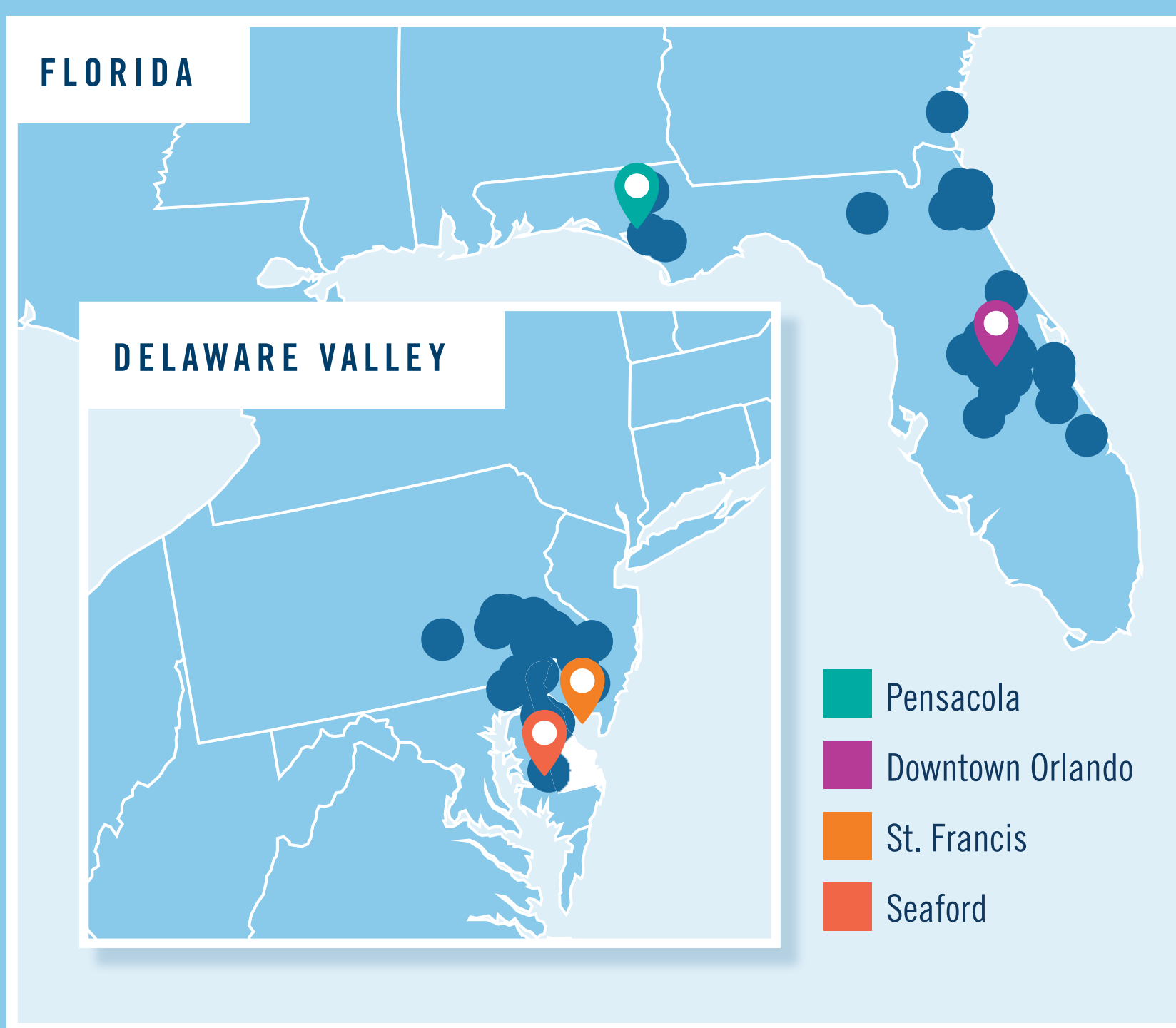# Pediatric Social Determinants of Health

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

### Domains

Food insecurity
Financial Stability
Transportation
Housing
Utilities
Social Support
Health Literacy
Personal and Family Safety and Stability
Neighborhood

### Our Project

Stakeholder Identification
Domains Selection
Question Design
Pilot Site Planning
Multi-setting Pilot
Edits and Process Changes
Final Version

**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

# PATIENT STORIES:

FLORIDA

DELAWARE VALLEY

- Pensacola
- Downtown Orlando
- St. Francis
- Seaford

### About Our Patients: Pensacola

| | | | |
|---|---|---|---|
| 68% | White | 84.8% | Florida |
| 17.53% | Black or African American | 14.4% | Alabama |
| 6% | Hispanic | | |
| 55% | Male | | |

**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.

### About Our Patients: St. Francis

| | | | |
|---|---|---|---|
| 56% | Hispanic/Latino | 79% | Medicaid and Chip |
| 31.13% | Black or African American | 20.2% | Commercial Payer |
| 25.8% | White | 6% | Unknown Insurance |
| 33% | Non-English Speaking | 2% | Tricare |

**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.

### About Our Patients: Downtown Orlando

| | |
|---|---|
| 62.6% | Medicaid/Mgd Medicaid |
| 34.3% | Private Insurance |
| 40% | Hispanic/Latino |
| 18% | Black/African American |

**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.

### About Our Patients: Seaford

| | |
|---|---|
| 66.9% | Medicaid and Chip |
| 31.5% | Commercial Payer |
| 28.8% | African American |
| 16% | Hispanic/Latino |

**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