains our patients highlighted as most important for us to address with them. (See Survey Item Attached). In addition we changed the food insecurity questions to include one of the validated food insecurity questions and one of our own that captures nutritional insecurity as many of our patients do not have food scarcity but nutritional insecurity.

CORE COMPONENTS & PRACTICE ACTIVITES

The goal of our program was to improve the emotional and social well-being of the families served at our pediatric primary care clinics by implementing universal screening for mental health and social determinants of health, referring to community-based organizations who have partnered with us on our community advisory



board, and integrating an early childhood developmental psychologist into a collaborative care model. The core components of this program included training providers to conduct mental health and SDH screening, build linkages to a network of community-based partner organizations and programs that address the needs identified, create and implement a workflow to universally screen patients for Mental Health (MH) and SDH, and integrate an early childhood developmental psychologist into the pediatric primary care clinic to comanage developmental and behavioral concerns as well as parental mental health services.

Core Components & Practice Activities

| Core Component | Activities | Operational Details |
|---|--|---|
| Training: | Train Pediatric Providers Train Clinic Staff Train Pediatric Residents | Monthly Case Based Lunch and Learns Monthly PCMH meetings Resident Didactics dedicated to Screenings and Referrals and Early Childhood Mental Health |
| Screening: Incorporate Universal Screening of SDH, MH and Development into Standard Practice | Conduct Needs Assessment Create SDH Screening Tool Integrate screening tools into EMR QI PDSA cycles | Hand out anonymous survey to over 200 patients Develop tool based on needs identified and community partnerships available Work with IT to integrate into EMR Monthly QI meeting and data analysis |
| Referring: Building connections with community based organizations addressing the identified needs of the community | Create a Community Advisory Board Build Referrals into EMR Establish Closed Loop Communication Referrals | Bi-annual Community Advisory Board Meetings Link referral information into EMR directly where the SDH screen is in place Determine with each organization how to get feedback on success of referrals for patients and organization, and build in QI cycles |
| Integrating Care: Integrate an Early Childhood Psychologist | Hire Early Childhood Psychologist Establish workflow Build EMR template | Partner with HealthySteps Training by HealthySteps for entire staff |



HEALTH EQUITY

Our entire project is rooted in the principles of reducing health inequities of the population we serve. In the true sense of health equity our tiered enrollment system in HealthySteps provides more consistent and dedicated care with our early childhood specialist for those with the most needs or risk factors identified. Additionally, we partner with a health home organization that specifically targets populations with two or more chronic medical conditions or any history of trauma for them or their family. This service provides more intensive care and health navigation for those with highest needs.

We serve a diverse patient population of various races, ethnicities and cultures including White, Asian, African American, Hispanic and American Indian, and it is well known that a language barrier and low literacy level can lead to significant health disparities. In order to maximize screening amongst all patients, we have translated our SDH screening in all the languages of patients we serve. For those patients who are unable to complete the screening on their own the medical assistants, nurses or physician will ask the patient the screening questions in their own language using interpreter services. We have also widened our outreach and secured partnerships with organizations that address both the cultural and linguistic needs of our community. We created a partnership with Citipro Early Intervention for families who speak Urdu and Bengali as they are able to accommodate them and previous organizations we partnered with were not, and we created a new partnership with the Arab American Family Support Center for our families who speak Arabic or associate culturally with the Arab American Community.

The pediatric physicians, pediatric residents, nursing staff and clerical staff who are involved in the project and working with implementing our screening are comprised of a diverse group from various ethnicities and languages spoken. The community based organizations we also refer patients to also come from various backgrounds and represent the patient population we serve and work with.

EVIDENCE OF EFFECTIVENESS

Using a QI PDSA cycle approach we have analyzed monthly data points to see number of patients screened and referred for SDH. We are currently in the middle of an ongoing research study evaluating the psychosocial and mental health needs of our patients during the COVID19 pandemic. This involves surveying our families social needs with a questionnaire assessing a broad range of social determinants of health including food and housing insecurity, as well as medical, learning, and legal needs. We have surveyed a cohort of families along three separate time points, allowing us to gather qualitative data about families' experiences with our community based organizations and referrals provided for whatever pertinent needs the families have had.

