

Partnerships for Early Childhood Development

Year 2 Update

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There is currently wide recognition that health outcomes can be largely driven by factors outside of health care. Among young children and their families, unmet social needs (e.g., inadequate food or housing) can lead to lifelong consequences for health and well-being. To address this issue, United Hospital Fund launched the **Partnerships for Early Childhood Development (PECD)** initiative in 2017. PECD is a grant program and learning collaborative that helps child-serving primary care practices screen for and address unmet social needs through strong clinical-community partnerships.

In July 2018, UHF published an in-depth report summarizing the experiences from the first year of PECD, *Clinical-Community Partnerships for Better Health: Observations from New York City's Partnerships for Early Childhood Development Initiative*. UHF recently completed the second year of this initiative, and this report is a brief update summarizing what was learned.

How Does PECD Work?

PECD is a New York City-based initiative with two components:

- A **grant initiative** that provides funding to help hospital-based, child-serving primary care practices partner with community-based social service organizations (CBOs). Together, the primary care teams and their community partners build a system of care for families that includes screening for psychosocial needs, referrals to community partner services, and effective feedback and follow-up. A portion of the grant funding supports the community partners.
- A **learning collaborative** that helps PECD grantees and community partners share best practices, troubleshoot challenges, and hold each other accountable for making progress by participating in regular reporting of measures.

Year 2 by the Numbers

- Over 8,400 families screened, compared to 4,490 families screened by these same teams in Year 1.
- 4,111 families screened positive for at least one social need—nearly half of all families screened.
- Of families that wanted help for their social need, 76% (over 2,000 families) received assisted referrals to PECD community partners. Nearly 500 other families received in-house supports or referrals to non-PECD community partners.
- Over 1,500 families made contact with the PECD community partners.
- The top five social needs identified were: housing, including environmental risks and utility needs (2,107); food insecurity (1,678); adult learning (670); transportation (598); and child care (378).*

* Not all PECD grantees were screened for the same social needs.

Who Is Involved?

Eight New York City hospital systems and 16 social service organizations participate. More information about these teams is included in the “Who Are the Teams?” section. The pediatric primary care practices collectively serve over 30,000 children under age 5 annually.

United Hospital Fund leads the initiative in partnership with The Altman Foundation, The New York Community Trust, and the William J. and Dorothy K. O’Neill Foundation.

The learning collaborative is chaired by Dr. Benard Dreyer, former President of the American Academy of Pediatrics.

What Did We Learn in Year 2?

In their second year, PECD teams refined their screening and referral processes, allowing them to reach many more families than during their first year of work. Nearly all teams also established a basic process for communicating the results of referrals back to the primary care team. They achieved this progress despite setbacks encountered during the implementation and expansion of new workflows in busy pediatric clinics and community organizations. Among the key lessons:

- ***It is essential that team-based care include liaisons from community organizations.*** Both the health care and community organizations found they needed to have at least one “point person” at both ends who was responsible for overseeing the process and handling day-to-day management and improvement work. At the larger and better-resourced health care institutions, this dedicated point person sometimes managed a broader team of volunteers and interns assisting with the screening and referral process. The most successful grantees included liaisons from community organizations as part of their clinical teams or in their weekly case management meetings.
- ***Electronic supports proved critical for streamlining the screening and referral processes and tracking families.*** Teams used a range of technologies to simplify and improve their systems of care. These included screening families with iPads, incorporating screening results into electronic medical records, using electronic resource referral platforms to identify available services outside of their existing

community partnerships, and developing databases and dashboards to track referral outcomes and share information between clinics and CBOs.

