Addressing the Social Determinants of Health: The Role of Home Visiting

Ounce of Prevention
National Home Visiting Summit
February 1, 2008

Darcy Lowell, Child First
Karen O'Donnell, Family Connects
Kathleen Strader, Healthy Families America

Plan for Workshop

- Definition of “social determinants of health” (SDOH)
- Major importance of social determinants with regard to development of brain and metabolic systems
- Home visiting as a unique opportunity
- Three evidence-based home visiting models and their approach to social determinants:
  - Family Connects
  - Healthy Families America
  - Child First
- Questions and Contributions

NATIONAL ALLIANCE of home visiting models

Mission

To improve the health and well-being of pregnant women, young children and their parents by elevating and advancing the field of evidenced-based home visiting through collaborative leadership.

Our activities include:

- Legislative and local advocacy
- Identifying cross-model issues that affect outcomes of interest for each model
- Collaborations on research
- Innovations to improve service

While each home visiting model is unique in intervention goals and outcomes, aspects of federal, state, and local mechanisms of home visiting implementation pertain to all.

NATIONAL ALLIANCE
of home visiting models

Nurse-Family Partnership
Helping First-Time Parents Succeed®

child first

FAMILY CONNECTS
NURSE HOME VISITS

Parents as Teachers®

Healthy Families America

Head Start®

SafeCare®
Stronger Families | Brighter Futures

HIPPYUSA®
Home Instruction for Parents of Preschool Youngsters

PARENT-CHILD HOME PROGRAM

Select or create a presentation

+ Create presentation

Select an existing presentation from your account

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Are you stuck or missing updates? Refresh

Log out

What does "social determinants of health" mean to you?

Take 2 minutes, and write down as many social determinants as you can think of!

Select or create a presentation

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Select an existing presentation from your account

Select your presentation

Are you stuck or missing updates? Refresh

Log out

Definition of SDOH

- Social determinants of health

  "The social determinants of health are the conditions in the environments in which people are born, live, learn, work, play, worship and age [that] affect a wide range of health, functioning and quality-of-life outcomes and risks."

  Healthy People 2020, U.S. Dept. of Health and Human Services

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We Know

- Socioeconomic factors are the fundamental causes of a wide range of health outcomes
- In some European countries, large disparities in health according to social class despite almost universal access to health care
- Number of US deaths in 2000 that were attributable to low education, racial segregation, and low social support was comparable with the number attributable to heart attack, cerebrovascular disease, and lung cancer, respectively

Public Health Report, Jan-Feb 2014

Four Domains of Social Determinants for Young Children

When working with a child, helpful to think of social determinants in these categories:

- Material – Environmental well-being
- Parental – Psychosocial well-being
- Social – Family well-being
- Parent-Child Relationship well-being

Charles Bruner

Child & Family Policy Center

Material – Environmental

- Low income/poverty
- Lack of educational opportunities
- Poor health care access
- Lack of transportation
- Food insecurity
- Crime and unsafe environment
- Lack of exercise opportunity
- Job insecurity
- Poor employment conditions
- Poor housing and homelessness
- Toxic exposures
  - Lead, waste, pollution

Parental – Psychosocial

- History of childhood trauma
- Current violence in the home
- Historical trauma
- Depression, PTSD, anxiety, other mental health issues
- Substance abuse and addiction
- Poor executive functioning capacity
- Poor emotional regulation
- Poor self-esteem, confidence, self-determination
- Lack of knowledge and competence

Social – Family

- Racial and ethnic discrimination
- Lack of social supports
- Lack of faith community
- Lack of availability or connection to social services
- Community violence
- New immigrant – language, culture, connections
- Isolation
- Unstable housing
- Overcrowding
- Incarceration

Parenting – Parent-Child

- Poor quality parent-child relationship
  - Disorganized or insecure attachment
- Child physical, sexual, or emotional abuse
- Child emotional or physical neglect

- Exposure to trauma – domestic or community violence
- Separation from or death of important caregiver
- Lack of other supportive or nurturing adults
- Lack of parental knowledge - child development & parenting
- Lack of safety and routines
- Lack of high quality early care and education

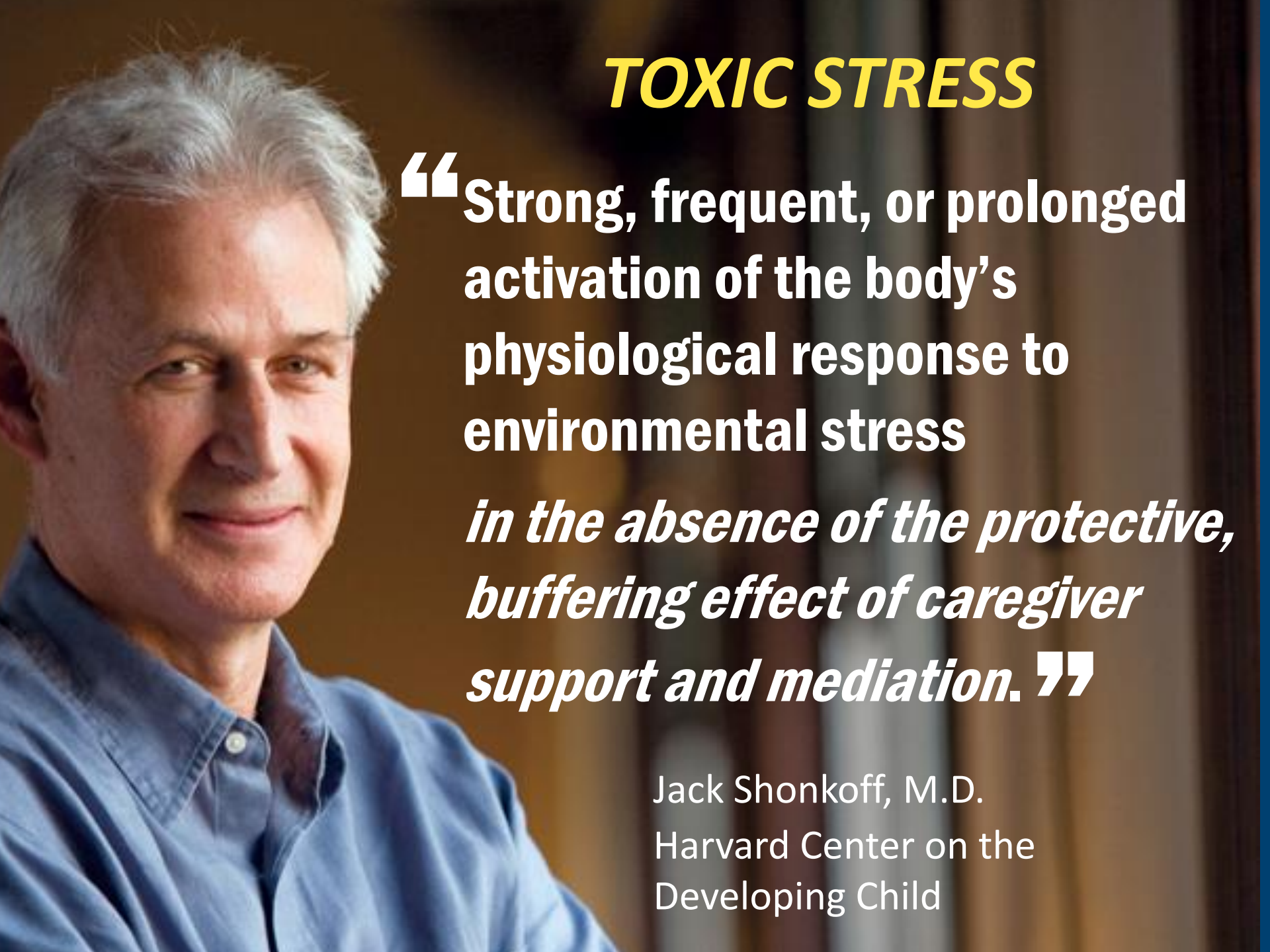
ACES and TOXIC STRESS

Adverse Childhood Experience Study

- Study done by Kaiser Permanente and CDC in 1995-97
  - Over 17,000 adults
  - 66% over age 50 years
  - Middle to upper middle class
  - 75% white
- Looked at experiences before age 18
- Found that there were 10 psychosocial risk factors that were highly correlated with major health problems

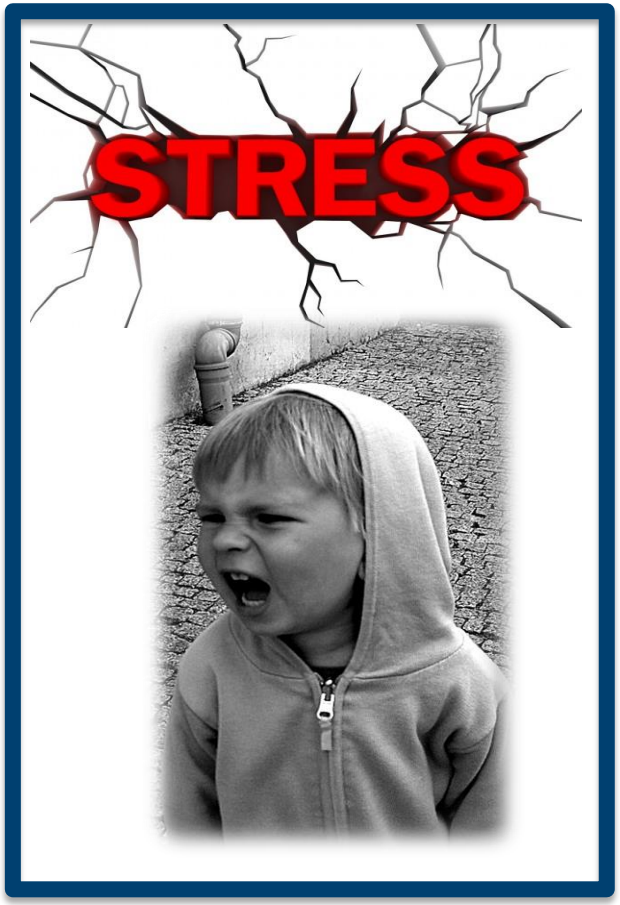
ACEs

- Child physical, emotional, or sexual abuse
- Child physical or emotional neglect
- Parental mental illness
- Parental substance abuse
- Parental incarceration
- Domestic violence toward mother
- Parental separation or divorce