Regarding the impact of HealthySteps, we gather data on a monthly basis about the number of patients referred and seen, as well as screening rates for Autism, Depression, and general mental health needs. Future goals



include surveying the developmental and social emotional health of patients enrolled in HealthySteps with the goal of ultimately comparing that particular cohort to patients of similar ages and demographic backgrounds seen in our practice but not enrolled in HealthySteps.

From March 2020-March 2021- a total of 494 patients were referred to our psychologist. With a total of 656 billable visits. The patients are broken down into three tiers based on the risks of the patients served. There were 227 patients in tier 2, 267 in tier 3. The following screening rates were achieved: MCHAT 475/905 patients screened = 52% (was 50% for the year prior), PSC17 4539/5885 patients screened = 77%, PHQ2 378/1000 patients screened = 38%.

From April 2019 to September 2021 we have screened more than 13,500 patients for Social Determinants of Health, screening about 58% of eligible patient encounters. About 58% of our population had at least one social need identified and over 3,100 patients were referred to community organizations on our community advisory board. Our biggest need was identified in adult literacy and learning, with 46% of those screening identifying this need, and over 2,300 patients' caregivers referred. Food Insecurity was identified in 19% of our population, with over 1,248 patients connected to food pantries, enrolled in food stamps or given other resources in the community. Housing needs were identified in 11% of the population with over 600 families referred. Legal needs were identified in 16% of our population with over 1,335 families referred to our medical legal partnership (Figure 4).

We recently published an article looking at the impact of one SDH measure for our families; automated letters to landlords advocating for patients with poor housing conditions.

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784773>. Between April and October 2019, 233 of 2480 (9%) families who were screened for social determinants of health needs had poor housing conditions. Of these families, 127 (55%) requested and received a physician-generated letter advocating for housing repairs (Figure 5).

A total of 96 (76%) families completed the follow-up telephone survey between June and December 2019. Of the 35 families (36%) who reported giving the letter to their landlords, 31 (89%) reported that the landlord acted to resolve the issue, and 26 (74%) reported complete resolution of the concern. The families who received the housing letter were significantly more likely than families who did not receive housing letters to experience food insecurity (31.5% vs 17.3%; $P < .001$), child care or developmental concerns (26.8% vs 12.1%; $P < .001$), and problems with finances or benefits (26.0% vs 9.8%; $P < .001$). For the 149 families who had a subsequent follow-up visit, there was no significant difference in those without poor housing conditions between families who did vs did not receive letters (44 of 61 [72%] vs 63 of 88 [72%]).

Additionally, we are studying a cohort of patients throughout the COVID pandemic and have collected the following data (Figure 6). Of the 423 patients enrolled in the study (See Figure 1), 215 (51%) were female, 279 (66%) were Hispanic, 248 (59%) reported English as a primary language, and 281 (66%) were covered by Medicaid (See Table 1). The following SDH needs significantly increased during COVID19: food (17% to 32%; $p < 0.001$), legal (19% to 30%; $p = 0.003$), public benefits (4% to 13.8%; $p < 0.001$) and housing (17.2% to 26%; $p = 0.002$). (See Table 2). Mental Health screening results did not differ significantly from baseline to during COVID19: positive PHQ2 depression screen (27.9% vs. 34.3%, $p = .39$), positive PHQ9 depression screen (45.5% vs. 64.1%, $p = .32$), or positive PSC17 (>15) measuring emotional and behavioral concerns (4.9% vs. 8.2%, $p = .13$). (See Table 3). During COVID19, patients with food (OR: 12.8 (1.4 – 118.3) or housing (OR: 3.9 (1.5 – 10.1) needs had a significantly higher likelihood of having emotional or behavioral needs ($p < 0.02$).

