Prematurity Collaborative

Clinical Public Health Practice

August 22, 2018
General Housekeeping

Please note the following:

All participants will be muted on entry

To speak to the group, remember to unmute yourself:

1. If you are connected through the computer audio, click the mic in the lower left hand corner of your screen to unmute and mute.

2. If you are connected through the phone press *6 to unmute and mute

Be sure to mute yourself when you are not speaking

Please do not place call on hold

Use the chat box, if you would like a moderator to call on you or share your comments with the group
Agenda for today’s meeting

• Welcome & Introductions
• Review of last meeting (July 19th)
• Review of draft work plan & continued prioritization
• Best Practice Sharing:
  • Dale Reisner, MD, Medical Director OBGyn Quality and Safety, Swedish Health Services, will share more about Washington State Hospital Association Safe Deliveries Road Map Pregnancy Bundles
  • Helen Bellanca, MD, MPH, Associate Medical Director, Health Share of Oregon, will discuss the Oregon Family Wellbeing Assessment
  • Tanweer, Kaleemullah, JD, LLM, MHA/MBA, Public Health Analyst – Health Systems Transformation, Harris County Public, will discuss Pathway and SDOH screening
• Next steps & Adjourn
Meeting Goals

1. Continue prioritization of the CPHP draft work plan (currently 7 activities)

2. Identify members willing to work on each activity

3. Learn more about currently available tools and resources in regard to two of our priorities (social determinants of health screening and prematurity prevention bundles)
1. July 19th Meeting Recap
Joint Work Group Meeting-7/19

• The Clinical Public Health Practice Work Group convened with the Policy Work Group and the Health Equity Work Group on the 19th to:
  • Discuss and review the 2018 Summit
  • Review and share work group accomplishments
  • Discuss, prioritize and identify common ground within the draft work plans
• We identified two collaborative activities to pursue together
  • A social determinants of health screening tool and accompanying toolkit
  • A toolkit around Group Prenatal Care
    • Possible integration of doulas and CHW’s

Time for our first poll!
2. Draft Work Plan & Prioritization
# CLINICAL PUBLIC HEALTH PRACTICE WORK PLAN

<table>
<thead>
<tr>
<th>ACTION (WHAT)</th>
<th>NATIONAL OR LOCAL?</th>
<th>PRIORITY IN STRATEGIC MAP</th>
<th>RANK</th>
<th>PARTNER</th>
<th>TIMING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate for PTB prevention best clinical practices to be HEDIS Measures</td>
<td>NATIONAL</td>
<td>(3) Optimize Clinical Practices to improve the health of women and adolescents. Ensure all women have appropriate prenatal care.</td>
<td>1</td>
<td></td>
<td>2018+</td>
</tr>
<tr>
<td>A prematurity prevention bundle (screening, algorithms, toolkits, workflow, messaging for prenatal providers and paraprofessionals etc.)—Follow up with LDA remaining work from 2017/2018 plan</td>
<td>NATIONAL SPREAD/ LOCAL IMPL.</td>
<td>(4) Optimize Clinical Practices to improve the health of women and adolescents. Ensure all women receive high quality prenatal care. Ensure appropriate care for women with a previous PTB.</td>
<td>1a</td>
<td></td>
<td>2018+</td>
</tr>
<tr>
<td>Identification or creation of a universal screening tool to identify social risk factors that may influence birth. (package tools on implicit bias, tools to strengthen connection with social service agencies, education on structural racism)</td>
<td>NATIONAL &amp; LOCAL</td>
<td>Foster and support population based solutions.</td>
<td>2</td>
<td>Yes in HE</td>
<td>2018/2019</td>
</tr>
<tr>
<td>ACTION (WHAT)</td>
<td>NATIONAL OR LOCAL?</td>
<td>PRIORITY IN STRATEGIC MAP</td>
<td>RANK</td>
<td>PARTNER</td>
<td>TIMING</td>
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</tr>
<tr>
<td>Resource Guide on partnering with CHW’s/ and Doulas</td>
<td>NATIONAL SPREAD/ LOCAL IMPLEM.</td>
<td>(3+)Optimize Clinical / Public Health systems and Practices to improve the health of women and adolescents. Ensure all women receive high quality prenatal care.</td>
<td>6/3</td>
<td>Yes, HE</td>
<td>2019</td>
</tr>
<tr>
<td>Toolkit on Preventive and Supportive Care before and After Pregnancy (focus on contraception and general health of women)</td>
<td>NATIONAL SPREAD/ LOCAL IMPLEM.</td>
<td>(4+)Optimize Clinical / Public Health systems and Practices to improve the health of women and adolescents. Support strategies to increase intentionality of pregnancy</td>
<td>4/4</td>
<td></td>
<td>2019</td>
</tr>
<tr>
<td>Factsheet and tools related to Group Prenatal Care (in partnership with Health Equity and Policy WG’s)</td>
<td>NATIONAL SPREAD/ LOCAL IMPLEMEN</td>
<td>(3+)Optimize Clinical / Public Health systems and Practices to improve the health of women and adolescents. Ensure all women receive high quality prenatal care.</td>
<td>5/5</td>
<td>Yes, HE &amp; Policy</td>
<td>2019</td>
</tr>
</tbody>
</table>

