Community Health Workers

Improving Care and Access to Resources for Obstetric Patients

Presented by:

Pamela Bruce, DNP, MSN, RN, CPPS
Director, Quality and Clinical Transformation
Vanderbilt Health Affiliated Network

Lindsay Knight, MHA, CPHQ
Sr. Project Manager
Vanderbilt Health Affiliated Network

Contributors:

Anna Chandler, RN, BSN, MBA
Manager, Network Operations
Vanderbilt Health Affiliated Network

Crystal Guzman
Community Health Worker
Vanderbilt Health Affiliated Network

Lisa Smith, MSN, RN, CCCTM
Manager, Clinical Programs
Vanderbilt Health Affiliated Network

R. Alan Bennett, MD FACOG
President
Gallatin Women's Center

Debbie Smith
Practice Administrator
Gallatin Women's Center

The development phases of the project were funded from the CMS Transforming Clinical Practice Initiative #1L1CMS331549

Vanderbilt Health
Affiliated Network

Practice Demographics

The Gallatin Women's Center has a large pre-natal patient population with approximately 350 babies born annually. Many mothers experience a lack of support and education related to pregnancy, birth and postpartum care, all which ultimately leads to an increased risk for unhealthy pregnancies and poor birth outcomes.

OBGYN located in Sumner County	4 OBGYNs 2 WHNPs	Around 12,000 patients
350-400 deliveries per year	OB population (60% Medicaid)	Socioeconomic challenges

Challenges of patient population:

- Behavioral health needs
- Substance abuse issues
- Homelessness
- Incarceration
- Transportation needs
- Unsafe domestic situations
- Poor nutrition
- Lack of resources for moms/babies
- Lack of adherence to pre-natal care
- Spanish-speaking

How a Community Health Worker could help:

Resource referrals and assistance for patients experiencing difficult issues such as living in an abusive situation

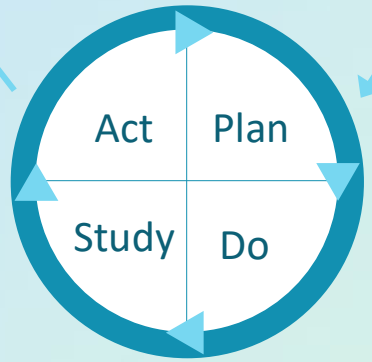
Assist with behavioral health referrals for substance addiction and other community resources for new moms and babies.

Vanderbilt Health
Affiliated Network

Methods

Model for Improvement

What are we trying to accomplish?	How will we know that a change is an improvement?	What change can we make that will result in improvement?



1. Establish Your Aim
2. Establish Your Measures
3. Determine the Changes to Test

The Model for Improvement, Langley et al., 2009

Interventions

Resource Referrals

Provides resources and referrals for patient needs related to housing, transportation, insurance, breastfeeding, drug use, domestic violence and other Social Determinants of Health

Coaching Support

Provides time and opportunity for individual conversations about fears, questions and challenges related to lifestyle, parenting, pregnancy and life skills

Post-ER follow-up

To ensure patient needs are met, follows up on SRMC's weekly list of patients who visited the ER unnecessarily

Population Stratification

Ensures each patient receives high risk survey to determine where unmet needs exist. Based on those needs, a plan with the CHW is developed.

Educational Materials

Gives verbal education and pre-natal packet with information related to pregnancy, breastfeeding, birth control, smoking etc.

Community Outreach

Meets with community resources to determine applicable resources for patients and resource repository

