

ABSTRACT:

1. PROJECT IDENTIFICATION

Project Title: Medical Care Management for Complex Prenatal Patients (MCMCPP)

Project Number: H17MC25695

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Grantee Organization: St. John's Well Child and Family Center

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Project Period: 3/1/13 - 2/28/18,

Total Amount of Grant Awarded: \$47,000 per year for 5 years

Project Title: Medical Care Management for Complex Prenatal Patients (MCMCPP)

PURPOSE: South L.A. has some of the worst health outcomes for mothers and children in all of Los Angeles County. There are a lack of able health partners in the area that collectively address the overwhelming medical needs of high-risk, complex prenatal patients, and many local providers have limited ability to coordinate the full range of primary care and social services needed to keep a mother and child healthy. The purpose of the MCMCPP is to address unmet need by providing a comprehensive medical care management program to positively impact maternal and infant health outcomes .

GOALS AND OBJECTIVES:

Goal: Improve health outcomes for low-income mothers and their children in South L.A.

Process Objective 1: Between 3/1/2013 and 2/28/2018, comprehensive medical care management services will be provided by one or more members of the care management team (e.g. RN Medical Care Manager (RNMCM), LVN/Prenatal Coordinators) to a minimum of 250 prenatal patients with complex annual needs, annually.

Outcome Objective 2: By the end of Year 5, 2/28/2018, St. John's care management will increase the proportion of healthy newborns born to mothers who received prenatal medical care management at St. John's who are seen for their first well baby visit at St. John's within four weeks after delivery from 0% to 80%. This outcome remains an objective for years 2-5.

Outcome Objective 3: By the end of Year 1 (2/28/14), increase from 72% to 78% the proportion of patients seen at St. John's with a positive pregnancy diagnosis who initiate prenatal care in their first trimester (Informed by Healthy People 2020). This outcome also remains an objective for years 2-5.

Outcome Objective 4: By the end of year 5, 2/28/2018, participation in the MCMCPP program will increase breastfeeding initiation and 6-week post-partum breastfeeding rates among patients and will increase 6-month exclusive postpartum breastfeeding rates among patients who received prenatal medical care management from 0% to 60%.

Outcome Objective 5: By the end of year 1 (2/28/2014), increase the percentage of women with complex and high risk pregnancies seen by the care management team (e.g. RN/MCM, LVN/Prenatal Coordinators) who receive prenatal counseling and education and opportunities for referral to additional community resources (e.g. WIC, home visitation, housing assistance) by the 28th week from 0% to 90% (informed by Institute for Clinical Systems Improvement).

Outcome Objective 6: By the end of year 5 (2/28/2018) a minimum of 75% of newborns born to mothers who have received medical care management through the program who have received all recommended immunizations by three months of age (baseline: 0)

METHODOLOGY: For the proposed MCMCPP project, a bilingual RN/MCM will provide individually tailored medical care management and coordination for perinatal patients with complex medical needs as well as linkage of their newborns to a pediatric provider. Activities include: outreach and education in order to inform the target population; stratification and enrollment of prenatal patients in the program according to their medical risk; intensive care management and education; patient and newborn linked to a medical home for follow up care post delivery; ongoing training of the providers and staff in cultural competency. This innovative project is highly cost effective.

EVALUATION: St. John's has established quality and performance measures for the MCMCPP project, and assesses progress monthly and annually. The following qualitative data was collected: the number

of patients who receive comprehensive medical care management; the number of newborns who are seen for their first well baby visit within four weeks after delivery; number of patients who initiate prenatal care in their first trimester; rates of breastfeeding at 6-week and exclusive breastfeeding a 6 months post-partum; number of women who receive prenatal counseling and education; number of newborns who receive all recommended immunizations by three months of age; patient demographics and financial viability/costs. These measures align with national standards commonly used by Medicare, Medicaid, AAP, ACOG, and health insurance and managed care organizations. Furthermore, St. John's administers a patient satisfaction survey annually.