- ***Parent feedback is an important source of information for quality improvement.*** All but one team incorporated parent feedback into their programs. Improvement activities based on parent feedback included refining screening tool questions, changing the frequency and interval of screenings, reducing the time between clinic visits and community organization outreach, and developing trusting relationships with parents before asking about sensitive information.
- ***Working with families after a referral and effectively closing the referral loop continues to be a challenge.*** Community organizations continue to struggle to increase the number of families who successfully connect with services following referrals. Promising strategies include documenting families' preferences for contact methods and timing, using visual cues in the clinic to help families later remember the referral discussions with the provider, and offering transportation so they can access services. While most teams have operationalized a system for communicating referral outcomes back to the clinic, these processes are often cumbersome and inefficient; as a result, the information doesn't always get back to the referring physician.
- ***Screening and referral relationships are a starting point for deeper collaboration.*** Efforts to develop stronger partner relationships have led several teams to expand the scope of their clinical-community work. This has included collaborating on community needs assessments, integrating some social services (such as Supplemental Nutrition Assistance Program enrollments) into the primary care practice, and formally incorporating the rotation of medical residents into community organizations as part of the residents' training. Some community organizations are also actively seeking additional clinical partners.
- ***The learning collaborative is valuable.*** Participants continue to report that the learning collaborative structure yields meaningful benefits. The collaborative provided protected time for clinicians and community organization staff to build relationships, plan their programs, collectively assess progress, and gain insight into what other practices are doing that could accelerate their own work. Learning collaborative sessions focused on critical topics, such as comparing e-referral platforms, engaging institutional leaders to grow support for clinical-community work, and techniques for building trusting relationships with parents. One grantee noted, "This type of collaboration is often difficult in a large city such as New York, especially when addressing complex and sensitive issues such as social determinants of health."

How Has PECD Helped Primary Care Providers, Community Organizations, and Families?

“Before implementing PECD, families at our clinic would approach our front desk asking for winter coats for their children, and our staff would try their best to help. In two years, we have created a system where we are proactively asking our families what they need and have processes in place to get them help.”

—Physician participant

“This project has allowed our medical institution to better learn about the needs of our community and the resources available to our families. It has helped our providers feel more invested in the social needs of their families and feel a rededication to the importance of these needs in our families’ overall health.”

—Physician participant

“Clinical-community partnership has definitely had a positive impact on our organization’s operations. We are looking for ways to not just sustain this collaboration but to develop more with this clinical partner and to replicate this with other clinical partners.”

—Social service provider participant

“I get a call [from the CBO]: ‘Can you come over, make an appointment? We’d like to help you guys, just got a referral from [Northwell] here.’ So okay... that was pretty quick... and then I get there, they know everything about me, like the navigators explained everything to them, and they were like, ‘We know this part, and we want to help you.’ It was really impressive.”

—Parent served by a PECD program

Who Are the Teams?

BronxCare Health System

Partners: Phipps Neighborhoods and Claremont Neighborhood Center

BronxCare Health System’s Department of Family Medicine has five participating primary care practices serving communities throughout the Bronx. Under PECD, BronxCare has partnered with Phipps Neighborhoods to expand its Reach Out and Read program, which includes encouraging families to visit Phipps “Reading Rooms” in the community, and has helped Claremont Neighborhood Center launch a social needs screening program at Claremont’s child care sites.

- **Most common social needs identified: employment, adult education, and eviction/utilities protection**

Cohen Children’s Medical Center (Northwell Health)

Partners: Child Center of New York and The Interfaith Nutrition Network

Cohen Children’s Medical Center serves communities in Eastern Queens and Long Island. Through PECD, Cohen Children’s has sought to build a strong partnership with the Child Center of New York (CCNY) through a variety of strategies, including piloting the use of volunteer navigators and rotating medical residents through CCNY’s sites. As part of the project, CCNY has also introduced social needs screening throughout its sites and has undertaken strategic planning to break down silos among its own programs. CCNY provides counseling on entitlement benefits, health insurance, financial guidance, social services, and legal services. Cohen Children’s has also partnered with The Interfaith Nutrition Network in Year 2 to support Long Island families who are food insecure and/or homeless.

- **Most common social needs identified: public benefits, adult education, and eviction/utilities protection**

Mount Sinai Hospital

Partners: Children’s Aid, New York Common Pantry, and LSA Family Health Service

Mount Sinai Pediatric Associates is a pediatric primary care practice serving communities in East Harlem. Under PECD, Mount Sinai has helped Children’s Aid launch a food-insecurity screening program and has launched its own social needs and environmental risks screening program in partnership with New York Common Pantry and LSA Family Health Service. New York Common Pantry is one of New York City’s largest, single-site, community-based food pantries, and LSA Family Health Service is a multi-service agency working to address needs such as food, health care, and safe housing.

