Improving Food Insecurity Screening in Children and Adolescents with Type 1 and Type 2 Diabetes

Jennifer Ruiz, BSN, RN, CPN[1]; Jeannie S. Huang[1,2], MD, MPH, Jacob Parker[1], Yesenia Parker[1], Anna Cymbaluk[1,2], MD, Christy Byer-Mendoza[1], MSN, RN, CPN, CNS; Kim McNamara[1], RN, BSN, CDCES; Andrea Huber[1], RN, BSN, CDCES; Carla Demeterco-Berggren[1,2], MD, PhD

Rady Children's Hospital, San Diego[1], University of California, San Diego[2], California, USA

T1D Exchange QI Learning Session

November 14-15 , 2023

Rady Children's Hospital San Diego

T1D Exchange

UC San Diego School of Medicine

Background

- Families raising a child with diabetes face higher health care costs and are more likely to be food insecure.
- At Rady Children's Hospital San Diego, results from a retrospective review including 806 children and adolescents with T1D or T2D screened for food insecurity (July 2020 to June 2021) showed:
  - 11.3% of T1D (n=701) scored positive for food insecurity
  - 22% of T2D (n=105) scored positive for food insecurity

HgbA1c Levels Stratified by Type of Diabetes and Food Insecurity Status at RCHSD

	Negative		Positive	
	T1D (N=621)	T2D (N=82)	T1D (N=80)	T2D (N=23)
HgbA1c				
Mean (SD)	8.04 (2.27)	7.37 (3.24)	8.66 (2.62)	9.40 (2.32)

p-values : T1D= 0.005**, T2D = 0.004**

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Aim Statement

To Increase the percentage of children and adolescents with T1D and T2D screened for food insecurity and documented resources provided for positive screens during diabetes clinic visit from 27% on April 2022 to 50% by May 31, 2023

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Interventions

- Standardizing screening performance at 6-month intervals
- Obtaining monthly data report on completion of food insecurity screening and resource provision for positive screens
- Health Maintenance created in the EMR
- Automating assignment of patient-entered questionnaires (PEQ) in English and Spanish to clinical encounters
- EMR documentation of resource provision
- Provider and staff engagement and training
- Adding a reminder to the clinic schedule tracker to ensure performance

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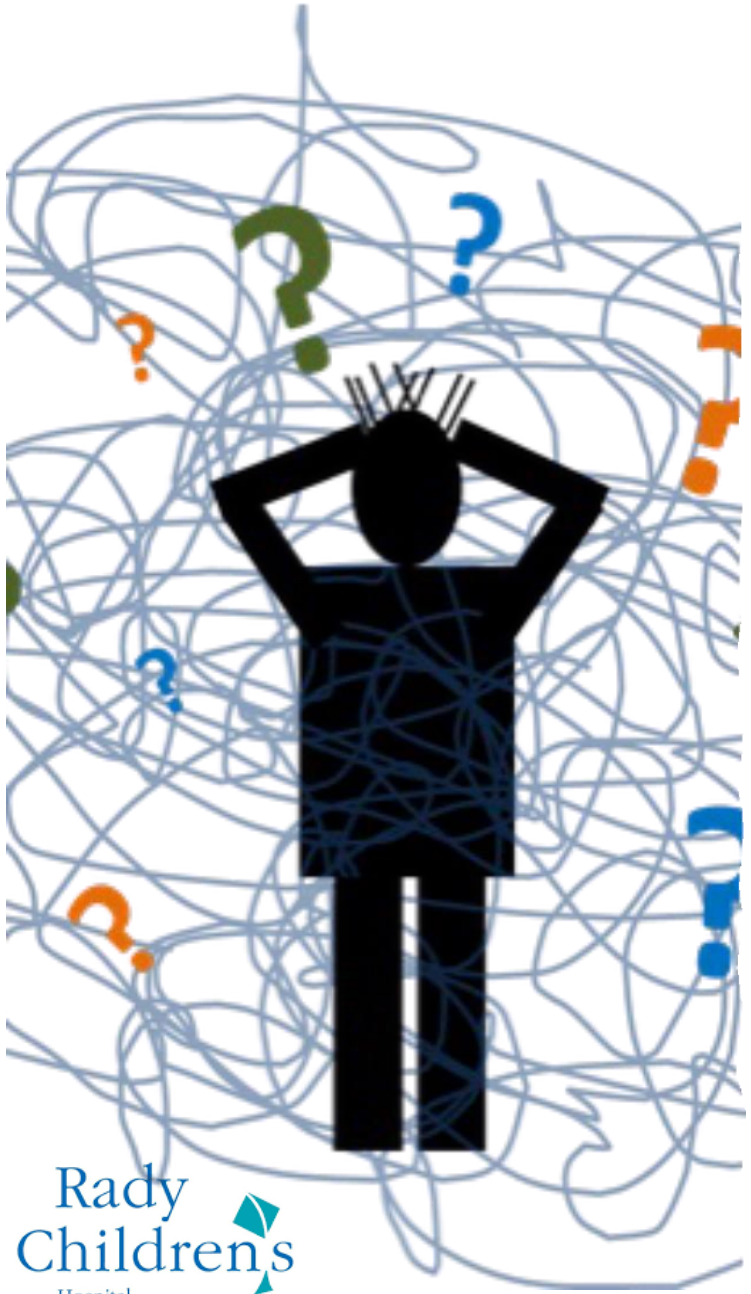

Who should be screened?

EPIC Health maintenance (aka care gaps) is the tool and background process used to identify **who** to screen and **how often** they should be screened

- Who?
  - All **active** patients (seen in the last 3 years or scheduled in the next 6 months)
- Frequency
  - At least every 6 months
  - Recommendation from the food insecurity task force

We want to be mindful of changes to economic circumstances but reduce burden of *screening*

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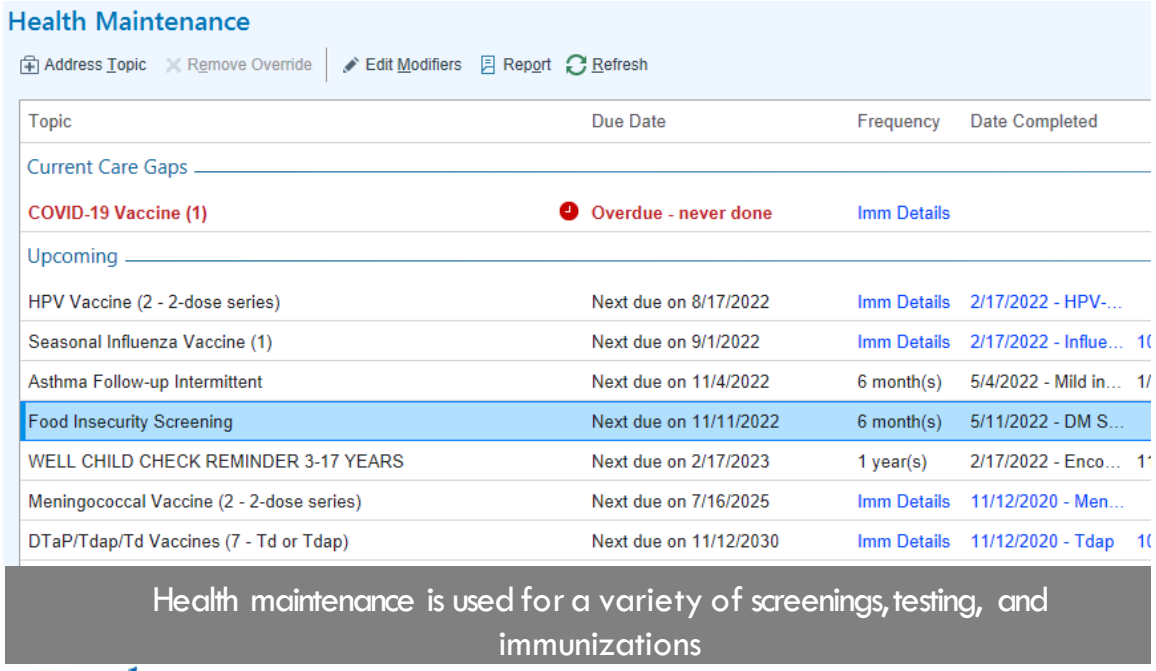
Health Maintenance

- Health maintenance runs in the background to calculate when the screening was last completed and when it will be due again
- Hunger Vital Sign *(Hager et al. Pediatrics 2009)*



Health maintenance is used for a variety of screenings, testing, and immunizations

- Patients can be screened for food insecurity using a Patient Entered Questionnaire (PEQ)
  - Removes stigma associated with asking & answering sensitive questions
  - Available in English and Spanish (automatically adjusts based on documented patient language)

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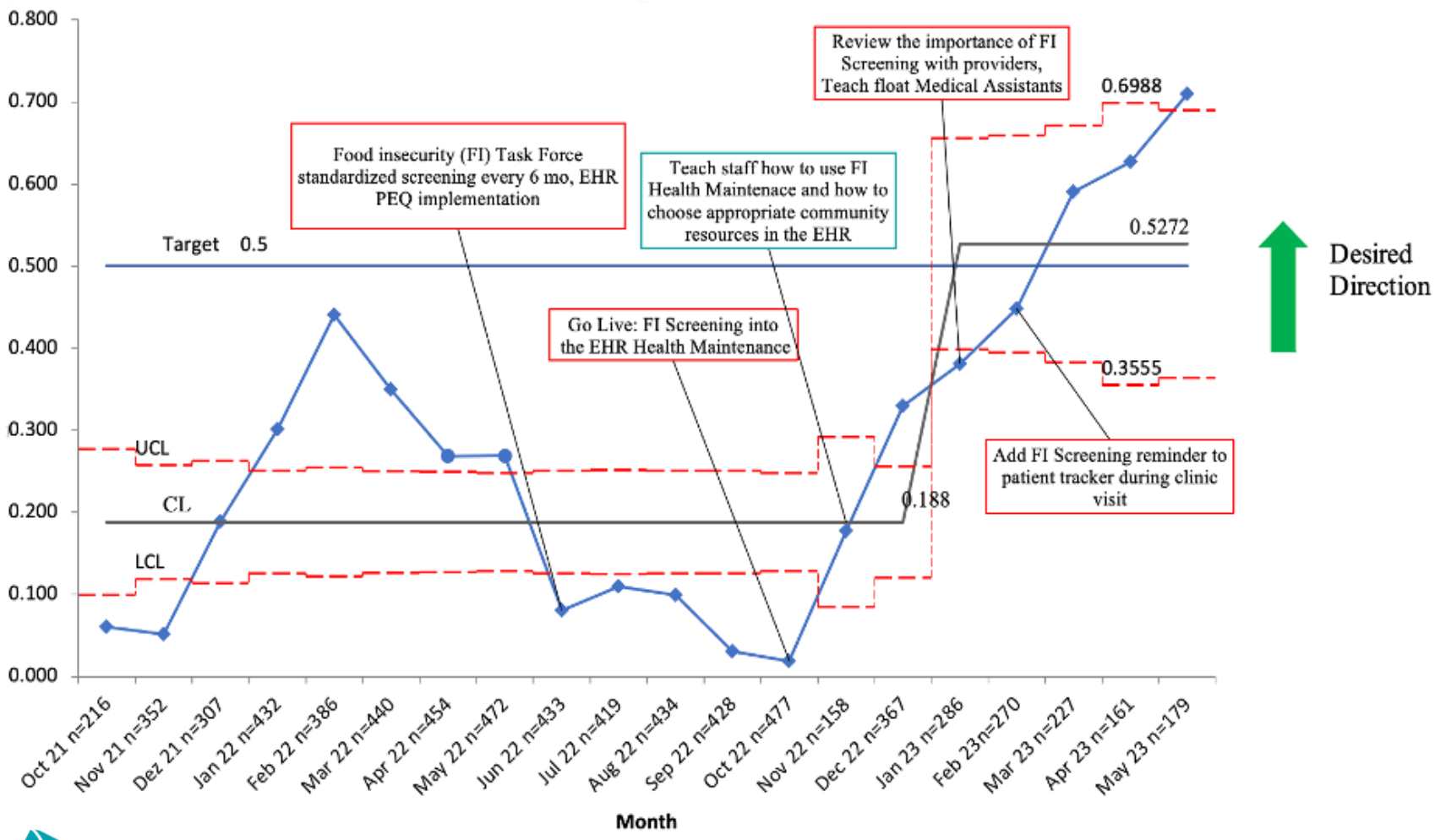
Percentage of children and adolescents with T1D or T2D screened for food insecurity



