Getting to One Infant Mortality
Screening & Referral Pilot Project

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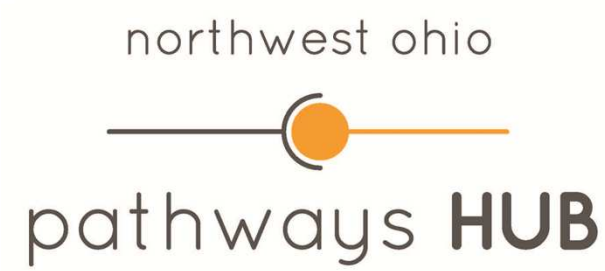
Carly Miller, MPH
Assistant Director
NW Ohio Pathways HUB
Hospital Council of Northwest Ohio

Kent Bishop, MD
President, Chief Medical Officer
Women's Services, ProMedica

Angela Brandt
Vice President, Operations
ProMedica Physician Group



Getting Started…

ProMedica

Infant Mortality Task Force

- When was it started?
- Why was it started?
- What was the goal?

Partnerships with Community Organizations

Toledo-Lucas County Getting to 1

- Co-Leads of Toledo-Lucas County Ohio Equity Institute presented to ProMedica Infant Mortality Task Force
- Identified social determinants of health as major preventable cause of infant mortality
- Discussions of how to identify and remove social determinants to improve birth outcomes/decrease infant deaths

Toledo-Lucas County

Getting to 1

In collaboration with Getting to One & the Northwest Ohio Pathways HUB, the ProMedica Infant Mortality Task Force created a screening process to identify women at greatest risk for a poor birth outcome and infant death as early as possible.

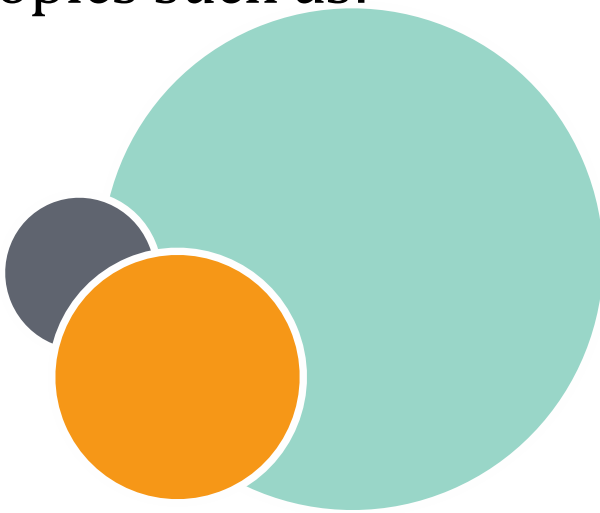
Screening & Education

This screening tool is being used to identify *specific,* ***social*** risk factors that would cause a woman to have a poor birth outcome or cause an infant to die in their first year of life, including:

- Insurance status
- Access to Care (Food, housing, transportation, childcare, etc.)
- Safety & Emotional Health (tobacco, substance use, mental health)

Additionally, the assessment discusses important topics such as:

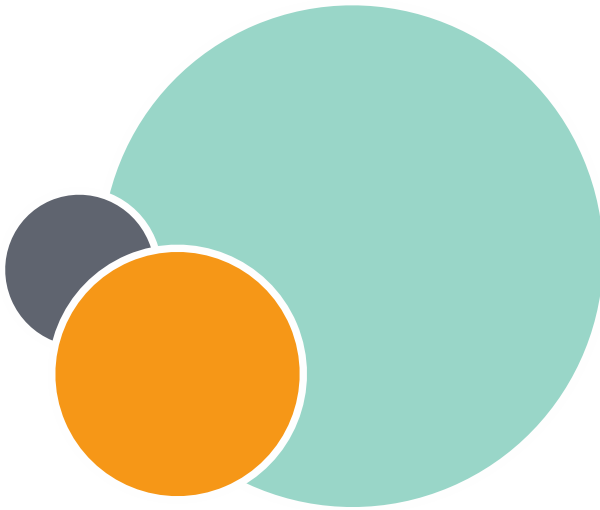
- Safe Sleep Education
- Birth Control/Safe Spacing
- Breastfeeding Benefits & Intention
- Progesterone

