PolicyLab

Webinar Transcript: Making the Business Case for Managing Social Complexity in Pediatrics

Moderator:

[Title Slide] *Hello everyone, and thank you for joining the PolicyLab webinar series. PolicyLab is a research center within Children's Hospital of Philadelphia's Research Institute. Our care for children and families drives our research, informing practice and policy to improve child health.* ***[Slide 2]*** *This webinar series is just one of the many tools we use to translate the work under our four research portfolios into evidence-based policy solutions at the local, state and federal levels.*

Today we'll be highlighting work from our intergenerational family services and health care coverage, access & quality portfolios while exploring a question we know is on the mind of many – how do we address social determinants of health to improve the health and well-being of kids and families? Dr. David Rubin and Leigh Wilson are going to walk you through the current landscape for tackling these issues in pediatrics, ways to build a business case to implement intergenerational social risk programs with leadership in your own organization and practical examples of these strategies at work. ***[Slide 3]*** *Dr. Rubin and Leigh both have first-hand experience and knowledge of how social determinants impact children in our communities. Dr. Rubin is the director of PolicyLab and of Population Health Innovation here at Children's Hospital of Philadelphia and is a pediatrician with more than 20 years of experience. Leigh Wilson is an improvement advisor for the Population Health Innovation Team and the Division of Social Work at Children's Hospital of Philadelphia as well as a trained social worker.*

[Title Slide] *Before I hand it over to them to get us started, let's go over a few logistical notes. We've collected questions from several of you who submitted them prior to the webinar via email. You can also submit questions during the presentation by using the chat function, which can be found on your webinar control panel. We hope to address as many questions as possible at the end of the presentation. All lines will remain muted for the duration of the webinar. We'll post a recording of this webinar to our website tomorrow and you can access it and other resources by visiting policylab.chop.edu. We encourage you to share via Twitter as well, tagging us – @PolicyLabCHOP.*

With that, I'll pass it over to Dr. Rubin and Leigh to get us started.

Dr. David Rubin: **[Slide 5]** Well, good morning everyone – or good afternoon. We've got a pretty, I think, both informative and kind of a fun presentation we have here for those folks who are investing a lot of time and energy thinking about this work. This is going to play out – just the ground rules to get started. This is going to play out as more of a conversation between Leigh and myself.

Leigh, you ready for that?

Leigh Wilson: I'm ready.

Dr. David Rubin: All right. And I think it – a little bit irreverent, a little bit sort of thought-provoking and assumes some basic knowledge, I think, of sort of the space around social determinants and much more about how do we move the ball down the field and how do we start to really get sustainable programs that actually achieve some of the, I think, aspirations of folks who are working in this field.

So you ready to get started there, Leigh?

Leigh Wilson: Let's get started. I'm excited.

Dr. David Rubin: All right. **[Slide 6]** So as a practicing pediatrician for over 20 years, as Laura has said, I've seen many patients and most of us who work with children will see many patients during our time where the elephant on the table for many of us is a lot of social problems that folks have. And whether you're working emergency, inpatient or ambulatory settings, it's very, very common. And usually when they happen, if I'm being totally honest with you guys, it's in the context of a busy office environment or a busy emergency department and I'm thinking like, oh my gosh, can I get my social worker to help out and wave their magic wand, because I don't have time for this but I know it's important. So then I try to call Leigh and –

What are you thinking, Leigh, when you get that call from me?

Leigh Wilson: Well, as a social worker – and I'm sure for those of you on the call who are social workers or case managers or community health workers – addressing social needs is really a core part of our practice and training, but from the perspective of a health care system, just because of the way our system is structured and because it's structured to provide really world-class medically

focused services, our work is often reactive and crisis driven when it comes to social determinants of health.

So Dave, the cases that you're probably seeing in primary care or the example of the emergency department that you're giving are probably the cases that have reached the crisis phase or are more urgent cases, and those are much harder for Dave or myself or the whole clinical team to address, and it probably means that we missed an opportunity sooner to intervene. So those are some of the things that we want to talk more about today.

Dr. David Rubin: **[Slide 7]** So many people are familiar with this slide. When I was starting to develop our program here, that was probably sort of what I thought was the money slide to show our leadership, right? And I think many folks would show this slide, which is the typical iceberg slide where above the waterline you have all those health care factors that we address every day in our clinical care but below the waterline is the much larger share of psychosocial risk factors that really do impact a child's health that are probably driving their health care use and their overall health more than the actual clinical conditions themselves.

