COMMUNITY HEALTH CARE ASSOCIATION of New York State

Advancing Maternal Health Through Community Partnerships

CHCANYS' Sexual & Reproductive Health Sub-Committee

May 13, 2021

Housekeeping

- Phones have been muted to prevent background noise
- Use the chat box to type questions during the webinar
- This webinar is being recorded and will soon be available to all participants
- Tell us how we did in the evaluation, at the end of each session, and a follow-up evaluation will be sent 3 months from today

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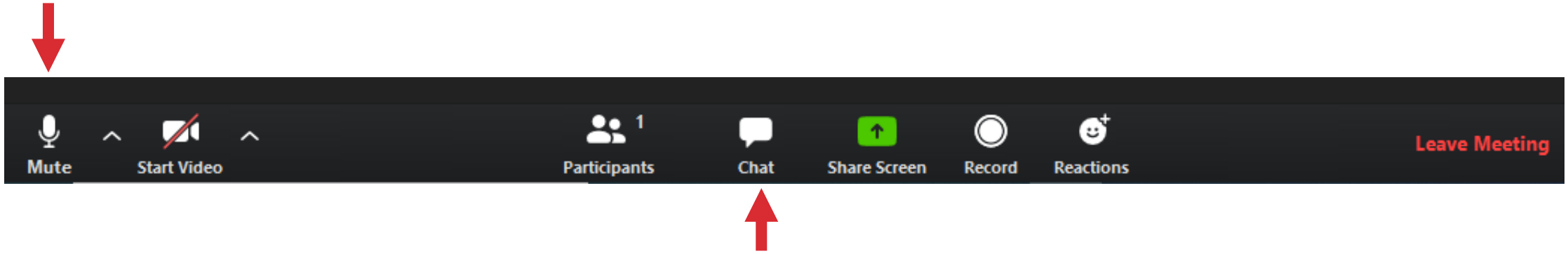
Zoom Meeting Controls

1. Manage your audio:
    - Dial ***6** to mute your phone, if your phone does not have a "Mute" button. Dial ***6** again to unmute.
    - Tap the "Mute" button on your phone or computer. Tap the "Mute" button again to unmute when you want to speak.



2. Use the chat box throughout the webinar

Agenda

I. Welcome

II. Presenter: Gracie-Ann Roberts-Harris, Senior Director, Maternal and Child Health Operations, Community Health Center of Richmond

III. Emily Holzman, Senior Client Success Specialist, Azara Healthcare. OB Module Showcase

IV. Opportunities for collaboration

Focus on Maternal Health Outcomes

Surgeon General's Call to Action to Improve Maternal Health[1]

- Reduce maternal mortality
- Reduce racial and ethnic, geographic, and age disparities
- Improve maternal health outcomes

https://www.health.ny.gov/community/infants_children/maternal_and_child_health_services/docs/2021_application.pdf

Community Health Center of Richmond-Staten Island Healthy Start

Gracie-Ann Roberts-Harris, DMSc, MPH, PA-C
Senior Director, Maternal and Child Health Operations
May 13th,2021

Community Health Center of Richmond Inc.

Federally Qualified Health Center founded in 2006

Four locations on Staten Island

NCQA NYS Patient-Centered Medical Home recognized

Joint Commission accredited

Serving~10,000 unique patients annually with ~40,000 total patient visits

Internal Medicine
Pediatrics
Obstetrics
Gynecology
Dentistry
Podiatry

Behavioral Health
Nutrition
Insurance Navigation
Maternal & Child health services

Maternal and Child Health Division

CHCR
COMMUNITY HEALTH CENTER OF RICHMOND

Healthy Start

Maternal and Infant Community Health Collaboratives (MICHC)