After controlling for baseline characteristics and measurements, age was positively associated with covid-era PSC-17 (aOR (95% CI): 1.363 (1.117 - 1.663), $p = 0.004$), however age was negatively associated with educational insecurity (aOR (95% CI): 0.923 (0.865 - 0.985), $p = 0.016$). Having commercial insurance was negatively associated with food insecurity (aOR (95% CI): 0.469 (0.259 - 0.846), $p = 0.012$), benefits insecurity (aOR (95%



CI): 0.4 (0.176 - 0.908), $p = 0.028$), and legal insecurity (aOR (95% CI): 0.528 (0.285 - 0.979) $p = 0.043$). Non-Hispanic ethnicity was negatively associated with food insecurity (aOR (95% CI): 0.36 (0.134 - 0.965), $p = 0.042$) while African/Black race was positively associated with educational insecurity (aOR (95% CI): 3.957 (1.121 - 13.972), $p = 0.033$). Finally, people screened in person vs via telephone had lower odds of legal insecurity (aOR (95% CI): 0.222 (0.111 - 0.447), $p < 0.0001$), and housing insecurity (aOR (95% CI): 0.411 (0.216 - 0.783), $p = 0.007$).

Our study showed the psychosocial impact on children and adolescents in the immediate aftermath of COVID19. While mental health symptoms did not increase during this time, we did see an increase in social needs. With the association of social needs with the development of mental illness, there is significant potential for children and adolescents to experience the onset of mental illness in the coming months and years. The increased needs families are having during COVID19 reinforce how vital it is for pediatricians to continue to screen and provide support for social and mental health needs as we consider the long-term consequences of COVID19. Additionally, our study population benefited from tele-medicine outreach and referrals to community based partners and behavioral health staff.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

Our practice is a collaboration between a dozen community-based organizations, primary care pediatricians, caregivers, and pediatric trainees. Our strong partnership is essential for assessing and addressing the needs of the community in an effective manner. Together each partner is able to provide feedback to help achieve optimal outcomes.

| Practice Collaborators and Partners | | |
|-------------------------------------|--|---|
| Partner/Collaborator | How are they involved in decision-making throughout practice processes? | Does this stakeholder have lived experience/come from a community impacted by the practice? |
| Parents of children in our practice | Parents are encouraged to complete surveys that ask for feedback about their experiences during well child visits and are used to inform clinic workflows and policies | Yes, parents we see are the primary care providers for children receiving primary care at our practice. |



| | | |
|--|--|---|
| <p>Community Based Organizations</p> | <p>We have created a community advisory board that meets biannually to review each organizations programming (updates and changes as well as new initiatives). This allows us to share our work with the organizations and voice the needs of our patients. This board also allows for the organizations to collaborate with each other and cross-refer.</p> | <p>Yes, all organizations serve the population we treat in our practice. The community organizations we partner with include: Arab-American Family Support Center CAMBA Homebase CDSC-Child Care Challenge Early Intervention City Pro JCCA MMC WIC Program MMC-CCB NYLAG The Jewish Board Wyckoff Asthma Program Catholic Charities MMC Pediatricians</p> |
| <p>Primary Care providers and Trainees</p> | <p>Through provider meetings and all staff meetings, providers are directly involved in initiatives to improve clinic procedures and workflows. We also created a HealthySteps Implementation Team that meets monthly to discuss perspectives on the program and engage in quality improvement initiatives. Pediatric residents are involved with HealthySteps via training and lectures as well as through rotations as part of their Development and Behavior training protocol.</p> | <p>The primary care providers and trainees in our program come from many different backgrounds which are representative of the community we serve and able to speak our patient's native language. Many of the trainees have done their medical school training abroad outside of the United States.</p> |

REPLICATION

Our practice began in one pediatric primary care clinic, and our social needs screening has now expanded to all three primary care clinic sites as well as our Inpatient pediatric floor. We rolled out each screening and referral process separately after conducting trainings with staff, primary care providers and trainees. Along the way we learned about the different needs of each population and were able to adapt the partnerships we had to meet these needs. For example, one of our practices and our Inpatient unit has a large Chinese speaking population, and we adapted our resources to include organizations that are able to communicate in Chinese. Our Inpatient unit also has the availability of a social worker so we worked as a team to come up with a workflow that would include social work referrals for certain unmet social needs, and direct community based organization referrals for others. We are working on expanding our HealthySteps practice to the other primary care clinics once we are able to secure more funding, as this will complete our full practice at all sites.