And so you show this slide at a board meeting – and I want you to imagine that you're an executive in the room – and you're saying, well, how do they respond to this? And in general, you get those sort of Maggie Simpson kind of blinking eyes, because I think there's a question of like, what are the boundaries of this? How much are we really responsible, in the context of all the priorities that we have around our clinical responsibilities, to be addressing the stuff below the waterline? And so you often get stopped dead in your tracks thinking, well, where do we go – and so the conversation just becomes this sort of circular argument that you feel like you've been having for years. Right? And that's the nature of – I think the challenge – and how do you get past that?

Leigh Wilson: **[Slide 8]** And Dave, I think the flip side of that is that from a social worker/community perspective, I think sometimes this topic can be frustrating, because social determinants of health is not a new concept. And sometimes I think we talk about it like it is, but it's such a core part of our discipline and services that have been provided for decades and decades. But within health care it's still a growing conversation about how we broaden our definition of what contributes to health. And there's been growing recognition among professional and national organizations about the importance of how do we proactively address social needs in the context of health

care and for pediatrics how do we do that in a way that can mitigate risk for children's health outcomes and development. And these recommendations from these professional organizations have been really helpful in providing a foundation and an incentive for health care systems as a whole to be thinking differently about this issue.

I'm guessing for those of you on the phone, you're very familiar with these organizations, but if you have questions, we're happy to address them in the question and answer period.

Dr. David Rubin: And I know, there's a – because we've been sort of having the conversation and now we have a lot of upstream pressure to start doing this work – and many Medicaid programs including our own here in Pennsylvania are starting to require us to incorporate this into practice, there's a little bit of a scary moment where you're like, how are we going to do this without completely burning out our provider workforce; are we really prepared to do this?

Leigh Wilson: **[Slide 9]** And related to that, I think, what is the current state of screening and referral? And I'm guessing for those of you from health care systems on the phone, this probably looks familiar that we have a lot of people who are working and doing a lot of really great work around implementing and referral within a health care context –

Dr. David Rubin: I call these people our do-gooder colleagues who are in their own little spot in the world trying to make a difference.

Leigh Wilson: Absolutely. And I think they are making a difference for the patient populations they work with, but because many of these projects are in or leaving pilot phase, what the result is is that we have fragmentation in the works. So even within our networks, we have different screening practice, we have different questions, different administration of the questions happening – which from a family perspective could mean that they're being asked different questions depending on where they come in for their services and also from a community agency perspective can mean that the same community agencies are getting approached by people within the same organization or within the same network to form separate partnerships. So what we're looking to do is not only implement this work in an effective way but also standardize it within our own organization.

Dr. David Rubin: So this is the sort of well-meaning folks really who in some ways we end up setting up these silos because it's the nature of sort of the –

everyone's out for the – trying to advocate for their programs and doing the right thing, but you get this system that doesn't seem to have some level of organization to it.

So all right. Well, let's talk about what some of the barriers have been. **[Slide 10]** From the physician's time, I think when you think about sort of things that are thrown out there, whether universal screening or a lot more attention in the clinical setting, I think it terrifies my colleagues, Leigh, honestly, if I'm being truthful. I mean, where am I going to fit that in? I'm not sure I have the training to do that, certainly have no idea where to send most of these folks if they screen positive, so I really – the idea of a bridge to nowhere is really not a concept I'd like to endorse, because it makes me feel completely ineffective and it feels like it's an overreach. And then you have a fear sometimes, I think, if you're being honest, of offending patients. They came here for their clinical care and I'm sort of hitting them with this kind of impersonal survey and I'm not sure everyone wants to kind of talk about that. And so I'm not sure how much of that is real or not, but these are the things that go through the mind of my colleagues.

So then at the hospital, again the lack of the sort of best practice. Often your community partnerships – sometimes they're organized to some degree, but how well have we created what we're going to talk about later – which are these resource maps which have centralized the function of identifying and cultivating our community agency partnerships? Often those aren't well developed. And then the almighty dollar, which is how are we going to build the workforce, what is the – how are we going to train our finance teams to create the mechanisms by which we can bill for – in many ways which are dyadic services or parental services that are intended for the parent and the family for the benefit of the child.

Leigh Wilson: And when it comes to community agencies, health care systems and community organizations have very different payment and funding structures I think which can make it really difficult for community agencies to build new services like referral pipelines or the data integration that could really help improve this work from a systems perspective. So things like technical assistance and capacity building within community agencies is something we really need to think about, even as we build new services within our health care system.