*Add suggestions, other activities to consider, edits or additions in the chat*
## CPHP WORK PLAN

<table>
<thead>
<tr>
<th>ACTION (WHAT)</th>
<th>NATIONAL IMPLEMENTATION OR LOCAL IMPLEMENTATION?</th>
<th>PRIORITY IN STRATEGIC MAP</th>
<th>RANK</th>
<th>PARTNER</th>
<th>TIMING</th>
</tr>
</thead>
<tbody>
<tr>
<td>A tool on how to gain access to baseline data and carry out data linkage</td>
<td>NATIONAL SPREAD/LOCAL IMPLEMENTATION</td>
<td>(1) Optimize Public Health systems to improve the health of women and adolescents</td>
<td>3/6</td>
<td></td>
<td>2019</td>
</tr>
<tr>
<td>Commentary on 17P to publish</td>
<td>NATIONAL</td>
<td>(2) Optimize Clinical and Public Health Systems and Practices.</td>
<td>7/7</td>
<td></td>
<td>Unsure</td>
</tr>
</tbody>
</table>

Time for some polls!
# JOINT EFFORTS

<table>
<thead>
<tr>
<th>Action</th>
<th>Rank</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification or creation of a universal screening tool to identify social risk factors that may influence birth. (package tools on implicit bias, tools to strengthen connection with social service agencies, education on structural racism)</td>
<td>1</td>
<td>2018/2019</td>
</tr>
<tr>
<td>Factsheet and tools related to Group Prenatal Care (in partnership with Health Equity and Policy WG’s)</td>
<td>2</td>
<td>2019</td>
</tr>
</tbody>
</table>

Time for more polling!
3. Best Practice Sharing
WA State Safe Delivery Road Map

Dr. Dale Reisner, Medical Director OBGyn Quality & Safety, Swedish Health Services

Safe Deliveries Roadmap

Advancing Safety for Mothers and Babies
A Roadmap from Pre-pregnancy to Postpartum

©2014

Safe Deliveries Roadmap

Evidence based best practice recommendations to guide care.

Special Interest Cohorts:
1) Maternity Unit Culture
2) Maternal Early Warning Triggers
3) Second stage labor management

Successes
Early Elective Deliveries
Cesarean Deliveries
94.2% reduction in EED
11% reduction in C/S

Balancing Measures:
Severe Maternal Morbidity
Unexpected Newborn Complications

Challenges
• Establishing measures for all phases of obstetric care requires creativity.
• Competing demands in hospitals make process improvement work challenging.
• Culture is significant.

Kathryn Bateman: kathrynb@wsha.org
Janine Reisinger: janiner@wsha.org

Tools:
• Implementation Guide
• Checklists
• Algorithms
• FAQs
• Program

Safe Deliveries Roadmap is a collaboration of experts, clinicians, and multiple stakeholders working together to improve maternity outcomes. Recommendations developed by over 100 experts outlining best practices for pre-pregnancy, pregnancy, labor, birth, and postpartum care.