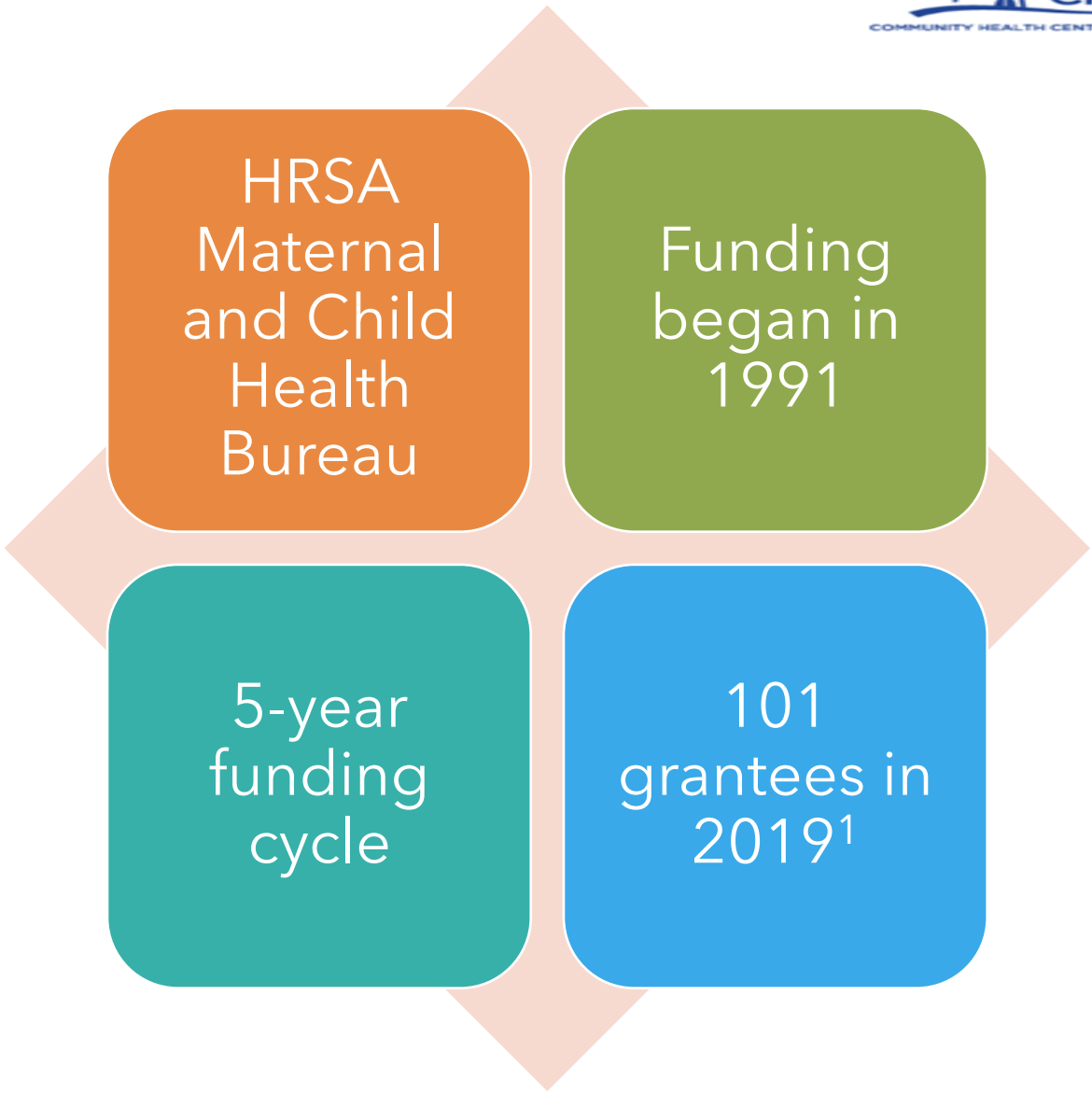
Breastfeeding Initiative

Healthy Women Healthy Future Doula program

Cribs for Kids

Staten Island Perinatal Network

Healthy Start Funding



[1] https://www.healthystartepic.org/healthy-start/program-overview

Healthy Start

Target: Communities with infant mortality rates at least 1.5 times the national average[2]

Goal: Reduce disparities in maternal and infant health

[2] https://mchb.hrsa.gov/maternal-child-health-initiatives/healthy

The Healthy Start Approach

The purpose of the Healthy Start (HS) program is to improve health outcomes before, during, and after pregnancy, and to reduce racial/ethnic differences in rates of infant death and adverse perinatal outcomes by:

- Improving women's health
- Improving family health and wellness
- Promoting systems change, and
- Assuring impact and effectiveness through workforce development, data collection, quality improvement, performance monitoring, and evaluation.

Program goals

Prenatal (300)

Inter-conception, preconception, children (0-18 months) (300 clients combined)

Fathers (100)

Healthy Start Programs in New York

Albert Einstein College of Medicine, Inc. (Bronx)

Community Health Center of Richmond, Inc. (Staten Island)

Fund for Public Health in New York, Inc. (Brooklyn)

Northern Manhattan Perinatal Partnership, Inc. (Manhattan)

Public Health Solutions (Queens)

County of Onondaga (Syracuse)

Staten Island Healthy Start

The Healthy Start program offers an array of services for women and their families, including:

- Case management and referral management
- Home and hospital visits
- Educational workshops on breastfeeding, parenting, newborn care, safe sleep, childbirth education reproductive health, male involvement services and support groups.

