## 3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)

**Project 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.

**Project Description:** High risk pregnancies do not end with the birth of the child, but can continue with high risk parenting situations. Women with high risk pregnancies due to age, social situation or concurrent medical or behavioral health conditions may need significant support beyond obstetrical care to grow a healthy child. Nuclear families and single mothers may not have access to functional parenting skill advice to assist them in the crucial first two years of a child's life.

**Project Requirements:** The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

For performing partner systems where the community assessment identifies significant high risk obstetrical/parenting cases, there are **three models** for intervention that may be utilized for this project. Systems should choose one primary project but may also choose requirements from the other two projects to add as part of their project.

*Model 1: Implementation of an evidence-based home visiting model for pregnant high risk mothers including high risk first time mothers. Potential programs include Nurse Family Partnership.*

1. Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high-risk mothers including high-risk first time mothers.
2. Develop a referral system for early identification of women who are or may be at high risk.
3. Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

*Model 2: Establish a care/referral community network based upon a regional center of excellence for high risk pregnancies and infants.*

1. 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).
2. 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.
3. Develop service MOUs between the multidisciplinary team and OB/GYN providers.
4. Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.

5. Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
6. Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
7. Use EHRs or other IT platforms to track all patients engaged in this project.

*Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program.*

1. Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.
2. Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.
3. Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.
4. Establish protocols for deployment of CHW.
5. Coordinate with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

**Project Selection**
For this project, one of the following three project models can be selected. Please indicate which of the three will be chosen:

- ☒ Model 1: Implementation of Nurse-Family Partnership program model for pregnant high risk first time mothers.
- ☐ Model 2: Establish a care/referral network based upon a regional center of excellence for high risk pregnancies and infants.
- ☐ Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaborative (MICHC) program.

## Project Response & Evaluation (Total Possible Points – 100):

**1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)**

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The CNA revealed numerous gaps in prenatal, maternity, and early childhood preventive care. Adolescent pregnancy rates are very high in WNY. Erie County ranks at the 25th percentile for preterm birth among comparable counties; Niagara is at the 0 percentile. Erie, Chautauqua and Cattaraugus rank in the bottom quartile for maternal mortality versus comparable counties. The WNY maternal mortality rate is 26.8 per 100,000 births, compared to 20.6 statewide. Based on Medicaid PQI, Erie and Cattaraugus are in the bottom quartile for preventing pediatric disease hospitalizations. Well-child visit rates (0-15 months) for all counties fell well below the statewide average. As for emergency visits, the rate for falls among children aged 1-4 was substantially higher (516 vs. 504) than the state rate. CNA data reveal numerous Medicaid-specific gaps. Medicaid low-birthweight rates for both Erie and Niagara are 10.2% compared to WNY (9.6%). The Medicaid rate of high-risk pregnancy is 12.7% for Erie, compared to 10.9% for WNY. It was determined that the evidence-based home visitation model, Nurse-Family Partnership (NFP), is the best model to address these gaps; working with women who are identified as qualified participants (first time high–risk Medicaid moms) will help to address socioeconomic issues contributing to unplanned pregnancy, poor birth outcomes and lack of prenatal and pediatric care. To be successful, strong service linkages will be established with physicians and community service programs, primary care centers, OB clinics and FQHCs in Erie and Niagara County to create a referral system for early identification of women who are or may be at risk. Qualified homecare nurses with a passion for serving the target population will be hired; they will be supported by social workers who can connect patients to appropriate agencies, classes and resources. Staff hired will be representative of the cultures and languages spoken by the target community. Staffing will be provided 7 days/week, including office hours, with emphasis placed on continuity of nurse home visitor assignments, staff training in coaching/outreach, and partnering with other community providers, particularly Community Health Workers, to reinforce continued engagement in the planned home visiting services. Because the Nurse Family Partnership (NFP) limits its focus to first-time Medicaid moms, we will focus on good preventive practices, including coordination with health providers for thorough prenatal and early child care. NFP results show improved spacing of subsequent pregnancies, improved parenting, reduced childhood injuries, and better preparation for preschool. Referral agreements will be strengthened with Catholic Medical Partners physicians and care coordinators, as well as other prenatal care providers and local supportive services including substance abuse, mental health, domestic violence, nutrition services, and other health and social services agencies. A quality oversight committee will be established with broad provider representation. Program participants will be tracked through the use of an EHR supported by McAuley Seton Home Care's Maternal Child team.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The target patient population to be impacted by this project is the Medicaid-eligible population of women of childbearing age who become pregnant for the first time in the counties of Erie and Niagara. McAuley Seton Homecare's Maternal Child team will implement NFP programing focused on the high risk areas in these counties, working within the restrictions of its homecare