RESULTS/OUTCOMES: Over the five-year program period, St. John's served 1,231 mothers in the MCMCPP program. St. John's MCMCPP program has met or exceeded all outcome measures. In addition to offering coordinated medical care management and comprehensive primary medical care for women with complex pregnancies, the MCMCPP has evolved to include additional obstetric services, stronger linkages to additional supportive services and has been able to serve a larger number of prenatal patients. The success of the MCMCPP program continues to inspire improvements in St. John's OB and prenatal program, especially with patient education and linkage to support services.

PUBLICATIONS/PRODUCTS: St. John's MCMCPP staff developed and implemented a "prenatal card" mimicking a punch card that links medical appointments, social service needs, health education and social events in one place. In addition, SJWCFC's contracted with a public relations and communications firm who developed outreach materials specific to the MCMCPP program.

DISSEMINATION/UTILIZATION OF RESULTS: St. John's engaged public relations and communications assistance to develop a comprehensive prenatal program strategic marketing and community outreach campaign in order promote the services offered through the prenatal program, including the MCMCPP program, and raise awareness among both local hospitals, healthcare providers, current and potential patients.

FUTURE PLANS/SUSTAINABILITY: St. John's will continue to expand its successful strategy of aggressive fundraising among private sources (institutions and individuals). In addition, St. John's will continue to ensure that all eligible patients are tied to the revenue stream for which they are eligible through enrollment in existing third party payor programs including Medi-Cal, and where applicable the State's Family Planning, Access, Care and Treatment (Family PACT). The short term impact of the MCMCPP program includes more high-risk pregnant women engaged in enter prenatal care early, more newborns born in high-risk pregnancies receive their first well baby visit within four weeks after delivery; more mothers with high-risk pregnancies initiate and sustain breastfeeding up to 6-months; and more infants born in high-risk pregnancies receive the recommended immunizations by three months of age. The long-term impact of the program on participants and their babies includes improved health outcomes. St. John's now serves a larger population of complex prenatal patients in concert with its dramatically increased capacity to link patients with additional healthcare services and a wide variety of supportive services capable of addressing the multiple stressors that can negatively impact maternal and child health outcomes. The implementation of MCMCPP has strengthened information sharing and care coordination between the hospital and all St. John's health centers and improved access to comprehensive medical services in a medical home for mothers during and after their pregnancy.

ANNOTATION: The primary goal of the MCMCPP is to improve health outcomes for low-income mothers and their children in South L.A. and to enhance the capacity of our Perinatal Health Initiative to provide diverse, interlocking services for complex prenatal patients who present with multiple needs. The goals and objectives of this project reflect our commitment to a holistic approach to patient care, integrating different components of the safety net delivery system under one roof.

KEY WORDS: Medical Care Management; Complex Prenatal Patients; Coordinated Care

MATERNAL AND CHILD HEALTH BUREAU (MCHB)
SPECIAL PROJECTS OF REGIONAL AND NATIONAL SIGNIFICANCE (SPRANS)

ST. JOHN'S WELL CHILD AND FAMILY CENTER
FINAL REPORT AND ABSTRACT

Narrative:

- 1. PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS: Briefly describe the major purpose(s) of the project and the needs and problems it addressed. Indicate the program priority under which the project was funded. Explain the relationship to the State Title V MCH Program and state/local AAP chapter(s).**

St John's Well Child and Family Center (St. John's) "Medical Care Management for Complex Prenatal Patients" (MCMCPP) Program added medical care management for complex prenatal patients to St. John's existing Perinatal Health Initiative and strengthened integration of the safety net delivery system critical to increasing access to healthcare services, coordinating care, and connecting mothers and newborns within our target population to a medical home. This program was funded under the Healthy Tomorrows Partnership for Children Program. In addition to offering coordinated medical care management and comprehensive primary medical care for women with complex pregnancies, the MCMCPP added additional obstetric services, stronger linkages to a diversity of supportive services and enabled service to a rapidly growing number of prenatal patients. The MCMCPP program has developed the capacity to address a wide range of stressors impacting the wellness of pregnant women and their babies, including but not limited to assessing for and coordinating care for mental health, substance abuse issues, housing, legal and childcare issues.