Healthy Start Team

- Project Director
- Project Manager
- Five Case Managers
- Fatherhood Coordinator
- Community Action Network Coordinator
- Women's Health Nurse Practitioner*

Healthy Start Screening Tools

Social Determinants of Health

- Social/emotional health
- Race/ethnicity
- Employment/income
- Intimate partner violence (IPV)
- Transportation
- Insurance
- Food security
- Housing
- Household composition

Clinical

- Depression screening
- Tobacco, alcohol, drug screening
- Usual source of care
- Reproductive life planning
- Pregnancy/childbirth history
- Birth weight and outcome
- Breastfeeding

Poll Question

How frequently does the health center care team screen & review the PRAPARE/social risk data with patients of childbearing age?

For example, SDOH data part of the pre-visit planning/patient triage, care team connects patients with resources, review/addition of ICD-10 Z codes in the patients' chart, etc.

Select one of the options below:

- At each visit
- Every 3 visits
- Quarterly
- Semiannually
- Annually
- My organization is not collecting SDOH/PRAPARE data at this time

Healthy Start Community Action Network

Mobilize healthcare organizations and social service organizations to coordinate care and steer local action to address social determinants of health related to birth outcomes.

Staten Island Community Action Network Membership

- Staten Island University Hospital
- Staten Island North Shore Alliance
- Staten Island Workforce1
- Staten Community Partnership Program (SICPP)
- Richmond University Medical Center
- NYC Department of Health & Mental Hygiene Center for Health Equity
- Literacy Inc
- Nine Healthy Start participants