Desired Direction

As of May 2023, the percentage of youth with diabetes screened for food insecurity increased by 44% from May 2022 baseline of 27% to 71% (goal of 50%)

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Conclusions

- Application of QI methodology enabled improved food insecurity screening rates at our diabetes center
- Utilizing EMR tools and data collection enabled automation to help standardize food insecurity screening protocols and data tracking Screening success can be potentiated by the EMR

Next Steps

- Continuous staff education and training to promote sustainability
- Collaboration with RCHSD Food Navigation Program
- Use the same approach to screen for other SDOH (transportation, housing)

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Thank you!

RCHSD Diabetes Clinic QI Team

Carla Demeterco-Berggren, MD, PhD (PI)
Anna Cymbaluk MD
Kim McNamara, RN, BSN, CDCES
Christy Byer-Mendoza, MSN, RN, CPN, CNS
Andrea Huber, RN, BSN, CDCES

RCHSD Food Insecurity Task Force

Dr. Jeannie Huang
Jacob Parker
Yesenia Parker

RCHSD Diabetes Clinic Medical Assistants

Norma Rodriguez
Rocio Padilla
Melissa Magadan
Alexia Sandoval
Cinthia Perez
Juliana Perez

RCHSD Care Redesign Department
Food Navigation Pilot Program

Dr. Keri Carstairs
Rhonda Sparr-Perkins
Donna M Donoghue
Erin Dale
Gail Garcellano

Jennifer Ruiz, BSN, RN, CPN
jenruiz@rchsd.org

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Establishing Social Determinants of Health Screening to Improve Pediatric Diabetes Patient Outcomes

Blake Adams, BSN; Margaret Shepherd, BS; Fatina Caldwell-Jones, DNP; Grace Nelson, MD;

University of Tennessee Health Science Center and Le Bonheur Children's Hospital

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Le Bonheur Children's Hospital

Introduction

- Our mission at Le Bonheur Diabetes Clinic is to partner with families and support them in finding ways to best manage their diabetes care.
- Despite the existing research correlating social factors with suboptimal glycemic control, our clinic had not been screening for Social Determinants of Health (SDOH) in our diabetic patient population.
- Our AIM was to screen 10% of our total patients with type 1 and type 2 diabetes for Social Determinants of Health based on a set of specific criteria from June 2023 through August 2023.

Methods

- Met bimonthly with a multidisciplinary team to establish screening parameters. We decided to focus screening on patients who had been diagnosed for at least 6 months and also had an A1C greater than 9.5%, a lapse in care for at least 6 months, or their anniversary of diagnosis date within 3 months of their appointment.
- Items explored included food insecurity, transportation barriers, household financial strain, social isolation, and both physical and mental/emotional abuse.
- Partnered with University of Michigan and utilized their “Partner’s in Care” surveys.
  - Surveys for 0–10-year-olds were filled out by the caregivers.
  - Surveys for 11–17-year-olds were filled out by the patients.

PDSA Cycle 1

Act:
Converted the final survey question that made intervention with resources or referrals optional into a statement.

Plan:
Met with multidisciplinary group to establish SDOH screening guidelines.

Met with staff to consider clinic flow and determine survey administration process.

Study:
14 completed screens with 4 positive (28%) and 3 referrals made. None of the patients and families elected for an optional social work consult.

Do:
The Medical Student screened 2 providers' schedules for 2 weeks ahead of time and gave the list to our clinic scheduler.

The scheduler created folders with age-appropriate surveys and gave them to our Medical Assistant for distribution during check-in. Surveys were placed in a basket for the Medical student to review.

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PDSA Cycle 2

Act:
Added a "Provider Only" section to the survey to allow for document of interview (referral made or resource offered).

Added resource handouts to our online shared drive as well as hard copies to our clinic resource center, so clinical staff had access in case of SW unavailability or a resource-only request from patient or family.

Reminded providers to clearly chart resources given in EMR.

Study:
19 completed screens with 12 positive (63%). 10 referrals made.

Plan:
Addended SDOH surveys with: "If needed our team will give you information and resources that can help. Let us know if you have any questions." Screened for 2 weeks and reassessed.

Do:
Screened for 2 weeks.

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PDSA Cycle 3

Act:
Reminded providers to fill out "Provider Only" section on surveys and reminded staff to prompt families to complete surveys.

Added a list of available resources to survey to pique interest, encourage honesty, and reduce hesitancy.

Study:
19 completed surveys with 6 positive (31%) and 5 referrals made.

Plan:
Added "Provider Only" section to survey to document referral vs. resource offered.

Added resource handouts to our online shared drive as well as hard copies to our clinic resource center, so clinical staff had access in case of SW unavailability or a resource-only request from patient or family.

Reminded providers to clearly chart resources given in EMR.

Do:
Screened for 2 weeks.

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PDSA Cycle 4

Act:
Decided to simplify our criteria in order to continue expanding SDOH screening. We centered screening on patients with A1C >9.5.

Plan:
Reminded providers to fill out "Provider Only" section on surveys and reminded staff to prompt families to complete surveys.

Added a list of available resources to survey.

Study:
13 completed surveys, 3 positive (23%) and 3 referrals

Do:
Screened 2 weeks.

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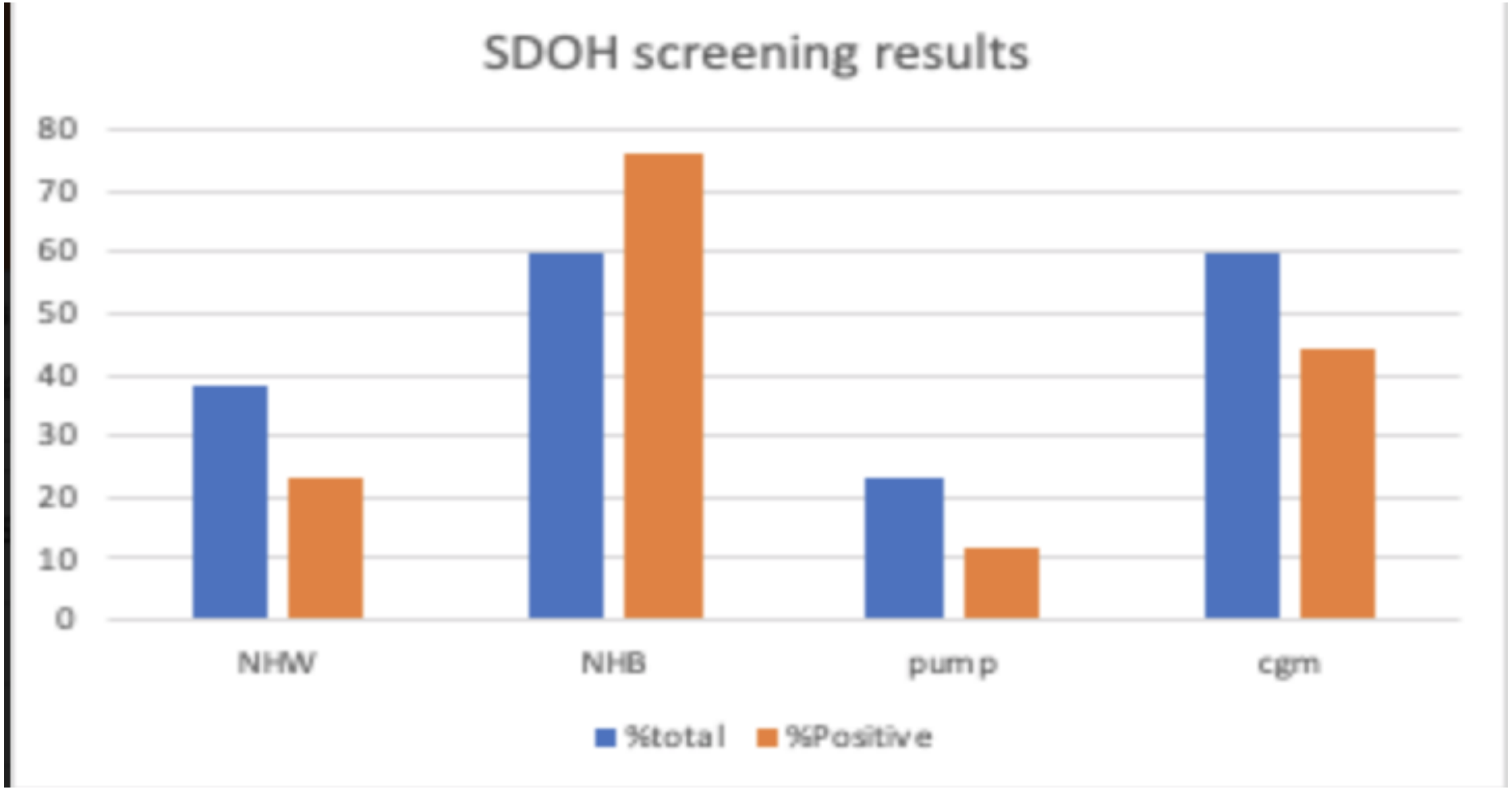
Results

- We successfully increased our clinic's SDOH screening rate from 0% to approximately 4.3%.
- 51.6% of eligible patients completed screens.
- 38.5% of completed screens were positive.
- 84% of patients that screened positive were offered social work referrals and/or appropriate resources.