St. John's service area is located in South Los Angeles (L.A.), a densely populated urban area of L.A. County in California. Of the estimated 1.2 million residents of South L.A., 63.5% are Latino, 32.5% are Black and 1.5% are Non-Hispanic White. Approximately 80% of patients seen at St. Johns clinics are

from households with incomes of less than 100% Federal Poverty Level (FPL). Data overwhelmingly indicate that families living in poverty show higher rates of poor birth outcomes and are less likely to have health insurance or access to quality health care. South L.A. has consistently exhibited some of the worst health outcomes for mothers and children in all of L.A. County. Data show that mothers from L.A. neighborhoods with concentrated poverty are 34% more likely to experience maternal health risks and 24% more likely to give birth to a baby with health complications. The overall rate of preterm births and low birth weight are higher in South L.A. than in L.A. County as a whole and in Los Angeles neighborhoods showing concentrated poverty, the rate of birth to young mothers below the age of 19 is nearly twice as high as the county average. Pregnant women of all ages living in areas of concentrated poverty are less likely to receive early prenatal care while pregnant teens are twice as likely as adults to delay or forgo prenatal care due to insufficient access to healthcare services.

There is a lack of able health partners in the area capable of collectively addressing the overwhelming medical needs of the MCMCPP target population. There are over 20 designated federal Medically Underserved Areas (MUA) and Health Professional Shortage Areas (HPSA) in South L.A. Many local providers have limited ability to coordinate the full range of primary care and social services needed to keep a mother and child healthy. Exacerbating the impact of this shortage, local providers often have limited ability to share patient information or coordinate the full range of primary care, specialty care, inpatient care, behavioral health and social services needed to support healthy outcomes for mothers and their children. The MCMCPP works to fill these resource gaps and serves as a highly effective and replicable model for regions facing similar challenges.

In concert with the launch of the MCMCPP, St. John's developed a collaborative relationship with the California Title V Maternal and Child Health Block Grant Program via membership with the Association of Maternal and Child Health Programs (AMCHP) and the AAP California Chapter 2 in Los Angeles to support the goals and objectives of the MCMCPP. As a collaborative partner, St. John's staff

collaborated with AMCHP to disseminate best practices learned following five years of program development, particularly sharing practices related to patient retention, improving service efficiency and branding and outreach strategies to encourage community building and patient trust. In addition, St. John's integrated Title V-funded programs such as Welcome Baby into the operations of the MCMCPP.

2. GOALS AND OBJECTIVES: Describe the goals and objectives of the project and show how they relate to the item above.

The primary goal of the MCMCPP is to improve health outcomes for low-income mothers and their children in South L.A. and to enhance the capacity of our Perinatal Health Initiative to provide diverse, interlocking services for complex prenatal patients who present with multiple needs. The goals and objectives of this project reflect our commitment to a holistic approach to patient care, integrating different components of the safety net delivery system under one roof.

Primary Objectives:

- Process Objective 1: Between 3/1/2013 and 2/28/2018, comprehensive medical care management services will be provided by one or more members of the care management team (e.g. RN Medical Care Manager (RNMCM), LVN/Prenatal Coordinators) to a minimum of 250 prenatal patients with complex annual needs, annually.
- Outcome Objective 2: By the end of Year 5, 2/28/2018, St. John's care management will increase the proportion of healthy newborns born to mothers who received prenatal medical care management at St. John's who are seen for their first well baby visit at St. John's within four weeks after delivery from 0% to 80%. This outcome remains an objective for years 2-5.
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- Outcome Objective 6: By the end of year 5 (2/28/2018) a minimum of 75% of newborns born to mothers who have received medical care management through the program who have received all recommended immunizations by three months of age (baseline: 0)

As outlined in Objectives 2, 3 and 5, the MCMCPP aims to build St. John's capacity to meet the holistic needs of a larger group of prenatal patients and to meet a diversity of patient needs throughout pregnancy, birth and infancy. As evidenced by patient data over the life of the grant, more St. John's families are utilizing MCMCPP services from the prenatal needs through to early childhood. Utilizing our RNMCM who is also a trained midwife, the program has increased its capacity to meet the needs of patients with higher risk pregnancies throughout the duration of the pregnancy and after birth.