INTERNAL CAPACITY

Our initial Internal team consisted of two primary care physician champions, one early childhood developmental psychologist, the medical director of general pediatrics, clinical informatics, quality improvement specialist, a nurse manager, and our business manager. The time commitment included bi-weekly meetings for the first 6 months that then transitioned to monthly meetings. Our lead physician champion dedicated 0.4FTE to the implementation of the program. Our team grew to include several volunteers and medical students who assisted with collecting and analyzing data and building our community-based partnerships. When we expanded to the Inpatient unit our team consisted of 3 pediatric hospitalist champions, pediatric resident representatives, medical director of pediatric hospital medicine, clinical Informatics, and pediatric social work and case management. We did not have a program manager, and if funding is available that would be helpful to maximize efficiency and productivity, although it is not essential to building a successful program.

PRACTICE TIMELINE

For more information on this practice's timeline and specific practice activities, please contact Yonit Lax, MD directly at ylax@maimonidesmed.org.

PRACTICE COST

The main cost to the practice is the hiring of an early childhood psychologist. To assist us with this cost we applied for and received the Healthy Tomorrow's Partnership grant of \$50,000 per year for 5 years. After this time, our practice will be able to sustain our psychologist established practices are now billed and financially sustainable. Additionally, there is matched in-kind cost of administration around the grant. These in-kind costs would vary based on institutional ability to dedicate personnel, and while there are not direct costs associated the time and effort of individuals is a cost to the system. The essential aspect here is having a physician champion who is able to dedicate significant time to success of implementation. For more information on this practice startup costs and budgets, please contact Yonit Lax, MD directly at ylax@maimonidesmed.org

| Budget | | | |
|--|---|---------------------|------------------------------------|
| Activity/Item | Brief Description | Quantity | Total |
| Early Childhood Psychologist/Social Worker | Full time clinician dedicated to practice of social and emotional needs of families with children ages 0-5. | 1 per practice site | Starting Salary at the Institution |



| | | | |
|------------------------|--|-----------------|-----------|
| In Kind Administration | Clinical Informatics Physician Champions Quality Improvement Medical Leadership | Varies per site | |
| Total Amount: | | | \$ Varies |

LESSONS LEARNED

It is critical to involve all important stakeholders in regular meetings about the program including providers as well as clinic staff, from nurses, to managers, to front desk staff. This allows for all parties to voice opinions and share feedback on what is working well and what needs improvement. We began HealthySteps just 2 months before COVID19 arrived in our local area. The pandemic significantly changed the way our practice functioned, from social distancing protocols among clinic staff, to the patients being seen in person for primary care visits. As a result, many of the initiatives we would have taken on in the first year were delayed. In the last year, we also experienced a significant amount of turnover in our staff, from providers to managers, which has complicated starting any new projects or initiatives due to the need to frequently retrain new staff and allow time for the clinic to adjust to new personnel.

Other challenges include education of all of the pediatric attendings and trainees, nursing staff and clerical staff in regards to the importance of asking these screening questions and providing appropriate referrals. Initially there was some resistance to implementation of a new project due to time constraints, new work flow, understaffing, and concern of the intimate nature of the screening questions invading patient privacy. This concern from staff about the personal nature of the questions was addressed through education to staff in regards to the needs of our patients and possible impacts we can have for the whole family and community by providing the appropriate resources for their needs (Figure 7). Getting patient feedback sooner in the process would have been helpful, as well as doing a focus group or having some patients on our advisory board to allow us to gain that insight early on.