SDOH results based on Race and Technology Use



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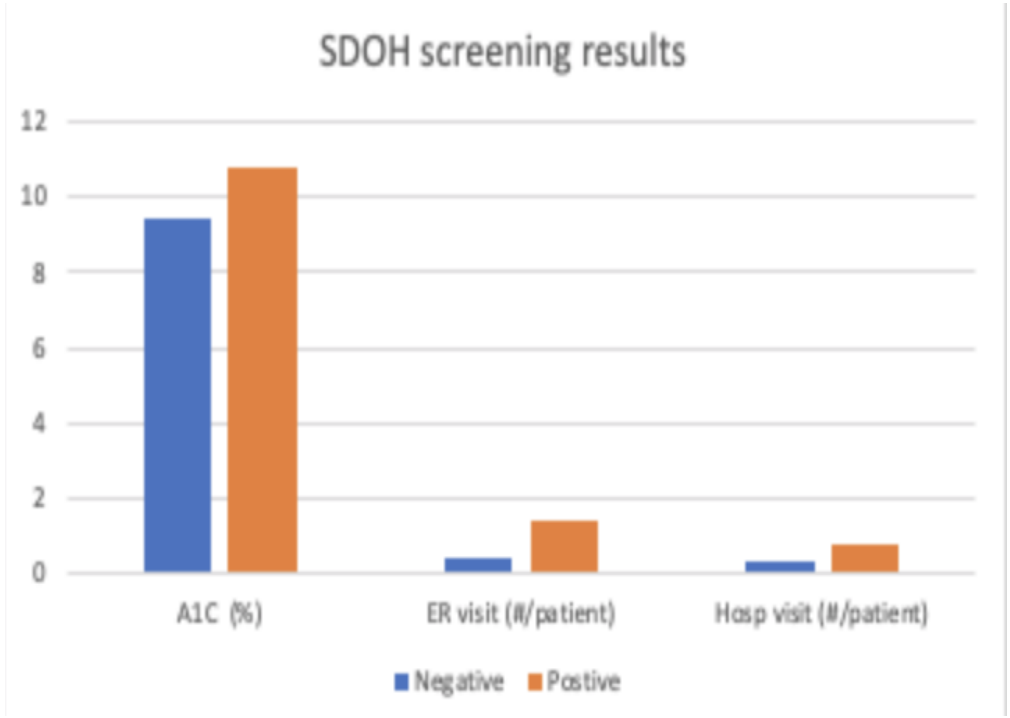
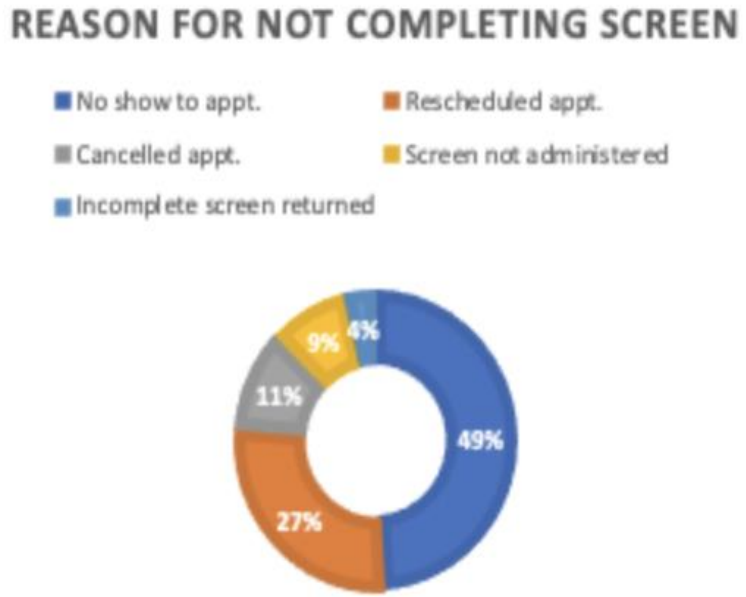
Data collected from SDOH Screening





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Conclusion

- Though we did see an improvement in our SDOH screening for our Type 1 and Type 2 diabetes patients, we haven't reached our goal rate of 10%.

- While we are anticipating an EMR transition that will support annual survey administration, we will focus on screening patients with an A1c over 9.5%.

References

- Hershey, Jennifer A., Jennifer Morone, Terri H. Lipman, and Colin P. Hawkes. "Social Determinants of Health, Goals and Outcomes in High-Risk Children With Type 1 Diabetes." *Canadian Journal of Diabetes* 45, no. 5 (July 2021): 444-450.e1. https://doi.org/10.1016/j.jcjd.2021.02.005.

- Sokol, Rebeccah L., Mehdipanah, Roshanak, Bess, Kiana, Mohammed, Layla, and Miller, Alison. "When Families Do Not Request Help: Assessing a Social Determinants of Health Screening Tool in Practice." *Journal of Pediatric Healthcare Partners Volume 35, Issue 5, P471-478, (September 2021). https://doi.org/10.1016/j.pedhc.2021.05.002.*

UPSTATE
MEDICAL UNIVERSITY
Joslin Diabetes Center

Screening for Social Determinants of Health in Adults with Diabetes

Ruth S. Weinstock MD PhD, Beth Wells MSN RN, Jamie Romeiser PhD, MPH, Emilie Hess MS, Joseph Erardi BS.

November 14, 2023

Goal: **To improve diabetes outcomes by identifying and addressing social needs.**

Objectives:

1. To screen for social determinants of health (SDOH) at routine visits

2. To provide resources and social worker support for those who have material needs.

Future: To determine if there is resolution/reduction in social needs and improved diabetes outcomes after referring adults with identified needs to our clinic social worker.

Methods

- **Population: Adults with T1D and T2D with visits from August 2022-April 2023.**
- **SDOH: 8 questions related to food, housing, finance, and transportation insecurities asked at routine medical visits by LPN.**
  - Positive screen: defined as a (+) response to any SDOH question.
- **Adults with an identified need (+ screen): offered referral to clinic social worker**.
- **Demographic & clinical characteristics obtained from EMR.**
  - Differences in characteristics were assessed by type of diabetes (Fisher Exact Test or Chi Square)
- **Predictors of Social Work referral acceptance in adults with (+) SDOH screen assessed using exploratory multivariable logistic regression.**

Cohort Characteristics

	All (%) [n=4704]	Type 1 (%) [n=1659]	Type 2 (%) [n=3045]
Screened	83.2	86.4	81.4
Age (Years, Median)	58	41	63
Female	51.8	49.2	53.3
African American	13.1	5.7	17.4
White	79.2	90	73.0
Private Insurance	39.3	57.9	28.5
Medicaid Insurance	17.4	20.9	15.3
Medicare Insurance	42.0	19.7	54.9
CGM Use	53.5	83.6	36.1
Pump Use	21.0	53.6	2.2

Results

Majority who screened positive had >1 material need

- 13.4% (n=192) T1D screened (+) (vs T2D 16.0% (n=396, p=0.03)
- T1D with (+) screen, 56.2 % (n=108) had >1 material need [vs T2D 60.4 % (n=239)]

African Americans were more likely to screen positive than Whites

- T1D: 31.7% AA (n=26) vs. 12.2% White (n=158; p <.0001)*
- T2D: 24.2% AA (n=104) vs 13.6% White (n=246; p<.0001)*

Adults with public (Medicare/Medicaid) insurance were more likely to screen positive than those with private insurance

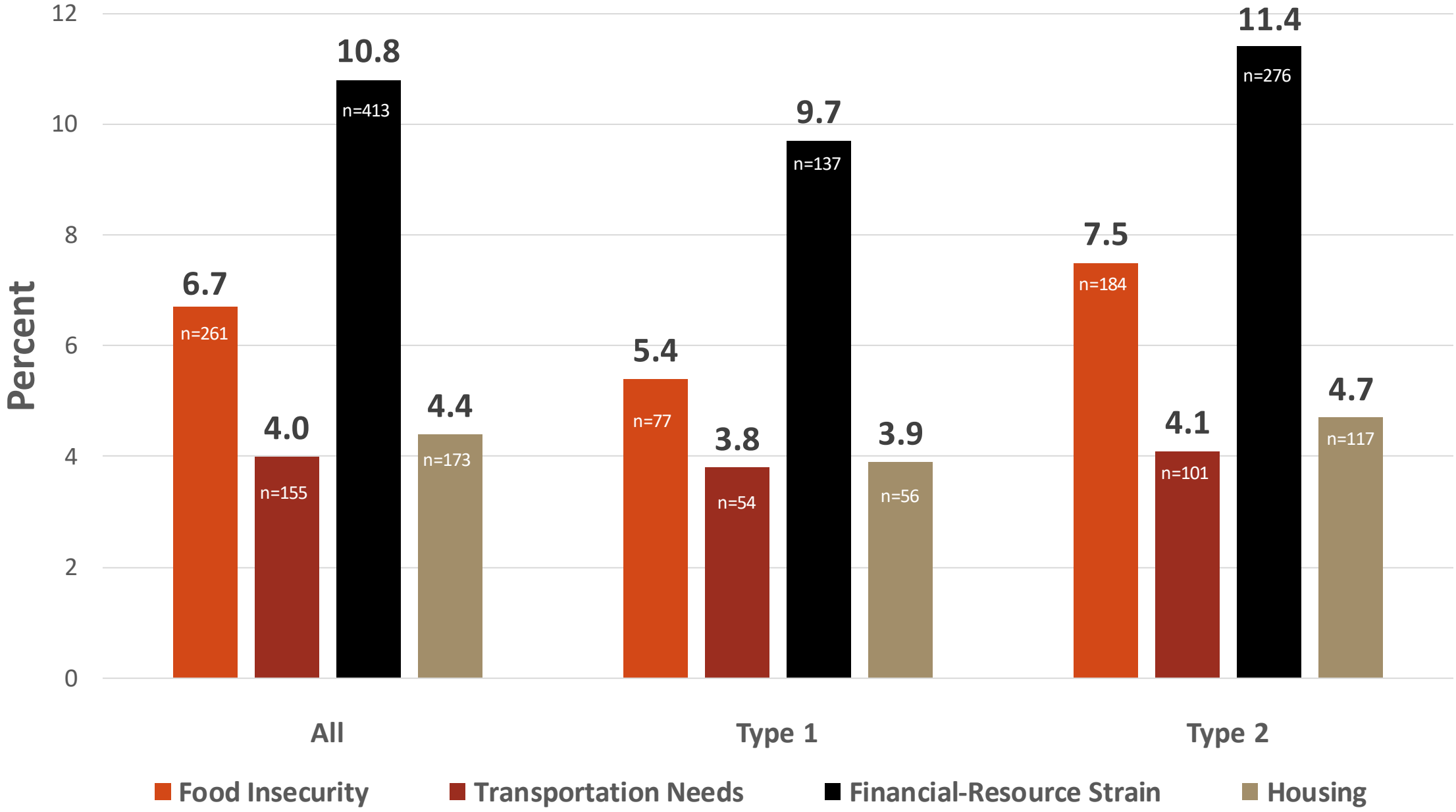
- T1D: 8.0% Private Insurance (n=66) vs. 21.0% Public Insurance (n=122) screened SDOH (+)(p<.0001)**
- T2D : 10.7% Private Insurance (n=75) vs. 18.2% Public Insurance (n=316) screened SDOH (+)(p<.0001)**

Adults not using a pump were more likely to screen positive than those using a pump

- T1D: 17.1 % vs. 10.2 % not using (n=114) vs using (n=78) pump therapy screened SDOH (+) (p<.0001)**

* FISHER EXACT TEST, ** CHI SQUARE

Percent of Adults with Positive Screen by Social Need



Social Work Referrals for T1D Adults with ≥1 Material Need

25.5% accepted referral to social work: similar percent by sex, race, ethnicity, age, and CGM and pump use.

