Project 3.f.i: Increase Support Programs for Maternal and Child Health (including high risk pregnancies)

Domain 3: Clinical Improvement Projects

Problem Statement:
The Infant mortality rate in the FLPPS region has marginally improved over the last two decades, moving from 7.3 deaths per 1,000 births in 1994 to 6.4 deaths per thousand births in 2011. There are current service gaps that impact maternal and child health including the lack of coordinated services for high risk mothers and lack of attention to the casual factors of toxic stress (of which poverty is an indicator). Poor perinatal outcomes are the 4th leading cause of Years of Potential Life Lost in the FLPPS region, a rates higher than the upstate NY average.

Summary Statement:
Provide women with high risk pregnancies additional support, beyond obstetrical care to ensure the birth of a healthy child. Provide families access to functional parenting skill advice to assist them in the crucial first two years of a child’s life.

Objective:
To reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the first two years of the child’s life.

Core Components and Deliverables:
- Implementation of an evidence based home visiting model for pregnant high risk mothers including high risk first time mothers.
  - Develop a referral system for early identification of woman who are or may be at high risk.
  - Establish a quality oversight committee of Ob/Gyn and primary care providers to monitor quality outcomes and implement new/changes activities as appropriate.
- Establish a care/referral community network based upon a regional center of excellence for high risk pregnancies and infants.
  - Identify and engage a regional medical center with expertise in management of high risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center)
  - Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high risk mother and infant with local community obstetricians and pediatric providers. Service availability will be pregnancy through at least the first year of life.
- Utilize best evidence care guidelines for management of high risk pregnancies and newborns.
- Ensure EHR and HIE/RHIO connectivity are in place to ensure real time data sharing, analytic capabilities, and implementation of uniform clinical protocols based upon evidence based guidelines.
• Establish Clinical Quality Committee composed of community practitioners and regional medical center experts to oversee quality of program.

• Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaborative (MICHC) program.
  • Access NYSDOH-funded CHW training program.
  • Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.
  • Identify appropriate candidates for Community Health Worker.
  • Establish protocols for deployment of CHW.
  • Coordinate with the Medicaid Managed Care organizations serving the target population.

Target Populations:
• Medicaid Expecting mothers. Mothers participating in the program during pregnancy and up to the first 2 years of child’s life.
• In Monroe County, the project focus will be on those receiving pre- and perinatal care. Across the rural counties, the project will target mothers of children age 0-24 months, and will work to improve the rates of well child visits, immunizations and lead screenings.

Assets:
• Existing evidence-based programs, MICHC model programming in Monroe and Livingston Counties, and experience providing this service
• Collaborative relationships between existing programs and community resources
• Perinatal Network is implementing Peer Place, expecting to be in place in March

Challenges:
• Toxic Stress
• Transportation
• Workforce
• Cultural Competence

Last revised: 5/7/15