Dr. David Rubin: **[Slide 11]** So let's pivot now and talk about where are we trying to go. So if we create a sort of vision in terms of what our teams at the

micro versus macro level are trying to do, what are we trying to accomplish here from a larger population health perspective within these health systems? And so we're going to pivot to that discussion now.

[Slide 12] So I want to credit my mentorship. I mean, Angelo – Dr. Angelo Giardino, who is now the department chair at Utah and just joined them a few months back, he was an early mentor to me in thinking about what I call the secret sauce for population health. And I don't think this is rocket science, but I think, to me, what we're trying to achieve is to be better about selecting the right population on the left **[Slide 13]** and then creating the right integrated team – to my colleagues who are concerned about provider burnout and physicians sort of lack of training, this is not intended to be, necessarily, a physician response. We're building teams of clinicians and coordinators and social workers and navigators or community health workers and we're trying to make the outcomes – thinking about, globally, what everyone's responsibility on the distributed team is to ensuring a certain patient experience and outcome. And then if we can figure out what they want their workflow to be and what their individual responsibilities, we can align them with the right technology and tools so that they're ultimately providing care that's coordinated for the right people at the right time in the right place and is very family centered.

[Slide 14] So how do we get there? **[Slide 15]** That doesn't happen overnight, but I can tell you, having navigated and watching some of my colleagues navigate this beyond my own environment, when you're speaking to your executive team, in some ways you need to understand what motivates them in terms of their stewardship of the organization so that you get visibility. Clearly the iceberg slide was not the way to get their attention. And so what I have found over time is there are three enterprise-related outcomes that I think a lot of executives think about. They share an interest in reducing fragmentation of services, particularly in the children's hospital space but in a lot of children's health systems with the centralization of a lot of sick kids and often children in Medicaid washing up on the shores of these health systems who are often responsible for tertiary care. Capacity issues and optimizing capacity management, keeping kids out of the hospitals is important so that there's enough throughput for all the kids that need to use our services. And then finally is most executives want to ensure that we're providing financial stewardship and value to the organization.

And so we're going to look at different business cases from here on through the lens of these outcomes and how you build a business case. **[Slide 16]** The case we're going to use for this is a case that's fairly common – I could change the clinical condition. But let's just say a mother, Mia, brings her 8-year-old son Tony to the emergency department because Tony's having an asthma flare. I go down to see Tony. He's been in the emergency room three times in the last three months, so he's a frequent flyer. We can tell his mom's clothes are – she's an obvious smoker. She has an extremely flat affect, so I wonder about depression – and I've got three rooms waiting to see me and people standing out in the hall. So I call my friend Leigh.

Leigh Wilson: Yeah. And if I put myself into the headspace of my colleagues in the emergency room, I know that most people in the room, they – including Dave, in this scenario – they are juggling a million things at once. So as a social worker, I would most likely go into the room and my main priority is doing a safety assessment **[Slide 17]** to determine any urgent needs when it comes to Tony. **[Slide 18]** So if I determine that he is safe, then most likely I'm going to send Mia home with a list of phone numbers and services that she can access for some of the needs that we get to talk about, whatever that may be that we get to address in the five or ten minutes that I have with them.

Dr. David Rubin: **[Slide 19]** So that's what happens. I think that's pretty standard of care in most places these days. How does that relate to our business case? Well, the status quo – we're in this fragmented world and we're just living it every day. Right, Leigh?

Leigh Wilson: Mm-hmm.

Dr. David Rubin: And I don't think we're doing too much to optimize capacity, manage it. I think there is that sort of needle in the stomach, that sort of agitation that you just got through your shift or your day but have you really helped these families or created some level of a game change for them. And I don't think we're optimizing capacity and we're certainly not improving our financial stewardship and value.

But we do need to recognize – next slide **[Slide 20]** – that there are benefits to the hospital and tradeoffs as we appraise the case of do nothing different. There is no upfront cost, and I think there is an assumption that based on our – I believe our responsibilities and

our interest in trying to do the most for our families that there's no upfront cost, there's no change to current workflow and people will just figure out, I suppose, how to do the best they can in resource-poor environments. But there are tradeoffs. We're burning out our providers – assuming that the physician and maybe a social worker, if they're available in that department, are going to be able to put out these fires. The children and families are not served well. There is an increasing risk in cost for Medicaid-enrolled patients, particularly at a time when we're talking about block granting Medicaid – and we're really not moving the needle there. And then there's a lot of fragmentation that also kind of irritates different people in terms of turf and an inefficient and costly workflow to your social workers and – right, Leigh?