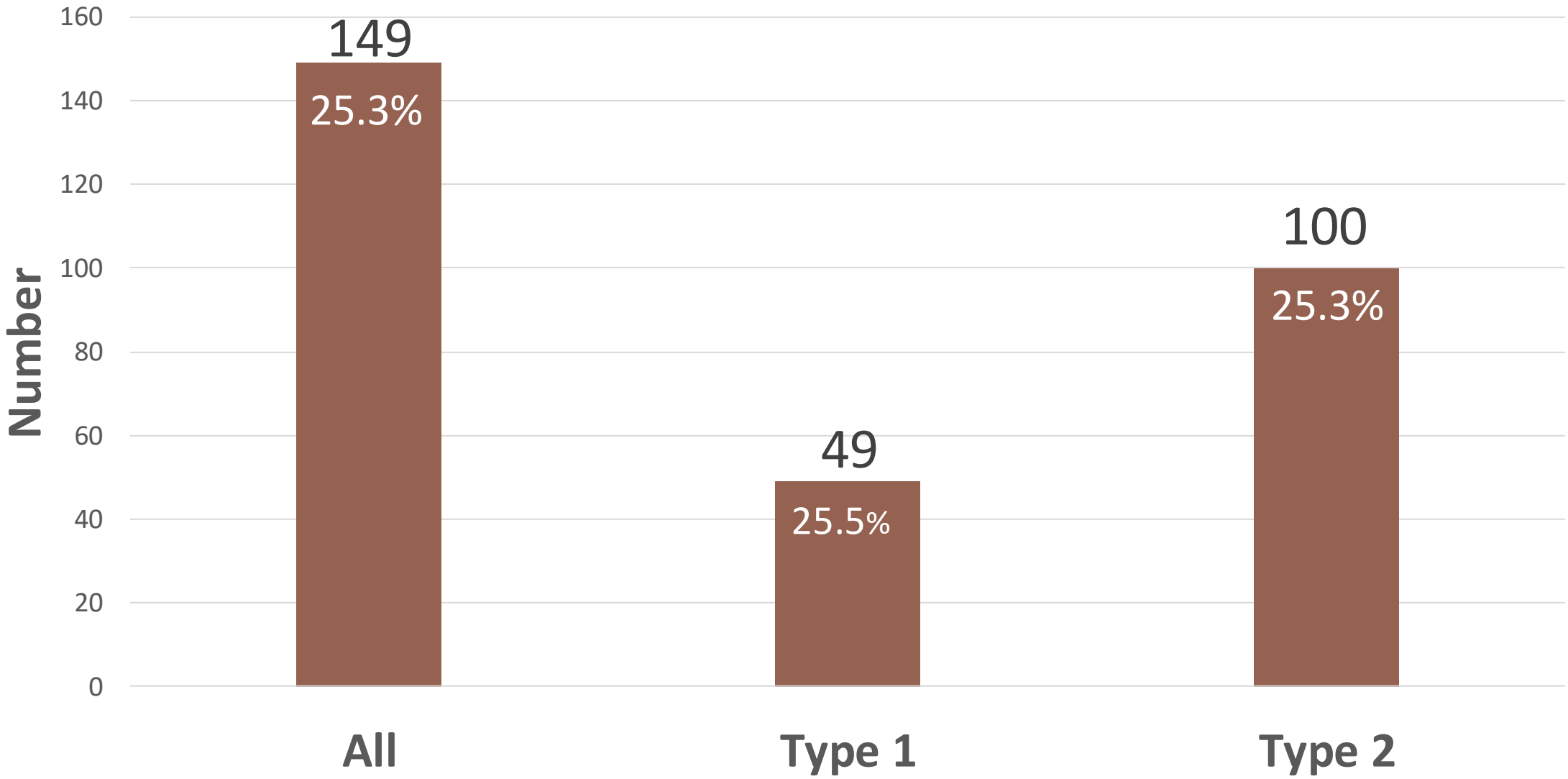
77.6% who accepted a referral to SW had > 1 social need.

Those with public insurance were 3.04 times as likely to accept a referral compared to those with private insurance (p=.01).

Adults with transportation needs were 2.29 times more likely to accept a referral compared to those who did not (p=.02).

Those with housing needs were 2.23 times more likely to accept a SW referral compared to those who did not (p=.03).

Acceptance of Social Work Referral in Adults with (+) SDOH Screen



Conclusions

Material needs are common in adults with diabetes.

Next steps:

Improve screening (offer confidential screening) and reduce barriers to acceptance of social work referral

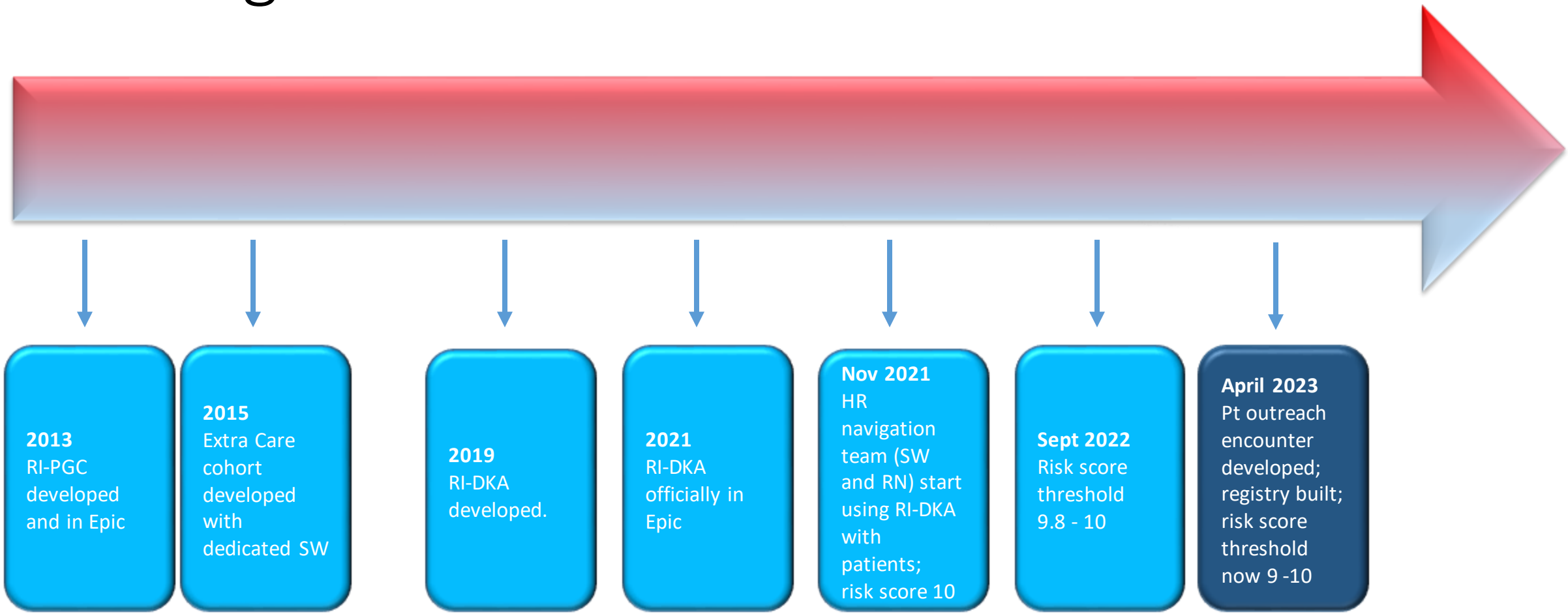
Improve accessibility of social worker at the time of the visit, acceptance of referrals and provision of needed resources

Determine if those who accepted social work referrals had a subsequent reduction in social needs and improvement in outcomes (A1c, CGM metrics, PHQ).

REACH Registry: Using EMR-Based Tools To Improve Outreach Services

Selorm Dei-Tutu MD, MPH, Rebecca Butler LMSW, Amelia Martinez RN, BSN, Kelly Timmons RN, BSN, Meghan Craven MD, MPH.
Texas Children's Hospital / Baylor College of Medicine

Background


2013
RI-PGC developed and in Epic
2015
Extra Care cohort developed with dedicated SW
2019
RI-DKA developed.
2021
RI-DKA officially in Epic
Nov 2021
HR navigation team (SW and RN) start using RI-DKA with patients; risk score 10
Sept 2022
Risk score threshold 9.8 - 10
April 2023
Pt outreach encounter developed; registry built; risk score threshold now 9 -10

RI-DKA Score

› Clin Diabetes. 2022 Spring;40(2):204-210. doi: 10.2337/cd21-0070. Epub 2022 Apr 15.