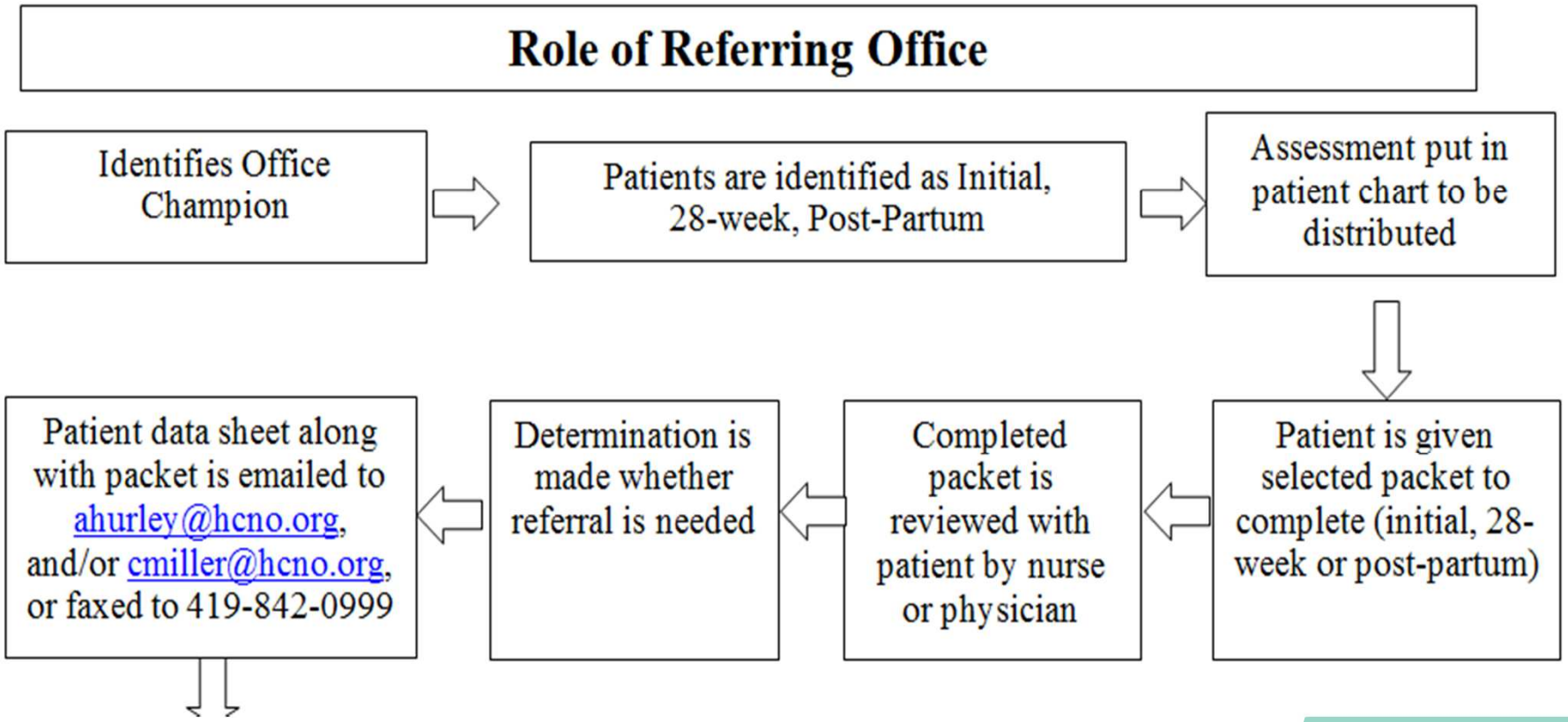


Screening

The Pregnancy Lifestyle Assessment is currently being distributed to all pregnant patients throughout the ProMedica Toledo Metro Region at 3 stages in their pregnancy:

1) The Initial Visit
2) The 28 Week Visit
3) The Postpartum Visit




Role of Referring Office
Identifies Office Champion
Patients are identified as Initial, 28-week, Post-Partum
Assessment put in patient chart to be distributed
Patient is given selected packet to complete (initial, 28-week or post-partum)
Completed packet is reviewed with patient by nurse or physician
Determination is made whether referral is needed
Patient data sheet along with packet is emailed to ahurley@hcno.org, and/or cmiller@hcno.org, or faxed to 419-842-0999

Role of the Referring Office

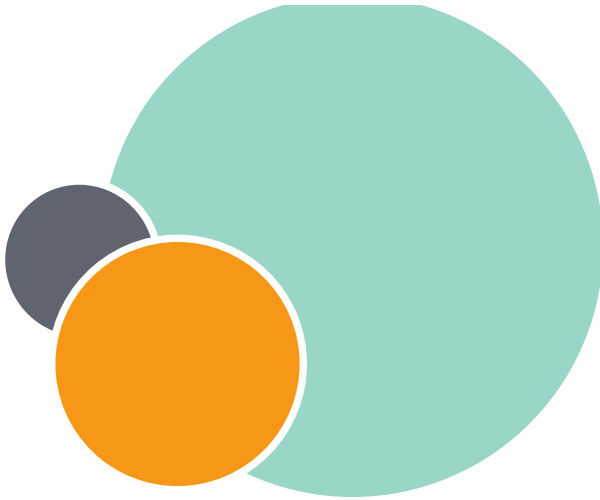
Follow Up *(For Office Use Only)*:

Education Provided: ☐ Family Planning/LARC ☐ Tobacco Use ☐ Folic Acid ☐ Breastfeeding ☐ Safe Sleep ☐ Progesterone
☐ Other: _____