Leigh Wilson: **[Slide 21]** Yeah. So let's talk about another way. There's been so much focus on standardized social risk screening. So what if we just implemented screening, Dave?

Dr. David Rubin: Well, yeah. This is what I think I've seen most of out there is a lot of people doing great work coming up with some standardized screening – let's get everybody in the room – this is the plan that says, okay, let's get all those do-gooder colleagues together and the folks from social work and interested parties and form a workgroup and then actually develop – let's all agree on the 10, 11 items that we're all going to screen for that can help us in resource planning but can also assume that we can standardize our IS screening of folks. **[Slide 22]** And so if we can up-front that to our providers, more people will get served, right? So Mia takes – in this situation, Mia would take an electronic screener. Maybe she's got a tablet that's presented to her at the door. She screens positively for her own behavioral health issues, some smoking issues, some housing insecurity. And then I do the same thing I did before, which is I ask Leigh to wave your magic wand.

And do you like this solution, Leigh?

Leigh Wilson: I mean, in the absence of a magic wand, there's some positives to it, that we might have identified needs that might have not come out previously – maybe Mia wasn't comfortable raising them, maybe we didn't have time to talk to her about them or ask her those questions. Maybe she felt more comfortable disclosing that information on a tablet than she would in a conversation with you or I.

But, as you pointed out, Dave, the result for Mia is the same in this case – that she's sent home with phone numbers for community services. So it's great that we identified need, but that does increase the volume of needs that we are then responding to with that five to ten minutes that we had previously without giving us really any backend tools to help us respond effectively and meaningfully to the needs that are being raised.

Dr. David Rubin: **[Slide 23]** So I think we all could argue that this definitely reduces fragmentation of services. I think it also can help with resource planning. I think once you can document need, maybe it can help with your executive team just to see what people are seeing out there or that we have a lot of historical data that you can do that with, as well, but somehow it feels more real when you can show them on your own group. While we reduce fragmentation of services, I'm not sure we're optimizing capacity management. In fact, I probably just increased the amount of volume coming to Leigh's phone, and so I'm not surprised when I get that sort of like two rings on the iPhone and then you get this little text back, sorry, I can't talk right now. Right? So you get used to that message, because she's completely inundated with the number of requests that are coming in. Right, Leigh?

Leigh Wilson: Absolutely.

Dr. David Rubin: And so I'm not sure we've figured out a system – at what I call the efferent end – of actually helping families, but we certainly are screening them more systematically. And then I'm not sure we've done anything to improve financial stewardship or value and so we can now appraise the benefits and the tradeoffs of this approach.

[Slide 24] I do think there's some upfront cost, but it's mostly in the – in convincing your IS team to do some screening and there's some tablet costs. You could often use grant funding to get some of these things started. There's certainly that reduction in fragmentation, I think a little bit more transparency in those resource discussions when budget time comes up, but there are tradeoffs. There's a continued risk of partial fragmentation for how patients' social needs are both triaged and addressed. And what I mean by this is you can triage them, but if you're not addressing them you're fragmenting – there's no full process that's been borne out there. Providers, if they're inundated with lots of folks with these social risks, they're going to feel compelled to somehow figure it out and they're going to be getting home later from work because they're getting caught 15, 20 minutes behind their schedule because

they're constantly having to run around, figure out what to do. We may have increased capacity management needs if we're not responding with a disciplined plan and there's – and I think we have to worry that the lack of response to positive screens can actually sour our patients on why are we asking these questions in the first place.

Leigh Wilson: I think it is interesting, Dave, that like we mentioned – and as I'm sure you all have experienced on the phone – there's a big focus on social risk screening right now. And Dave mentioned the state Medicaid requirements that are coming down the pipeline to screen within primary care. And I think that there's just not as much focus on that – the backend piece and what are we going to do to respond when we get that positive screen. And I think also when we talk about costs, often we think first about the monetary cost of intervention. So I think patient experience is a really big factor and asking families to disclose information when we come in is something that we just need to be responsible with.

Dr. David Rubin: **[Slide 25]** So this is where the meat of the talk is. **[Slide 26]** We're going to talk about a different strategy that we're trying to deploy here, which is what we call a tiered service delivery strategy, and it's particularly effective when your resources are scarce – you can't do a one-size-fits-all model for everyone. And so I'm going to let Leigh go ahead and talk about it, because this is her baby.