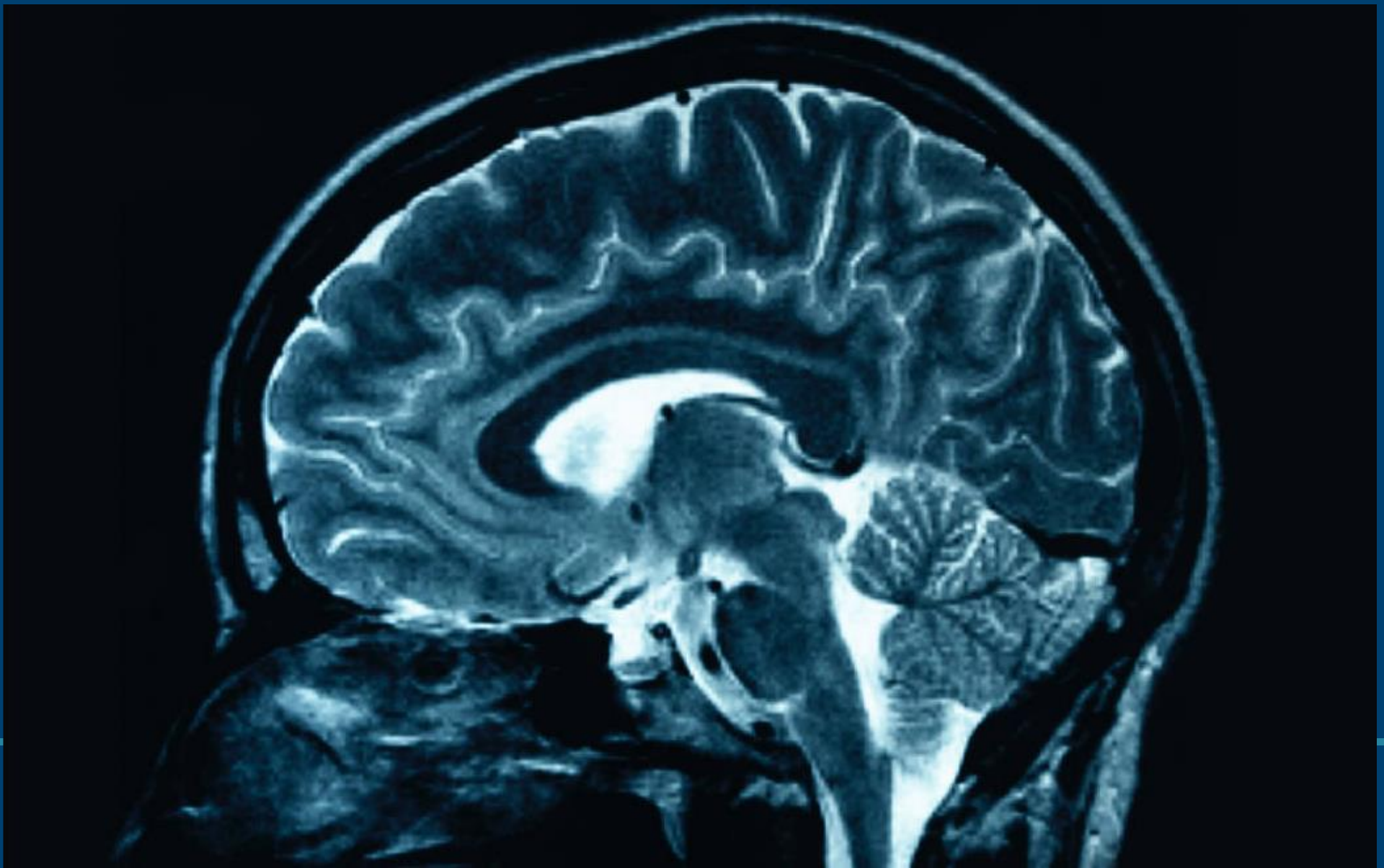

TOXIC STRESS
“Strong, frequent, or prolonged activation of the body’s physiological response to environmental stress
in the absence of the protective, buffering effect of caregiver support and mediation.”
Jack Shonkoff, M.D.
Harvard Center on the Developing Child

Toxic Stress

Toxic stress describes how the brain and metabolic systems **respond** to chronic, unremitting social and environmental stress and trauma



The Developing Brain



Nature **AND** Nurture

- Environment is critical for genetic expression.
- The child's interactions with the environment turn genes on and off: **EPIGENETICS**
- Neural networks are created based on **repetition** of experiences.
- Experience builds the architecture of the brain and metabolic systems

Brain Plasticity

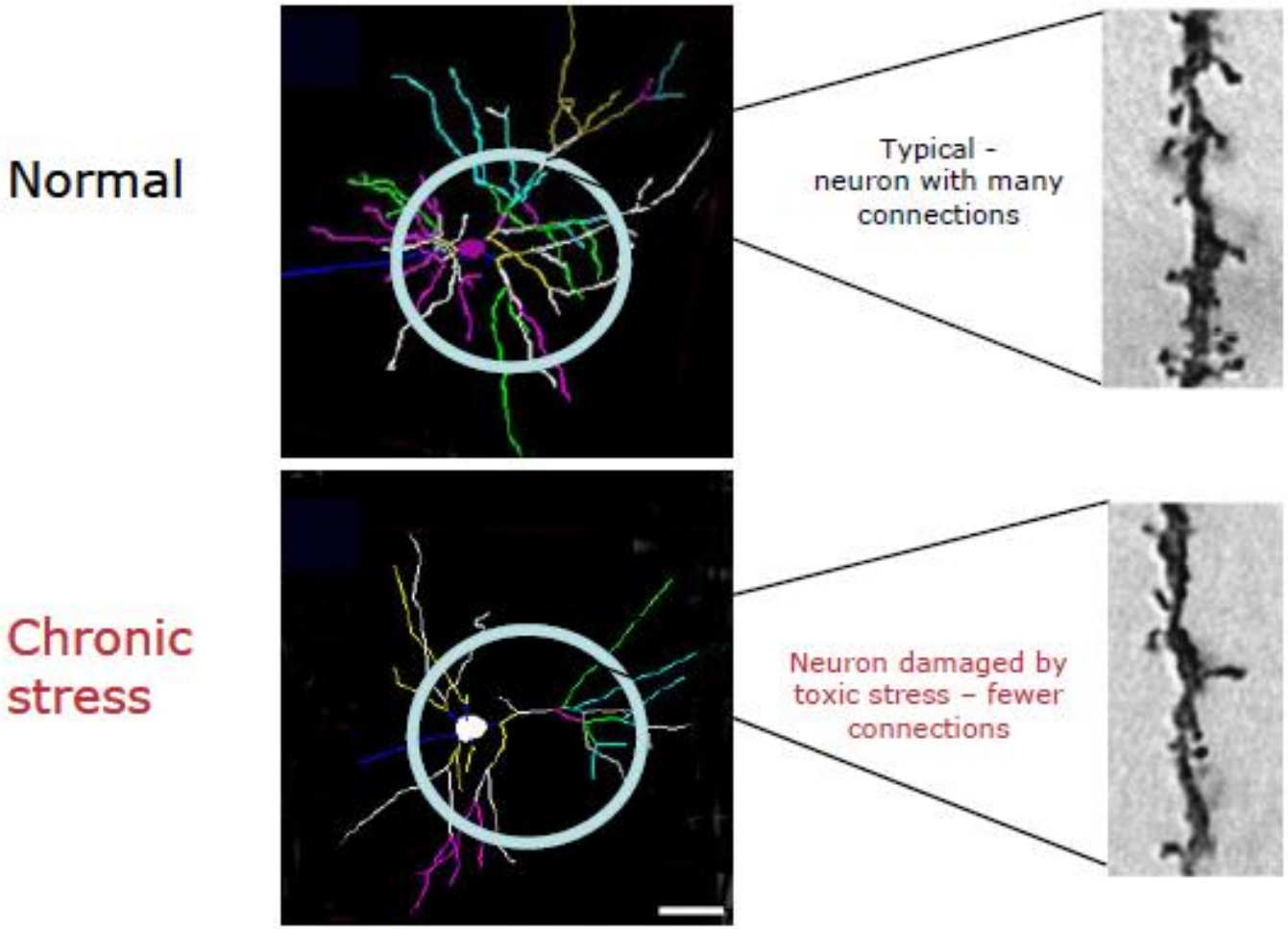
- Brain plasticity is enormous at birth, but decreases over time.
  - **Change is easy early in development.**
  - **Change is difficult with increasing age**.
    - Extremely costly
    - Poor outcomes

What Happens in the Face of Chronic Environmental and Social Stressors?

Wear and tear (allostatic load) associated with chronic exposure to stressors is associated with physiologic changes across multiple, biologic, regulatory systems including:

- Hypothalamic-pituitary-adrenal axis (HPA axis)
- Sympathetic nervous system
- Immune/inflammatory system
- Metabolic system
- Cardiovascular system

Persistent Stress Alters Brain Architecture



Prefrontal Cortex and Hippocampus

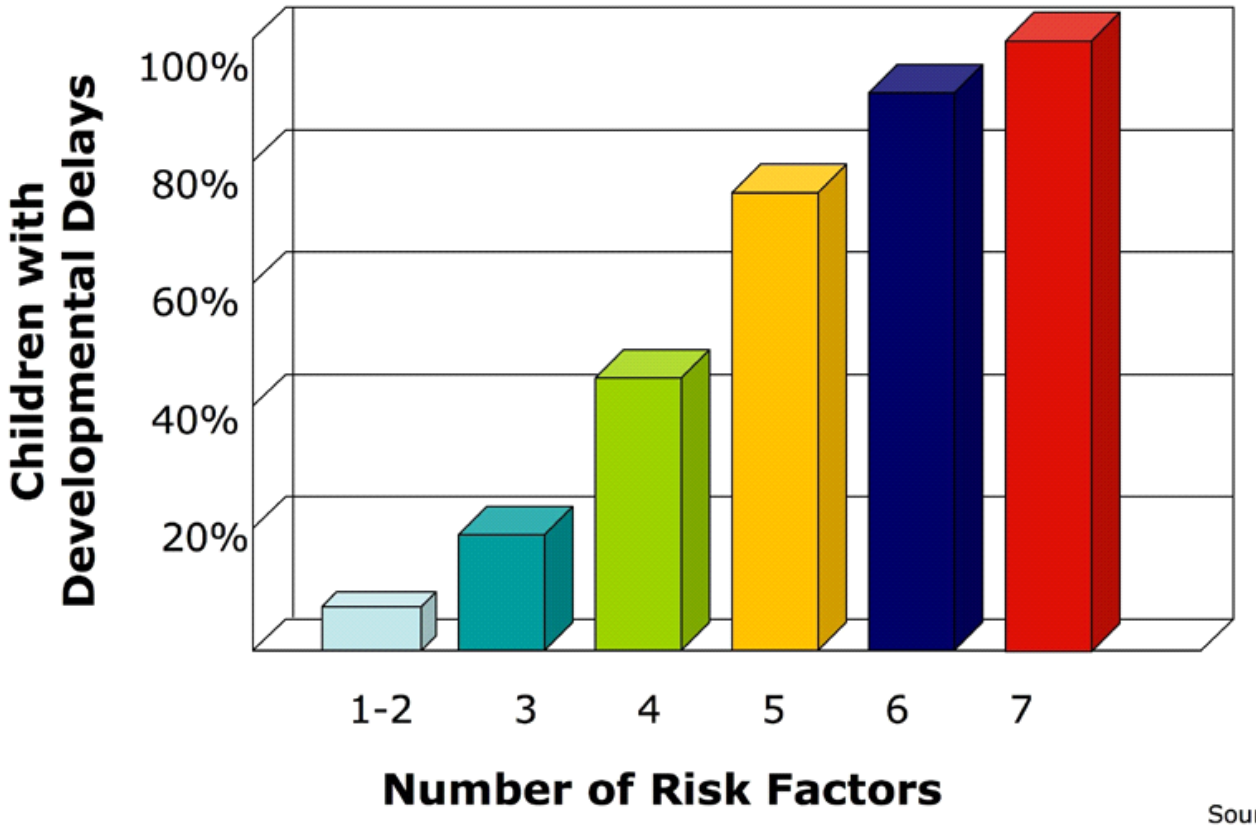
Source: C. Nelson (2008)
Bock et al Cer Cort 15:802 (2005)