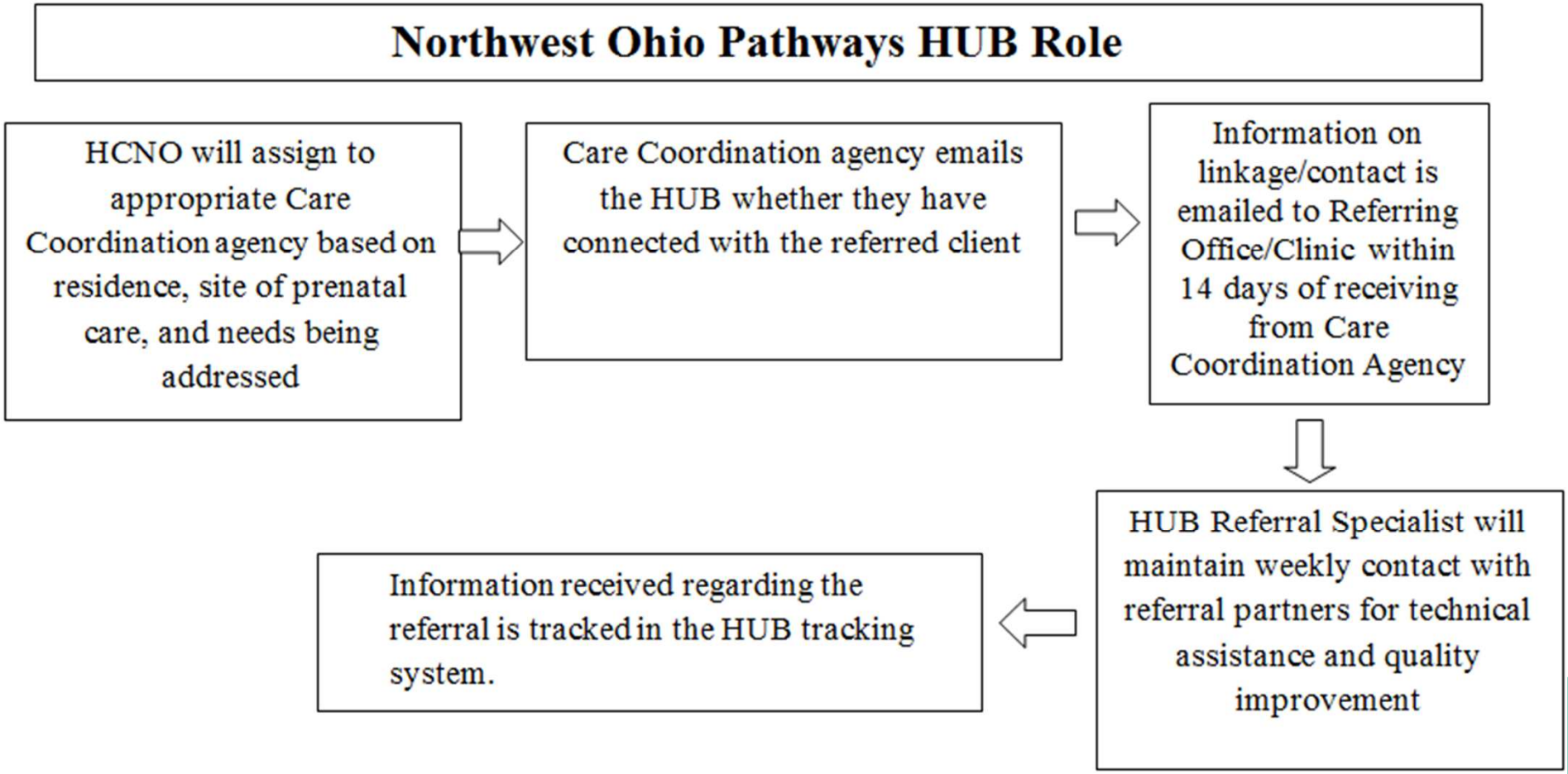
Referrals Recommended: ☐ Insurance ☐ Housing ☐ Transportation ☐ Childcare ☐ Food ☐ Medication Assistance
☐ Tobacco Cessation ☐ Substance Use ☐ DV ☐ Mental Health ☐ Lactation Consultant
☐ Other: _____

Provider Notes: _____

Distributed By: _____ **Date:** _____ **Time:** _____



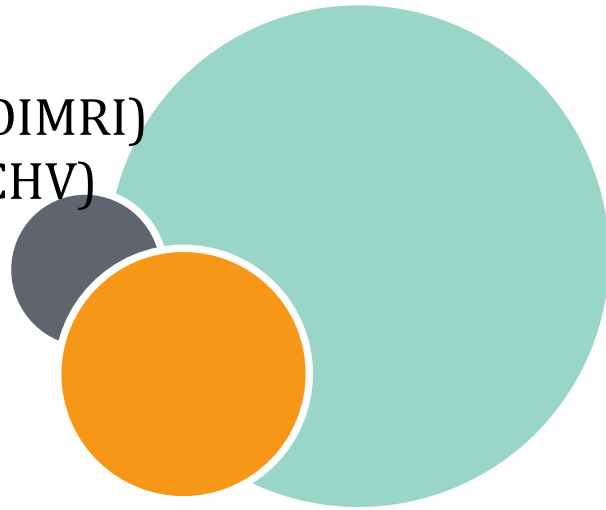
Northwest Ohio Pathways HUB Role



Referral

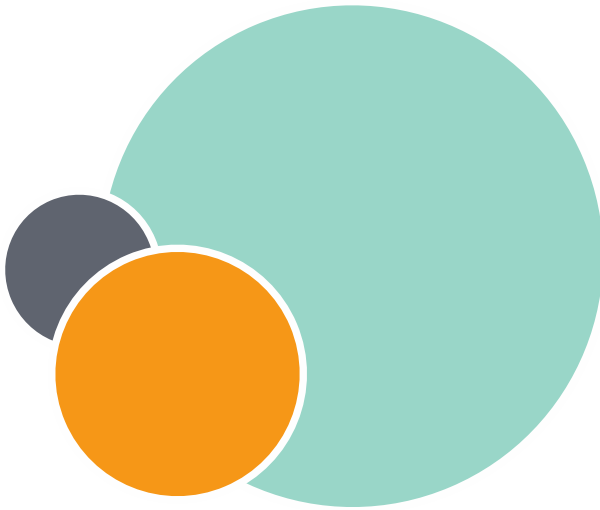
When a woman is identified as having risk factors requiring a referral to community resources, physician offices send a referral to the Northwest Ohio Pathways HUB, who will connect the client to the appropriate resource to remove the identified barrier to care, including home visitation programs:

- Pathways
- Toledo-Lucas County Healthy Start
- Help Me Grow Home Visitation
- Early Head Start
- Neighborhood Health Association Perinatal Outreach (OIMRI)
- Maternal Infant Early Childhood Home Visitation (MIECHV)