Leigh Wilson: So this is probably not an unfamiliar model, because it's very familiar to allocate resources based on the level of risk. But what it's starting to do is to incorporate not just medical risk into how we identify need among our patients but also social risk and putting social risk into that formula. So what we want to do is to ensure that services are matched appropriately to patients' medical and social needs, and we want to maximize the value of the investment we're making in social risks services. So a tiered service delivery model, it creates an economy of scale – so it provides at the base access to standardized screening and referral to all children as a means of identifying risk and need among patients and then from there, for patients who have low medical and social complexity, provides brief or less-costly interventions to the middle tier. And then to the top tier, who are our highest risk patients, it's allocating more intensive resources – more intensive as in more resource-intensive and time-intensive resources such as interdisciplinary service coordination. So it's really ensuring that the resources are maximized by allocating them to the patients who need them the most.

Dr. David Rubin: And I also think you also, as you move into those top tiers, that's where your community health workers are doing more visits out to the home, there's really more of an extension out to the home and not just in our offices. And those are much more resource – it can be more resource-intense.

Leigh Wilson: Absolutely. And it's recognizing that there is a continuum of social needs. I think a lot of times this work can be really overwhelming because there is such a large proportion of our patients who are facing poverty-related needs that this gives a framework for ensuring that we are really targeting the highest-need patients.

Dr. David Rubin: **[Slide 27]** So let's talk about the – from a vision perspective, how does this work. Well, it definitely reduces fragmentation of services and if we do a good job in terms of optimizing the services we're providing to those different tiers and we believe that those services are going to manage risk away from the hospital, then potentially we're going to affect hospitalization rates, particularly around ambulatory sensitive conditions or ED rates, et cetera.

And so for those quality improvement folks out there, we can talk about how do you marry this as part – that the driver here is that we're doing a much, much better assessment of risk and tailoring services to the right families will lead to a reduction in the use of the emergency department for ambulatory sensitive conditions or to reduce length of stay among families or reduce rehospitalizations among families with larger social risks.

And then finally, if we do that, we are also going to improve stewardship and value. Many of the families or most of the families who are going to be impacted here are probably children in the Medicaid program and as – and those tend – those insurance plans don't tend to reimburse as well as those commercial plans that are responsible for a lot of your tertiary care and the folks coming from outlying areas, and if we – in some ways, from a cost-avoidance perspective, if we're actually getting more children in Medicaid out of the hospital from the neighborhoods around the hospital and we're making room for that child coming in for complex cardiac repairs, et cetera, we're probably improving the overall financial stewardship and value to the organization.

[Slide 28] So the benefits – let's talk about the benefits. So there's potential for a long-term return on investment. I mean, this is not easy work, but I think if it's done well, I think there's a long-term

return in terms of how we're managing risk within the organization. There's a reduction in fragmentation as there was in the previous option. We hope if done well that there's improved patient and provider experience and then we're optimizing health care utilization – and capacity management – but from a tradeoff perspective, what can seem daunting – and this is where people are like, yeah, whatever, Dave, because this seems like the Cadillac and we're just trying to get morsels – we're trying to get breadcrumbs to kind of help pay for this. But there's a moderate upfront investment to achieve that full vision and there's a fair amount of training you need. So that's a big V vision, right, Leigh?

Leigh Wilson: Yeah.

Dr. David Rubin: I mean, I would say – and that's what I think people get scared about. But I would say is, let's try to unpack this a little bit more. **[Slide 29]** So let's acknowledge that you don't have a lot of resources. Right? So how do we start to anchor ourselves within our own health systems to do this work? And the reality is you're not going to start at the bottom, often, with the standardized screening and referral and the big platforms we're about to talk – you're going to go hunting for those programs that have some interdisciplinary resources. Maybe it's your asthma program. Maybe it's a program for children with complex medical needs and you're going to help them standardize the way they're appraising risk and to start to build out for the social workers where they exist better clinical workflows that are aligned with improving quality within those teams. So I would say that your best bet is to focus on your proof of concept with the integrated care teams that already have existing resources so that you can make – better elaborate what the business case is going to be when you actually get down to it.

[Slide 30] There we go. So anyway, so that's exactly the strategy we've chosen. There were a couple of areas we chose to invest in. From a disease-management model, we worked on creating an interdisciplinary governance group for asthma population health in our health system. They're looking at – and by helping them pinpoint our hotspot very quickly, the high-frequency utilizers of emergency department and inpatient services, we sort of tasked them in an integrated fashion with coming up with a – what they call a high-utilizer bundle. They were doing standardized risk screening, they were including assessment of social determinants but really, on the back end, what they were doing is as they identified these kids, they started creating a plan to give them meds

at the bedside, to do an enhanced education, expedited referral to specialists where necessary – but then they immediately, within I think about a week's time, handed them to our community asthma prevention program that included community health workers which were going out to the homes to do much more sophisticated social risk screening on top of the medical – the education.