Collaborative Learning:
• Strategies and tools
• In-person Safe Tables
• Web-based education
• Metrics: outcome and process measures to evaluate success

Carol Wagner, Senior VP, Patient Safety
Kathryn Bateman, Sr Director, Integrated Care
Janine Reisinger, Director, Integrated Care
Dr. Thomas Benedetti, Expert
Dr. Dale Reisner, Expert
Mara Zabari, Consultant
Oregon Family Well-Being Assessment

Providence Pilot results

Helen K. Bellanca, MD, MPH
June 2018
Oregon Family Well-Being Assessment

Product of work by a subcommittee of the Oregon Perinatal Collaborative

Goal was to build a standardized, universal assessment of behavioral health and social risks in pregnancy

Purpose is to connect women with needed care and services, and also to aggregate data to understand the needs on a population level.
There is a paper version of the tool, intended to be handed out in the waiting room before a prenatal visit. It takes about 10 min to complete.
The Interviewer Guide is a reference copy for the clinic to help them decide what to do with the answers.

In the Interviewer Guide, some answers are in red font, meaning if the person answered this way it needs extra attention.

At the end of the section there is a risk assessment and next steps.
Domains

1. Demographics
2. Pregnancy intentions
3. Health and Social Supports
4. Emotional Health and Wellness
5. Substance use
6. Relationship Health
7. Other children and adults in the household
8. Assets and Resources
How do women complete the assessment?

Most (>80%) complete it at home on the computer through a link that is emailed to them when they make their first prenatal appointment.

Some fill it out on a tablet in the waiting room when they come to the clinic.

A few require an in-person interview.
Where do the assessment and data live?

Most clinic systems use a web-based app to deliver the assessment and compile the results. Some results are then manually transferred to the EHR.

Some clinics built it into their EHR, but this has been difficult in terms of protecting information and compiling data.

Some deliver the assessment on paper and then enter results into Excel.
Providence implemented the tool in 2015, with 4 metro-area OB clinics using it to screen all their new OB patients.

Pilot screened 361 women (30% Medicaid). To date, more than 2000 women have been screened at Providence.
Providence Pilot

Demographics

Age groups
- 17 & under: 1.2%
- 18 to 19: 1.6%
- 20 to 35: 78.1%
- 35 to 40: 13.7%
- above 40: 4.7%
- Null: 0.8%

Race groups
- Asian: 24.2%
- Black: 3.5%
- White: 53.5%
- Other: 14.5%
- Unknown: 4.3%

Immigration status
- No: 84.4%
- Yes: 9.0%
- Null: 6.6%

Languages
- English: 91.0%
- Spanish: 3.5%
- Other: 5.5%
Providence Pilot

Demographics

Relationship status:
- Married: 73.4%
- Partnered: 17.6%
- Single: 8.2%
- Null: 0.8%

Education:
- Less than high school: 4.3%
- High school: 22.7%
- College: 50.0%
- Graduate school: 19.9%
- Null: 3.1%

Insurance:
- Commercial (non-PHP): 45.3%
- Commercial (PHP): 28.1%
- Tricare: 2.3%
- Medicare: 1.2%
- Null: 23.0%

Employment:
- Full time: 58.2%
- Unemployed, not looking: 20.3%
- Part-time: 12.1%
- Unemployed, looking: 5.9%
- Seasonal work: 0.8%
- Null: 0.0%
Providence Pilot

Indicator Groups – all 2021

<table>
<thead>
<tr>
<th>Areas of Concern</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for basic resource support</td>
<td>25.5%</td>
</tr>
<tr>
<td>Need for health connection</td>
<td>70.1%</td>
</tr>
<tr>
<td>Need for home visiting support</td>
<td>26.0%</td>
</tr>
<tr>
<td>Need for parenting support</td>
<td>27.1%</td>
</tr>
<tr>
<td>Need for social/emotional support</td>
<td>27.4%</td>
</tr>
<tr>
<td>Other mental health concern</td>
<td>30.2%</td>
</tr>
<tr>
<td>Positive depression screen</td>
<td>8.3%</td>
</tr>
<tr>
<td>Relationship concerns</td>
<td>2.5%</td>
</tr>
<tr>
<td>Substance exposure concern (including alcohol and tobacco)</td>
<td>31.3%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>6.1%</td>
</tr>
<tr>
<td>Not grouped under any Concern</td>
<td>10.8%</td>
</tr>
</tbody>
</table>
Providence Pilot