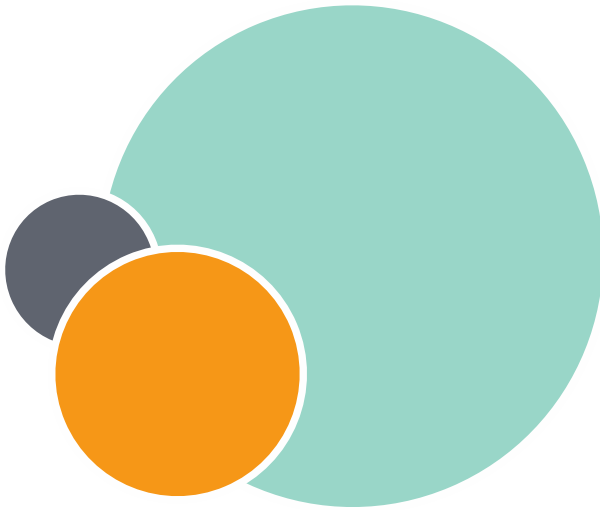
Outcomes

April 1- September 30, 2015



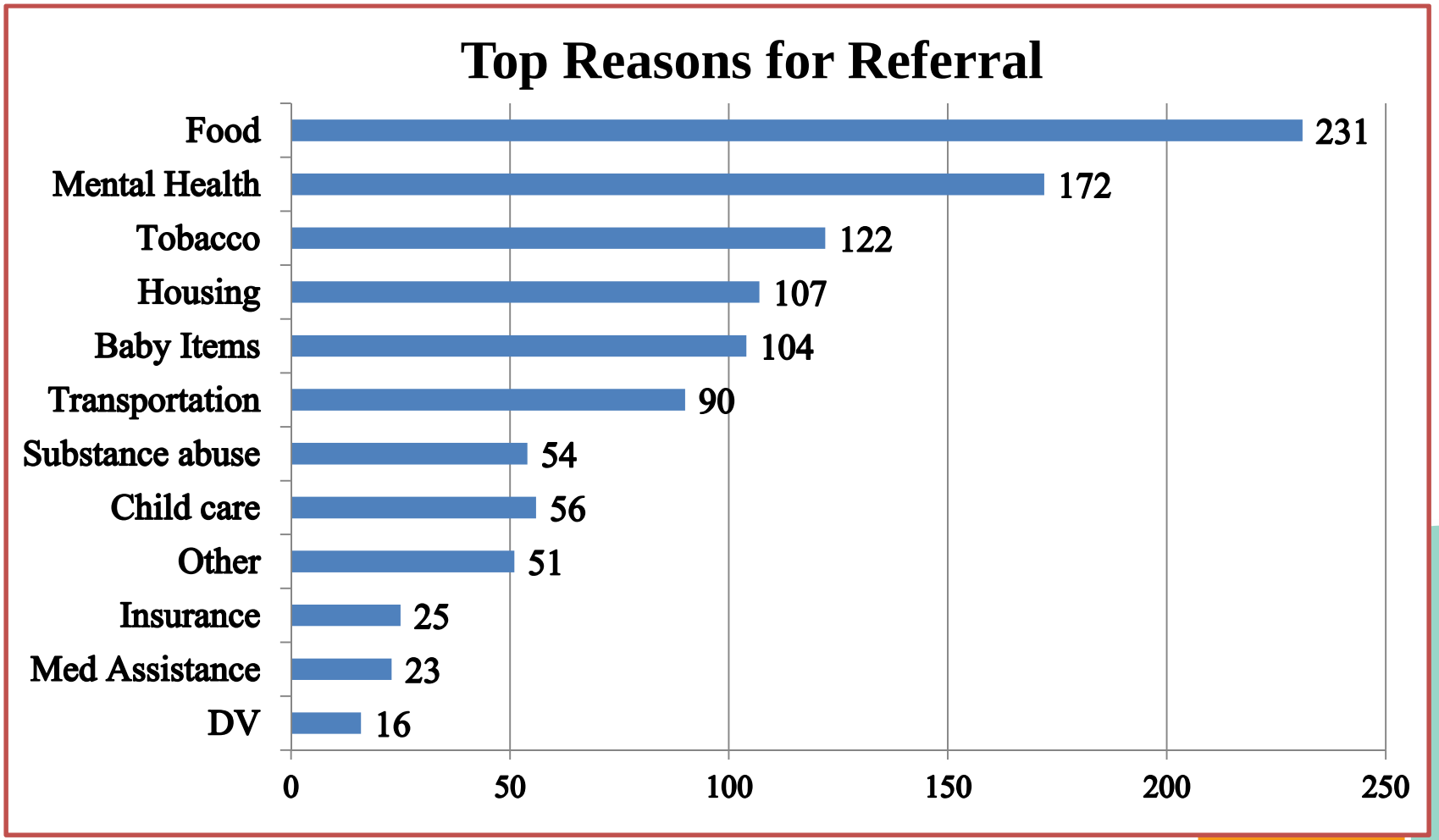
Referrals

From April 1- September 30, 2015 approximately 1826 questionnaires were completed. Of the 1826, 330 (18%) were referred to the Pathways HUB.