3. METHODOLOGY: Briefly describe the program activities used to attain goals/objectives and comment on innovation, cost, and other characteristics of the methodology.

Program Activities

The MCMCPP project engages members of St. John's staff, led by our bilingual RNMCM to

provide individually tailored medical care management and coordination for perinatal patients with complex medical needs as well as linkage of their newborns to a pediatric provider. Activities include: outreach and education in order to inform the target population; stratification and enrollment of prenatal patients in the program according to medical risk; intensive care management and education provided by the RNMCM; patients and newborns linked to a medical home for follow up care post delivery; ongoing training of the providers and staff in cultural competency. The MCMCPP has also become the epicenter of a hub of coordinated services provided by St. John's and partner programs that together work to not only address medical need, but to also address that social determinants of health.

To address Objective 1, St. John's hired an RN Care Manager (RNMCM) to provide individually tailored medical care management and coordination for perinatal patients with complex medical needs. The candidate selected is also trained as a midwife and plays an integral role in the continued development of the MCMCPP. The RNMCM is supported by the addition of a Family Specialist at St. John's under Project DULCE, who plays an integral role in identifying high risk perinatal patients, building trusting relationships with clients over long periods of time and facilitating connections with relevant social service agencies depending on the needs of each individual client. For example, clients born into slum housing are connected to the Healthy Homes Collaborative where a promotora supports the family with low-tech solutions to combat environmental hazards in the home. Clients experiencing postpartum depression are linked directly to resources for behavioral health.

MCMCPP Patient Care Flow

Prenatal patients with complex and high-risk pregnancies are identified by the primary care and OB providers and referred to the RNMCM. After initial referral, the RNMCM reaches out to the patient to schedule initial assessments and educational sessions. The RNMCM and/or members of the care team provide education to expecting mothers regarding what to anticipate at various stages of their pregnancy, including necessary tests and screens that occur during different gestational periods.

Additionally, patients are provided with education regarding prenatal nutrition and instructions for following prenatal care schedules and any medical care plan that has been created for the patient during their pregnancy. Each patient within the program is also referred to St. John's Registered Dietitian for individualized counseling regarding nutrition during their pregnancy based on their medical history, current conditions and general needs.

Education is also provided to prenatal patients in the MCMCPP throughout their pregnancy by the care management team during appointments, periodic check-ins and assessments. Patients are also referred to *Comunicando Bien*, a bilingual, evidence-based curriculum of prenatal education classes developed by March of Dimes. It is taught by MCMCPP care team members and offered in sessions that cycle every eight weeks and cover topics such as prenatal nutrition, what to expect during pregnancy, and breastfeeding. During the prenatal education classes, MCMCPP patients share experiences with one another and learn from each other.

After delivery, the RNMCML links mothers and their babies to follow-up pediatric care at St. John's. The MCMCPP care team actively follows up with the mothers to ensure their post-partum medical check-up is scheduled, coordinates the first visit with the pediatrician and request all medical information from the hospital where she delivered to update the patient medical records. MCMCPP patients are incentivized to return to St. John's post-delivery for their post-partum Comprehensive Perinatal Services Program (CPSP) assessment during which a breast pump can be issued by the RNMCML. At this time, patients are also provided additional education and support in accordance with CPSP protocols, and any issues encountered with breastfeeding thus far can be addressed.