Adversity in Early Childhood

High stress leads to lifelong problems in:

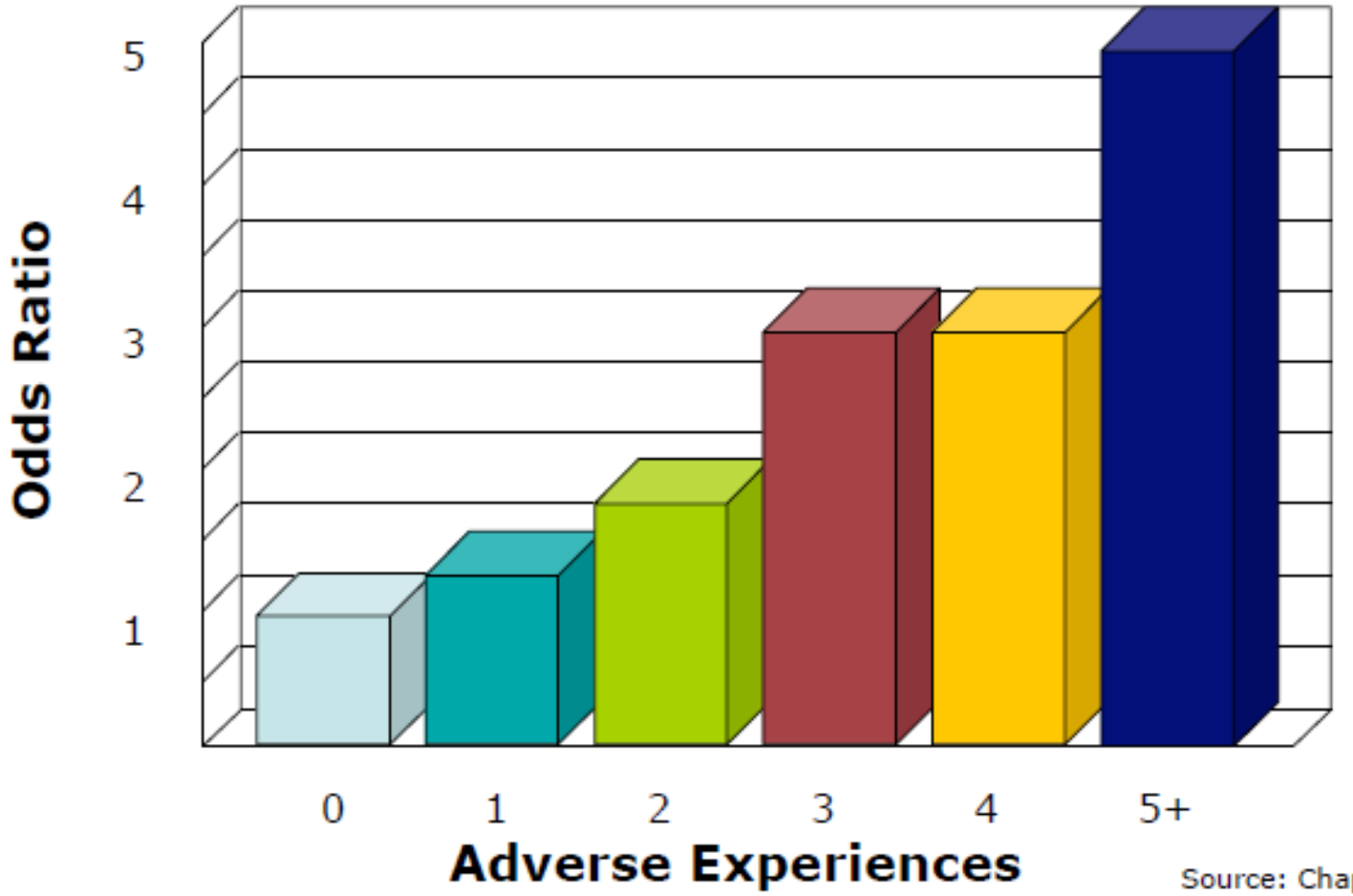
- **Mental health**
  - Depression, anxiety, PTSD, emotional dysregulation, substance abuse
- **Development and learning**
  - Cognition, executive functioning - memory, attention, inhibition, information processing
- **Physical health**
  - Diabetes, heart disease, lung disease, hypertension, stroke, obesity, cancer, immune disorders

Significant Adversity Impairs Development in the First Three Years



Source: Barth et al. (2008)

Risk Factors for Adult Depression are Embedded in Adverse Childhood Experiences



Source: Chapman et al, 2004

Power of Relationships

Responsive Early Relationships

- Infant entirely dependent on caregiver
- Caregiver helps mediate the environment and regulate the infant so stress response system is not overwhelmed
- **"Serve and return"** largely determines how the wiring of the brain takes place

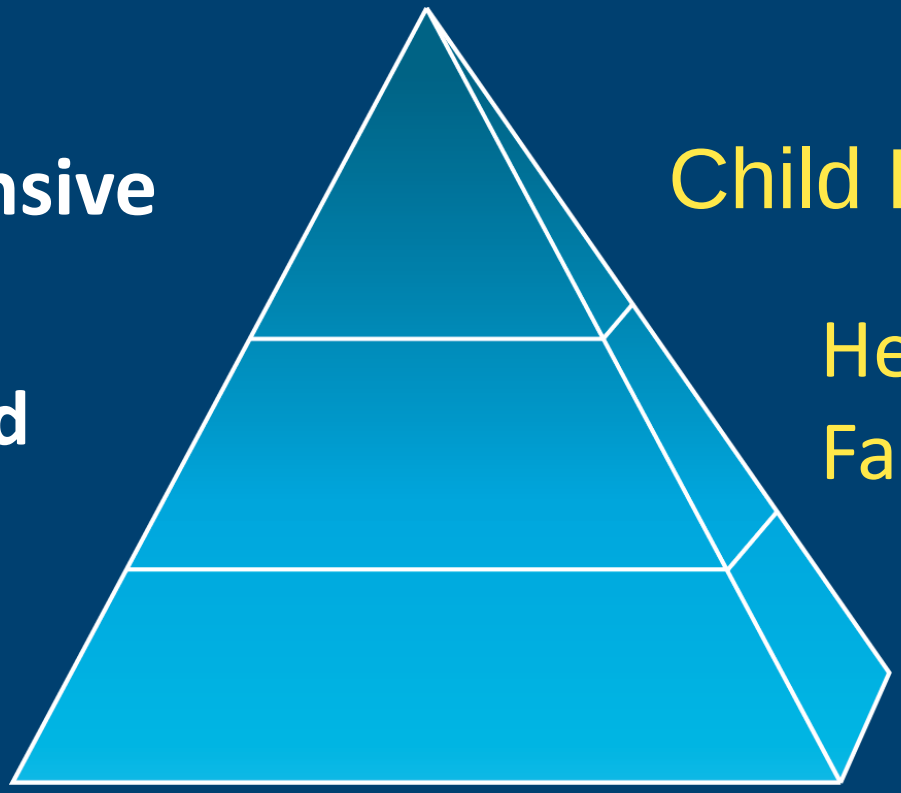
Responsive Early Relationships

- This relationship is critical in protecting the developing brain and metabolic systems from the impact of high chronic stress
- Major source of child resilience

Home Visiting: An Opportunity!

- Critical to **identify** and pay attention to these social determinants
- Many different routes to address them
- Each home visiting model has its own approach
- Need to look at the unique level of risk and specific needs of individual families
- Look for best match between HV model and family
- HV models collaborate closely to meet family needs

Continuum of Care for Different Levels of Risk



AN EVIDENCE BASED MODEL: COMMUNITY BASED CARE FOR NEWBORNS AND FAMILIES

WHAT IS FAMILY CONNECTS ABOUT?

Realizes the shift in home visiting to include universal assessment of family needs to promote linkages to community resources and services

Targeted models → *Universal models* → *Collaboration*

- Why and how universal?
- Brief description of the program

1. Getting the community aligned with the program
2. Providing nurse home visits in the early postpartum period
3. Monitoring program implementation

- How FC addresses social determinants of health

FAMILY CONNECTS
NURSE HOME VISITS

WHAT IS FAMILY CONNECTS ABOUT?

Postnatal nurse home visits to:

Connect with *every* mother (and father) at birth (2-3 weeks)

- Share the joy of the birth!
- Assess *unique* family risks (and needs) - not every family has the same strengths, risks, and needs.
- Respond to immediate family needs, such as feeding, weight gain, sleep, parenting stress, and so forth.
- Assess and address family needs related to a priori identified social determinants of health outcomes.

Connect family with *matched* local community services and resources based on *individually identified risk and need*.

FAMILY CONNECTS
NURSE HOME VISITS

WHAT IS THE CENTRAL AIM OF FAMILY CONNECTS?

The program is designed for community-level change, including:

- Provide early and meaningful linkages into the local system of care
  - Based on need and choice
  - Rather than on broad demographic risk factors
  - To promote:
    - Child and parent health and well being
    - Reduced rates of child maltreatment
    - Secure relationships with medical homes

FAMILY CONNECTS
NURSE HOME VISITS

HOW IS COMMUNITY LEVEL CHANGE ACHIEVED?

- Every family in the identified “community” with a newborn is eligible.
  - City, county, neighborhood, health system
- Family Connects is voluntary.
- Family Connects works to align community resources using family input about what services in the local system of care they need and choose.
- The model also leads to identification of gaps in the local system of care.

FAMILY CONNECTS
NURSE HOME VISITS

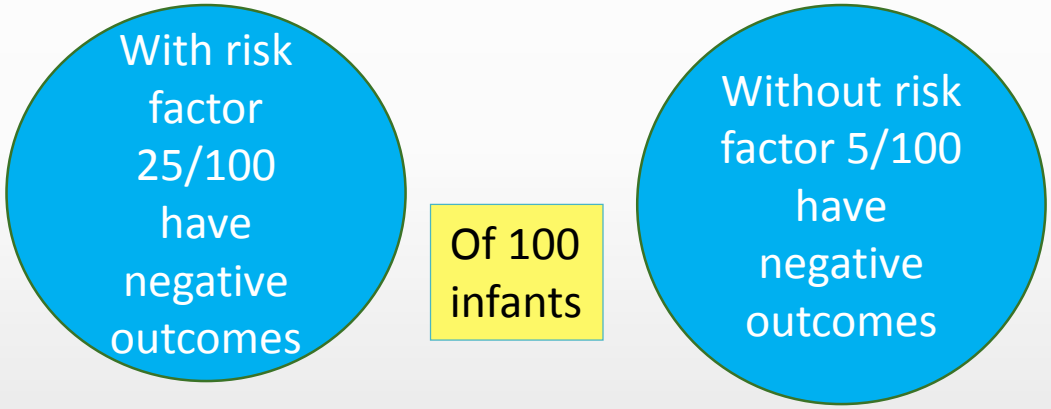
WHY IS THE PROGRAM UNIVERSAL?