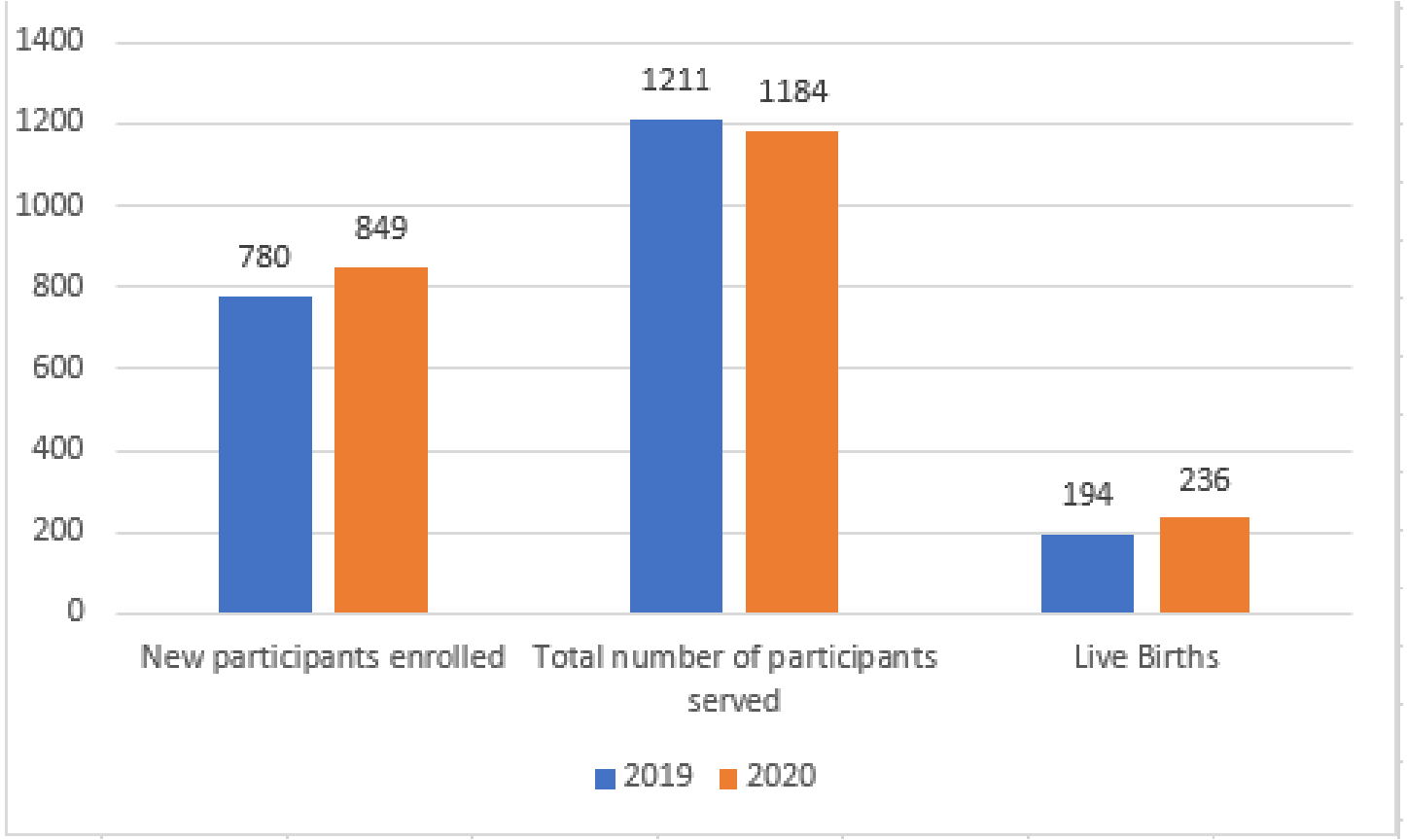
Quality Improvement

Healthy Start performance measures incorporated into the clinical improvement program at CHC Richmond.

Data tracked using a case management software system and *eClinicalWorks*

Performance measures reviewed monthly.

Healthy Start Data



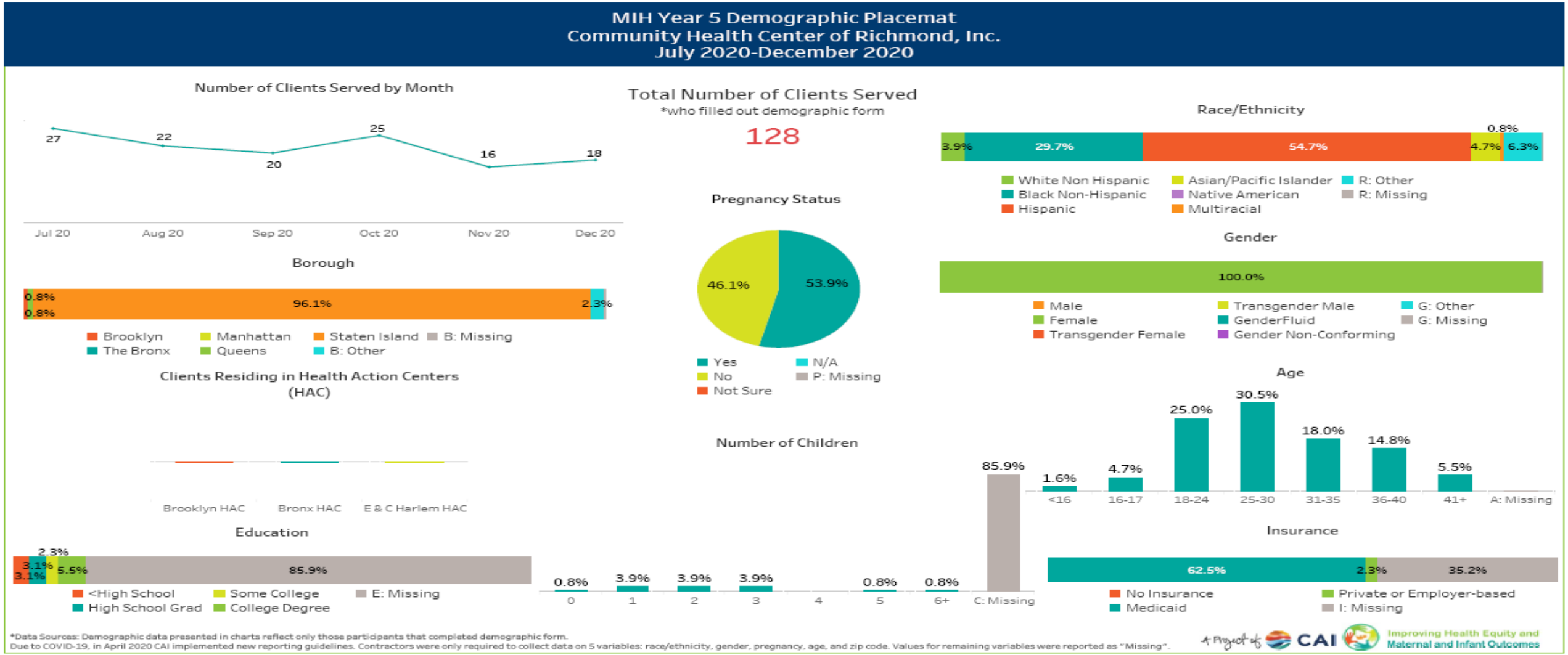
Healthy Start Benchmarks and Goals

Exceeding Goal	Meeting Goal	Needs Improvement
• Health insurance • Well women visits • Well child visits • Depression screening • Intimate partner violence screening • Breastfeeding • Reproductive plan	• Father/Partner involvement • Safe sleep • Fully Implemented Community Action Network • Quality Improvement	• Postpartum visit • Childhood reading