Partnerships

In order to achieve grant objectives, St. John's leveraged relationships with several local providers. For example, in 2012, St. John's embarked on a Perinatal Health Improvement initiative in partnership with St. Francis Hospital, then assumed operations of St. Francis Medical Center's existing

pediatric and obstetric practice with specialty care provided by a Perinatologist. St. John's also leveraged its long-term partnership with Planned Parenthood of Los Angeles to share referrals and maximize availability of reproductive and family planning resources. These partnerships and structural shifts, among others, enabled the launch of the more sophisticated and coordinated referral process for natal and prenatal patients and their babies that served as the precursor for the MCMCPP. This continuously improving process links mothers seen for prenatal care at St. John's health centers to St. Francis Hospital for delivery, the links them back to St. John's for continued services. The MCMCPP acted as a further development of this program, enhancing and improving St John's capacity to meet the needs of complex prenatal patients.

St. John's has created additional programs that support the objectives and outcomes of the MCMCPP program and the RNMCM works closely with each project and their corresponding staff. Project DULCE (Developmental Understanding & Legal Collaboration for Everyone) is a pilot program based on the evidence-based pediatric care intervention that proactively addresses social determinants of health and promotes the healthy development of infants from birth to six months of age through the reduction or elimination of toxic stress in the home. Project DULCE provides families with support for age-related information on child development and any unmet legal needs in addition to ongoing support from a Family Specialist, along with support and referrals for housing, food, and other pressing needs. Families meet with the Project DULCE Family Specialist at routine visits. The Family Specialist also provides home visits and telephone check-ins, dependent on the families' preferences and needs. The Family Specialist works closely with the MCMCPP care team and is in contact with new mothers to be sure of continuity of care for them and their babies.

In collaboration with the Service Employees International Union, United Healthcare Workers West (SEIU-UHW), St. John's launched another program in August 2016 for home visits by Licensed Vocational Nurses (LVNs) to prenatal patients of St. John's. The goal of the program is to demonstrate a

new model of care for Medi-Cal beneficiaries and hopes to demonstrate that timely, lower-cost, and high care is possible through mobile LVNs supported by physicians through new technologies. For many of St. John's patients, it is difficult to get in for prenatal visits due to poor public transportation and poverty, thus deploying LVNs for home visits reduces that barrier. Under the supervision of St. John's physicians, LVNs, employed by Nursing and Caregivers Cooperative, Inc., a healthcare worker-cooperative founded, owned and operated by LVNs, provides mobile visits and education to prenatal patients in their homes. St. John's contacts eligible patients who may be interested in these visits, schedules appointments, and then coordinate to deploy LVNs to these visits. The mobile LVNs identify high risk and complex prenatal patients, then refer to MCMCPP program as needed, but the ability to do home visits reduces the incidence of missed appointments, thus bolstering prenatal visits and care.

Innovation and Cost Effectiveness

Early identification and intervention of high-risk pregnancies are critical to improve individual and public health, while saving health care dollars. SJWCFC's MCMCPP Program is innovative in that it takes a population health management approach to identifying high-risk, complex prenatal patients and delivering medical care management. A bilingual RN/MCM provides individually tailored medical care management and coordination for perinatal patients with complex medical needs as well as linkage of their newborns to a pediatric provider. These efforts are further bolstered by our innovative strategies designed to increase patient loyalty and long-term relationships with St. Johns. This occurs through our approach to branding, appointment scheduling and patient engagement strategies that have proven effective in generating trust (both between medical providers and clients and between referral organizations and clients), increasing reliability for appointment attendance (as clients are able to make appointments far in advance and receive a document outlining all appointments throughout their pregnancy and delivery), opportunities for relational support building amongst clients (via monthly baby showers and other community events for expectant mother) and general education opportunities for

clients that help address the often complex, interlocking challenges our clients are facing. St. John's staff developed and implemented an attractive, well-designed "St. John's prenatal card" mimicking a punch card that links medical appointments, social service needs, health education and social events in one place. Mothers that complete needed tests, labs, visits, courses and assessments are eligible for raffle prizes distributed at St. John's well-attended twice monthly celebratory baby showers for expectant mothers. This deceptively simple tool has proven effective at supporting clients to organize often complex appointment schedules while also providing mothers with opportunities to meet and support one another socially via the baby showers. St. John's staff has found that all aspects of the MCMCPP outlined above have contributed to our organizational capacity to meet the objectives outlined in this grant.