- A public health approach is needed for community-level change.
  - Systematic and individualized linkages with community resources and services for all families
  - Unlike programs that target families by demographic features
  - So, families get what they need and want, no more and no less.
  - And there is no stigma for accepting services when everyone is eligible.
- Family Connects is the first step into the community's system of care for children and families…
- For which interventions with social determinants are key

FAMILY CONNECTS
NURSE HOME VISITS

WHY ARE SOCIAL DETERMINANTS SO CRITCIAL AN OPPORTUNITY FOR HOME VISITING MODELS?

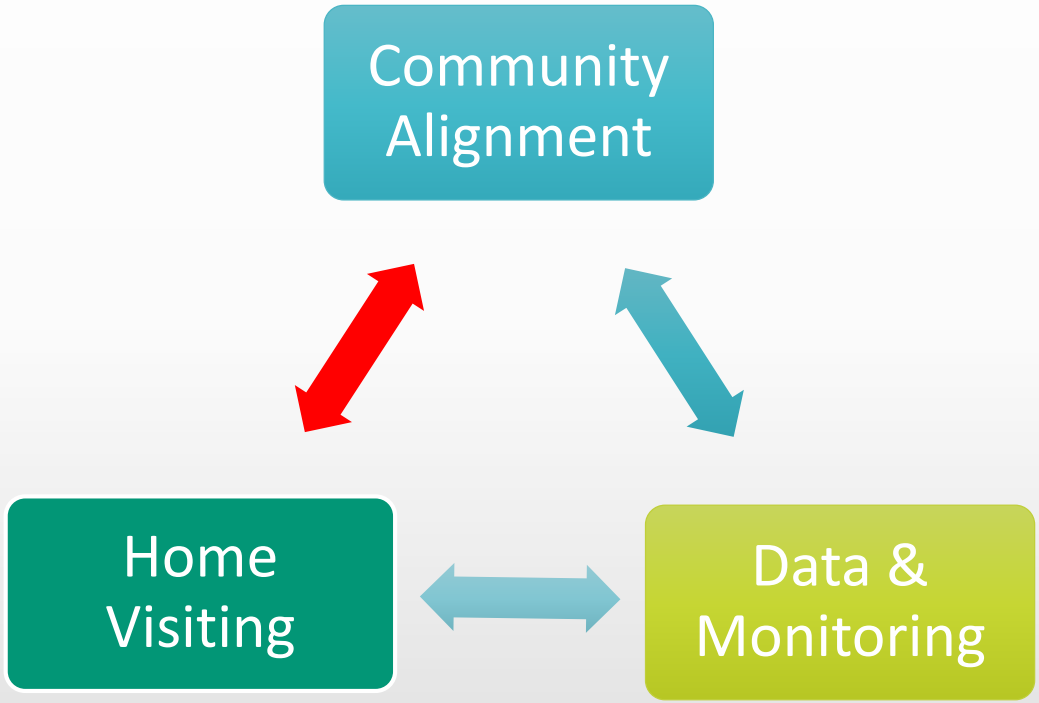
Economic and social conditions influence health.
Yet, the assessment of risks is not enough; many with risk from SD do just fine…
What accounts for the variability in outcomes?



So, explain the variability... Most with risk factor do not have negative outcome
- Resilience
- Protective factors

Home visitng models have the potential of narrowing the gap (look at the evidence base of our HV models!)

FAMILY CONNECTS: PROGRAM COMPONENTS



THE (INITIAL) INTEGRATED HOME VISIT

- Occurs at 2-3 weeks postpartum, approximately 2 hours
- **Use of Family Support Matrix assessment tool: 12 domains of family risk and need**
- Physical assessments: Postpartum and newborn
- Responses to immediate parents questions and concerns
- Supportive and anticipatory guidance
- **Discussion of and linkages to community resources**
- Follows a detailed protocol presented in a friendly and informal manner (high inference methodology)
- Follow up to assess linkages with resources

FAMILY CONNECTS
NURSE HOME VISITS

THE FAMILY SUPPORT MATRIX

FAMILY CONNECTS

	SUPPORT FOR HEALTH CARE			SUPPORT FOR CARING FOR INFANT		
	Maternal Health	**Infant Health**	**Health Care Plans**	**Child Care Plans**	**Parent-Child Relationship**	**Management of Infant Crying**
GOAL	*Mother is recovering from delivery; in good health, able to care for infant. Plans for family planning are in place.*	*Infant born at or near term and is in good health. Lactation support in place as needed.*	*Health care for infant and mother is planned and scheduled, and adequate health insurance is in place. Medical home established.*	*Parent(s) has childcare plans, including emergency and respite care with plans for day care, if needed.*	*Parent(s) and infant are growing into a positive and responsive relationship with knowledge about development.*	*Parent(s) describes infant crying as normal, meaningful, and has appropriate planned responses. Parent expects increases in infant crying at appropriate ages.*
No concerns, no immediate needs.	1- Mother is recovering as expected with few concerns.	1- Infant health good. Weight gain and feeding within expectations for age.	1- PCP identified for infant and mother, infant's first visit completed and next scheduled. Postpartum visit completed or scheduled.	1- Parent identifies care for each day when needed, emergency, and planned respite.	1- Parent understands infant's needs, is responsive to different infant signals and provides appropriate stimulation.	1- Parent sees infant crying as normal and responds accordingly. May find cry difficult at times but has strategies for coping.
Some needs for family well being in this factor, addressed during 1st home visit.	2- Mother has minor health issues but not expected to affect parenting. Guidance and/ or resources given during visit.	2- Minor infant health concerns (e.g., feeding, oral and skin care); educate and/or recommend resources.	2- Uncertainty about medical home, regular care, or insurance. Guidance and/or resources shared and plan in place during visit.	2- Care plan for 3 areas not in place, but adequate plan developed and/or resources suggested. Need for plans acknowledged.	2- Parent is not always understanding of infant cues and is perplexed or frustrated. Provided support and resources.	2- Parent is concerned about crying and needs reassurance; developed coping plan during visit. Parent does not ascribe negative intentionality to crying.
Significant family concerns and needs in this factor. Resources and follow up needed.	3- Mother's health presents a concern for infant and family. Follow up with visit and referral to health resource, as needed.	3- Infant has health concerns. Requires follow up visit with link to health care provider, lactation support, or other community resources.	3- Uncertainty about medical home, need, or plan. Follow up to ensure link to health care providers.	3- Care plan for all 3 areas needed but not in place, even following discussion. Follow up and/or referral.	3- Parent not aware of needs or unable to be responsive to various infant signals. Follow up with visit and/or referral.	3- Parent is unable to cope with crying without external intervention and/or views negative intentions from infant. Follow up and/or referral.
This is an emergency situation for family risk and needs.	4- Mother's health risk for self/ infant care immediate. Urgent follow up necessary.	4- Child has health or developmental problems requiring immediate care.	4- Failure to provide for primary care for infant. Need immediate intervention.	4- Emergency child care problem. Contact DSS or other emergency resource.	4- Parent at risk of neglecting or harming the child. Call CPS.	4- Crying is difficult for parent and parent at risk of neglecting or harming child. Call CPS.
	SUPPORT FOR A SAFE HOME			**SUPPORT FOR PARENT(S)**		
	Household Safety/Material Supports	**Family and Community Safety**	**History with Parenting Difficulties**	**Parent Well Being**	**Substance Abuse**	**Parent Emotional Support**
GOAL	*Family has resources for basic needs, including safety measures (crib, alarms, etc.) No environmental concerns.*	*Family experiences safety and security in family and in neighborhood.*	*Parent has no apparent historical vulnerability for child maltreatment.*	*Parent(s) mental health adequate for meeting parenting demands.*	*Parent and family show no drug using/seeking in household; no concerns about alcohol use that could interfere with parenting.*	*Parent has emotional, practical, and social support for parenting.*
No concerns, no immediate needs.	1. Finances and environment adequate for food, shelter, transport, and equipment for infant care.	1. No concerns about potential violence. Parent reports feeling safe for infant and family.	1. No known history of maltreatment as a child or parenting difficulties with own children.	1. Parent mental health is sound. No anxiety or depression in excess of normal adjustment.	1. Parent denies use now or in past and interviewer has no reason for concern.	1. Parent names other person(s) who provide emotional, practical, and social support for parenting.
Some needs for family well being in this factor, addressed during 1st home visit.	2. Financial, safety & material resources limited or under-utilized. Guidance and/or resources recommended.	2. Mild concerns. Issues discussed and resource information about emergency services offered and provided.	2. Parent history of mal-treatment as a child or having CPS report as a parent with good resolution. Resources recommended.	2. Some concern is present and discussed supportively during visit. Resources recommended if continued concerns.	2. Possible past history but current use is denied. Discussion with suggested resources if need occurs.	2. Parent initially lacking in support, but develops plan for seeking support during visit.
Family concerns and needs in this factor. Resources and follow up needed.	3. Financial and material resources inadequate or environmental concerns. Follow up and/or refer for support needed.	3. Concerns about safety in the home or neighborhood. Follow up and/or refer to appropriate resources.	3. Recent CPS involvement and/or ongoing concerns. Follow up and refer to appropriate resources.	3. Parent screens positive for anxiety or depression. Follow up and refer to local services/resources.	3. Substance use is a concern by parent and/or visitor. Follow up and/or refer to treatment.	3. Parent lacking in support, which presents risk for family well being. Follow up and/or refer to parenting support resources.
This is an emergency situation for family risk and needs.	4. Family status is urgent. Immediately contact DSS field worker or other contact.	4. Serious immediate concerns about safety. Call police or CPS as appropriate.	4. Concerns related to ongoing CPS investigation. Current suspicion always reported to CPS.	4. Urgent need for mental health services. Contact emergency services.	4. Substance abuse a major issue. Contact CPS and provide access to treatment.	4. Isolation creates risk for infant. Re-visit, institute emergency services, CPS, police, as needed.
Rate general impression of family status and/or needs						
1. No concerns	2. Concerns addressed in visit.	3. Serious needs requiring follow up and/or referral.	4. Urgent needs	Revised 8/25/14		

Domains and Factors of Interest: Family Support Matrix (FSM) + Social Determinants as Assessed