Indicator Groups – Medicaid only (105, 22%)

Areas of Concern

Need for basic resource support: 42.9%

Other areas of concern:
- Need for health connection: 84.8%
- Need for home visiting support: 42.9%
- Need for parenting support: 38.1%
- Need for social/emotional support: 41.9%
- Other mental health concern: 32.4%
- Positive depression screen: 14.3%
- Relationship concerns: 2.9%
- Substance exposure concern (including alcohol and tobacco): 25.7%
- Tobacco: 8.6%
- Not grouped under any Concern: 6.7%
Medicaid only

Women who need a health connection

Areas of Concern

Need for health connection 84.8%

Component Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a dentist?</td>
<td>29.9%</td>
<td>70.1%</td>
</tr>
<tr>
<td>Have you had a dental checkup in the past year?</td>
<td>29.6%</td>
<td>70.4%</td>
</tr>
<tr>
<td>Do you have a regular doctor</td>
<td>36.4%</td>
<td>63.6%</td>
</tr>
</tbody>
</table>
Medicaid only

Women who need basic resource support

<table>
<thead>
<tr>
<th>Past 3 months, how often had trouble paying for basic needs (hou, food, clo)</th>
<th>Never</th>
<th>Some days</th>
<th>Most days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65.3%</td>
<td>25.3%</td>
<td>4.2%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past 3 months, how often has transportation limited you</th>
<th>Never</th>
<th>Some days</th>
<th>Most days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>66.3%</td>
<td>25.3%</td>
<td>5.3%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past 3 months, how often have you worried about having enough food?</th>
<th>Never</th>
<th>Some days</th>
<th>Most days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>70.7%</td>
<td>23.9%</td>
<td>4.3%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past 3 months, how often worried about having a safe and stable place to live</th>
<th>Never</th>
<th>Some days</th>
<th>Most days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>87.4%</td>
<td>8.4%</td>
<td>3.2%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
### Medicaid only

#### Women who need parenting support

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Unsure</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel that you have the social and emotional support you need for pregnancy and parenting?</td>
<td></td>
<td>6.4%</td>
<td>2.1%</td>
</tr>
<tr>
<td>How would you describe the involvement of the father of the baby?</td>
<td></td>
<td>3.3%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Are you interested in getting information about how ACES might affect parenting and your health?</td>
<td></td>
<td>2.6%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Are you less than 19 years of age?</td>
<td></td>
<td>1.3%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Do any of the children you parent have special needs?</td>
<td></td>
<td>3.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Have you used any street drugs (like methamphetamines, heroin, or cocaine)</td>
<td></td>
<td>0.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>In past 2 weeks, how often have you felt that your stress has made it hard to do what you need to do?</td>
<td></td>
<td>2.2%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

- Percentages based on survey responses among Medicaid recipients of childbearing age.
Our Goal: A healthy + productive next generation

- **PREGNANCY**
  - Planned Mom/Child

- **BIRTH**
  - Loving Connection with Caregivers
  - Healthy Mom/Child

- **0-3**
  - Strong Attachments

- **3-6**
  - Ready for Kindergarten

- **6-12**
  - Academic Success

- **6-12**
  - Skills, Experiences, and Supports for Development

- **12-21**
  - Positive Relationships

- **21+**
  - Broadening Skills, Social Supports
  - Healthy Lifestyle

- **21+**
  - Loving Connection with Caregivers
  - Skills, Experiences, and Supports for Development

Footer details: View > header & footer > Apply to all
Factors that Derail a Healthy Life Course

- **Unintended PREGNANCY**
  - Parents Not Ready to Parent

- **BIRTH**
  - Poor Attachment
    - 0-3
  - Not Ready for Kindergarten
    - 3-6
  - Academic Failure, Substance Use, Criminality
    - 6-12
  - Lack of Employment, Social Isolation, Dysfunction
    - 12-21
  - Unhealthy Behaviors, Lack of Support
    - 21+

- **ADULT W/HEALTH CHALLENGES**
  - Adult Violence, Substance Use, Lack of Resources
  - Abuse, Neglect
  - Behavioral Problems, Skill Deficits

Footer details: View > header & footer > Apply to all
Preventing high utilizers means investing in early life health

Adults with serious physical and mental health problems and substance use disorders often have childhoods that are marked by trauma, insecure attachment with caregivers, and poor coping skills.

