Supporting Pregnant Women of Color Using the Community-Centered Health Home

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#IHISummit
Session Objectives

- Understand how an OB primary care practice can apply the CCHH model to address health equity and social determinants of health in low-income, high-needs communities
- Identify aspects of the CCHH model that they could apply in their primary care practices and communities
- Discuss how best to engage with community partners and with individuals, based on the experiences of MAHEC-OB
Presenter Disclosures

These presenters have no monetary disclosures. We do disclose that we always have more to learn.
If you are already working in public health medicine, why are you here?
Overview of CCH model

MAHEC OB Perinatal Care
Community Centered Health Home Model
Blue Cross Blue Shield Foundation NC
Current Health Care Spending: $2.2 Trillion

Factors Influencing Health:
- Behaviors & Environment: 70%
- Genetics: 20%
- Medical Care: 10%

National Health Expenditures:
- Prevention: 3%
- Health Care Services: 97%

Source: Prevention Institute

Traditional Approach

Health Promotion and Programs
- Short-term impact
- Reach: limited group size
- High dose; unknown sustainability
- Helpful to generate demand

Community Barriers → Exercise Classes → 5-A-Day → My Plate

Individual Responsibility
Patient example
A Balanced Approach:

Integrating Community Change

Policy, Systems, Environments

Community Barriers

Opportunity and Social Supports

Much Better!!

Health Promotion and Programs
- Short-term impact
- Reach: limited group size
- High dose; unknown sustainability

Individual Responsibility

Where the Field is Going/Growing
- Longer term impact
- Population reach
- Larger lever
- Helpful for sustaining change
CLINICAL/COMMUNITY
POPULATION HEALTH INTERVENTION MODEL

INQUIRY

DATA COLLECTION

IDENTIFY PRIORITY HEALTH ISSUES

ENVIRONMENTAL & POLICY CHANGE

PARTNERSHIP FORMATION
- Health Care
- Public Health
- Community Organizations

COMPREHENSIVE STRATEGY DEVELOPMENT

COORDINATED CLINICAL & COMMUNITY PREVENTION ACTIVITY

OUTCOMES

IMPROVED HEALTH

COST SAVINGS

EVIDENCE-BASE FOR EFFECTIVE PRACTICE
MAHEC Patients
2014

- Medicaid
- Self Pay
- Private
2015 total pregnant patients in the year 2014

- High Risk
- Low Risk
MAHEC 40 Year Timeline

1974
MAHEC Founded

1992
Obstetrics & Gynecology Residency founded

1995
Hendersonville Family Medicine Residency founded

2005
Geriatric Medicine Fellowship founded

2009
UNC School of Medicine Asheville Campus founded

2010
Hospice and Palliative Medicine Fellowship founded

1975
Asheville Family Medicine Residency founded

2007
General Dentistry Residency founded

2012
Family Medicine Obstetrics Fellowship founded
MAHEC OB
Pregnant patient

ACEs

Legal Issues

Childcare

Community Programs

Income I/employment

Physical Activity

Nutrition

Parenting Education

Social support

Mental Health services

Faith/Religious support

Housing

Language/Literacy Services
### What data is readily available 2015
- CCWNC: CMIS reports
- OBCM: state reports (?)
- MAHEC EHR: ___ reports (?)
- HHS: Medicaid, WIC, FNS/food stamps,

### What we learned/heard 2017
- EHR difficult to mine
- Systems do not communicate
- Often not reflective of what community members (patients) actually shared

### Which partners are involved 2015
- MAHEC OB
- BC HHS
- CCWNC
- YWCA
- Pisgah Legal Services
- WNCCHS
- Children First Communities and Schools

### What we learned/heard 2017
- Women from PVA and Emma
- ABIPA
- Homegrown Families
- NC Center for Health and Wellness
- BC Commissioners
- Vaya
- Project NAF
### Assessment

#### Identify Priority Health Issues

#### Comprehensive Strategy Development

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### What health issues are currently a priority? 2015

<table>
<thead>
<tr>
<th>Diagnoses:</th>
<th>Precursors/SDH:</th>
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</thead>
<tbody>
<tr>
<td>- Diabetes</td>
<td>- Intimate partner violence</td>
</tr>
<tr>
<td>- Gestational diabetes</td>
<td>- Stress / ACEs</td>
</tr>
<tr>
<td>- Depression</td>
<td></td>
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<tr>
<td>- Hypertension/Pre-eclampsia</td>
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### What we learned/heard 2017

<table>
<thead>
<tr>
<th></th>
<th>Precursors/SDH:</th>
</tr>
</thead>
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<tr>
<td>- Infant Mortality</td>
<td>- Intimate partner violence</td>
</tr>
<tr>
<td></td>
<td>- Stress / ACEs</td>
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<tr>
<td></td>
<td>- Mistrust</td>
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<td></td>
<td>- Racism</td>
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<td>- Limited availability for advancing</td>
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<td>- Self esteem issues</td>
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### What strategies are currently in place to address health issues above? 2015

- Centering Pregnancy
- OB Care Mgmt/ CCWNC
- Integrated Behavioral H.

### What we learned/heard 2017

- Clinic restructure
- Addressing racism
- Monthly meetings in the community
- Doulas
- Community led events
- ......
**What current policy work is happening? 2015**
- .....  
- .....  
- .....  

**What we learned/heard 2017**
- Support from the County  
- Partners with Success Equation  
- Overlap with NC perinatal strategic plan  
- .....  
- .....  

**What clinical-community efforts are currently happening? 2015**
- CCC-CHIP Diabetes Referral Pilot  
- Centering Pregnancy education sessions (HelpMate, Pisgah Legal, etc.)  

**What we learned/heard 2017**
- Mother to Mother  
- Madre to Madre  
- Doulas  
- Breastfeeding Peer Counselors  
- Community Health Workers  
- .....  
- .....
**Outcomes**

**Improved Health**

**Cost Savings**

**Evidence-Base for Effective Practice**

<table>
<thead>
<tr>
<th>What outcomes are currently being aimed for &amp; tracked? 2015</th>
<th>What we learned/heard 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>- @MAHEC.....</td>
<td>- Metrics have been identified for implementation that were collaboratively agreed upon</td>
</tr>
<tr>
<td>- @BCHHS.....</td>
<td>- Community Health Worker for comprehensive data extraction</td>
</tr>
<tr>
<td>- @CCWNC/OBCM.....</td>
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<tr>
<td>- @PLS.....</td>
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<tr>
<td>- @YWCA.....</td>
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</table>
Organizational structure of collaborative effort & guidelines – process, decision making

Identify & Build Capacities needed to create CCHH model

Build CCHH model/System for: screening, triaging, referring, tracking, sharing, follow-up (SDH)

Improved maternal/child health outcomes