NEXT STEPS

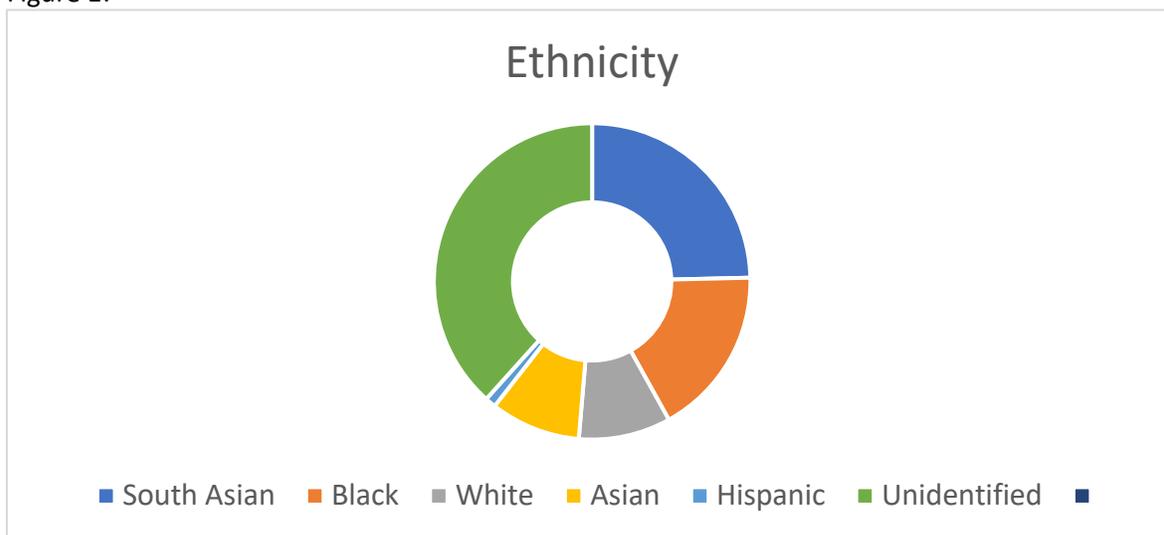
When we initially began we started in one clinical outpatient practice, and we have expanded to the other two pediatric primary care clinics for screening and referrals of SDH. Our SDH screenings and referrals is now happening universally in our pediatric inpatient unit in the hospital. Our goal is to expand the delivery of early childhood behavioral and mental health with the hiring of additionally behavioral health staff in the coming year that would allow us to expand that to our other outpatient clinics and the inpatient side.

We aim to improve our screening rates across all three practices for mental health and psychosocial needs. We also aim to engage in more evaluation efforts of HealthySteps to better understand the impact of the program on our clinics and patient population.