An Automated Risk Index for Diabetic Ketoacidosis in Pediatric Patients With Type 1 Diabetes: The RI-DKA

David D Schwartz [1], Rosa Banuelos [2], Serife Uysal [3], Mili Vakharia [3], Kristen R Hendrix [3 4], Kelly Fegan-Bohm [3], Sarah K Lyons [3], Rona Sonabend [3], Sheila K Gunn [3], Selorm Dei-Tutu [3]

Affiliations + expand

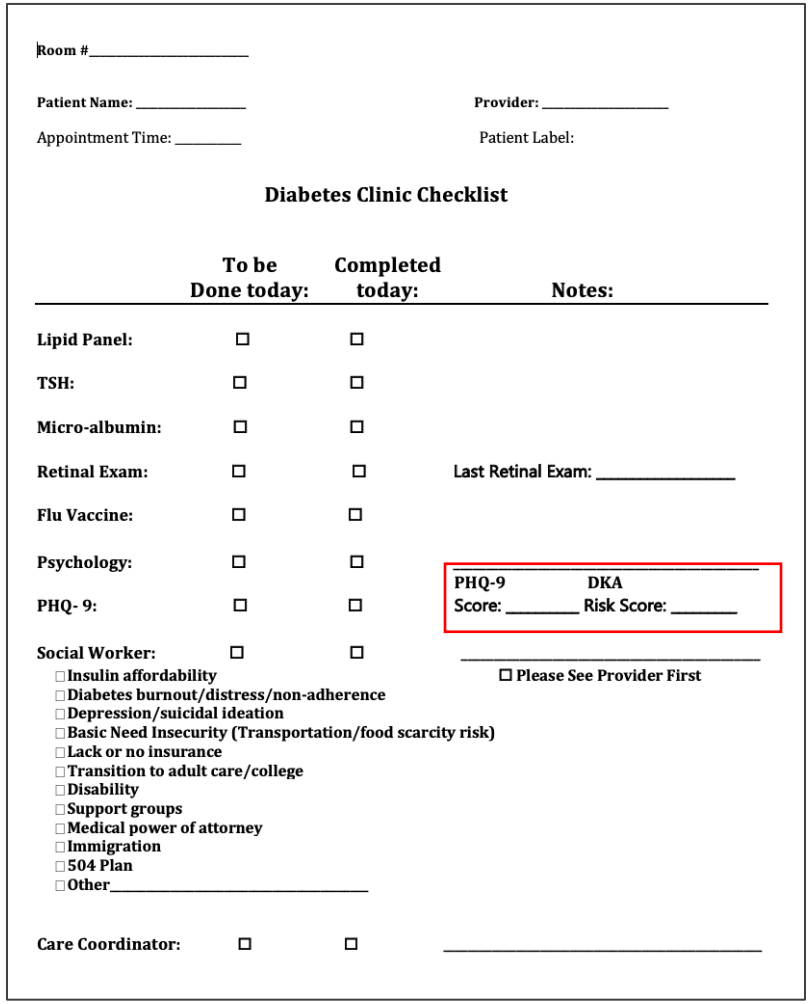
PMID: 35669298 PMCID: PMC9160557 DOI: 10.2337/cd21-0070

Free PMC article

Score	Category
-3.5 – 2	Low risk
2.5 – 6.5	Medium risk
7 – 10	High risk
10.5 – 14	Very high risk

Interventions

- 2-week post DKA follow up by phone
- Monthly check ins via phone calls
  - Facilitate diabetes education
  - Facilitate prescription management
  - Facilitate psychosocial care
- In-person check-ins during clinic appointments
  - Pre-visit planning w/ passport
- Appointment reminders and facilitate transportation



Room #_____

Patient Name: _____ Provider: _____

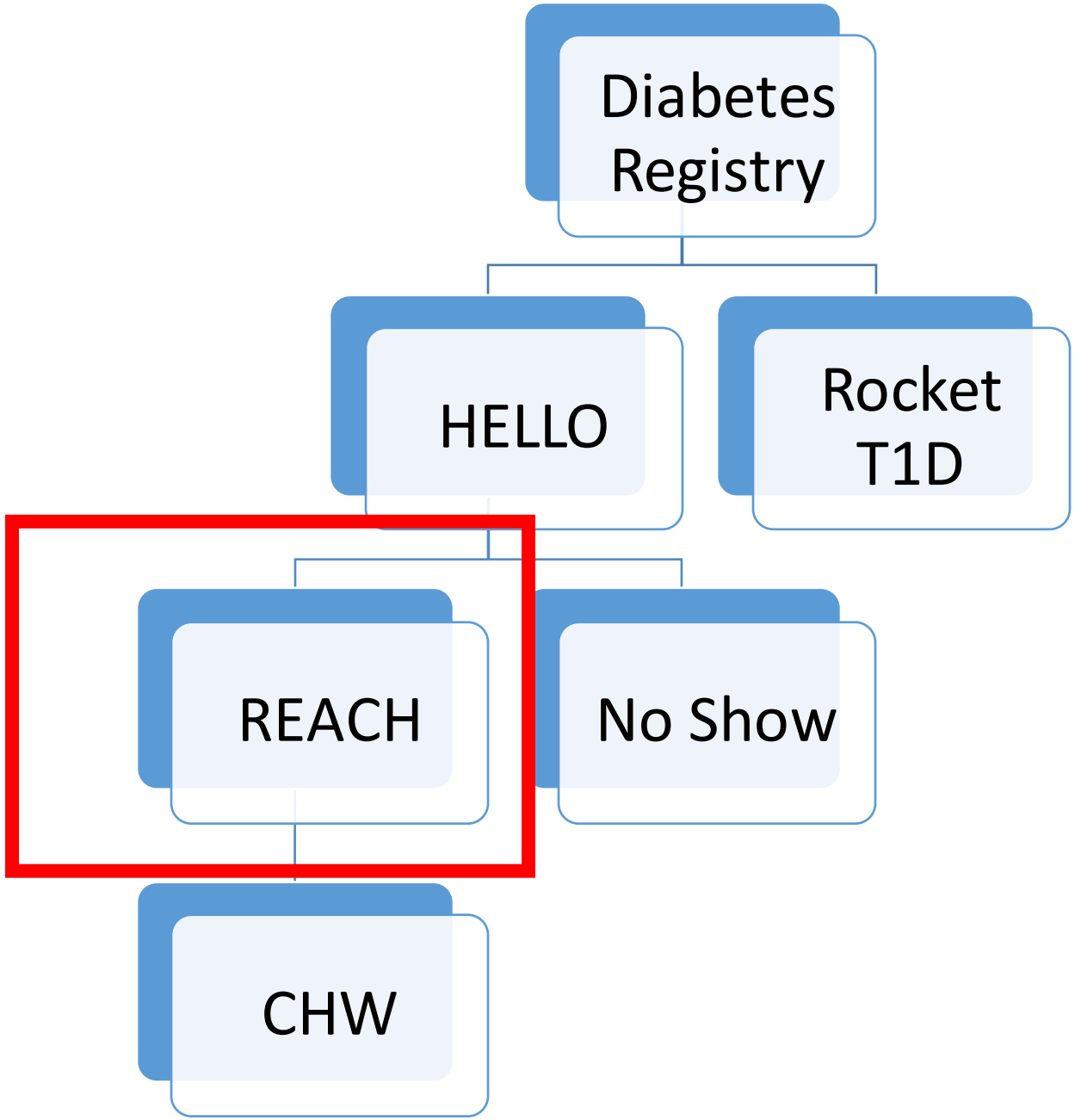
Appointment Time: _____ Patient Label:

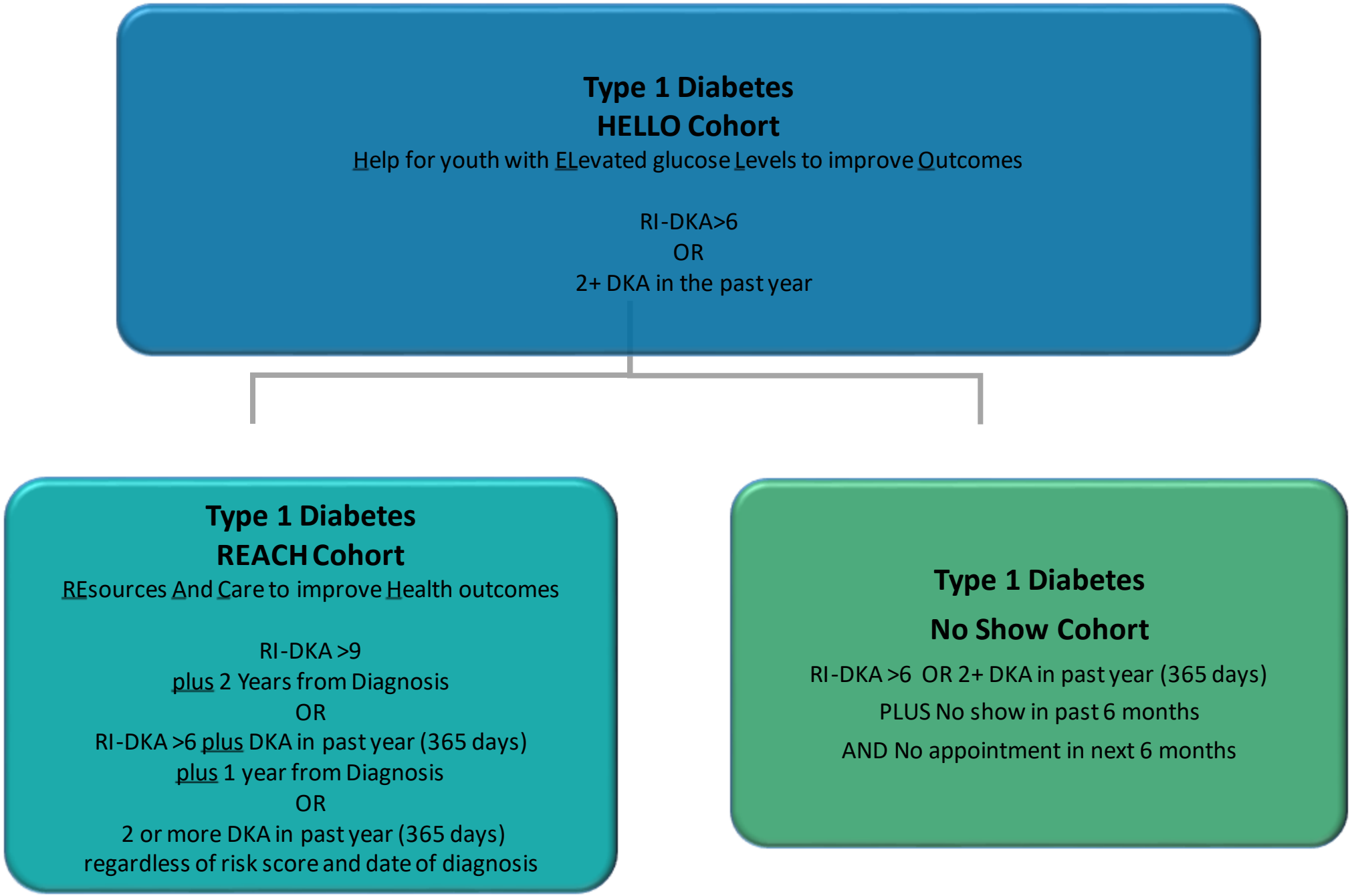
Diabetes Clinic Checklist

	To be Done today:	Completed today:	Notes:
Lipid Panel:	☐	☐	
TSH:	☐	☐	
Micro-albumin:	☐	☐	
Retinal Exam:	☐	☐	Last Retinal Exam: _____
Flu Vaccine:	☐	☐	
Psychology:	☐	☐	
PHQ- 9:	☐	☐	PHQ-9 Score: _____ DKA Risk Score: _____
Social Worker:	☐	☐	☐ Please See Provider First