Support for Health Care

1. Maternal Health
2. Infant Health
3. Health Care Plans

Support for a Safe Home

7. Household Safety/Material Supports
   - **SOCIAL GRADIENT**
   - **FOOD**
   - **TRANSPORTATION**
8. Family and Community Safety
9. History with Parenting Difficulties
   - **EARLY LIFE ADVERSITY**

Support for Infant Care

4. Child Care Plans
5. Parent-Child Relationship
6. Management of Crying

Support for Parent(s)

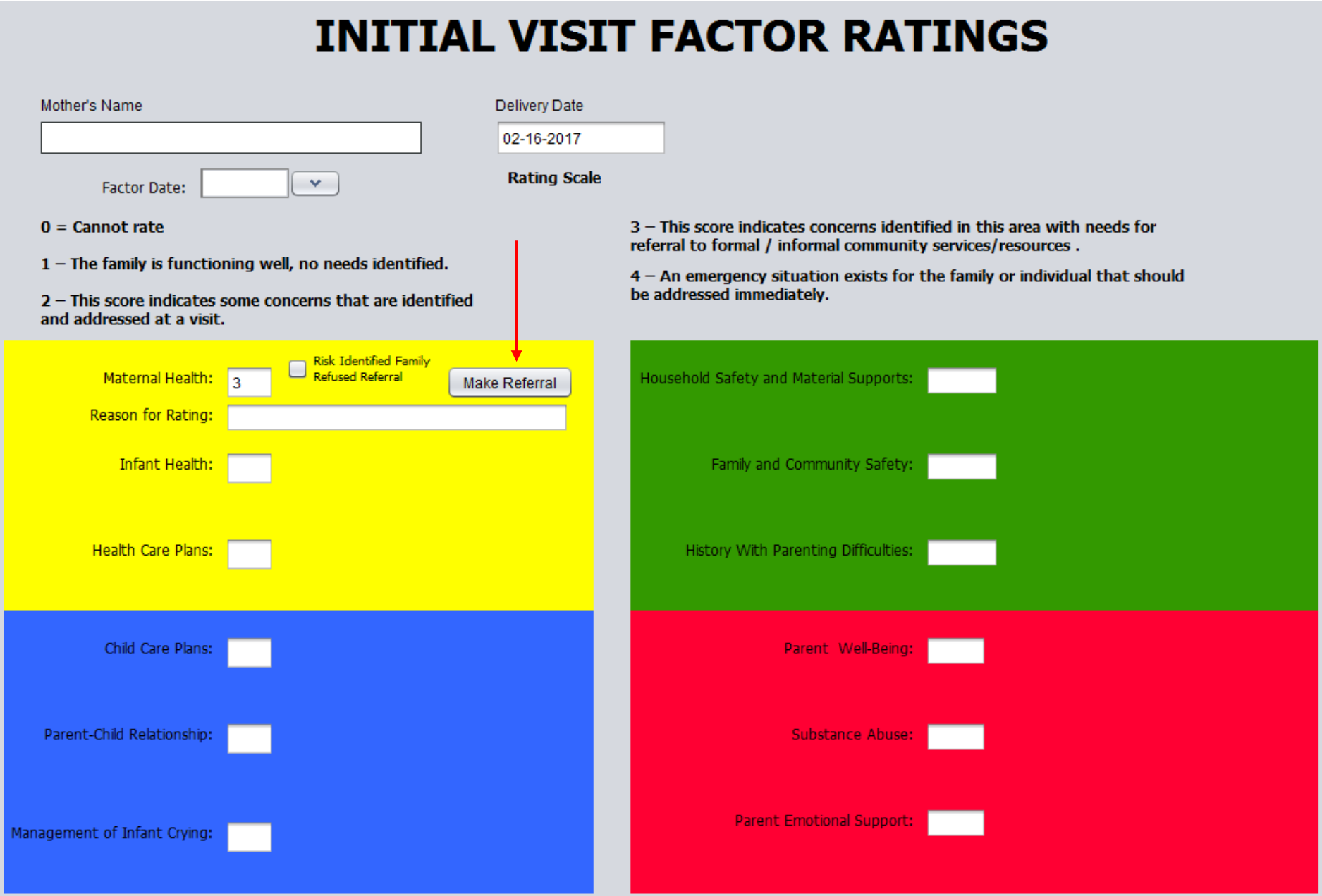
10. Parent Well Being
11. Substance Abuse in Household
    - **ADDICTION**
12. Parent Emotional Support
    - **STRESS**
    - **SOCIAL EXCLUSION/ISOLATION**
    - **SOCIAL SUPPORT**

Each factor is rated as:

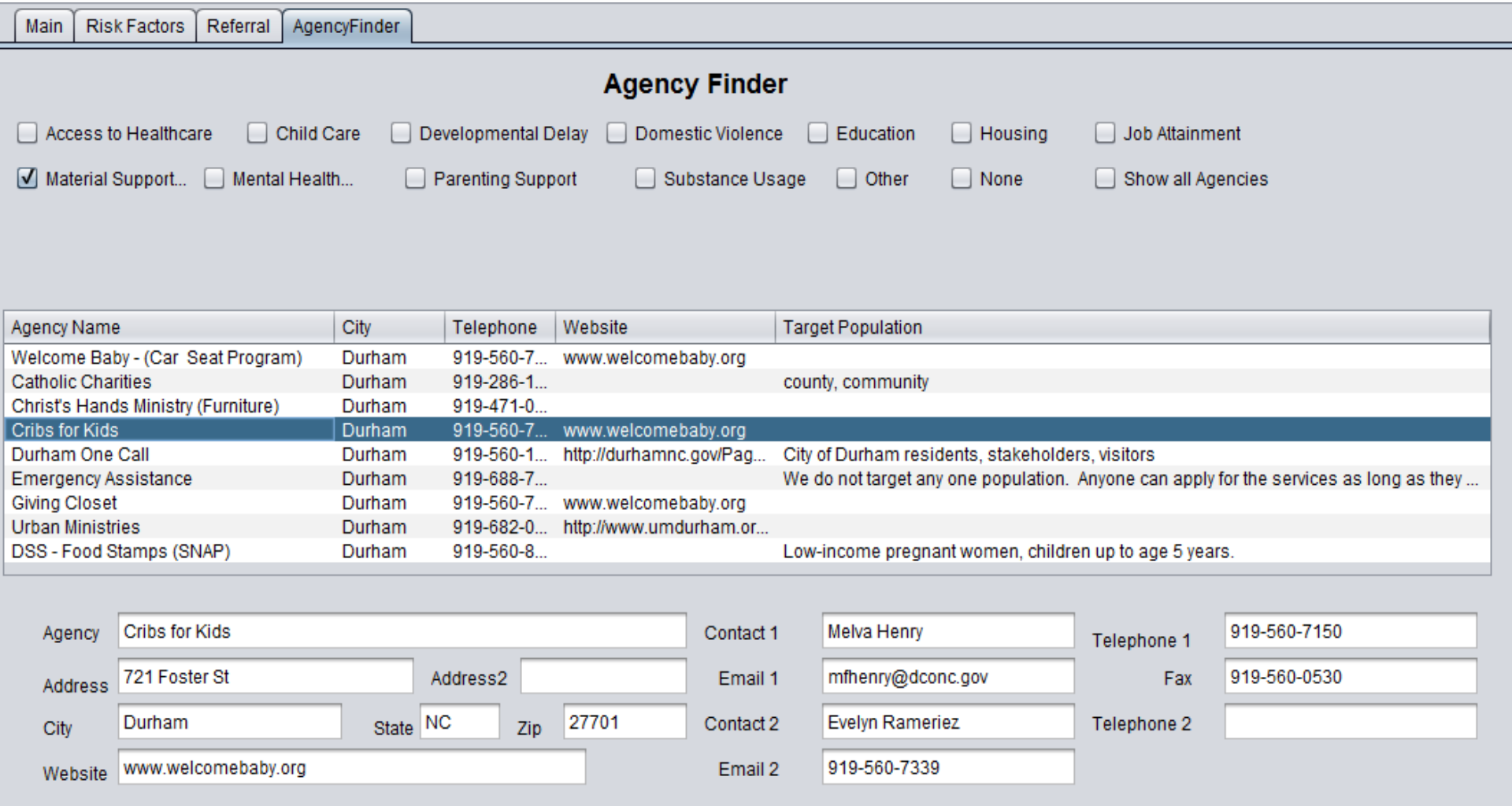
1 = No family needs
2 = Needs addressed during visit
3 = Community resources needed
4= Emergency intervention needed

FAMILY CONNECTS
NURSE HOME VISITS

When a factor is scored as a “3” the “make a referral” button appears. Clicking this button takes you to the screen on slide 2.



The agency finder includes a searchable directory of all community agencies. You can sort by clicking on the relevant risk domain. Selecting an individual agency pulls up contact information.



TALK TO US

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SEE PROGRAM HANDOUT

FAMILY CONNECTS
NURSE HOME VISITS

Healthy Families America®

Home Visiting to Address Social Determinants of Health

SERVING FAMILIES FOR 25 YEARS

Kathleen Strader, MSW, IMH-E® (IV)
National Director, HFA Implementation and Accreditation

HFA Vision and Goals

All children will receive nurturing care from their family, increasing their potential to lead a healthy and productive life.

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth.
- Cultivate and strengthen nurturing parent-child relationships.
- Promote healthy childhood growth and development.
- Enhance family functioning by reducing risk and building protective factors.

Healthy Families America®

SERVING FAMILIES FOR 25 YEARS

HFA: Four Key Principles

* 1. Every family receives a comprehensive psycho-social assessment
* 2. Emphasize relationship and attachment
* 3. Utilize trauma-informed practice
* 4. Build reflective capacity

Grounded in attachment theory and using an infant mental health approach, HFA believes that early, nurturing relationships lay the foundation for lifelong healthy development

Healthy Families America®

SERVING FAMILIES FOR 25 YEARS

Comprehensive Assessment

Relationship & Attachment


Trauma-Informed
Practice


Reflective
Capacity

HFA Impact on Social Determinants

- **Socio-economic circumstances – education, poverty**
- **Stress – lack of control over life, insecurity, low self-esteem**
- **Early Life – prenatal environment, insecure attachment, poor stimulation**
- **Social exclusion – minority groups, disabled, refugees, homeless**
- Work – job satisfaction
- Unemployment
- **Social Support – trusting relationships, emotional connections**
- **Addiction – drug, alcohol and tobacco use**
- Food – accessibility and quality
- Transportation – safe, physical outlets to get from place to place

Socio-Economic Circumstances

*moms are 5 times more likely to be in school; 35.2% vs. 6.8% of moms in school (AZ)

* kids show improved school performance in 1st grade (NY) 3.5% of children enrolled in HFA are likely to be retained in the first grade, versus 7.1% in the control group

13.2% of children enrolled in HFA are likely to participate in gifted programs, versus 7.7% in the control group

Stress

Compared to control families, HFA parents:

* showed reduced maternal depression rates in 2 years by nearly twice as much compared to control group
* showed stronger parenting efficacy (*AK*, *HI2*)
* had reduced parenting stress levels (*MA2-*
* had more positive perspectives on their parenting roles and responsibilities (*GA*, *HI1*, *NY2*)