This is sort of where Mia and Tony would fall, and I can tell you that integrated response supported by QI **[Slide 31]** led to fairly demonstrable results on our team. And you can see where they implemented – in this slide, which is a typical quality improvement slide, it shows the rate of our readmissions among our high-frequency utilizers, which was hovering at about 25 percent until our bundle was implemented in this tight integration with our community teams. And you can see the readmission rate among these high utilizers dropped in half to about 12 percent. And so that's real data from a capacity management perspective that starts to turn heads as opposed to the iceberg slide – right? – and that there's a real value in what you're trying to achieve.

Now on the next slide **[Slide 32]**, we also looked at our sort of programs for children with medical complexity. And one of the programs we started to develop – and there were several, of course – at our organization was a partnership with a managed care plan in the area at our largest primary care site at CHOP where we have 30,000 patients per year. This is a typical academic sort of practice site, a lot of residents, a lot of Medicaid patients and we had over 500 medically complex children enrolled in this program. The managed care organization provided the funding through – care management funds through the Medicaid program for five nurse coordinators, a social worker and two community health workers. **[Slide 33]** We surrounded them with quality improvement resources and in the end we showed that after a much more intensive care coordination, interdisciplinary involvement including the assessment of social risk within these families and much more engagement with the community health response we could reduce their hospitalization rates overall, which decreased by about – greater than 20 percent, and we saw similar decreases in emergency department use and we've now replicated this approach in several different settings at our health system, so much so that on our final slide **[Slide 34]**, because we made a bet with scarce resources around children in Medicaid – both the complex kids and the kids with asthma – around some of our early resource deployment, we had the knowledge that they were disproportionately responsible for most of our bed days in our hospital.

And so we demonstrated in this slide, which shows in blue at the top the seasonal rates of hospital admissions among our primary care children in Medicaid. In green are the seasonal rates of the children who are not in network to our primary care sites who are in the community. And what we demonstrate here is you can see that we greatly reduced hospitalizations over time per 1,000 beneficiaries. This was across 95,000 children in our Medicaid program – and we did not deliver a dose of these interventions to most kids; it was a fraction. It was probably five, ten percent of the kids, at most. But they were the right five to ten percent, and the result was we reduced our days by about 6,500 bed days annually in our Medicaid program and we have a paper coming out describing this program and the results and this comparative effectiveness trial that we report here.

And so, to me, what we've now done is taken what seems like this daunting issue about where do we start and we've sort of said, well, let's prove it on this very precise populations and show what the impact is from the business case so that we can now start – as we start to replicate the other specialty care programs we're starting now to create needs where every program is saying, you know what we really need, Dave, is a really good resource map. **[Slide 35]** And so now we're getting to that bottom tier which is screening and referral, and Leigh's going to talk a little bit about that.

Leigh Wilson: **[Slide 36]** So we're really excited. Sort of as Dave just described, we at CHOP really started with the top two tiers, but we're excited to be able to work our way down to now be thinking about the standardization of screening and referral. **[Slide 37]** So I'm guessing many of you on the webinar have encountered or discussed resource mapping, so it probably looks familiar to you. **[Slide 38]** But we have been working with an interdisciplinary team across CHOP and across our network to really think about how we can test the use of resource mapping and including social risk screening in the inpatient and ambulatory setting.

And resource mapping has a few different functions. So first it can create a centralized database that's available to all families and all providers of community resources that is really easily searchable by things like ZIP Code, income level and other programmatic or personnel filters. But beyond that, resource mapping also has the ability to connect to social risk screeners, to integrate with the electronic health record and to track data analytics for searches and referrals – so all functions that are fairly new within the health care

space but are really exciting when we think about wanting to provide access to standard screening and referral for all of our patients across the network. So what we're trying to work toward with this project is having a system that is scalable and could be standardized.

Dr. David Rubin: I think there's another element, though, Leigh, too, which is when you're starting to get capacity where you've done multiple programs, you're then – your pivot, particularly in your advocacy with your leadership, is that we need an economy of scale. If I only had a social worker who was managing my relationships with our community agencies and building out this resource map and storing it in one place – whether you're the enhanced care management team, the asthma team, the sickle cell team, the oncology team, you could be pulling off the same set of resources. And so there's a certain economy of scale that develops and that's less fragmentation and better stewardship.