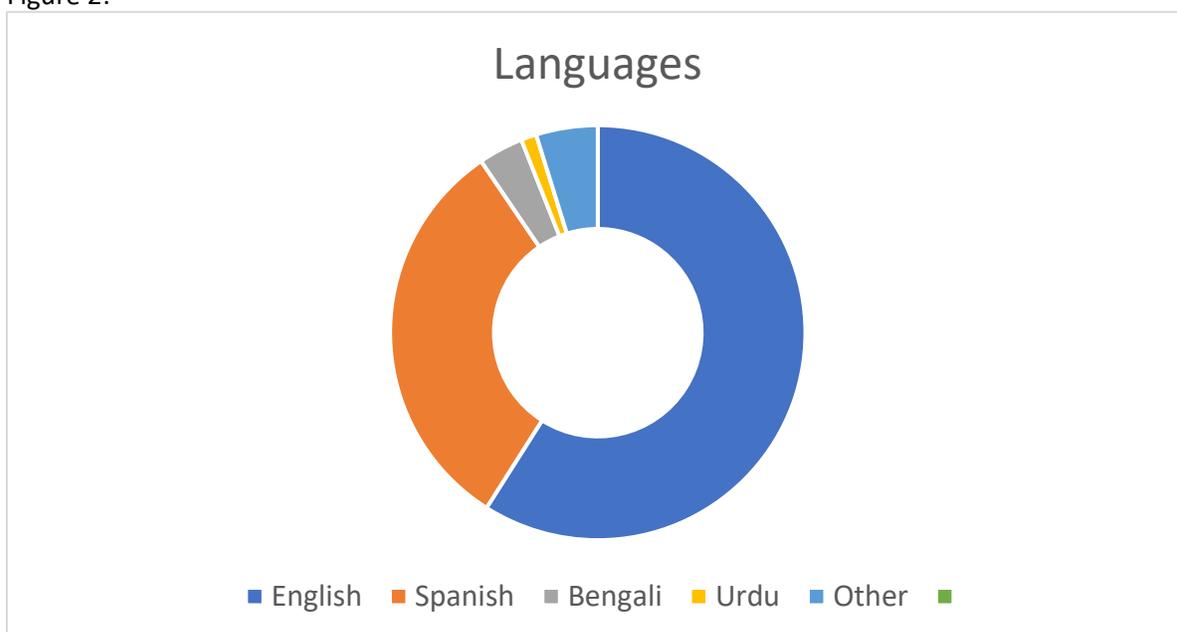


APPENDIX

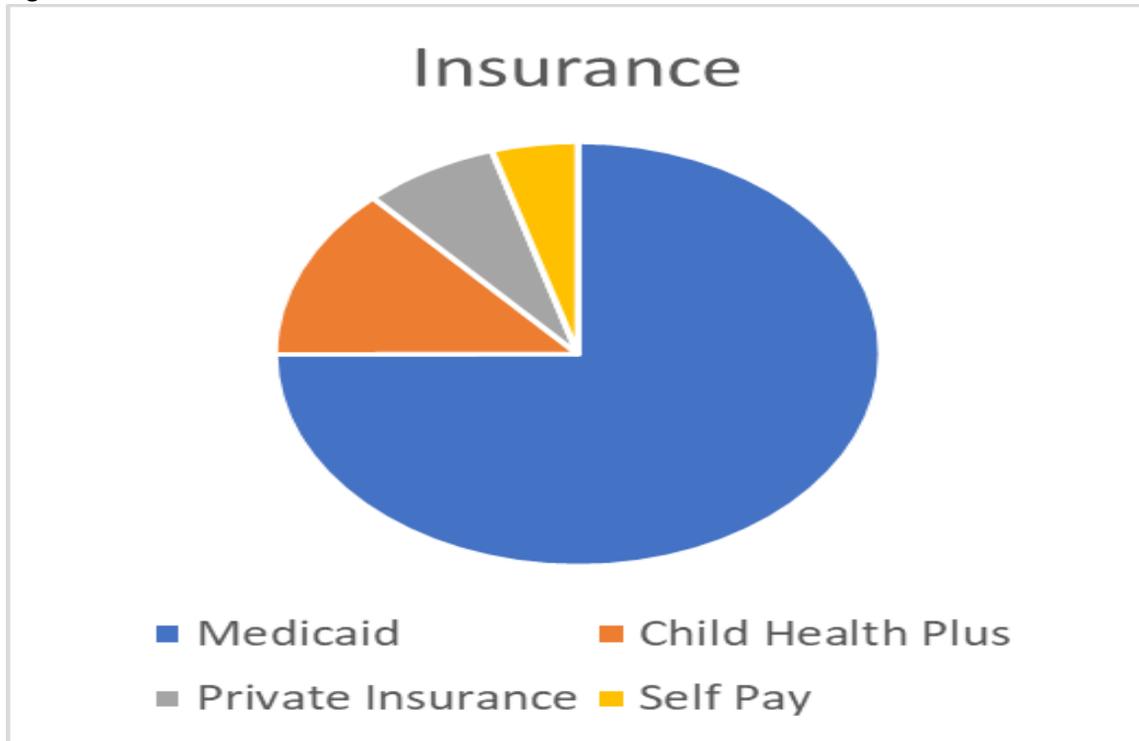
- Figure 1:



- Figure 2:



- Figure 3:



- Figure 4:

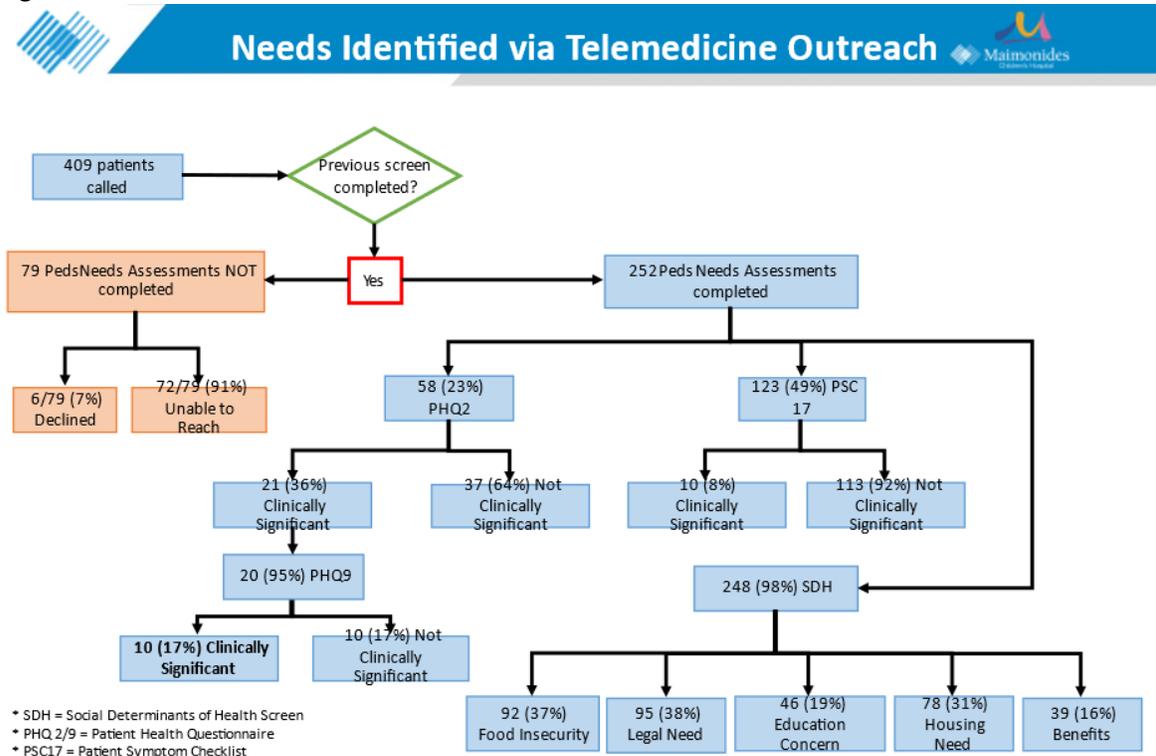
Population Needs Identified



Results



• Figure 5:



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• Figure 6:

Pediatric Academic Societies Conference 2021

Social Determinants of Health (SDH) and Pediatric Mental Health (MH) Before and During COVID19 in NY City Primary Care Pediatrics

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BACKGROUND

In March 2020, NY City instituted a shelter in place order, dramatically affecting the social and economic landscape in our area. Our pediatric primary care practices universally screen for SDH and MH needs, providing an opportunity to assess changes in our population's needs during COVID19.

OBJECTIVES

To determine changes during COVID19 of:

- Prevalence of pediatric depression symptoms using PHQ2/9 scores in children ages 11-21
- Prevalence of MH concerns using the PSC-17 score in children ages 4-21
- Changes in SDH needs.

DESIGN/METHODS

This is a prospective cohort study. Baseline data from this population was collected during primary care visits from March 2019 – March 2021.

Outcome measures:

- PHQ2 score >0, PHQ9 scores ≥ 5
- PSC17 scores ≥ 15
- SDH needs.

Follow up data was collected from June-August 2020.

ANALYSIS

McNemar's and Fisher's Exact tests were performed. P value of ≤ 0.01 was considered significant. Univariable logistic regression analyses were performed to examine the impact of demographic variables on the change in outcome variables over time.