Through focused and attentive management and coordination of care, the MCMCPP ensures that complex prenatal patients receive the highest quality services, which in the long run proves to be cost effective. Research demonstrates that prenatal care generates cost savings for women with high-risk pregnancies. Intensive prenatal care saves \$1.37 for every \$1 invested in augmented prenatal care (Sackett, 2004) and reduces hospital and NICU admissions among infants, resulting in cost savings ranging from \$1,768 to \$5,560 per birth (Reece et al, 2002).

4. EVALUATION: Briefly describe the evaluation methods used to assess the effectiveness of the project in attaining goals/objectives.

St. John's has established quality and performance measures for the MCMCPP project, and assesses progress monthly and annually. The following qualitative data was collected: the number of patients who receive comprehensive medical care management; the number of newborns who are seen for their first well baby visit within four weeks after delivery; number of patients who initiate prenatal care in their first trimester; rates of breastfeeding at 6-week and exclusive breastfeeding a 6 months

post-partum; number of women who receive prenatal counseling and education; number of newborns who receive all recommended immunizations by three months of age; patient demographics and financial viability/costs. These measures align with national standards commonly used by Medicare, Medicaid, AAP, ACOG, and health insurance and managed care organizations. Furthermore, St. John's administers a patient satisfaction survey annually.

St. John's Quality Improvement Director queries this process and outcome data via its robust electronic health record system, conducts analysis of the data, and creates reports. These reports are shared monthly with the Advisory Committee, senior management, medical leadership and the Board of Directors and used to inform and guide the development, modification, and implementation of the MCMCPP and assure continuous quality improvement. MCMCPP staff meet monthly to review and discuss data results in order to determine if the program is meeting the need, and if additional interventions are required, new adaptations needed, or additional services are necessary.

5. RESULTS/OUTCOMES: Summarize the major results. Highlight any health status outcomes, systems changes, lessons learned and outcomes, which have potential for transfer and replication. Provide the number of individuals identified by racial and ethnic group who were served.

Demographics: individuals by racial and ethnic groups served

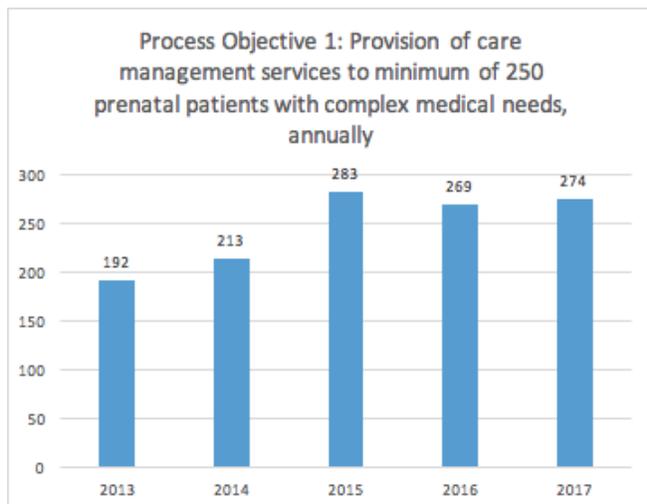
Over the five-year program period, St. John's served 1,231 mothers in the MCMCPP program. Of the target population, 85% is Hispanic/Latino and 13% African-American. Eighty percent of women served were from households with incomes of less than 100% FPL; 100% served had incomes below 200% FPL.

Summary of major results

St. John's is pleased to report that our MCMCPP program has grown and developed over the course of the life of the grant and that we have met or exceeded all outcome measures. In addition to offering coordinated medical care management and comprehensive primary medical care for women

with complex pregnancies, the MCMCPP has evolved to include additional obstetric services, stronger linkages to additional supportive services and has been able to serve a larger number of prenatal patients. The success of the MCMCPP program continues to inspire improvements in St. John’s OB and prenatal program, especially with patient education and linkage to support services. OB services continue to be held six days per week with a total of three OB providers, and two Certified Nurse Midwives, along with a Family Practice MD and NP. This staff is all very supportive of the MCMCPP program and work with the care team to ensure that patients with complex pregnancies who participate in the program are provided comprehensive care.