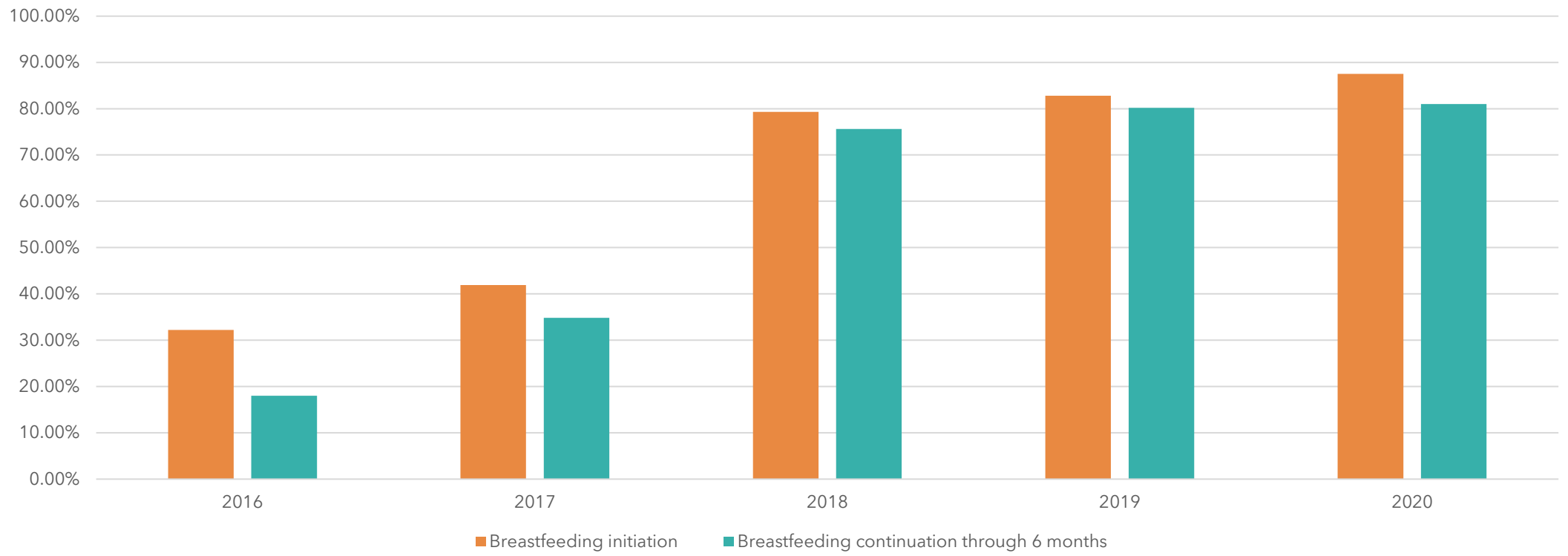
Breastfeeding Initiative Activities

- Workshops
- Baby Café/Support Group
- One-on-one breastfeeding support
- Lactation lounge

Breastfeeding Data



Healthy Start Breastfeeding rates



Healthy Women Healthy Futures Doula Program

- Healthy Women, Healthy Futures (HWHF) is a New York City funded initiative that provides birth and postpartum doula services to be accessible to low-income women residing in NYC at no cost.
- HWHF identifies, trains, and assists community residents to become doulas. CHC Richmond serves as the coordinating agency in Staten Island for HWHF initiative. Currently, there 35 doulas contracted in Staten Island. During the 2019-2020 fiscal year 123 women received birth and postpartum Doula services in Staten Island.