- ☐ Insulin affordability
- ☐ Diabetes burnout/distress/non-adherence
- ☐ Depression/suicidal ideation
- ☐ Basic Need Insecurity (Transportation/food scarcity risk)
- ☐ Lack or no insurance
- ☐ Transition to adult care/college
- ☐ Disability
- ☐ Support groups
- ☐ Medical power of attorney
- ☐ Immigration
- ☐ 504 Plan
- ☐ Other_____

Care Coordinator: ☐ ☐ _____


Diabetes Registry
HELLO
Rocket T1D
REACH
No Show
CHW


Type 1 Diabetes
HELLO Cohort
Help for youth with ELevated glucose Levels to improve Outcomes
RI-DKA>6
OR
2+ DKA in the past year
Type 1 Diabetes
REACH Cohort
REsources And Care to improve Health outcomes
RI-DKA >9
plus 2 Years from Diagnosis
OR
RI-DKA >6 plus DKA in past year (365 days)
plus 1 year from Diagnosis
OR
2 or more DKA in past year (365 days)
regardless of risk score and date of diagnosis
Type 1 Diabetes
No Show Cohort
RI-DKA >6 OR 2+ DKA in past year (365 days)
PLUS No show in past 6 months
AND No appointment in next 6 months

New REACH Patients

Report completed: Wed 9/6 02:38 PM

19 New Patients

RN/CDCES Outreach Tasks

Report completed: Wed 9/6 02:38 PM

16 Overdue	0 Due Today	0 Due Next 10 Days

REACH Registry Summary

Report completed: Tue 9/5 02:33 PM Results expired: Wed 9/6 02:33 PM

REACH Patients (All)	242
Active Patients	50
Inactive Patients	8
[No Value]	184

Registry Reports

REACH Registry Panel Metrics

Last Refresh: 02:47:20 PM

	Jun	Jul	Aug	MTD
REACH No Show Rate	7.66 %	11.72 %	10.25 %	10.70 %

Diabetes REACH Cohort Intake

Extra Care Cohort Intake

Extra Care Cohort Status: **active** | dismissed

Reason for enrollment: **social needs** | technology needs | learning deficit | **DKA** | risk score | other

Enrollment Date: 1/18/2023

Primary location of care: **Medical Center** | West Campus | Woodlands | Sugar Land | Clear Lake | Cy Fair | Austin

✔ Close

Diabetes REACH Cohort: All Patients [25297297] as of Tue 9/5/2023 2:33 PM

Chart | Encounter | Communication | Synopsis | Results Review | Place Orders | Questionnaire Series | Research Studies | MW - Next Endo Appt

Detail List | Explore | DKA Risk Summary | Enrollment | Dismissal | Status | Documented Time This Month | Primary Location | Total Patients | Next Appt Dept

Filter | Clear All Filters | Re-run Report | Refresh Selected | Select All

SW Next Outreach	RN/CDE Next Outreach	Enrollment Reason	DKA Risk Score	Location	Status	Enrollment Date	Next Endo Appt	Next Endo Appt Dept	Last Endo OV	Last DKA Past 12m	Last Outreach	Monthly Outreach	RN/CDC Time This M
07/05/2023		DKA	10	Medical Center	active	06/05/2023	Scroll to selected row	MW ENDOCRINE CLNC	05/24/2023	07/12/2023	08/28/2023	appointment reminder	0
07/05/2023	08/01/2023	social needs	9.9	Medical Center	active	04/17/2023	10/25/2023	MW ENDOCRINE CLNC	08/16/2023		07/18/2023	visit questions/concerns	0
07/12/2023	06/08/2023	DKA	9.8	Medical Center	active	06/12/2023	09/13/2023	MW ENDOCRINE CLNC	07/28/2023	10/30/2022	06/06/2023	monthly outreach	0
07/14/2023		DKA	10	Medical Center	active	06/14/2023	09/11/2023	MW ENDOCRINE CLNC	07/13/2023	10/16/2022	08/22/2023	appointment reminder	0

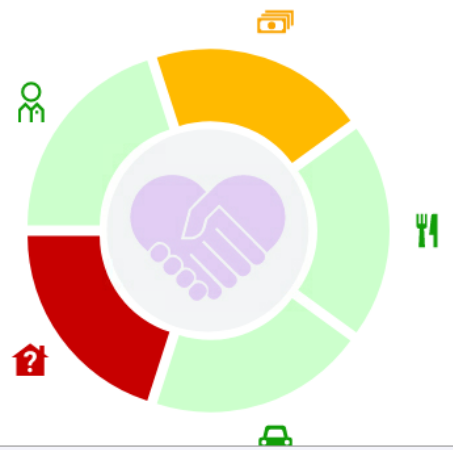
LPOC | Demo / Social | Care Team / Visit Details | Labs | Risk Profile | DKA Risk Trend | Depression Screen | Registry Details | On

Care Coordination Notes

Recent Visits

Telemedicine

Social Determinants of Health



Outpatient Medications

Meds Overview

Enable clinical decision support by reconciling outside information

	Last Edited
Accu-Chek FastClix Lancets MISC USE TO CHECK BLOOD GLUCOSE UP TO 6 TIMES PER DAY in case of CGM failure	1 month ago
acetone (urine) (KETOSTIX) TEST STRIP CHECK KETONES WHEN ILL OR WHEN BG>250	1 month ago
BAQSIMI ONE PACK 3 MG/DOSE POWD GIVE 3MG IN ONE NOSTRIL AS NEEDED FOR SEVERE HYPOGLYCEMIA	2 weeks ago
Blood Glucose Monitoring Suppl (FREESTYLE LITE) w/Device KIT USE AS DIRECTED PER PACKAGE INSTRUCTIONS OR AS DIRECTED BY PRESCRIBER	1 month ago

64 of 242 results match filters

Diabetes REACH Phone

REACH Outreach

Outreach topic: appointment assistance | visit questions/concerns | return call | form processing | appointment reminder | **monthly outreach** | referral | refill request | 2 wk DKA follow up

Diabetes Management

Overall feeling: **well** | not well

Diabetes management since last visit: good | **fair** | frustrating | difficult

How do you get your insulin?: pump | **shots**

Do you have enough insulin supplies for the month?: **yes** | no

Do you have enough testing supplies for the month?: **yes** | no

Are you taking short acting insulin as recommended?: **yes** | no | sometimes

Are you taking long-acting insulin as recommended?: **yes** | no | sometimes

Who is supervising/giving long-acting insulin on the weekends?: guardian | **self** | sibling | family friend | other

Are you on CGM?: **yes** | no

How has it been going?: good | fair | **technical problems**

Do you visit the school nurse?: yes | no | sometimes

Referrals

Referral(s) made: **yes** | no

Time/Follow Up

Social Work

SW time spent with patient/care coordination: 30

Care Management

Clinic Visit Topic(s) Discussed	adherence	giving long-acting insulin	giving short-acting insulin	diabetes distress/burnout
	utilizing school nurse	home environment	Rx financial assistance	troubleshooting technology
	DKA assessment goal	refill request	camps	school orders/accommodations
	referral to CDCES	referral to dietitian	mental health referral	coordination to other clinic
	school nurse contact	insurance assistance	transition/adult care	financial counseling
	medicaid resources	form completion	SDOH referral	transportation assistance
	parking assistance			
Coordination of Services	camps	school orders/accommodations	referral to CDCES	referral to dietitian
	mental health referral	coordination to other clinic	school nurse contact	financial counseling
	medicaid resources	form completion	SDOH referral	transportation assistance
	parking assistance	insurance assistance		
Outcome	patient's visit kept	completion/review of labs	decrease A1c	increase A1c
	met with high risk RN	met with high risk SW	met with dietitian	met with CDCES
	no DKA 6 months	no DKA 7-12 months	advised family/patient on diabetes home mgmt	no ER visit
	ordered supplies/refills	referral to community resource/agency	transportation/parking	use CGM more than 50%
	attended mental health appointment			
Goal Met at Visit	no DKA <3 months	advised family/patient on diabetes home management	referral to interdisciplinary team member	reviewed goals
	no ER visit	reviewed labs	referral to community resource/agency	unmet need
	met family's needs/questions/concerns	ordered supplies/refills	transportation/parking	no need met
	advocacy for patient			

Time/Follow Up

Social Work

SW time spent with patient/care coordination

SW next outreach date

RN/CDCES

RN/CDE time spent with patient/care coordination

Conclusions and Future Directions

- Epic tools can be leveraged for population health management
  - Track REACH specific outcomes through our internal QI data application
- Community Health Worker as an extension of the Extra Care team, focus on 5 goals:
  - Improve **appointment management** and **communication** with the care team
  - Increase **access to healthy food** options
  - Navigate current barriers to access in **diabetes technology**
  - Apply for **public benefits** and patient assistance programs
  - Identify adult insurance plan for **transition** and schedule with an adult care provider

Acknowledgements

- Extra care team
- Kelly Timmons, BSN, RN
- Helmsley Diabetes Care Innovation Award (G-2206-05307)

To Contract or Not to Contract?: Paying for NICH to Address the Social Drivers of Diabetes Outcomes