Early Environment

* 88% fewer acts of serious abuse through age 7 compared to control group
* 48% reduction in Low Birth Weight
* 22% reduction in birth complications
* 26% increased well-child visits

* Increased breastfeeding

HFA improves parents' access to health care for their child by helping them:

* obtain insurance coverage
* establish a medical home for routine and preventive health care needs

HFA shows significant impacts on parent-child interaction in numerous studies. A rigorous study showed significant improvements at two years on overall PCI scores while scores for control families declined

Social Exclusion

5-6 year follow-up shows reduced homelessness. Mothers in HFA (28%) vs referral and information group (41%) experienced homelessness (MA)

Social Support

Quasi-experimental study found positive impact on mom's perceived support (WI)

Addiction

41% reduction in alcohol dependency compared to control group (AZ)

Child First

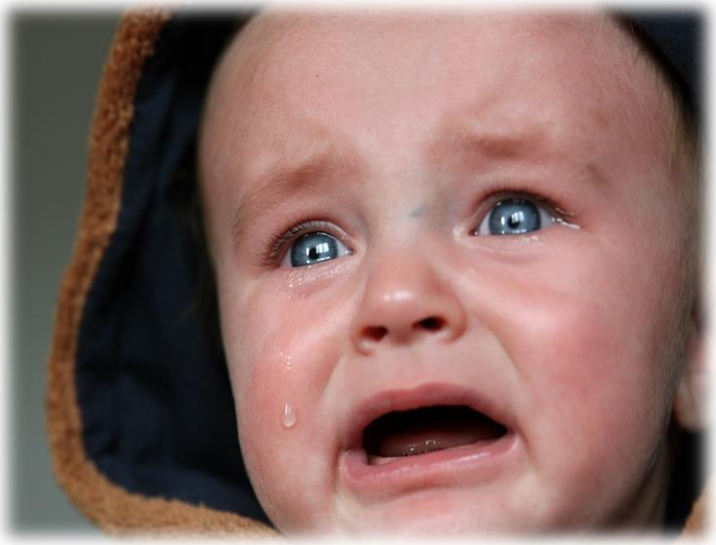
Darcy Lowell, MD
Founder and CEO

February 1, 2018

Child First Mission

Intervene with the most vulnerable young children and families at the earliest possible time to prevent and heal the effects of trauma and adversity

Child First Goals



1) Promote child and parent mental health
2) Promote child development and learning
3) Enhance parent and child executive capacity
4) Prevent child abuse and neglect

Serving the Most Vulnerable

A Two Generation Intervention

Children

- Prenatal to age 6 years
- Emotional/behavioral and developmental problems, abuse and neglect

Caregivers

Parents facing multiple challenges

Extreme poverty

Domestic/Community violence

Parental mental health issues

Health and dental issues

Poor quality child care

Incarceration

Substance abuse

Homelessness

Illiteracy & lack of education

Lack of basic needs

Trauma

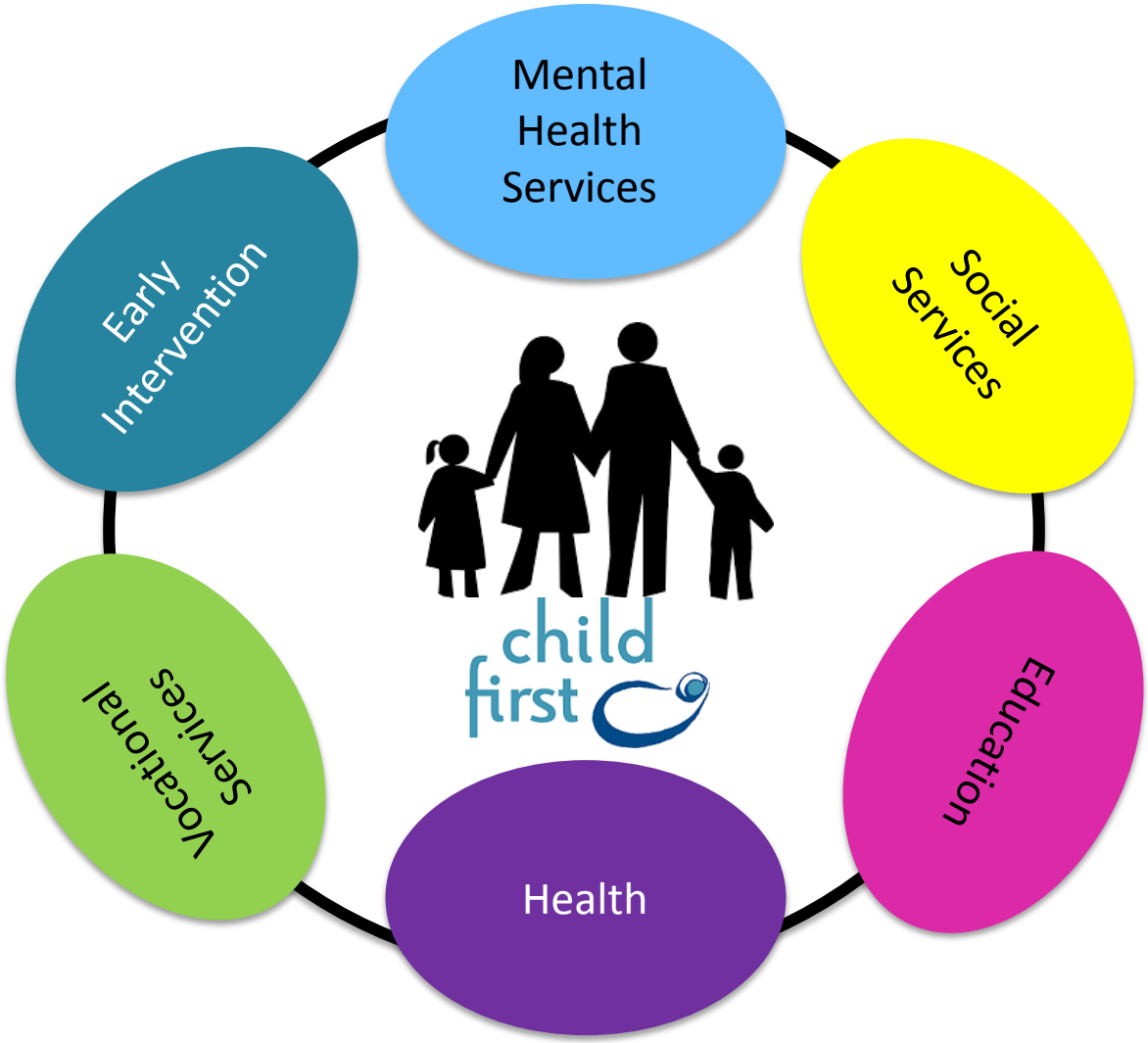
Unemployment

Isolation & lack of social supports

Teen and single parenthood

child first

Early Childhood System of Care



Community Collaboration

- Health: Pediatric primary care, Obstetrics, specialists
- Early care and education, child care
- Schools
- Child protective services
- Other child mental health providers
- Other home visiting models
- Early intervention (IDEA Part C)
- Family support and resource centers
- Shelters and housing
- Adult education, job training, literacy
- Adult mental health and substance abuse
- DV services
- Court system
- Faith-based community

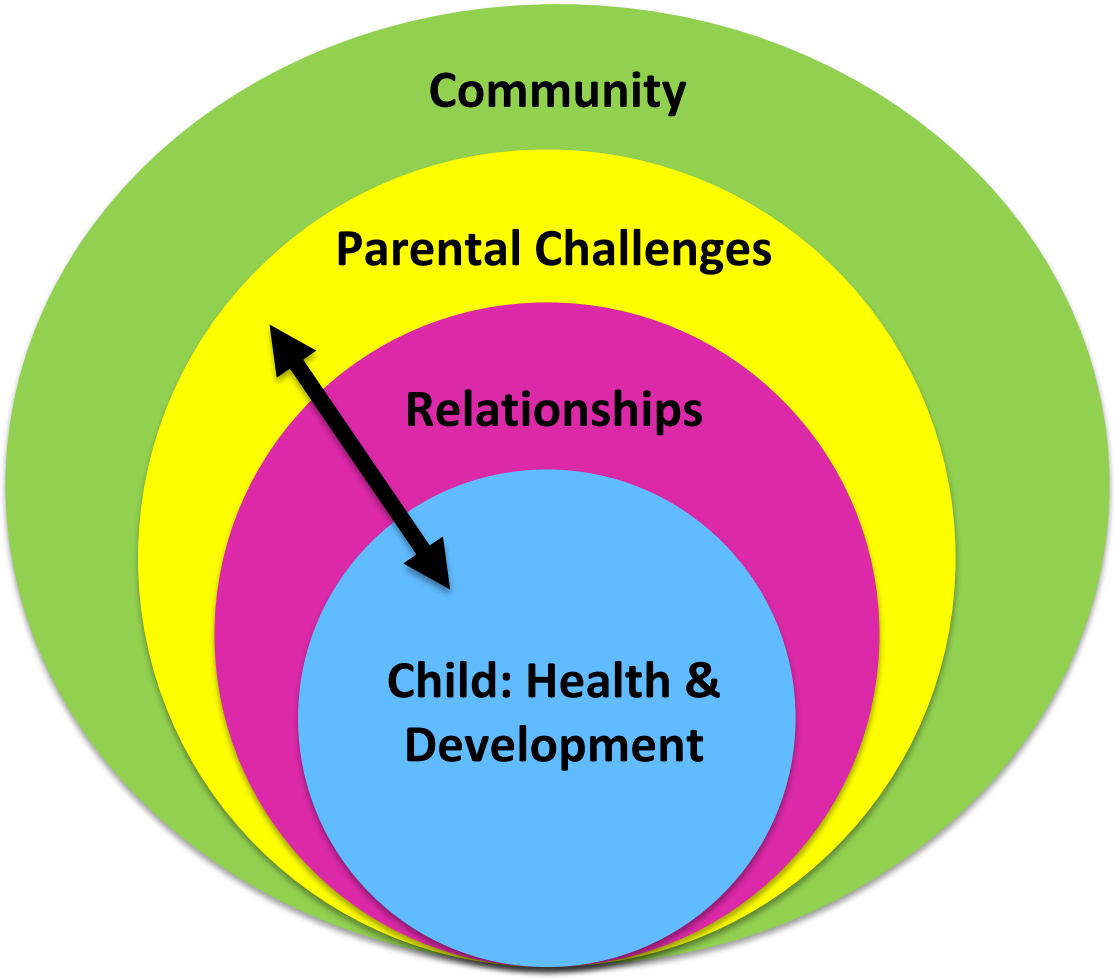
Parent Questionnaire

- Screen for social determinants of health
- Any community setting: Pediatrics, early care and education, early intervention, etc.
- Identifies potentially high risk families that need further conversation and follow-up
- Provides global picture of areas of parental worry and concern

