PROJECT GOAL: To develop a pediatric social determinant screening tool that can be used across a multi-state pediatric health system.

National Advocacy
Nemours plus other pediatric data

Statewide Lobbying
Nemours data, community health needs assessment

Community Alignment and Leadership
Nemours data, community resource inventory

Health System Budgeting and Resourcing
Financial and staffing analysis, prioritization of internal interventions

Clinic Processes and Workflows
Sustainable processes to address each clinic’s needs

Individual Patient and Family Interventions
Culturally informed, patient-centered focus on SDOH

About Our Patients: Pensacola
- 68% White
- 17.53% Black or African American
- 6% Hispanic

About Our Patients: St. Francis
- 56% Hispanic/Latino
- 31.13% Black or African American
- 25.8% White

About Our Patients: Downtown Orlando
- 62.6% Medicaid/Medicaid
- 24.3% Private Insurance
- 8% Hispanic/Latino

About Our Patients: Seaford
- 66.9% Medicaid and Chip
- 31.5% Commercial Payer
- 16% Hispanic/Latino

FLORIDA

PATIENT STORIES:

Amber is a 13-year-old Type 1 diabetic. She resides with her grandmother in Alabama (over a 2-hour drive). The family struggles with transportation and financial issues. These issues have caused several cancelled/no-show appointments. The patient is covered by Alabama Medicaid, which will not transport across state lines.

Andre is one of several siblings who recently lost his father to a drive-by shooting. Andre’s mother is struggling both with the trauma of that event and with paying bills. Her electricity was recently disconnected, impacting the whole family.

Ricky is a 9-year-old boy who lives in a small apartment with his grandfather and two younger brothers. His grandfather is disabled and has difficulty providing fresh food for the family. They rely on food pantries for their daily meals and subsequently consume a diet that is very high in calories, sodium and fat.

Cory is a 4-month-old, hep-C positive baby born to a heroin-addicted mother in a region heavily impacted by the opioid epidemic. As a result of the family and community environment, he does not receive reliable newborn care.

NEXT STEPS:
- Build questionnaire in our electronic health record
- Build standard analytics that look at race, ethnicity, language and other demographic data alongside SDOH data
- Determine the scope of intervention support that will be maintained by the organization (dollars, resources, etc.)
- Design a technical model for addressing SDOH needs (EHR prompts, resource directories, alerts, etc.)
- Design local workflows appropriate to each care setting
- Begin improvement cycles