Michael A. Harris, PhD

David V. Wagner, PhD

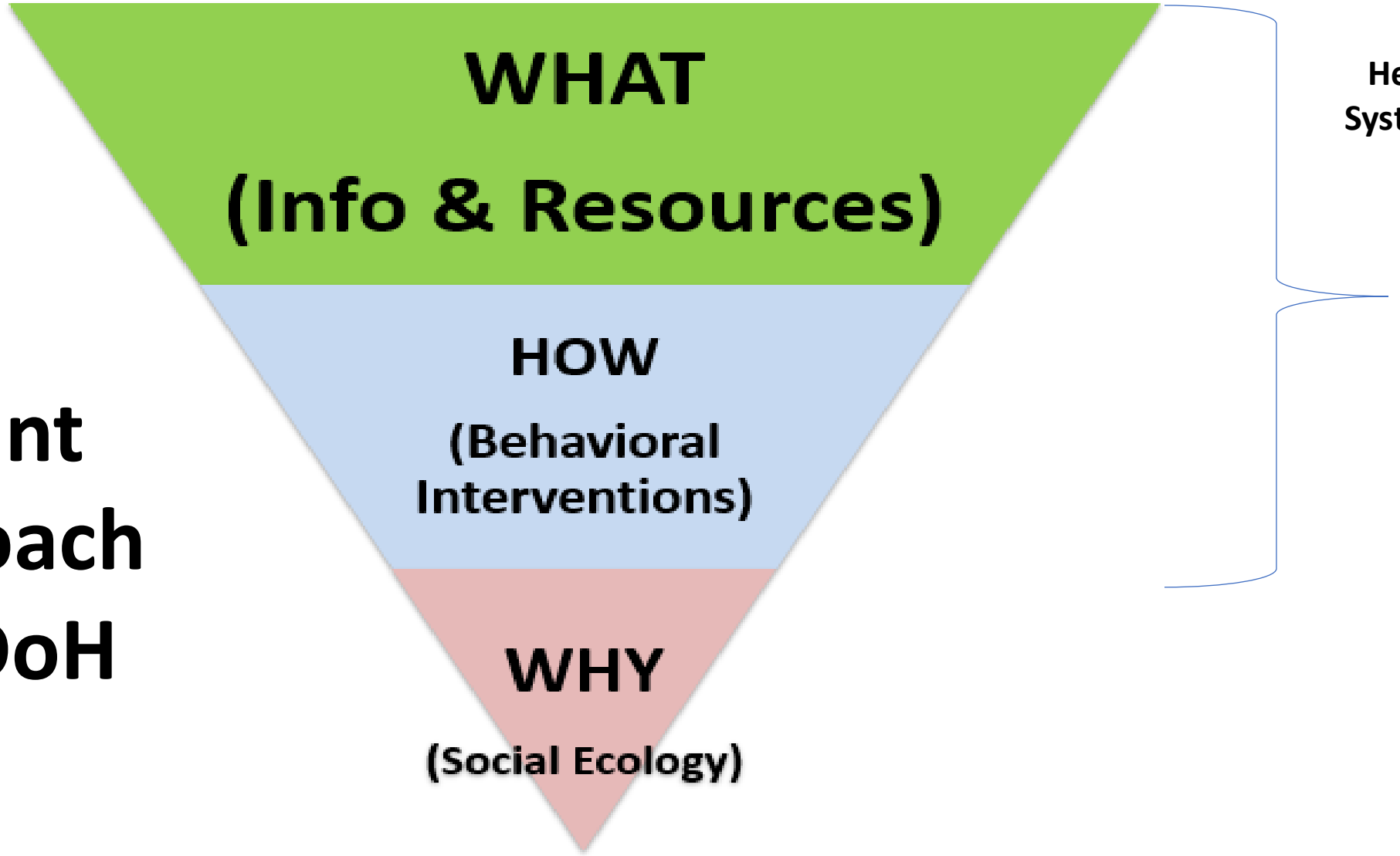
Samantha Barry-Menkhaus, PhD

THE LEONA M. AND HARRY B.

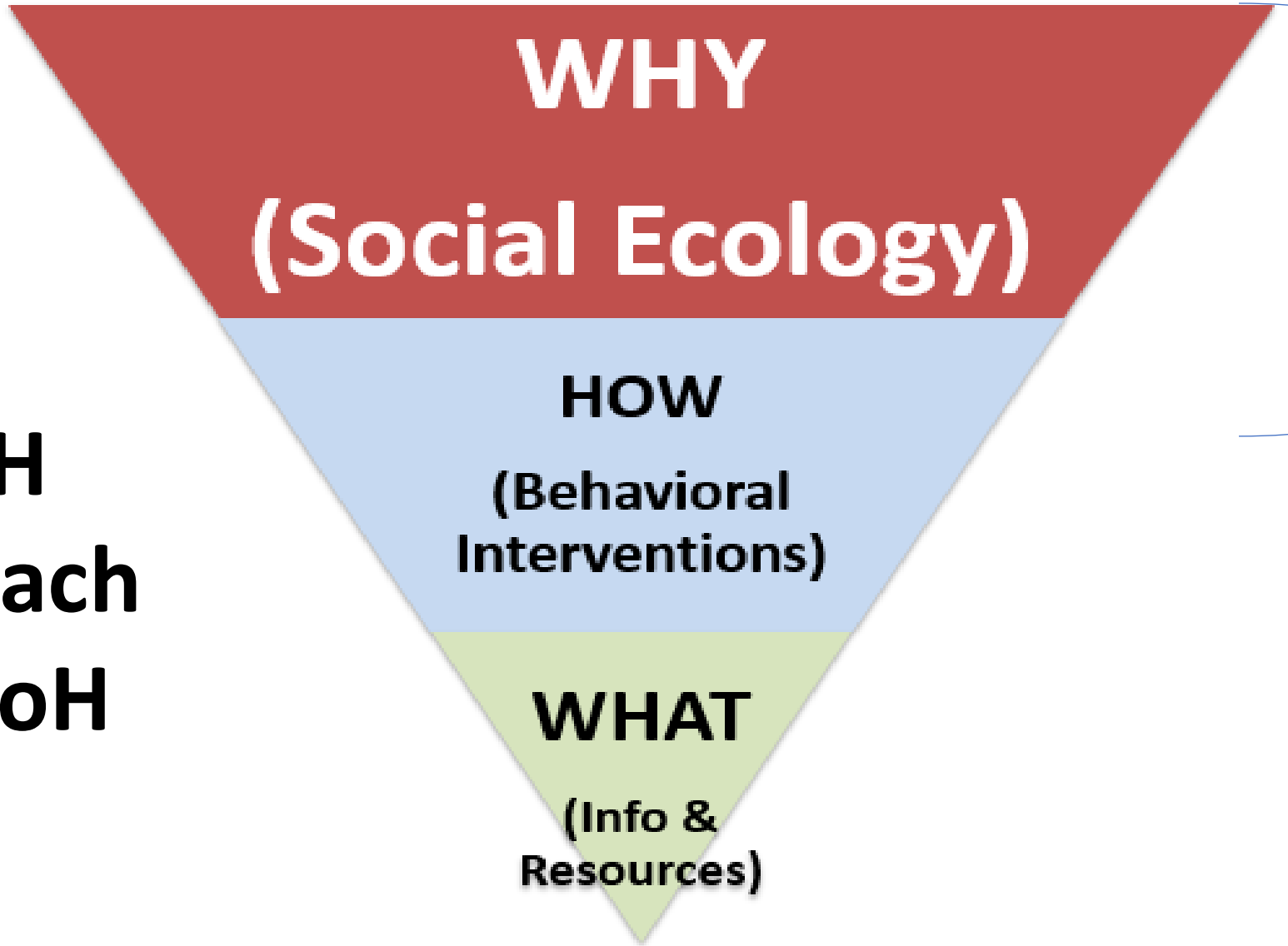
HELMSLEY

CHARITABLE TRUST

Extant Approach to SDoH



NICH Approach to SDoH



Lived Experience-Based

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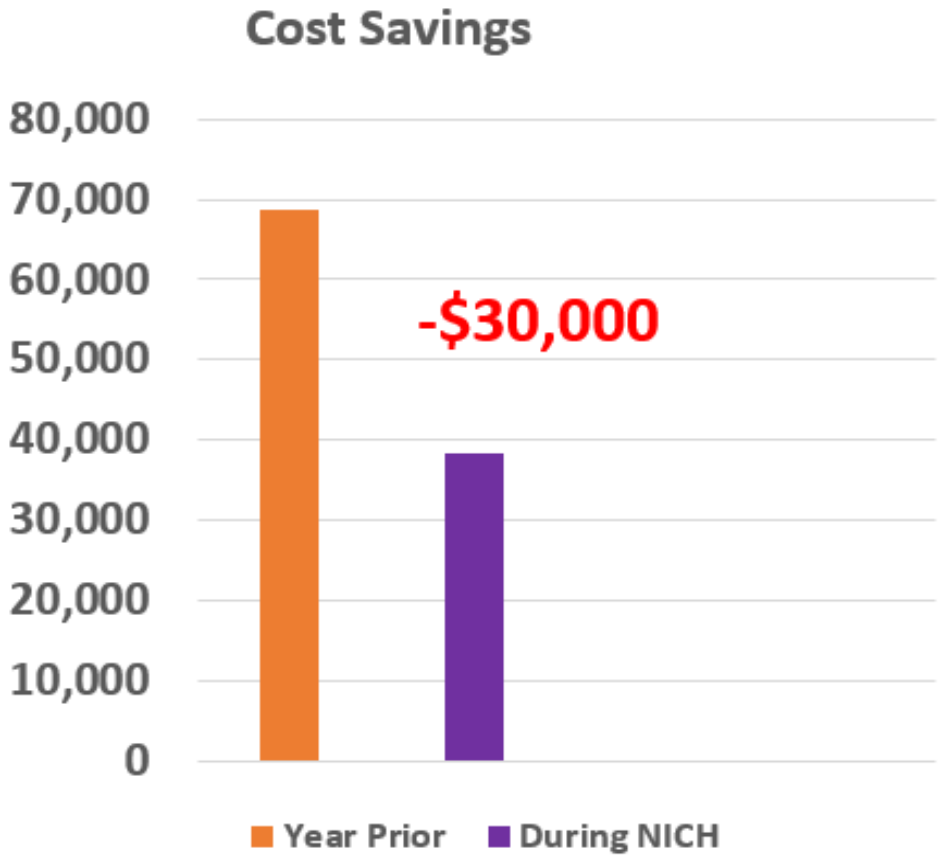
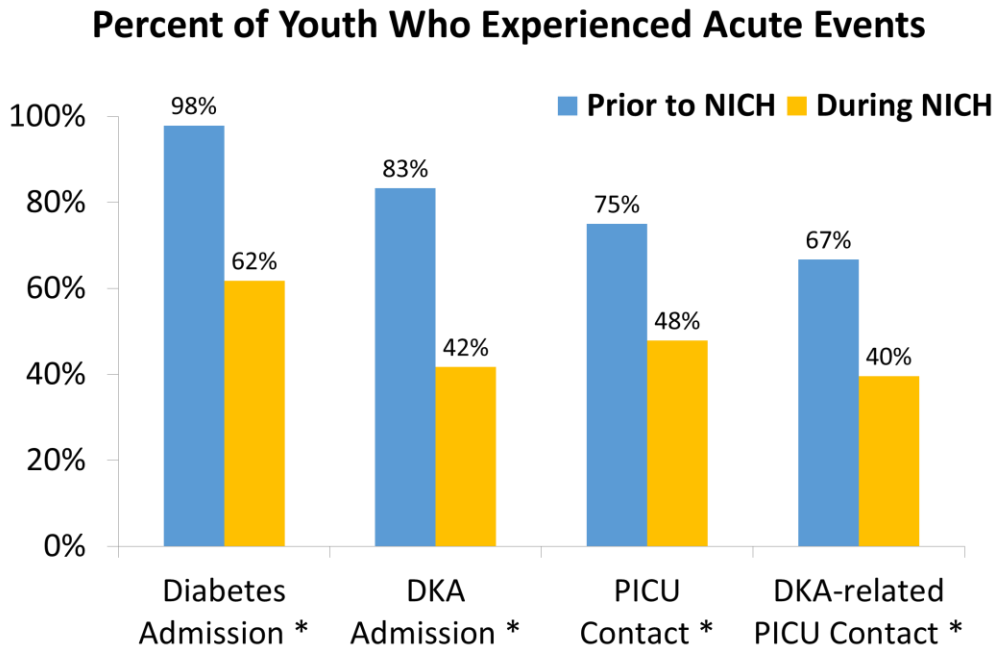
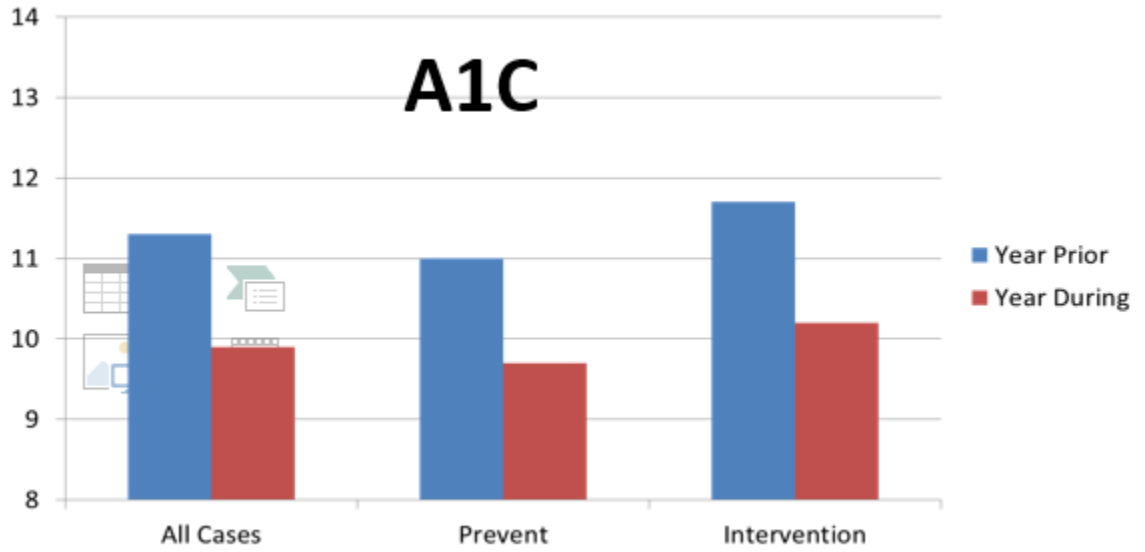
NICH