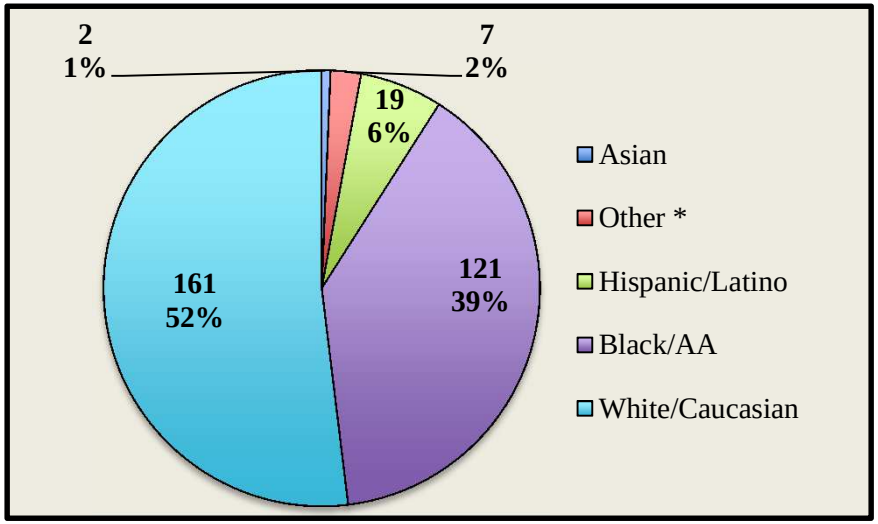
Identified Patient Needs

N= 330

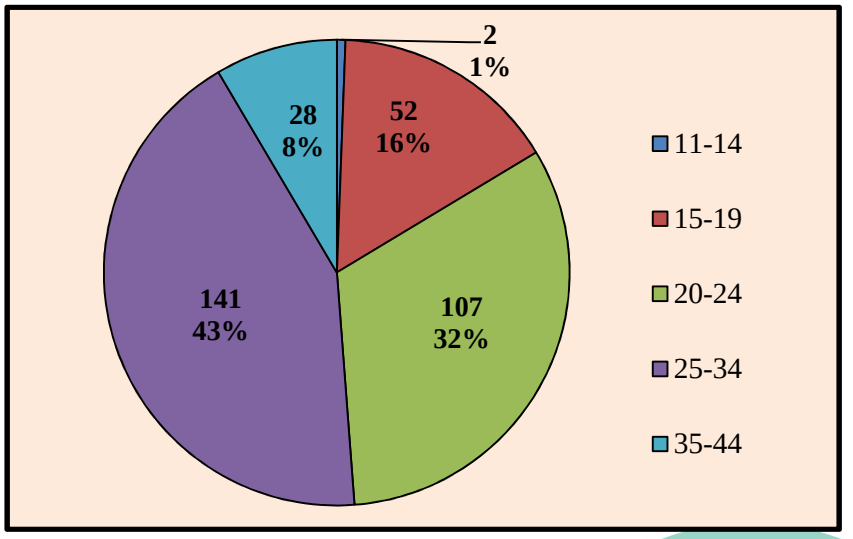


Patient Demographics

Referrals by Race/Ethnicity

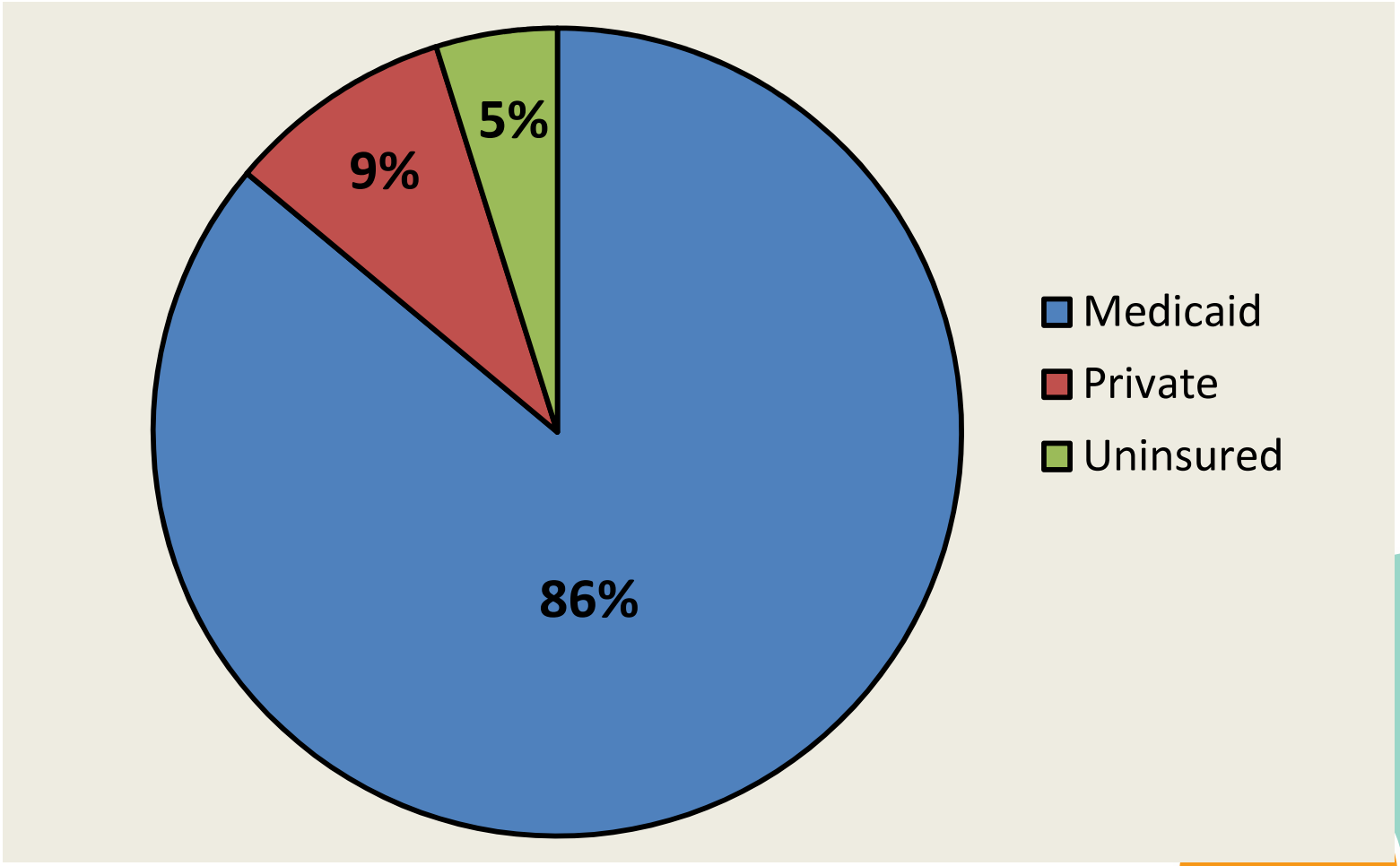