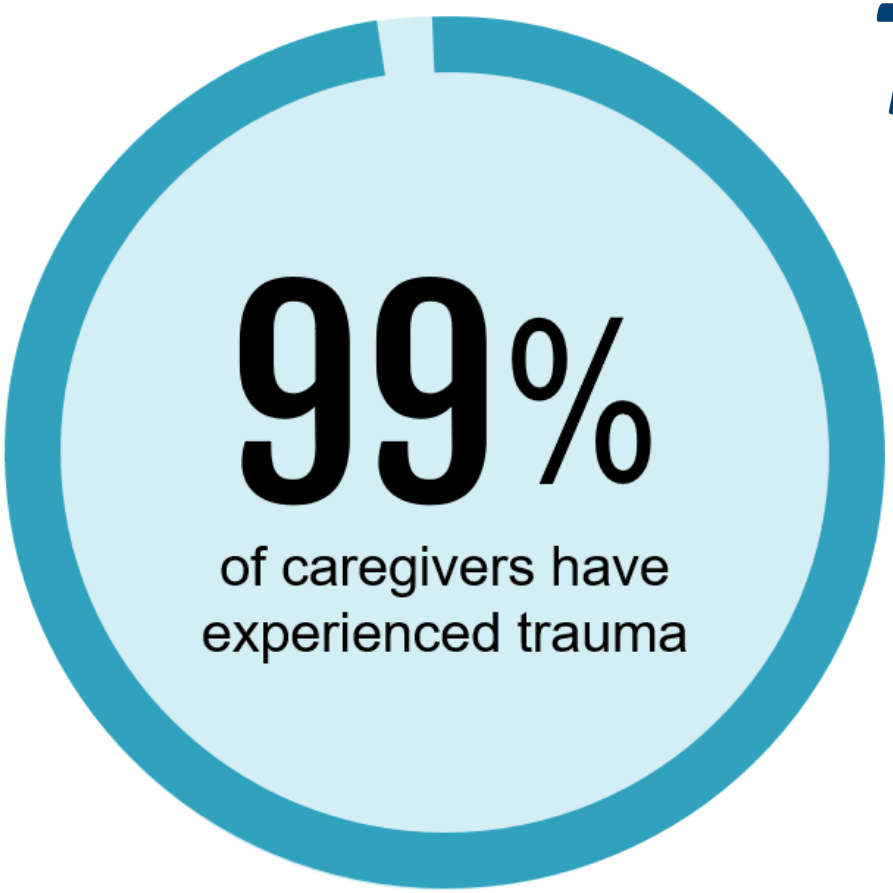
Parent Questionnaire
STRESSORS

- Child's development ..... ➢ 51%
- Child's emotions and behavior..... ➢ 75%
- Depression..... ➢ 59%
- Homelessness..... ➢ 31%
- Single or teen parent..... ➢ 54%
- Domestic violence..... ➢ 32%
- Substance abuse..... ➢ 52%
- Incarceration..... ➢ 39%
- Child welfare – abuse or neglect..... ➢ 63%
- Trauma in parent's childhood..... ➢ 58%

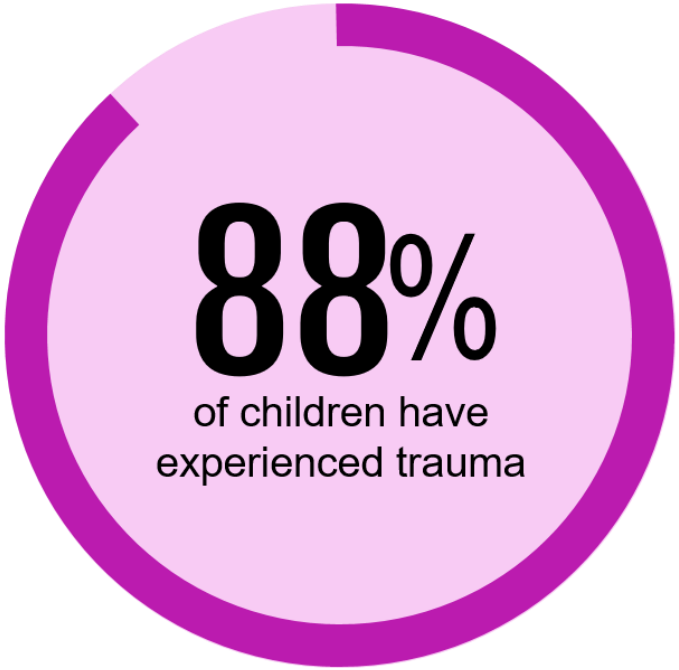
Ecological Approach



Trauma



Parents

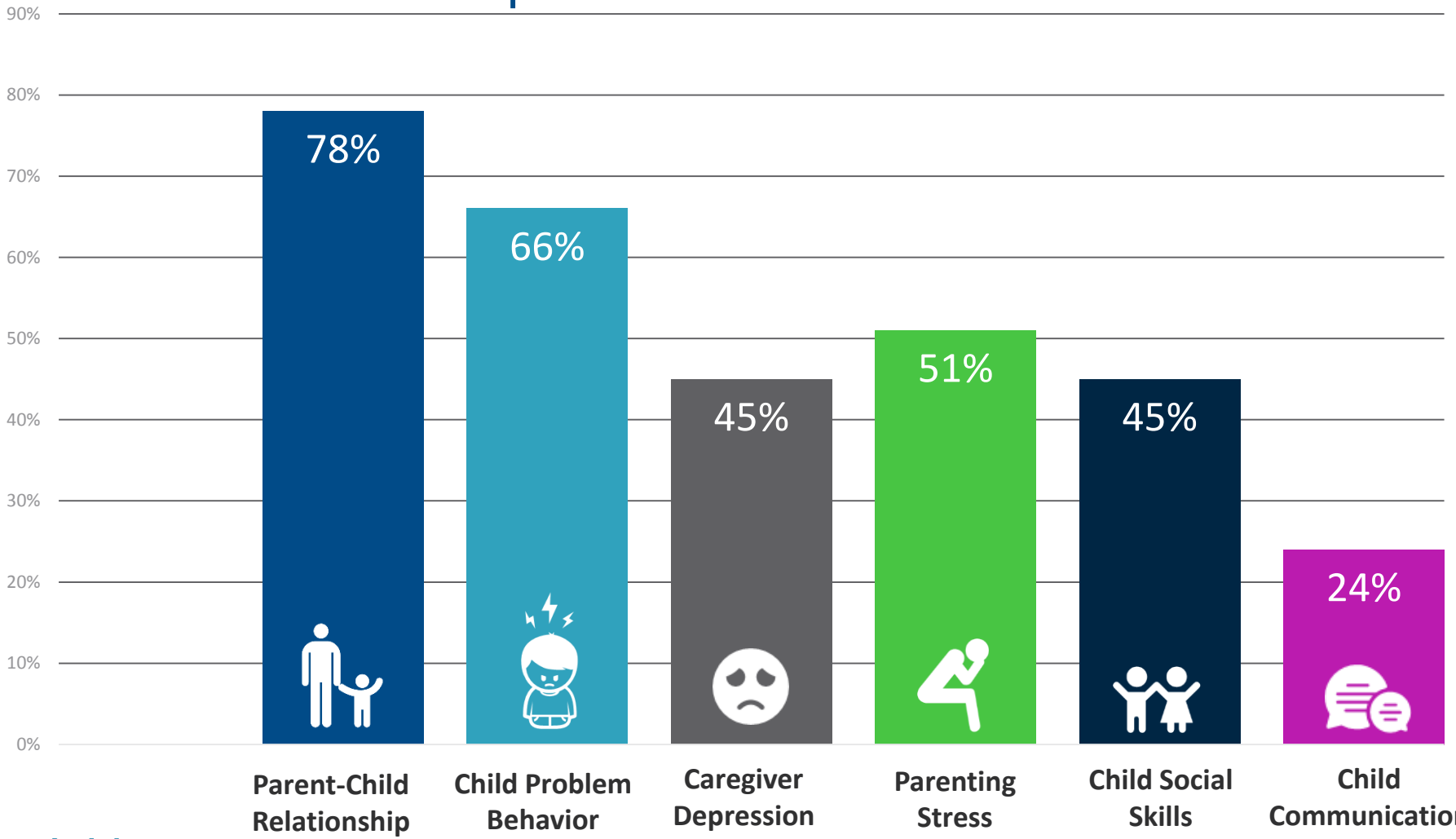


Children

*Data from past year (2016-2017)

Prevalence of Problems

Reported at Baseline



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Child First Team Intervention

1

Care Coordinators decrease toxic psychosocial stress by connecting children and families to needed services and supports.

2

Mental Health - Developmental Clinicians facilitate responsive, nurturing parent-child relationships that can protect developing brains.

Home-based Intervention

- Engagement and trust building
- Family stabilization
- Comprehensive assessment
- Child and Family Plan of Care
- Child-Parent Psychotherapy
- Build executive functioning
- Mental health classroom consultation
- Comprehensive community-based services and supports

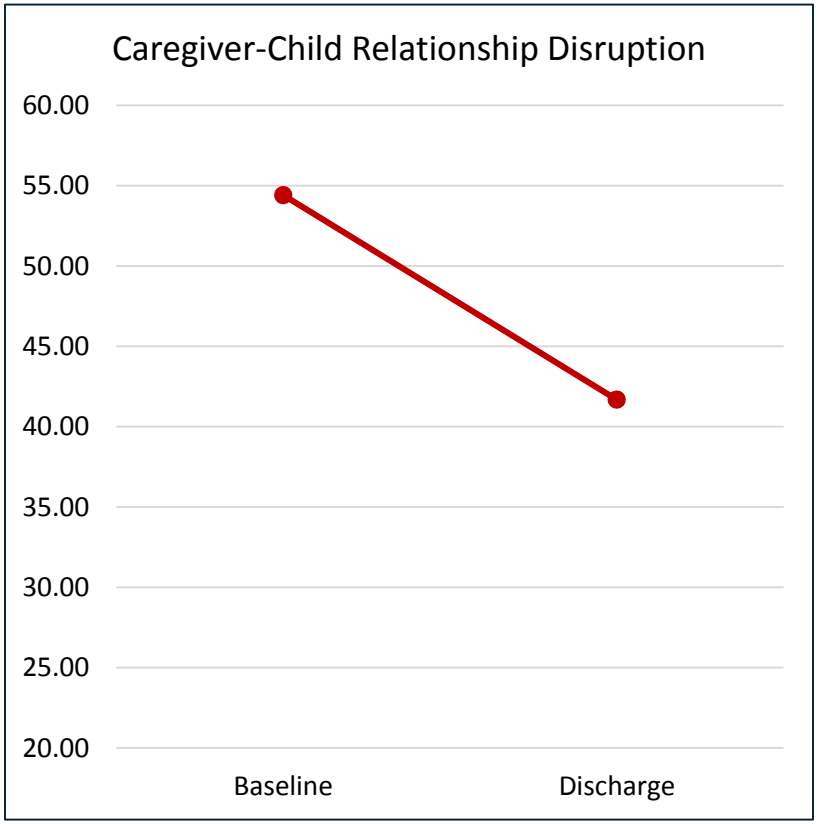
Child-Parent Psychotherapy

- Heal the damage caused by trauma and adversity for both the child and parent
  - Develop deep understanding of both child and parent trauma histories, and how the past plays out in the present
- Help parents reflect upon and understand the meaning of their children's behavior
- Help parents regulate and express their emotions
- Develop protective, nurturing, caregiving relationships
  - Foster attunement, safety, and delight in the relationships between parents and children
  - Promote secure attachment