Leigh Wilson: Absolutely. It's a way to really leverage technology to share expertise both within clinical teams and across clinical teams in the network. And I think beyond the centralized database that it provides, the integration with the electronic health record is a really key piece for being able to communicate within the clinical team about needs that have been screened for or referrals that have been made for that family – for example, between an inpatient and an outpatient setting. And I think the resource map also has developing functionality around communicating with community agencies – so how can we better partner with community agencies to be able to track referrals or have some kind of bidirectional communication to know that our patients and families are connecting or to help support them if they are not.

[Slide 39] So we are still in the early phase of this work. So either in the question and answer period or following this webinar, if there are others who are also looking into resource mapping or have already had some lessons learned, we would be happy to connect around it. So we're really in the phase of building out the resource map in partnership with our clinical teams and will be really focused on workflow. We've talked about provider burnout earlier in the webinar, and technology is only as good as the teams that can use it or as the workflow itself. ***[Note: Speakers experienced technical difficulties with audio starting at 00:37:14. Normal audio resumes at 00:37:47.]*** So we're really focused on implementing this in a really intentional way that's both beneficial **[inaudible 00:37:14]** to our providers. So we are

excited to be able to provide more updates **[inaudible 00:37:18]** to really test that integrated system starting in the spring and summer.

Dr. David Rubin: **[Slide 40]** So I think **[inaudible 00:37:26]** some of your questions **[inaudible 00:37:27]** after the Q&A **[inaudible 00:37:29]** to do so. But what I would say **[inaudible 00:37:33]**, tiered deliver approach you don't need to accomplish all at once, and that's my take-home message. It can be daunting. It can be scary, but at the same time I think **[inaudible 00:37:44]** –

Hello. Are we back? We're back. I hope.

But anyway, I just wanted to say that the menu of the tiered delivery – this is the part where we tell you the cat walked on the phone. But I think the sum total, before we get to the Q&A here, is that tiered service delivery to me is a menu by which you can work on to actually start to get some direction and standardization about how you're going to build out, I think, a fuller model, to marry that to data and quality improvement within your organizations so you can have much more substantive conversations not just with your leaders but with your insurance plans and I think ultimately to achieve your goal of interdisciplinary teams that are improving your screening for social risk and referral and hopefully ultimately for greater visibility in your enterprise operating plans.

And Leigh, what's your thoughts as we wrap this up?

Leigh Wilson: Yeah. I would just add the quality improvement approach is a really great way to leverage your interdisciplinary team. So the use of interdisciplinary teams like community health workers and care coordinators and social workers I think has been rapidly developing within health care. And, Dave, I know doctors know everything, but in the absence of the magic wand that – until we have a magic wand, I think the expertise of these interdisciplinary teams can really be leveraged as you are deciding and making decisions around how to approach the tiered service delivery model and where you want to start and what's best for your health care system.

Dr. David Rubin: **[Slide 41]** And with that I'd just like to thank the many partners that have allowed us to break ground here at CHOP and recognize that this is not – there are a lot of people you need to kind of – you need to build an army, if you will, and there's a lot of great people that can come together within your own organizations to help you.

So I think it's time for some fun Q&A. What do you think, Leigh? **[Final Questions Slide]** Those of you guys that have to go, we understand. But maybe we can get – dive into some very specific questions that people are interested in.

Leigh Wilson: Absolutely. I think we can just take a minute or two, since I know we're almost at time. And I believe for those of you on the webinar and those of you who can stay, you can use the chat function to submit any question that you have for us. And you're obviously welcome to reach out to either Dave or I after the webinar.

So Dave, maybe we can start with this question around being in a small hospital. So we got this question by email. It's how can you incorporate or push for these ideas as a hospitalist in a small hospital, especially where funding can come from and how you can move beyond the borders of the hospital?

Dr. David Rubin: Well I mean, ultimately, you've got to find those partners, I think, within your health system. And I recognize that it's very hard – you may not have as well-integrated electronic health record data. A lot of your smaller hospitals are often out in communities that are a little smaller. I think if you can endear yourself to the social work resources or case management resources and form a little bit of an interdisciplinary team yourself, you can start to build out that resource map – you can get a local foundation or a local funder to help start to do that with you within your organization. And I think if you build out that resource map, I think you can take the same approach. Do you have a program for the kids with medical complexity who are using your hospital frequently? Are there specific populations that you might be able to just say, we're not going to do this for the thousand kids, we're going to do this for a couple hundred kids that we know are frequent users of our services and really try to marry a program for those children. And so I still think finding that population, finding interdisciplinary partners is the sort of way I would attack that problem, even if I were in a small institution. What do you think?