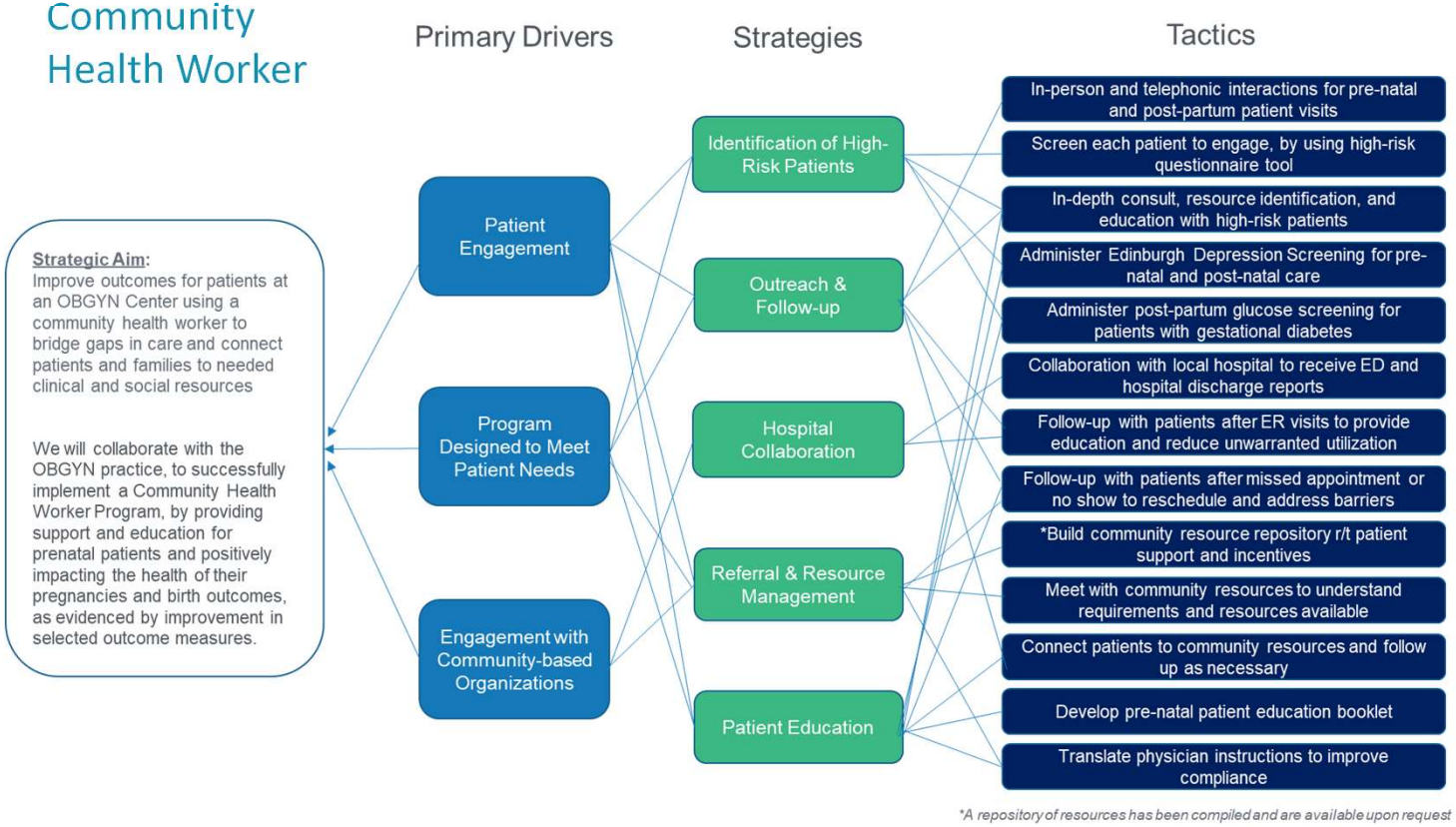
Measures of Success

- Attempted breastfeeding rate
- Patient selected a method of birth control
- ED visit during pregnancy, without delivering
- Patient had postpartum check-up
- Edinburgh Depression screening performed postpartum
- Glucose screen performed postpartum

Vanderbilt Health
Affiliated Network

Driver Diagram

Community Health Worker



*A repository of resources has been compiled and are available upon request

Program Elements

- Pre- and postpartum OB visits
- Community resource referrals and follow-up
- Collaborate with local hospital to reduce unwarranted utilization

VHAN's Community Health Worker Program

VHAN's Community Health Worker Program will provide support and education for prenatal patients and positively impact the health of their pregnancies and birth outcomes, as evidenced by improvement in selected outcome measures.

Vanderbilt Health
Affiliated Network

The Community Health Worker (CHW) Program

Current Status, Results & Next Steps

Current Status

- The program has been successful in improving the care and access to resources for obstetric patients, but we continue to refine it.
- The public health emergency has had a short-term impact on the number of referrals to the program, based on the ability to adequately screen patients.
- The staff reports high patient and practice satisfaction with the CHW role.

Preliminary Results

Measure	Baseline	Approx. Change
Attempted breastfeeding rate	N/A	50%
ED visit during pregnancy, without delivering	11%	10%
Glucose screen performed postpartum	29%	86%
Patient selected a method of birth control	65%	98%
Patient had postpartum check-up	78%	96%
Edinburgh Depression screening performed postpartum	80%	99%

Predominant Resource Referrals

Access/Missed Appointments
- Transportation
- Insurance Issues
- ED Follow-Up

Physical and Behavioral Health
- Nutritional support (breastfeeding, obesity, diabetes resources)
- Dependency Issues (drug, alcohol, tobacco)
- Depression (positive Edinburgh Score)

Social Determinants of Health
- Homelessness
- Food insecurity
- Unemployment

Next Steps

- Collect patient satisfaction data to formulate qualitative success stories
- Further define & study the impact of CHW program on ED utilization
- CHW involvement and connection with state and local collaboratives
- Continued collaboration with practice and community hospital
- Broaden efforts into neighboring pediatric practice as an extension of the program and impact on continuum of care

Thank you.

We welcome your thoughts, feedback, and questions.

Please contact Lindsay Knight at
Lindsay.B.Knight@vumc.org