Parent-Child Relationship

CCIS

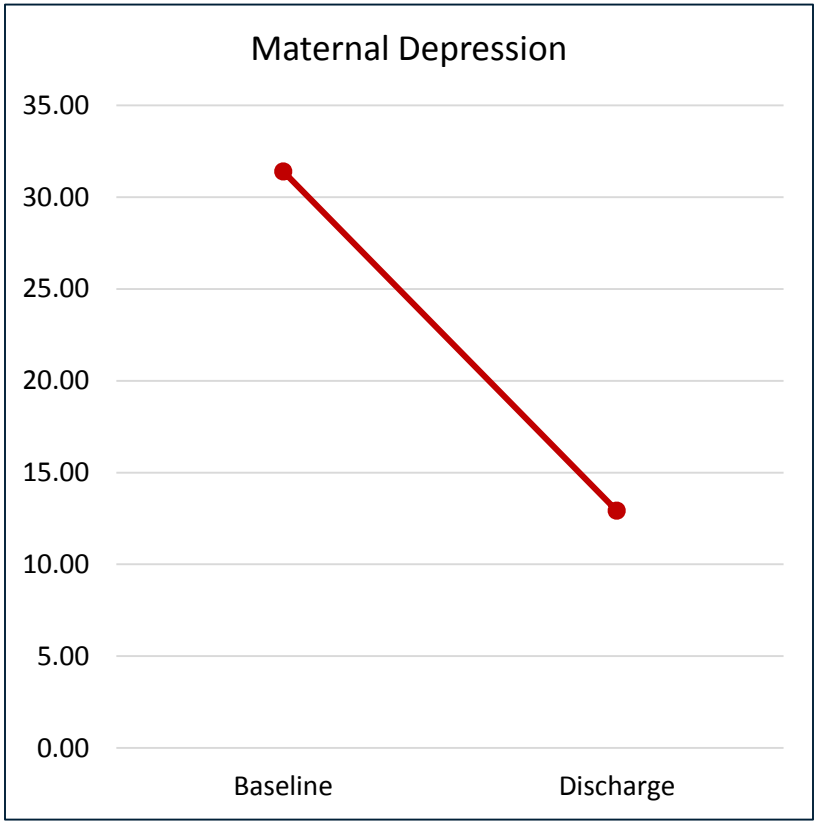
- Problems in the parent-child relationship showed strong improvement from baseline to discharge.
- Statistical significance: p<.0001
- Effect size: Cohen's d=0.9427



Maternal Depression

Center for Epidemiology Scale-Depression-Revised (CESD-R)

- Mothers that presented with depression at baseline showed strong improvement.
- Statistical significance: p<.0001
- Effect size: Cohen's d=1.7675



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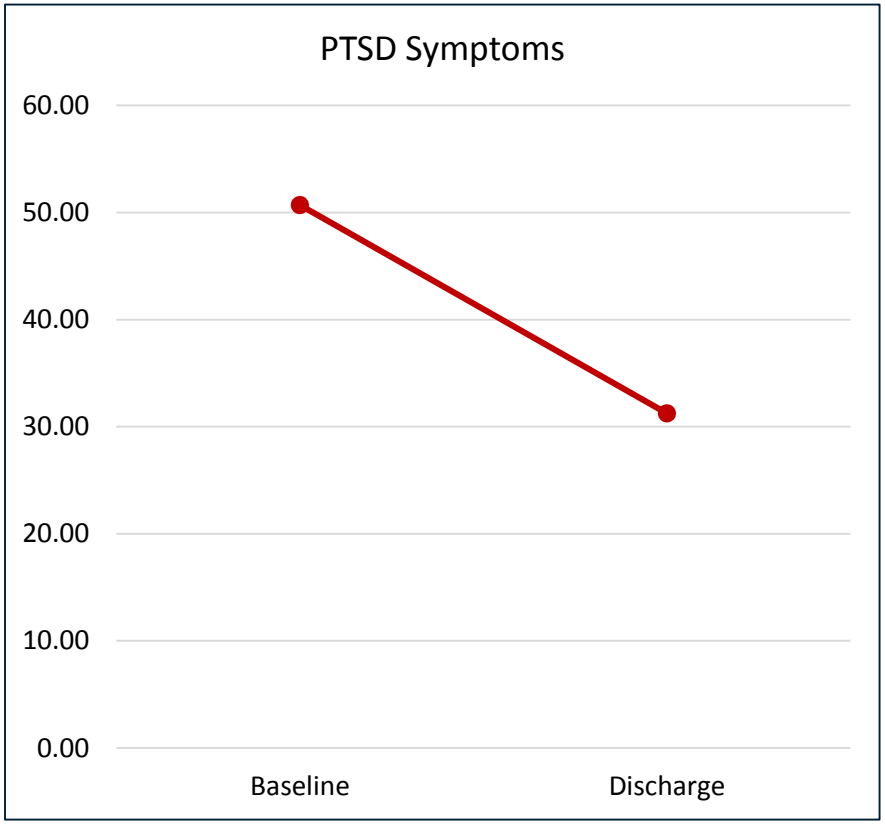
Post Traumatic Stress Disorder

PTSD Checklist – Civilian Version (PCL-C)

- Caregivers that presented with PTSD symptoms at baseline showed strong improvement.
- Statistical significance: $p<0.0001$
- Effect size: Cohen's d=1.4506



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Connection to Comprehensive Services

- **HOW** this is accomplished is critical
- Parents are often very wary, afraid, distrustful
- Care coordinators must be:
  - Highly reflective
  - Non-judgmental and respectful
  - Build trusting relationships
- Parents' priorities and goals must be primary
- Build executive functioning capacity

Connection to Services

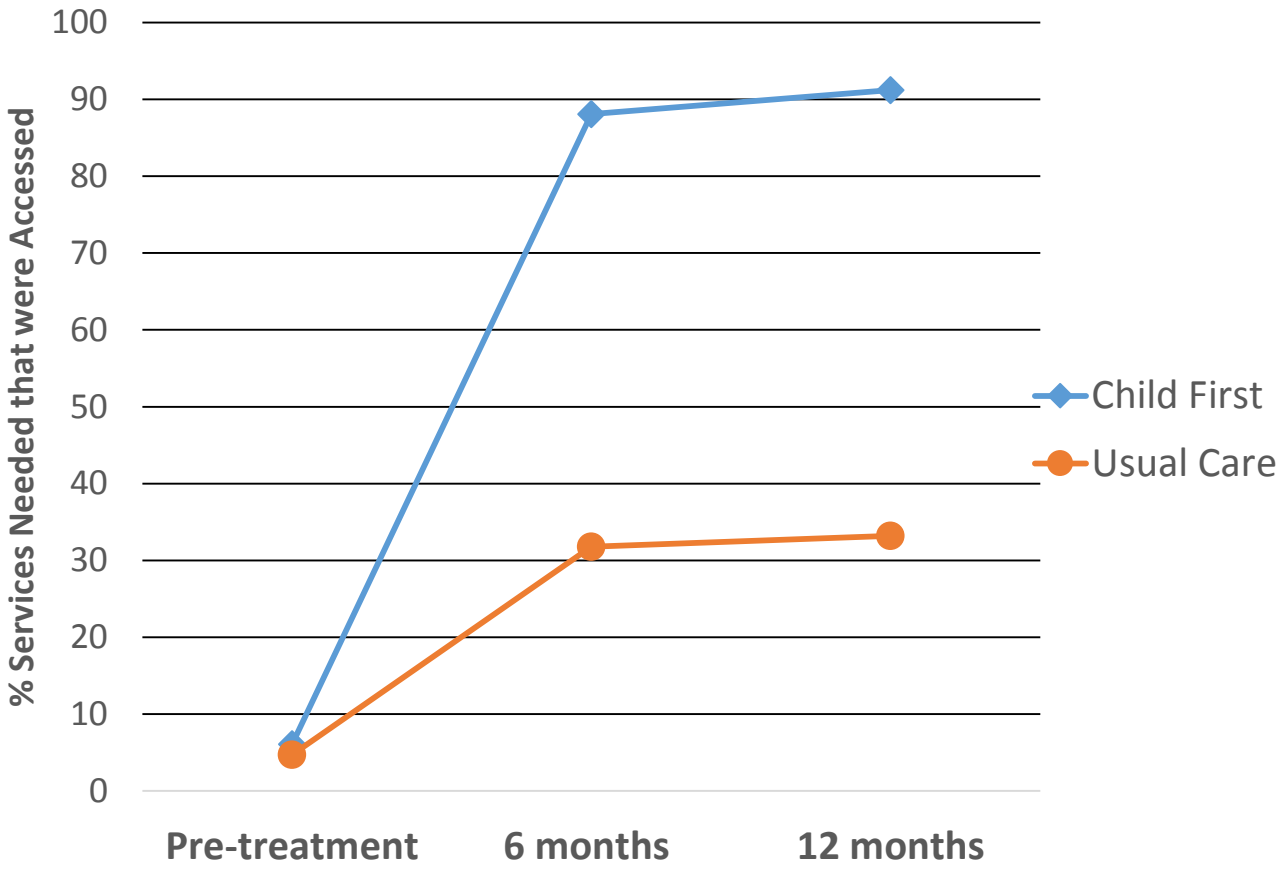
- Primary or specialty pediatric care
- Early care and education
- Early intervention – IDEA Part C
- Special education
- Child mental health
- Parenting groups
- Family Resource Centers
- Parent mentors and aides
- Adult mental health
- Substance abuse treatment
- Adult health care
- Legal aide
- Domestic violence services
- Housing / shelters
- Job training
- Computer training
- Clothing and furniture
- Transportation
- Food stamps / SNAP
- Food banks
- Medicaid
- GED
- Literacy
- ESL
- WIC
- TANF
- SSI
- CSHCN

Access to Services (RCT Data)

92% Child First

versus

33% Usual Care



Opportunity to Address SDOH!

- SDOH are a powerful influence on the health and well-being of the children that we serve
- The great majority of our home visiting models address these through both through a combination of building relationships and connection to services and supports
- Working collaboratively, we can make a profound difference in the lives of vulnerable children and families

Thank you!

Darcy Lowell, MD
Founder and CEO
dlowell@childfirst.org

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What additional strategies have you found success in addressing SDOH?

Thank you!

Darcy Lowell, Child First

Karen O'Donnell, Family Connects

Kathleen Strader, Healthy Families America