- **Most common social needs identified: home environment (e.g., mold and pests), tobacco smoke exposure, and food support**

NewYork-Presbyterian/Columbia University Irving Medical Center

Partner: Northern Manhattan Perinatal Partnership

NewYork-Presbyterian/Columbia has four pediatric ambulatory care network sites, primarily serving Northern Manhattan and the South Bronx, that participate in PECD. The primary site, Charles Rangel Community Health Center, serves communities in Central Harlem and has been piloting the development of a close working relationship with the Northern Manhattan Perinatal Partnership (NMPP). The two entities (the health center and NMPP) are co-managing a community health worker with expertise in early childhood; this arrangement has helped more families successfully connect with NMPP. A multi-service agency, NMPP provides a range of pregnancy and parenting supports.

- **Most common social needs identified: housing, food support, and transportation**

NewYork-Presbyterian/Queens

Partner: Public Health Solutions

NewYork-Presbyterian (NYP) Queens’s Theresa Lang Children’s Ambulatory Center and Jackson Heights Family Health Center serve the Flushing and Jackson Heights communities of Queens. Under PECD, NYP Queens has strengthened its partnership with Public Health Solutions with a focus on ensuring vulnerable

young children and new mothers receive high-quality community services, such as home visitation. As New York City's largest public health nonprofit organization, Public Health Solutions provides a range of maternal and child health services and connects families to additional supports throughout the city.

- **Most common social needs identified: breastfeeding, food support, and adult education**

NYC Health + Hospitals/Gotham Health, Gouverneur

Partners: Grand Street Settlement, Henry Street Settlement, University Settlement, and Educational Alliance

Gouverneur Health, one of NYC Health and Hospitals' Gotham Health Community Clinics, is in the Lower East Side of Manhattan. Through PECD, Gouverneur's pediatrics department has restructured its clinical workflow to seamlessly integrate social needs screening into its well-child visits, with the aim of connecting families to four bedrock organizations of the Lower East Side: Grand Street Settlement, Henry Street Settlement, University Settlement, and Educational Alliance. Collectively, these partners provide child care, parenting classes, assistance in accessing benefits, Early Intervention services, and other supports.

- **Most common social needs identified: adult education, child care, and employment**

NYU School of Medicine/Family Health Centers at NYU Langone

Partner: OHEL Children's Home and Family Services

NYU Langone's Sunset Park Family Health Center is a federally qualified health center serving the Sunset Park community of Brooklyn. Under PECD, NYU Langone partnered with OHEL Children's Home and Family Services to initially provide offsite group classes on parent-child behavior and, later, to integrate these classes into the clinic. Sunset Park clinicians also screen for social needs, and as needed make referrals to NYU's Family Support Services Center.

- **Most common social needs identified: adult education, food support, and child care**

St. John's Episcopal Hospital

Partners: Sheltering Arms and Queens Family Resource Center

St. John's Episcopal Hospital's Pediatric Health Services Department is a primary care pediatric practice serving the Far Rockaway community of Queens. Through PECD, St. John's has piloted the use of a social worker—hired from the community—to connect families to Sheltering Arms and the Queens Family Resource Center. Sheltering Arms provides child care, foster care, summer camps, and social services, and the Queens Family Resource Center provides parenting classes and assistance in accessing benefits.

- **Most common social needs identified: child care, children's behavioral needs, and housing**

What Comes Next?

PECD will continue for a third and final year with the existing eight partnership teams. This will allow grantees to further refine their systems of care and—crucially—evaluate how this initiative has made a difference in the lives of young children and their parents. UHF will document the results of the evaluation and the shared experiences of the partnership teams so that these lessons might serve as guidance for other pediatric practices seeking to better integrate community services.

Embarking on a third year is a significant milestone for these partnerships. Many child health providers and community organizations across the nation are eager to work together. PECD has shown that establishing effective social needs screening and referral systems is a feasible and rewarding effort. It has also demonstrated that such an effort depends on modest financial support and a local learning collaborative structure that aids in the development of working relationships between clinicians and social service providers. The PECD model can be replicated by other nonprofit organizations, funders, or local governments seeking to integrate health and social care. ■

United Hospital Fund is an independent, nonprofit organization working to build a more effective health care system for New Yorkers, one that is affordable and accessible, provides a better patient experience and the highest quality of care, and achieves optimal outcomes—with a special focus on the needs of the most vulnerable. To learn more about UHF or the PECD initiative, visit our website: www.uhfnyc.org.