Doula Intake forms

Social Determinants of Health

- Race/ethnicity
- Employment/income
- Intimate partner violence (IPV)
- Insurance
- Food security
- Housing
- Language

Clinical

- Depression screening
- Tobacco, alcohol, drug screening
- Birth plan
- Pregnancy/childbirth history
- Birth weight and outcome
- Apgar score

HWHF Citywide Contacts

Healthy Women Healthy Futures

Borough Coordinators

Brooklyn
Denise West
Deputy Executive Director
Brooklyn Perinatal Network, Inc. (BPN)
259 Bristol Street, 2nd floor Suite 242
Brooklyn NY 11212
T: 718 643-8258 ext. 21
F: 718-522-3644
Dwest@bpnetwork.org

Queens, Bronx, Manhattan
Abena Amory
HWHF Program Coordinator
Caribbean Women's Health Association
3512 Church Avenue
Brooklyn, NY 11203
T: 718 826-2942 ext. 221
C: 929-425-4804
F: 718-826-2948
Abenathedoula@gmail.com

Staten Island
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Senior Director, MCH Operations
CHC Richmond, Inc. (CHCR)
135 Canal Street, Suite 300
Staten Island, NY 10304
T: 917- 830-1200
F: 718-447-8013
Gharris@chcrichmond.org

Want Free Quality Doula services?

Are you Pregnant?

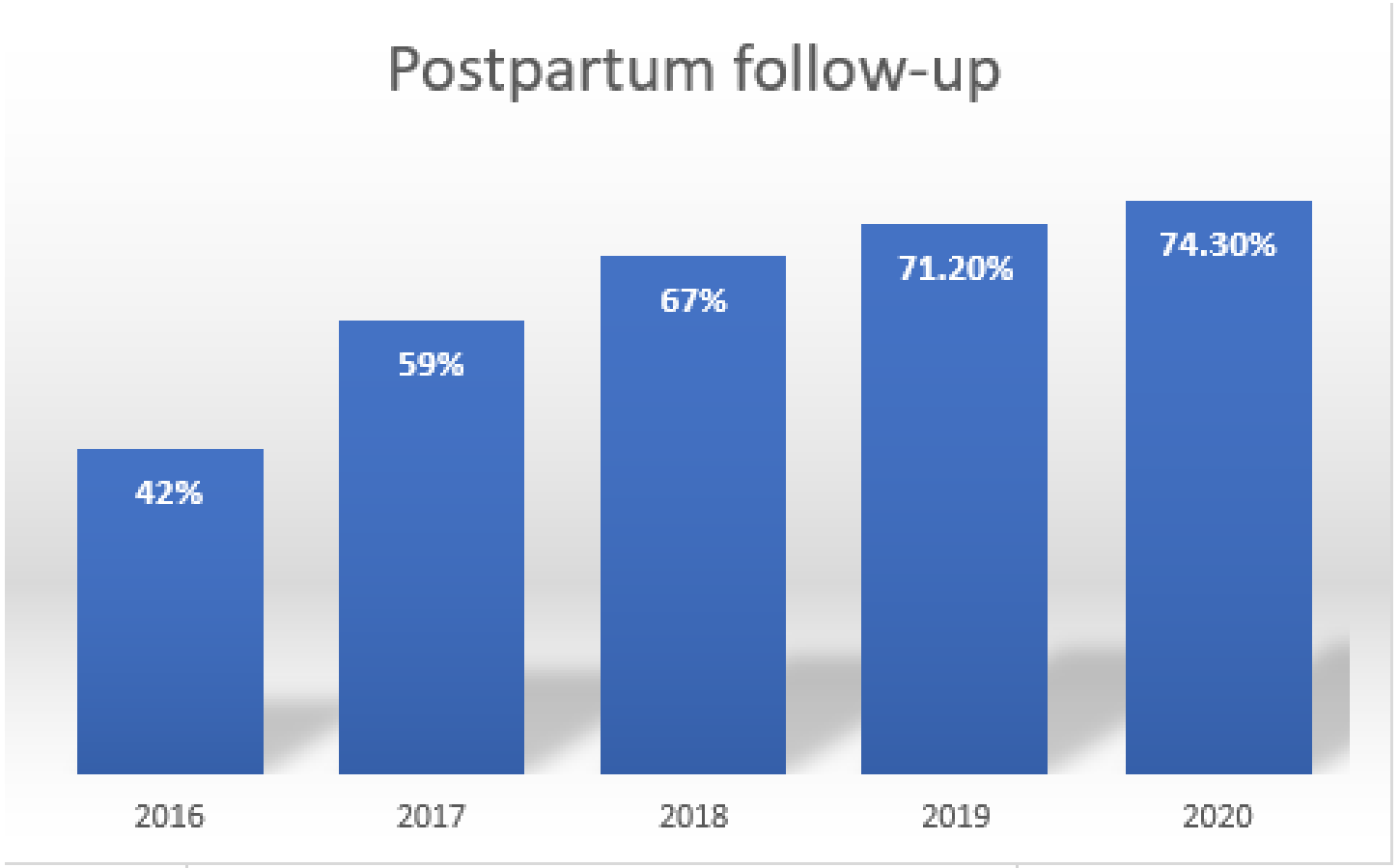
Did you recently give birth?