Leigh Wilson: Absolutely. And assuming that a small hospital may mean also a smaller community, I think leveraging the community expertise and the community agencies within that community and sometimes forming a partnership with the one or two really major community agencies in the community can be a great way to start, because you can start to form referral pipelines or even some co-located services just based on the existing resources outside the hospital's walls.

Dr. David Rubin: What else we got?

Leigh Wilson: So let's see. How about this one? Health care professionals are increasingly being pulled in many directions, particularly in pediatrics, and they're taking on more and more. So how do you get buy-in from multiple members of an integrated team to address social determinants? I think this is a great question.

Dr. David Rubin: Well, I think I recognize that I can't – as a physician, I couldn't build this program without other folks. This is not a physician response. I think people have to hang up their own sort of – I think if we do this burdening the physician or the nurse practitioners on the frontline it's going to fail under its weight. To me you have to start building the work across team members, and I would think fairly broadly. Sometimes it's nurses, sometimes it's social workers, sometimes it's your patient service representative who's really interested in this. And these folks live in the same communities. And so this is really about teamwork and starting to build a team and thinking about how do we distribute a workflow if we want to make progress here.

Leigh Wilson: And I think this comes back to the quality improvement approach that we've mentioned, is I think it's really important to start small, is a lot of this work is building in new workflows into teams that are already overwhelmed by the existing medical services that they are providing. So starting really small and making sure that it's being implemented in a way that isn't adding extra work to people's plates but also appealing to the changes that the interdisciplinary team wants to make. So we've talked about provider burnout. We've talked about how often these issues are probably coming up for multiple people on the team. So appealing to those changes and being clear about the gap that these services can fill.

Dr. David Rubin: I think we're having some technical problems with the chat function on the – so people, I'm going to ask you to send – if you have questions, send them to policylab.webinars@gmail.com. Webinars – plural. Policylab.webinars@gmail.com. We'll accept your questions through the backdoor. We're thinking on the fly here, right?

Leigh Wilson: Mm-hmm.

Dr. David Rubin: Never love your plan, right? So policylab.webinars@gmail.com. What else? I think we had a couple of other questions, maybe.

Leigh Wilson: Yeah. So in the meantime, feel free to send your questions there. But I think this is a really great question, too, Dave. So what if you can only accomplish plan B, is it worth it? So you can really only have the capacity or the funding to implement social risk screening.

Dr. David Rubin: I don't know. I think knowing the condition on the ground for our providers, I'm skeptical of that. I think if that's the only place you're going to be able to go, I think you're going to get a lot of resistance from your provider teams.

Leigh Wilson: Yeah. I think we also have to think about this from the perspective of the patient and families, that whenever we screen we just have to be really clear about – and transparent with the family about why we are screening. So I think it's a common response to this when we talk just about screening to say that the family's experiencing the need no matter what, whether we're asking about it or not, and that sometimes we need some of that baseline data if we don't even know the prevalence of the need in the community. I think there's a lot of validity to that, but I think if you are screening and you don't have the capacity to be able to support the family in response to a positive need and maybe it's more in research context, then you have to be really transparent with patients and families about that before you screen them and sort of let them make that decision when they answer your questions or disclose a social need to you.

So Dave, I know we're at time, and for those of you who may have emailed questions to the Gmail account, we are happy to follow up or you are happy – or you are welcome to email us –

Dr. David Rubin: Directly.

Leigh Wilson: – following this webinar.

Dr. David Rubin: And just remember, policylab.webinars@gmail.com. Or Leigh, were you going to give out – your cell phone number, I think, was the other plan, right? To everyone on the phone?

Leigh Wilson: Maybe – maybe not quite.

Dr. David Rubin: All right. Well anyway, we thank you guys for coming today. Come visit us at the website. Reach out to Leigh and myself. Be happy to answer some questions offline. And did you have something else you wanted to say?

Leigh Wilson: Yeah. I just wanted to let everyone know that we'll be posting a recording of the webinar to our website. So we encourage you to share and – or to go back and listen if you are compelled to listen a second time. And we just really appreciate everyone who was able to join today. Thanks so much.

Dr. David Rubin: Thank you.

End of audio

Duration 47 minutes