If we want to prevent the next generation of high utilizers, we need to invest in healthy pregnancies, nurturing in childhood, and supports and services that families need.
Thank you

Contact information

Helen Bellanca, MD, MPH
Associate Medical Director
Health Share of Oregon
Helen@healthshareoregon.org
503-416-4983
Harris County, TX Guide to Clinical Screening for Social Determinants of Health

Tanweer, Kaleemullah, JD, LLM, MHA/MBA, Public Health Analyst – Health Systems Transformation, Harris County Public
Social Determinants of Health Screening

Goals and Process

Tanweer Kaleemullah, Harris County Public Health
March of Dimes
August 22, 2018
Harris County is the third most populous county with over 4.7 million people spread over 1,778 square miles.
HARRIS COUNTY, TX

Population Growth from 1990 - 2016

<table>
<thead>
<tr>
<th>Region</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.A.</td>
<td>30%</td>
</tr>
<tr>
<td>Cook County</td>
<td>3%</td>
</tr>
<tr>
<td>LA County</td>
<td>15%</td>
</tr>
<tr>
<td>Harris County</td>
<td>67%</td>
</tr>
</tbody>
</table>

Population Size, 2016

- Unincorporated: 2.0M
- City of Houston: 2.2M
- Other municipalities: 500K

Source: Population Study, Harris County Budget Management Department, February 2016. Available at: http://www.harriscountytx.gov/budget/
.... So How Can We Move Healthcare Upstream?
Healthy Sector

Education Sector

Healthcare Sector

Community Engagement & Input

Built Environment

Early Childhood

Breastfeeding

Civic Youth Engagement

HEALTHY LIVING MATTERS
Connecting Policy to the Future

A Houston/Harris County Childhood Obesity Prevention Collaborative
Understand the Healthcare-SDH Landscape

- Engage Partners/Research

Penetrating the Business/Clinical Side of Healthcare

- SDH Screening
- Education
  - Medical Schools (and other clinical schools)
  - CME
- Medical-Legal Partnerships
Types of Obstacles

- Interest and intent but delay actions

- **Deter, cause disinterest, or create inaction**

*When trying to move healthcare upstream, any obstacle is a mountain but especially the second type*
Toxic Barriers

- Lack of Awareness (new problem)
- Organizational Silos (old problem)
SDH
Clinical Screening
Initial Questions/Direction

- Scope
- Audience (adults, children, elders, all?)
- Action from data collected?
- Overall outcome
- Data and who will host it?
- Who owns this process (leading it)?
Memorial Hermann Healthcare System
- Food Insecurity – 2 FI USDA Questions
  - ER, School-Based Clinics -> Clinic, EMR, Full System
  - Expanded Pilot – 5 SDH Questions + 4 ER visits + Chronic Disease -> PRAPARE

Texas Children’s Hospital System/Baylor Medical School (pilots)
- Outpatient (SEEK)
- Inpatient (WE CARE-Houston)
- Harris Health Clinic (2 FI Questions; WE CARE)

Hopes Grant
- UT Medical School Clinics, Depelchin Children’s Center (SEEK)

Clinton Health Matters Initiative-General Electric
- Expanding on Memorial Hermann’s FI Screening (2 Questions)
- Garnered various hospitals and clinics to agree to screen for FI
- Medical records & Population health intervention

Others
- CMS Accountable Health Communities grant
- CCHH’s & PRAPARE FQHC Pilots (Episcopal Health Foundation)
Current State

• In addition to PRAPARE, became aware of other SDH screening tools:
  • SEEK (copyrighted)
  • WE CARE
  • WE CARE – Houston
  • Others

• Several SDH clinical activities (great!) ... but everyone going in own direction
SDH Screening