- A birth doula is trained and experienced in childbirth and provides continuous physical, emotional and informational support to mothers and their partners before, during and after childbirth. Services include:
  - Prenatal visits
  - Support during labor
  - Visits after delivery
  - Follow-up phone calls
- A postpartum doula is trained to help with the transition into new parenthood by providing education, emotional support and help around the house in the postpartum period.
  - Total of 21 hours of care in the home after delivery

Please contact your borough coordinator for more information.

Doula care is paid for by the City Council of NYC through the Healthy Women Healthy Futures Initiative

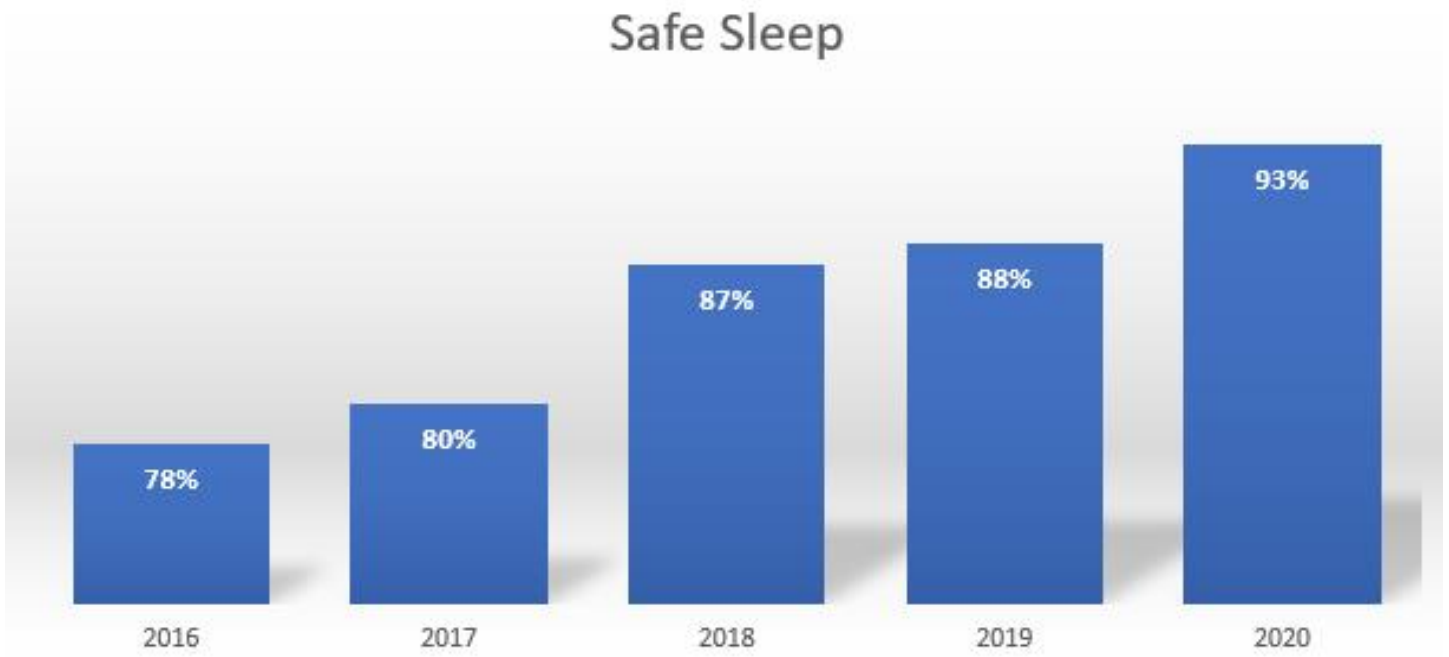
Postpartum Follow-up



Cribs for Kids

- Funded through NYC DOHMH
- Prevent infant sleep-related deaths
- Safe sleep education
- Provides portable cribs

Safe Sleep Data



Healthy Start Operations and COVID-19

March 24, 2020-May 31, 2020

- 454 telephone encounters and 9 face-to-face virtual visits for 300 unique clients
- 77 postpartum clients
- 144 prenatal clients
- 69 Inter-conception clients
- 10 preconception clients

Discussion

Azara OB Module

Health centers interested in obtaining the OB Module can contact Mercy Mbogori at mmbogori@CHCANYS.ORG

Announcement: Last Chance!