RESULTS

Table 1. Pre vs During Covid, Psychological measures and Social Determinants of Health

| Psychological Measure | Pre-Covid Era | Covid Era | | p-value |
|--------------------------|-------------------------------------|------------------------|--------------------------|---------|
| | | Positive (n=48) | Negative (n=92) | |
| PHQ 2 (n=140) | Positive (n=39) Negative (n=101) | 20 (14.3%) 28 (20%) | 19 (13.6%) 73 (52.1%) | 0.39 |
| PHQ 9 (n=11) | Positive (n=5) Negative (n=6) | 4 (36.4%) 3 (27.7%) | 1 (9.1%) 3 (27.7%) | 0.32 |
| PSC 17: Mean (sd), n=184 | 7.18 (4.7) | 6.21 (5.5) | | 0.01 |

Table 2. Pre vs During Covid, Psychological measures and Social Determinants of Health

| Social Determinants (n=337) | Pre-Covid Era | Covid Era | | p-value |
|-----------------------------|---------------------------------------|-------------------------|--------------------------|---------|
| | | Have a need (n=108) | No Need (n=228) | |
| Food insecurity (n=336) | Have a need (n=80) No Need (n=276) | 32 (9.5%) 76 (22.6%) | 28 (8.3%) 200 (59.5%) | <.0001 |
| Legal (n=335) | Have a need (n=64) No Need (n=271) | 31 (9.3%) 70 (20.9%) | 33 (14.1%) 201 (60%) | 0.0003 |
| Housing insecurity (n=337) | Have a need (n=58) No Need (n=279) | 28 (8.3%) 60 (17.8%) | 30 (8.9%) 219 (65%) | 0.0016 |
| Education (n=336) | Have a need (n=47) No Need (n=289) | 14 (4.2%) 45 (13.4%) | 33 (9.8%) 244 (72.8%) | 0.17 |
| Benefits (n=332) | Have a need (n=14) No Need (n=318) | 5 (1.5%) 41 (12.4%) | 9 (2.7%) 277 (83.4%) | <.0001 |

RESULTS

- No significant change in MH screening results during COVID19 compared to baseline.
- SDH needs significantly increased during COVID19: food, legal, public benefits, housing.
- Patients with food, housing or legal needs had a significantly higher likelihood of having emotional or MH needs.

After control for demographics the following were found to be significant:

- Non-Hispanic patients with commercial insurance were less likely to have food insecurity.
- Adolescents were more likely to see an increase in behavioral and MH concerns during COVID.

CONCLUSIONS

- No significant change found in MH in our population during the first 6 months of COVID19.
- Significant increase in social needs.
- Higher likelihood of MH concerns among patients with increased social needs.

IMPLICATIONS

Future research is warranted to better understand the impact of the pandemic in future months. Our research will continue by reassessing our cohort this summer across all outcome measures.

Demographics (Total population N=448):

| Ethnicity | Count (%) |
|---------------------------|-----------|
| Hispanic or Latino | 291 (64%) |
| Not Hispanic or Latino | 130 (29%) |
| Unknown | 19 (4%) |
| Race | Count (%) |
| Black or African American | 63 (14%) |
| White | 158 (35%) |
| Asian | 63 (12%) |
| Other | 190 (43%) |
| Unknown | 19 (4%) |
| Gender | Count (%) |
| Female | 222 (50%) |
| Male | 218 (50%) |
| Language | Count (%) |
| English | 257 (58%) |
| Spanish | 161 (37%) |
| Other | 22 (5%) |
| Insurance | Count (%) |
| Managed Medicaid | 282 (65%) |
| Commercial | 135 (31%) |
| Self-paying insurance | 19 (4%) |



• Figure 7:



Challenges



Increasing screening rates to meet our target of 80%

3 clinical sites with unique needs
Staff turnover
COVID



Partnerships with AAP + MCH



Disseminating beyond MMC



Family representatives on CAB



Measuring impact