Healthcare Sector Action Team (HSAT) - hospitals, clinics, public health, health plans, foundations, academia, and government agencies

- Encourage More SDH Screening in Healthcare
- Use Current Activities as an Engine
- Create Unified (not uniform) and Cohesive Path
- Share & Learn from Experiences
<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>WE CARE</th>
<th>WE CARE – Houston</th>
<th>SEEK</th>
<th>PREPARE</th>
<th>CMS AHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading Level</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Would Like to Learn English</td>
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<tr>
<td>Employment</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Smoking</td>
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<tr>
<td>Drug Use</td>
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<tr>
<td>Alcohol Use</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Communication/Isolation</td>
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<tr>
<td>Custenance</td>
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<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Stress</td>
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<tr>
<td>Parental Violence*</td>
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<td>X</td>
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<tr>
<td>Housing</td>
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<td></td>
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<tr>
<td>Food Insecure</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Childcare</td>
<td></td>
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<td></td>
</tr>
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* May be taken off of next WE CARE version due to lack of positive responses
SDH Discussions/Case Studies

- Not everyone is at the same level of competency
- SDH Screening – included mental health fields
- Questions
  - Ethics of asking (or ethics of not asking)
  - Which questions to ask?
  - Role of staff/clinicians when screening occurring?
- Studies - Complexity of SDHs
  - Obesity effected by activity, nutrition, and …
  - Environmental and Behavioral effects
  - IPV
  - Housing
- Voice of the Community (CHWs Perspective)
- Shared (experiences) … Shared (information & updates)
- Bridging
SDH Screening – Output

- Create Core Measures (for single providers and large organizations* - ranked SDH fields)
- Recommend SDH Tool*
- Provider Guidance & Address Questions, Concerns, Barriers for Providers/Organizations
- HSAT Partners as Agents to Encourage and Promote Recommendations, Common Themes
- Keep Conversation Going – Normalize SDH Screening

*Keep in Mind other Local initiatives Like the CMS Grant
• Case studies
• Discussions
• Feedback
• Being Critical of Ourselves
• After about a year ...
Q & A
Contact Information

Tanweer Kaleemullah
Tanweer.Kaleemullah@phs.hctx.net
Harris County Public Health

{ Vision }
- Healthy People,
- Healthy Communities,
- A Healthy Harris County

{ Values }
- Excellence
- Compassion
- Flexibility
- Integrity
- Accountability
- Professionalism
- Equity

{ Mission }
- Promoting a Health and Safe Community
- Preventing Injury and Illness
- Protecting You

www.hcphtx.org
4. Work Group Activities
1. HEDIS Measures/PTB Prevention Bundle
2. Resource Guide on partnering with CHW’s/ and Doulas
3. Preventive and supportive care before and after pregnancy toolkit
4. A tool on how to gain access to baseline data and carry out data linkage
5. Commentary on 17P
6. Social Determinants of Health Screening Tool in partnership with Health Equity
7. Group Prenatal Care Toolkit in partnership with Health Equity and Policy

1. If you are willing, able and interested in contributing your time and expertise to one of the activities we have prioritized, please add your name in the chat box and the activity next to it and we will reach out to you.

2. If you know of other best practices or important work going on in these areas, please write that in the chat box or email us at Collaborative@marchofdimes.org.

3. If you are willing to lead and assist with meeting set up and coordination for other meetings regarding these activities, please chat in your name, the activity and the word leader next to it.
5. Schedule & Evaluation
### 2018 Collaborative Meeting Schedule (EST)

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If you are interested in attending Workgroup meetings please email us at collaborative@marchofdimes.org to receive specific meeting information.
Evaluation

• If you are not an official member of the Clinical Public Health Practice Work Group, please email us at Collaborative@marchofdimes.org to join and receive all of our emails, calendar appointments, meeting summaries, slide decks, resources and more.
In the chat box, you will see a link to a brief post-meeting survey that will take you less than 5 minutes to complete. Your feedback is very important to us, so thank you in advance.

The link for the survey is: [http://marchofdimes.org/workgroup](http://marchofdimes.org/workgroup)

Click on the Chat icon in your toolbox to access the survey link.
7. Adjourn