Vermont Oxford Network Potentially Better Practices for Follow Through

Dear Colleagues,

We can all be proud of the advances in neonatal care that have resulted in dramatic improvements in mortality and short-term morbidities for high-risk infants. But the long-term health and well-being of these infants and their families also depend on their wealth, income, immigration status, the color of their skin and where they live. Our challenge is to provide the highest quality care in the hospital and to "follow through", accepting that our responsibility extends beyond the hospital walls by addressing these social determinants of health. We must learn to practice social as well as technical medicine.

Accepting this responsibility and acting upon it can be daunting even in normal times. These are not normal times. A pandemic rages. Millions have been infected; hundreds of thousands have died. Minorities, the poor, and those in living in disadvantaged neighborhoods with already insufficient access to medical and social services are at the greatest danger. Sparked by horrific killings of African Americans at the hands of police, people around the world are courageously protesting to end the racism which is the root cause of racial and ethnic disparities in health. Following through for patients and families is more important than ever.

The Potentially Better Practices for Follow Through from Vermont Oxford Network are intended as a starting point for individuals and teams that are ready to "follow through". Find something on the list that makes sense for your neonatal unit. Adapt a change idea to work in your local context. Test it. Start small. If others on your team are not ready, find a change you can make as an individual.

Add your voice to those around the world crying out for social justice by following through.

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I. Promote a culture of equity

1. Provide training and education in the social determinants of health to staff[1,2]
2. Provide cultural sensitivity training to staff[3–7]
3. Acknowledge and manage implicit and explicit personal bias[8–14]
4. Promote a culture of equity[15–17]
5. Create a disparities dashboard[18–20]
6. Create a culture committed to follow through[18,21]

II. Identify social risks of families and provide interventions to prevent and mitigate those risks

7. Screen all families for social risks and social support using a standardized tool[22–29]
8. Use electronic health records to identify patterns and inform clinical decisions[27,30–32]
9. Include a social worker or other social health professional on the team[33,34]
10. Create alliances with community organizations (clinical-community partnerships)[35–44]
11. Include a paralegal or attorney on the team[45–47]
12. Provide parenting and family support tailored to individual family strengths and needs[48–51]
13. Provide mental health services for families during the hospital stay[52–57]
14. Provide referrals for drugs, alcohol, and smoking cessation counselling and treatment[58–63]
15. Provide housing, meals, and transportation vouchers for families[64–70]
16. Provide back to sleep education[71–80]
17. Provide sibling care for families[81,82]
18. Practice family integrated care tailored to the capabilities and needs of families[51,83–85]
19. Provide trauma-informed care[51,86,87]
20. Provide lactation support using peer counsellors and other approaches[88–99]
21. Assess eligibility for SSI, WIC, early intervention, and other public benefits[100–103]
22. Provide language support and culturally appropriate translation services for families[104–107]

II A. Take action to assist to families after discharge (transition to home)

23. Provide discharge education and planning tailored to each family's needs[51,106,108–112]
24. Begin discharge planning and teaching at admission[113]
25. Estimate discharge date at admission and revise regularly during the stay[114–116]
26. Implement a medical home model for patients and families[117–121]
27. Establish effective communications with the primary care provider[121]
28. Create a health coach program[122]
29. Connect families with appropriate community organizations and services[18,103,123–127]
30. Screen for developmental risk[128]

31. Provide high risk infant follow up[128–135]
32. Conduct home visits before discharge and at intervals after discharge[51,136–142]
33. Facilitate parent support groups and peer counselling that extend beyond the stay[88,98]
34. Implement strategies to identify and minimize risk for readmission[143–149]
35. Provide telehealth support after discharge[150–155]
36. Use technology and social media to support families[156–165]
37. Facilitate access to all necessary clinical specialists after discharge[121,134]
38. Provide reminders to facilitate health behaviors and keeping of appointments[79,166–169]
39. Provide mental health and addiction services for families after the stay[54,57,170]
40. Provide family planning education and contraception referral[171–176]
41. Develop meaningful clinical-community partnerships[21]

II B. Maintain support for families through infancy

42. Use parent coaches to support families[98,99]
43. Provide evidence based early intervention programs[103,177–182]
44. Utilize innovative approaches to medical visits[99,183–186]
45. Establish a reach out and read program for patients and siblings[187–192]
46. Provide medical and developmental follow up[128–135]
47. Provide resources regarding available public benefits at follow-up visits[100]
48. Establish partnerships with pre-K programs for patients and siblings[193,194]
49. Develop and support tools that utilize parent reported outcomes[195]
50. Provide access to quality high risk obstetrical care[196–204]
51. Launch a fruit and vegetable prescription program[205–208]

III. Develop robust quality improvement efforts to ensure equitable, high-quality hospital and follow through care to all newborns by eliminating modifiable disparities

52. Establish measurable improvement aims related to social determinants of health[209–211]
53. Adopt standardized measures for social determinants of health[19,20,27,212]
54. Develop strategies to support QI participation by parents including economically challenged, non-traditional and racially and ethnically diverse families[213,214]
55. Include pediatricians and other primary care providers for children on QI teams[215]
56. Establish a charter with organizational leaders setting goals and resources for family advisors[216]
57. Provide salary support for family advisors[216]

IV. Advocate for social justice at the local, state, and national levels

58. Conduct and disseminate research that identifies disparities in access and outcomes[21,210]

59. Serve on committees and in leadership roles within the local health system and raise awareness of need for social justice in healthcare[44,217–219]
60. Actively recruit a diverse workforce with respect to race, ethnicity, gender, age, religion, and sexual orientation[220]
61. Educate organizational leaders about social determinants of health
62. Engage organizational leaders with a social determinants of health charter
63. Advocate, organize, inform and lobby to change policy at the local, state and national levels[221–224]
64. Play a role in addressing global health inequities[217,225,226]
65. Advocate for environmental health and justice[227–230]
66. Name racism and ask, "How is racism operating here?"[223,231]
67. Engage local, state, and federal agencies with responsibilities for infants and families
68. Advocate to include population health and social justice in the organizational mission[232,233]
69. **Speak out!**

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