Creating Connections to Improve Maternal Child Health

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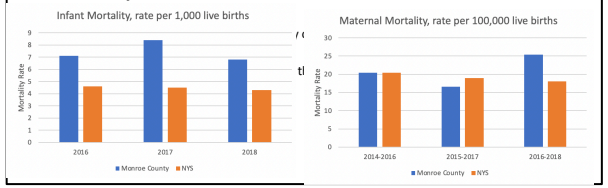
INTRODUCTION

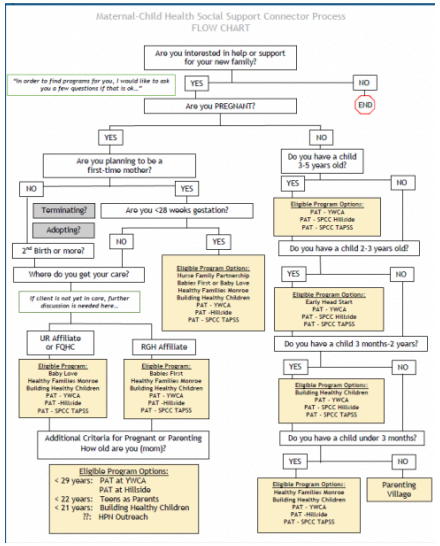
There are numerous social support services that provide resources to pregnant women and parents with young children in Monroe County. But, unfortunately, many people are not connected to services which they could benefit. This lack of connection to support services can exacerbate disparities in maternal-child health outcomes. This pilot project seeks to connect pregnant women and parents with children under 5 to support services that can provide them with the resources they need.



COMMUNITY PARTNER

Highland Family Medicine is a primary care practice located in the South Wedge neighborhood in Rochester. The south wedge is within the 14620 zip code which has a poverty rate between 20-32%. This demonstrates that there is likely unmet needs among the members of this community. Highland Family Medicine is the largest single site primary care practice in Rochester, serving over 25,000 patients. The large patient population provided access to diverse patients with different socioeconomic and racial backgrounds. In partnership with social workers and attending physicians at this site, patients that were part of the target population were identified and asked to participate in this project.

COMMUNITY HEALTH IMPROVEMENT PROJECT



- Prototype Eligibility Flow chart previously developed for systems integration project
- Utilizing a patient-centered model discussion with patients were conducted to determine if they have any needs and which support services they were eligible for would provide the necessary resources
- Follow-up is completed 1-2 weeks later to ensure the patient has connected with the organization.

18 total patient discussions

7 with unmet needs, including diapers, care coordination, and social support.

5 successfully connected with support service

1 loss to follow up

1 chose not to contact support service

CONCLUSIONS

- Social work at Highland Family Medicine refers patients to social service programs
- Nurse care manager provides medical management as well as social supports for medically complex prenatal patients
- Patients are usually referred to provider-based programs
- Overall, this project does have a small sample size (N=18). However, the results do support the hypothesis that utilizing an eligibility flow chart and a closed loop referral system does successfully connect patients with organizations that can meet their needs.
- Provider's offices are a good location to identify patients within the target population and implement this pilot

IMPACT AND SUSTAINABILITY

- Developing a texting tool housed in 2-1-1
- This tool can be used as a resource for pregnant women, caregivers of young children, and providers
- Provide eligibility flow chart to social work and providers

15/17 patients have used or heard of 2-1-1