Referrals by Age of Mother

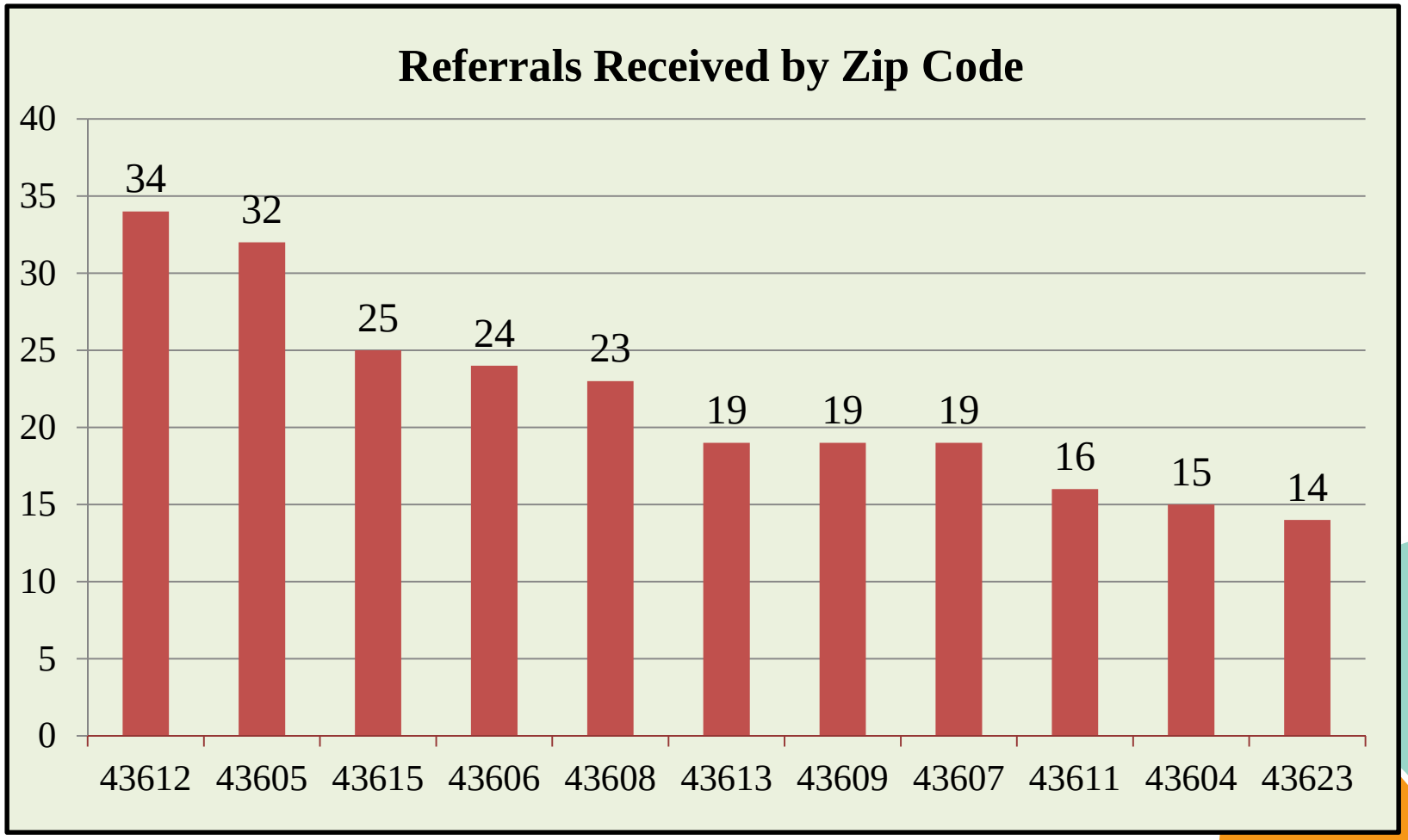


- The median age for referred clients was 25
- 52% of clients identified as Caucasian, 39% African American, 6% Hispanic