agency reach and licensure governed by NYS. Expansion to Chautauqua and Cattaraugus Counties will be reviewed for development in year three. Estimated target population for Erie and Niagara Counties is 2,500 first time moms annually whose payer is Medicaid. Because the Nurse Family Partnership model has strict limits as to the number of patients that can be enrolled in a program, we have identified a population of 300 patients that will be actively engaged by Demonstration Year 4.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Current assets are McAuley Seton Home Care's Maternal Child Team, comprised of 7.5 Registered Nurses and a Clinical Manager, providing 6,526 home visits annually to a primarily low-income, vulnerable population with complex needs. The Maternal Child unit's breastfeeding support team is the largest in WNY, with 5 International Board Certified Lactation Consultants. The population served by the McAuley Seton Maternal Child Team resides mainly in the City of Buffalo and inner suburbs, and includes large populations of African Americans, Native Americans, Hispanics, Somalis, and persons of Middle Eastern descent in addition to Caucasians. McAuley Seton Home Care has sponsored its Maternal Child team for the past 15 years. Our current home visits include a complete physical and social assessment of mother and baby within 24 hours of referral. The nurse communicates closely with primary and pediatric physicians regarding their assessment and follow-up recommendations. Education materials are reviewed, taking into consideration patient literacy and education levels. Linkage is made with community and social service agencies. The experience and competence of the Maternal Child Nurses is key in achieving positive outcomes. In addition to our Maternal Child Program, McAuley Seton Home Care also provides Early Intervention Services to pre-school children in Erie County. Catholic Health has also been operating a "Centering Pregnancy" model and prior to that a Parenting program that mimicked the Centering philosophy. Our OB site at Sisters Hospital has been providing this care model for nearly 2 years. Over 50 women have been in this program and 100% went full term/did not need the NICU for the care of their babies. It has been a very big success. Given Catholic Health's track record and its desire to implement the Nurse Family Partnership program, we remain committed to enhance our current evidence-based programs and establish this new program to provide yet another level of care for women in need and their families. Additional community resources are available through long-term partners such as Buffalo Prenatal-Perinatal, Buffalo Public Schools, Erie County Health Dep't, East Hill Foundation, Oishei Foundation, Health Foundation of Western and Central NY, Horizon Health Services, March of Dimes, WNY Public Health Alliance, and Catholic Charities WIC program. These organizations encompass the full breadth of community services from providers of prenatal care, family planning, substance abuse, mental health, domestic violence, nutrition services, child protective services and other health and social services. All have been instrumental in support of the Centering Pregnancy program. Numerous community resources however are still needed and funding will help address these gap needs. Given that NFP program requirements are exactly prescribed and require absolute fidelity to the model, McAuley Seton will be required to pay the necessary fees, including Program Development

Startup Fee, Data Transmission Setup Fee, tuition for initial education session & administrator orientation, and Dyadic Measurement staff training necessary to implement the feeding scales.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The first challenge concerns staffing; the supply of nurses meeting experience/educational qualifications may be limited. Related is the potential for nurse turnover. These will be addressed by enlisting aid from Catholic Health HR, with its innovative "Talent Network" approach. Another challenge involves slow program acceptance by referral sources. The PPS must convince referring and collaborating agencies of the NFP's importance, and obtain their commitment. This will be addressed by leveraging relationships developed during the DSRIP implementation process. Informal linkages can and will be nurtured into formal alliances. It may be a challenge to identify affordable and easily accessible services/resources to which NFP clients may be referred. Related issues include securing motivation/time from community leaders to participate, and follow-through on community collaborator commitments. Again, our relationships with community agencies participating in DSRIP will ensure prompt resolution. Internal challenges include prioritizing day-to-day tasks and unexpected client issues to ensure the schedule is followed. Adherence to the program's model elements for admissions, visit frequency & supervision must be monitored. The NFP must be able to remain in control of client intake functions so caseloads are balanced & manageable. Another issue will be the preventing IT interruptions. All these can be mitigated via education. NFP managers/staff will be educated in NFP best practices and encouraged to network with other NFP programs nationwide, and the national NFP office in Denver.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

The two area PPS's have collaborated extensively resulting in the joint decision to select two different models to serve the broadest segment of the WNY population. Community Partners WNY has chosen the focused NFP model while the ECMC PPS will pursue community health worker development. The PPS, including McAuley Seton Home Care, has and will collaborate closely with all maternal and child health providers, other home visiting agencies, as well as all major local health and social services providers. Irrespective of the PPS affiliation of these providers. Sisters of Charity Hospital, Catholic Medical Partners and Catholic Health System have an extensive record of regional collaboration which has continued throughout the PPS development process.

**2. <u>Scale of Implementation</u> (Total Possible Points - 40):**

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

***Please use the accompanying Speed & Scale Excel document to complete this section.***

**3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):**

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

***Please use the accompanying Speed & Scale Excel document to complete this section.***

**4. Project Resource Needs and Other Initiatives (Not Scored)**

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

| Yes | No |
|---|---|
| ☒ | ☐ |

**If yes:** Please describe why capital funding is necessary for the Project to be successful.

The Nurse Family Partnership has a very prescriptive requirement of resources needed for their staffing model and programs. Each of the Nurse Home Visitors, as well as the Nurse Supervisor, will require a laptop computer that can be brought to home visits in the field. The Administrative/Data Support person will require a desktop computer. Other new office equipment required includes two locking 2-drawer filing cabinets for storage of confidential records. In general support of the program, the Nurse Home Visitors will require digital cameras to record the appearance of their patients, and cellular telephones to communicate with one another and to the McAuley Seton Home Care project office from the field. The program will also require clinical supplies, including blood pressure cuffs, stethoscopes, thermometers, disposable measuring tapes, pregnancy calculators, baby scales, pediatric pads to measure length, bags to carry this equipment, and luggage carriers to transport heavy and/or cumbersome items.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

| Yes | No |
|---|---|
| ☐ | ☒ |

**If yes:** Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

***Please note:*** *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| | | | | |
| | | | | |

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

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**5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>**

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards <u>completion of project requirements</u>, <u>scale of project implementation,</u> and <u>patient engagement progress</u> in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.