Results







Challenges

NICH

Budget Dust

Go after the most costly

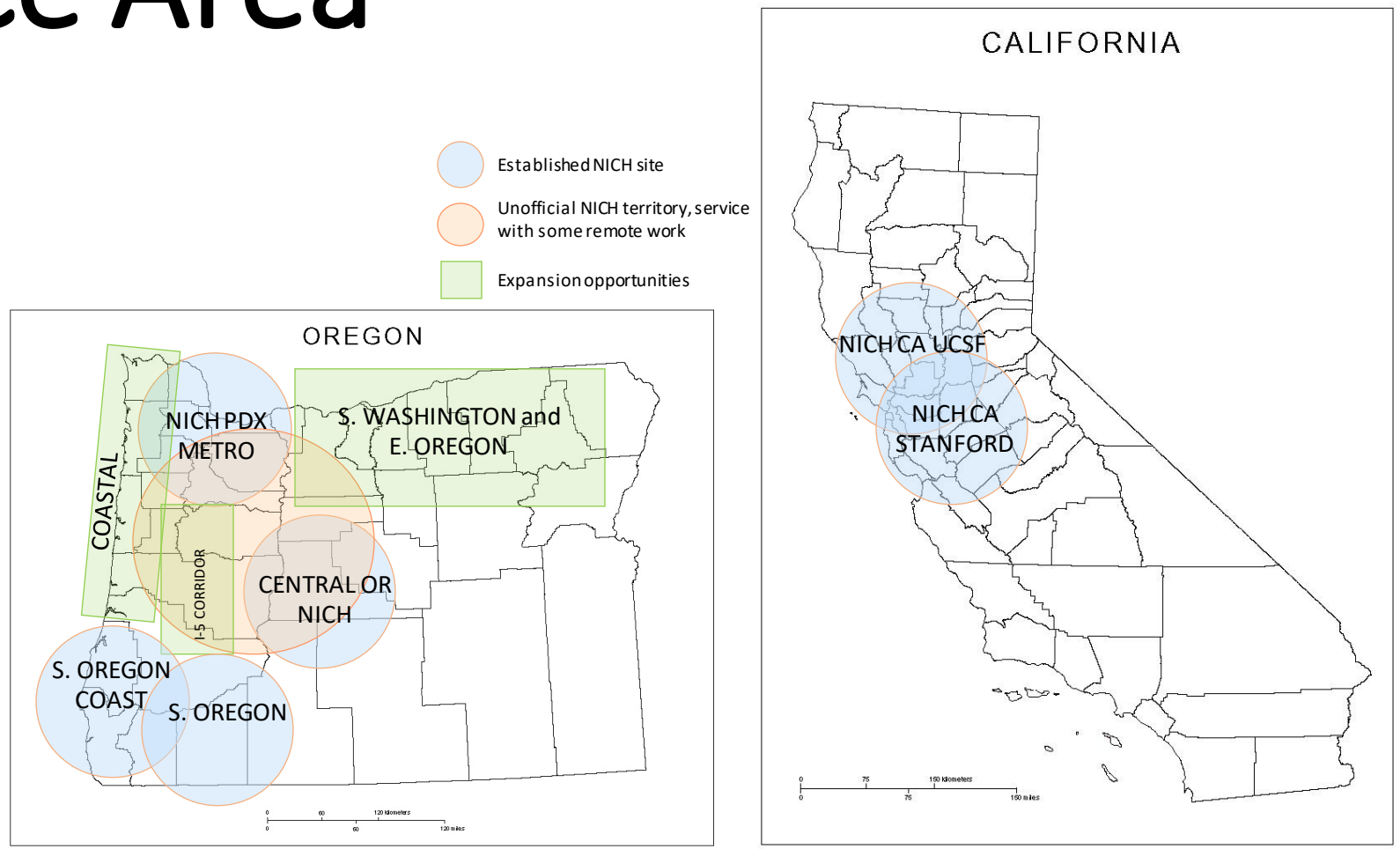
Lack of Ownership

Demonstrate value to health care system including hospital and payors

Medical Centers do Medical Care

Provides infrastructure to address social challenges

Service Area



Why aren’t people falling over themselves to get NICH?

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NICH

To Contract or Not to Contract?

- **Reduce costs**
- Improve health
- Improve care
- Reduce provider burnout
- Decrease health disparities

To Contract or Not to Contract?

- **Reducing avoidable utilization**
- Taking pressure of ED/PICU
  - *Keeping patients out of ED/PICU for avoidable reasons*
- Reducing LOS
  - *Freeing up beds for higher acuity patients*
- Decreasing no shows - outpatient
- Billing Codes – G codes
  - *Successfully getting Medicaid to pay for service*
- ↓ Physician Burnout, ↑ Physician QOL
  - Sig costs in turnover (~ $250k-$800k in direct costs)
- Health Disparities and Health Equity is Hot
- Foundation Support
  - *Highly appealing to donors*

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To Contract or Not to Contract?

- **Reduce costs**
- **Improve health**
- **Improve care**
- **Reduce provider burnout**
- **Decrease health disparities**

To Contract or Not to Contract?

- **Reducing avoidable utilization**
- **Taking pressure of ED/PICU**
  - ***Keeping patients out of ED/PICU for avoidable reasons***
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  - ***Freeing up beds for higher acuity patients***
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- **Billing Codes – G codes**
  - ***Successfully getting Medicaid to pay for service***
- **↓ Physician Burnout, ↑ Physician QOL**
  - **Sig costs in turnover (~ $250k-$800k in direct costs)**
- **Health Disparities and Health Equity are priorities (kinda)**
- **Foundation Support**
  - ***Highly appealing to donors***

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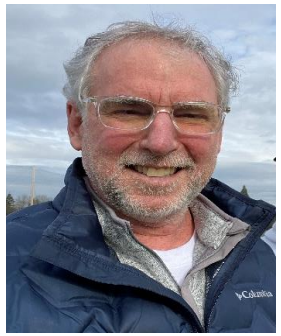


Michael A. Harris, PhD

Developer and Director

Kim Spiro, PhD

Co-Developer and Clinical Director

David V. Wagner, PhD

Research Director

Kristen Leadem, MA

Dissemination Lead

OHSU

Stephanie Stover

Richarnae Harris

Flora Richey

Kayley Oka

Sam Edwards

Ricardo Aguilar Estrada

Hayley Parra-Cain

Vanessa Quan

Jeffrey Kuang

NICH

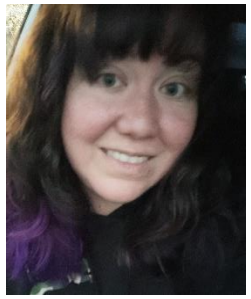
Crystal Lappin
(Central Oregon)

Kandace Wharry
(Central Oregon)

Itzel Coronel
(Central Oregon)

Matthew Heywood
(Lane County)

Aurora Silva-Ramirez
(Marion/Polk Counties)

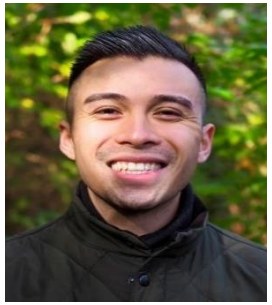


Michel Cota
(Coos/Curry Counties)

Bailey Etter

Josh O'Rourke

(NICH LAUNCH)



Chris Phanthavong
SENIOR/LEAD Interventionist

NICH Operations

Samareh Shadbeh
Intake/Referral

Brian Tierney
Operations Manager

NICH Supervisors

Ingrid Gomez

Nefthaly Cisneros

Joseph Jackson

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Thank You.

Novel Interventions in Children's Healthcare

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