PRAPARE Smart Form Subsidy for eClinicalWorks Users:

CHCANYS has a limited-time opportunity expiring in *June 2021* to support health centers' systematic collection and response to patients' social needs by subsidizing the PRAPARE smart form in eClinicalWorks for a limited number of health centers.

If your health center is interested, please contact Gabriela Gonzalez at ggonzalez@CHCANYS.ORG

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Join the Diabetes and CVD Prevention and Control Initiative

- Cohort III Kicks off July 2021 through June 2022

- Primary Focus Areas Include:
  - Maximizing HIT
    - Stratification by health disparities
  - Referrals to evidence-based community programs
    - DPP/DSME
  - Health education and nutrition counseling
    - SMBP
  - Practice transformation and process Improvement

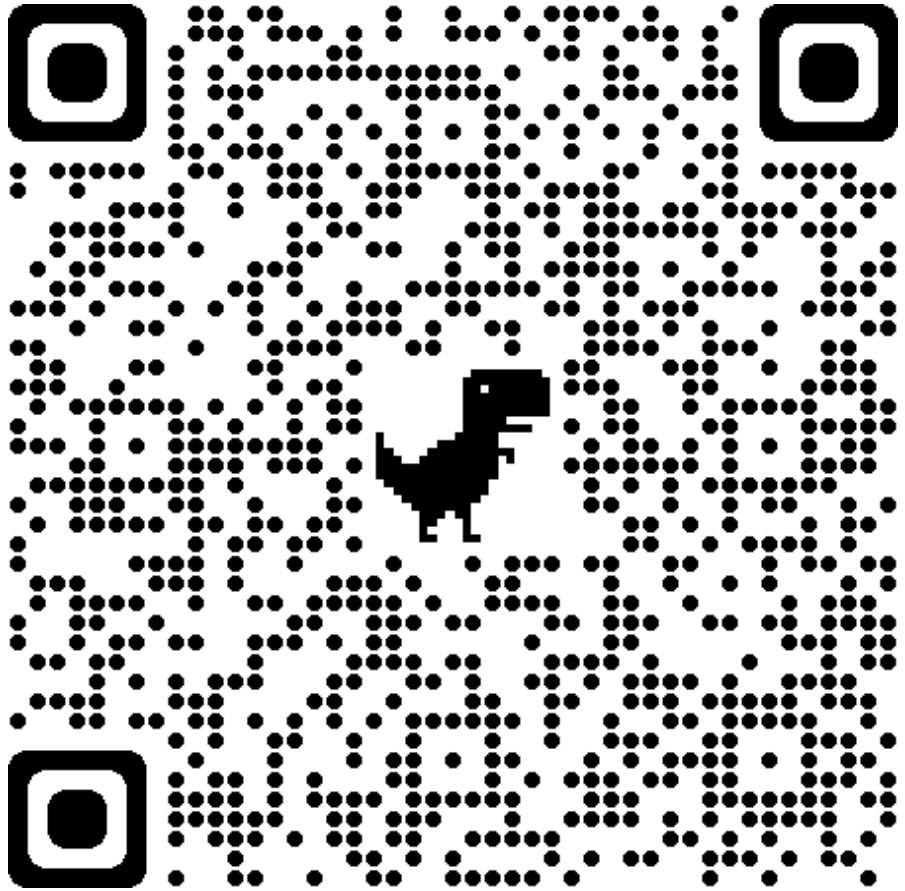
- Project Evaluation

Scan Me

To Fill Out an Interest Form

Webinar Evaluation

Tell us how we did today by completing a short evaluation! Community Health Centers will receive a follow-up evaluation in 3 months from today. Feel free to share what topics you would like to hear in the future, thank you.



https://wh1.snapsurveys.com/s.asp?k=159965450484&session_name=MaternalHealthWebinar&session_number=1&org=CEI

Resources:

- CHCANYS' Social Determinants of Health Webpage
- NACHC Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- The Surgeon General's Call to Action to Improve Maternal Health
- Healthy People 2030 Objectives – Pregnancy and Childbirth
- New York State Department of Health: Community, Family & Minority Health
  - Maternal and Child Health (MCH) Dashboard
  - Maternal and Infant Community Health Collaboratives Initiative: Online Training for Community Health Workers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