Insurance Status

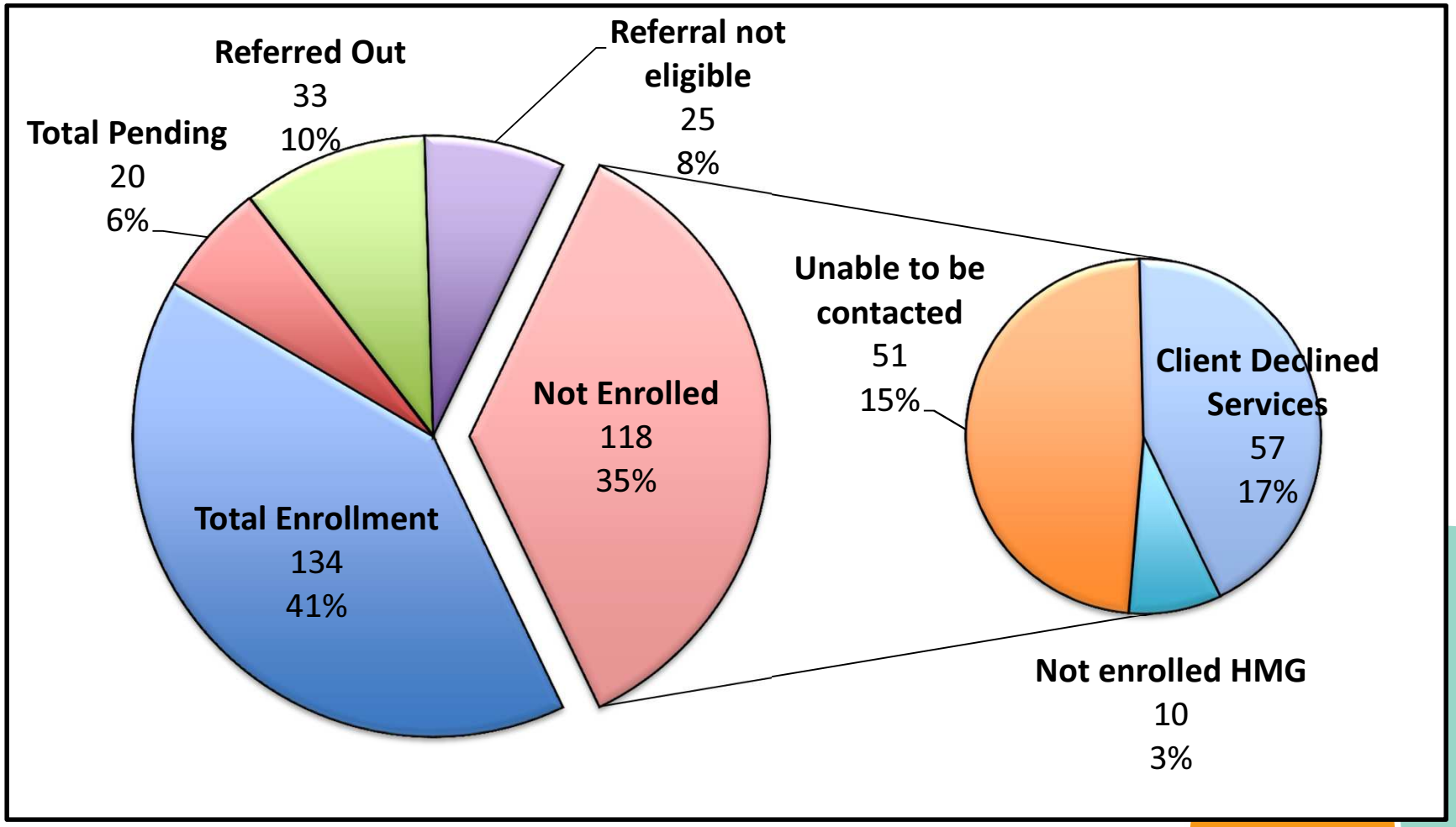


Referral by Geographic Area



Referral Outcomes

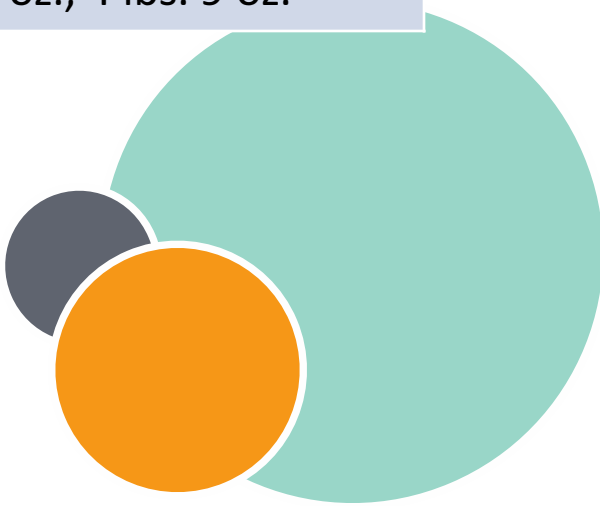
N= 330



Birth Outcomes
April 1- October 25, 2015

Total Number of Births	29 (including 1 set of twins)
Healthy Birth Weight (excluding twins)	20
Low Birth Weight (excluding twins)	6
Preterm Deliveries	6
Infant Death	1 (congenital defect- referred for supportive services)
Twins	34 weeks gestation, 5 lbs. 0 oz., 4 lbs. 9 oz.

*At this time, birth outcomes are only able to be collected for clients enrolled into Pathways program



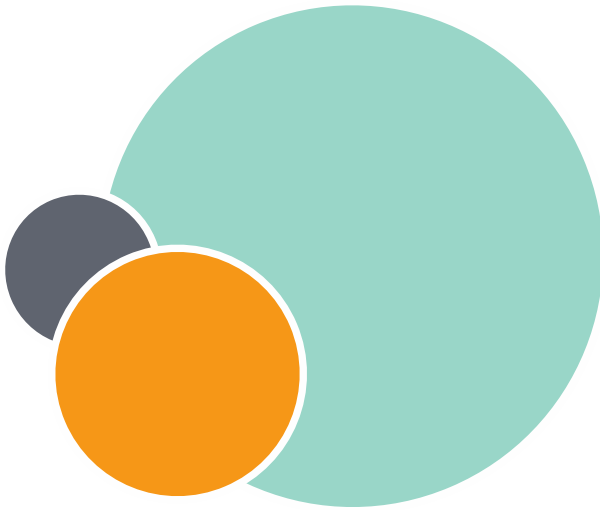
Analysis of Low Birth Weight Births

Of the 6 moms who delivered babies born Low Birth Weight…

- 5 were African American
- 3 resided in 43608 zip code
- 5 were referred at 28 weeks (3rd Trimester), 1 referred at initial
- Average length of time in Pathways program was 7 weeks

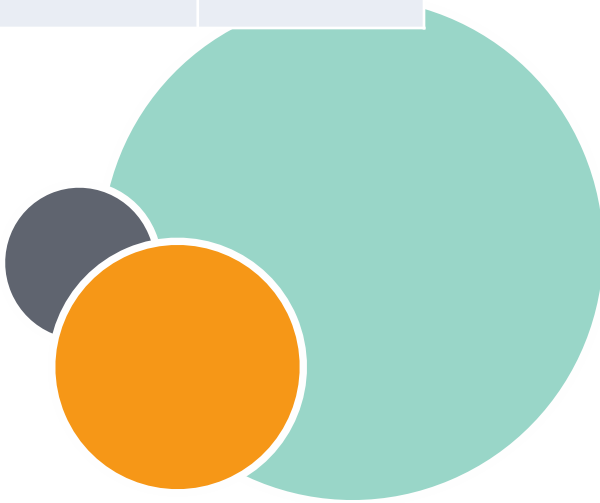
Top Indicated Reasons for Referral:

- Food (3/6)
- Housing (3/6)
- Mental Health (3/6)
- Transportation (3/6)
- Tobacco Use (2/6)
- Substance Use (2/6)



Additional Outcomes

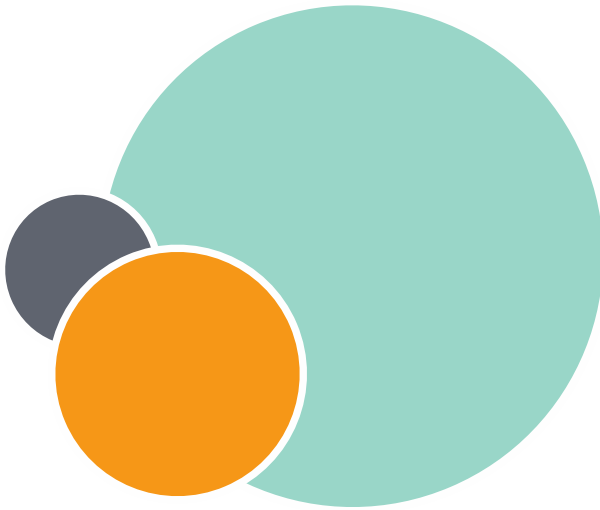
	How it's Measured	Attended	Eligible
Postpartum Appointment	Appointment attended 21-56 days after delivery	9	11
Well Baby Visit	Attendance of visit w/ pediatrician	27	28
Reliable Family Planning Method	Family planning method selected and in place at postpartum appointment	5	11
Breastfeeding	Mother breastfeeding at postpartum	5	10



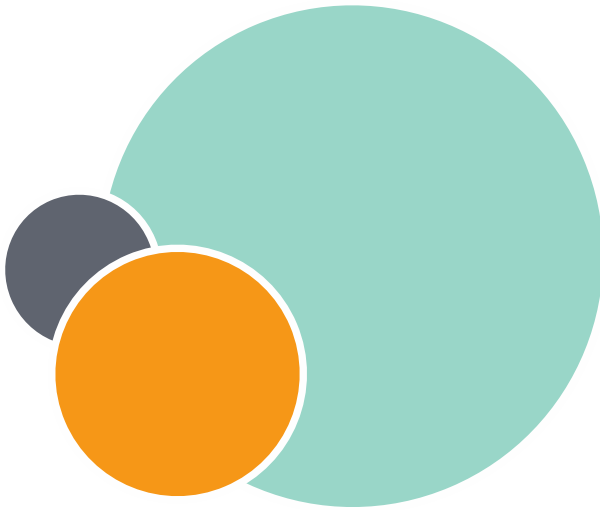
Success Story

Meet Kristin

- 31 years old, Caucasian
- Referred to the HUB by her ProMedica provider at 26 weeks for opiate dependence
- Connected to a Community Health Worker at Mercy who specializes in opiate addiction in pregnancy
- Got her a next day appointment with Substance Abuse Services Inc. (SASI)
- Began daily dosing of methadone
- Delivered a 6lb., 15 oz., baby at 39 weeks
- Baby spent no time in the NICU and went home with mom

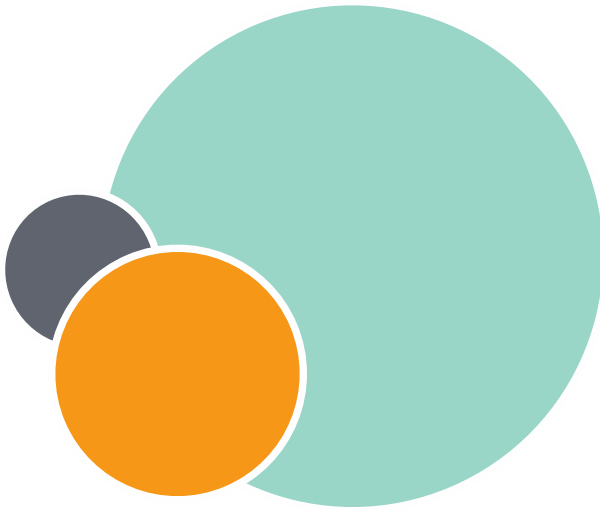


Provider's Perspective



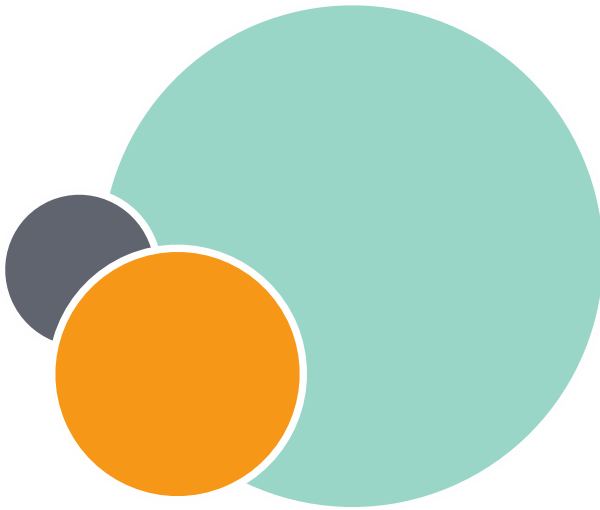
Next Steps

- Training and implementation of Pediatric Providers
- Implementation of Emergency Departments
- Engaging and Implementing other Healthcare Systems
- Implementation in WIC offices



Lessons Learned

- Collaboration is the key to success
- Need to identify a local champion
- Need to be flexible- what works in one office may not work in every office



Discussion