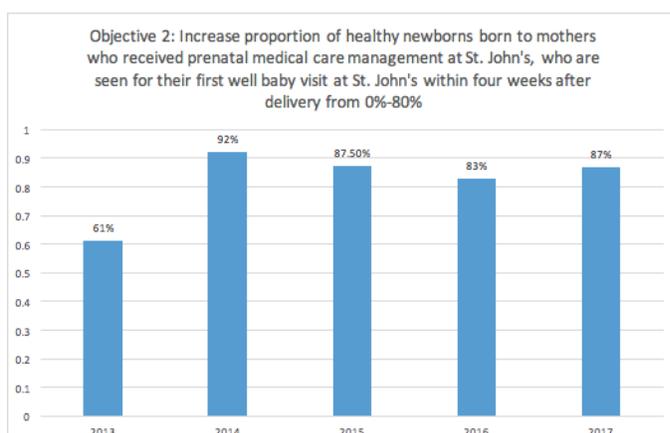
Outcomes



In the second year of the life of the grant, the MCMCPP evaluation was revised by St. John’s Internal Evaluator in conference with the Chief Medical Officer, women’s health providers, the RNMCM and Advisory Committee members. The Internal Evaluator made modifications to the evaluation plan and program objectives, with input from Advisory

Committee members, the American Academy of Pediatrics and the HRSA Healthy Tomorrows evaluation technical assistance representative. Final revisions to the evaluation plan were approved by the Advisory

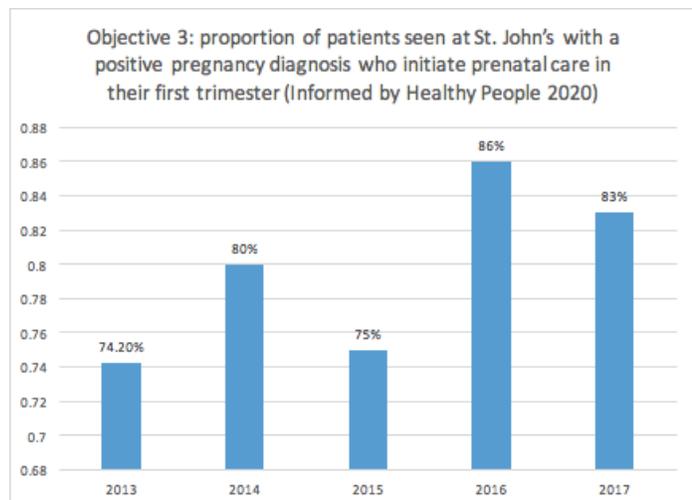
Committee and submitted to HRSA in October of 2014.



St. John's is pleased to report that we met or exceeded the Process Objective 1 target of serving 250 prenatal patients with complex medical needs annually. Over the five years of the grant, St. John's served 1,231 prenatal patients. The MCMCPP care team continues to support the RNMCM in coordinating care for prenatal patients with complex pregnancies. The RNMCM sees the majority of patients in the program, and is assisted by the prenatal coordinators to provide prenatal education, facilitate appointments, coordination of obtaining and providing health related documents and information to appropriate medical providers in the clinic and hospital setting whenever necessary, transportation and support services, and facilitating appointments for related services offered on-site at St. John's (e.g. dental, behavioral health, homeless services, early childhood programs, etc.)

Choosing a provider for their babies can be confusing for new mothers, thus the RNMCM follows up with all women post-partum to discuss their options. They are encouraged to bring their baby back to St. John's for well-baby care, but are

also told that they are free to see a pediatric provider of their choosing. During the first year of the MCMCPP, of patients with complex pregnancies who received medical care management from the RNMCM, 61% attended primary medical visits at St. John's with their babies through six weeks post-partum. However, The target of 80% was

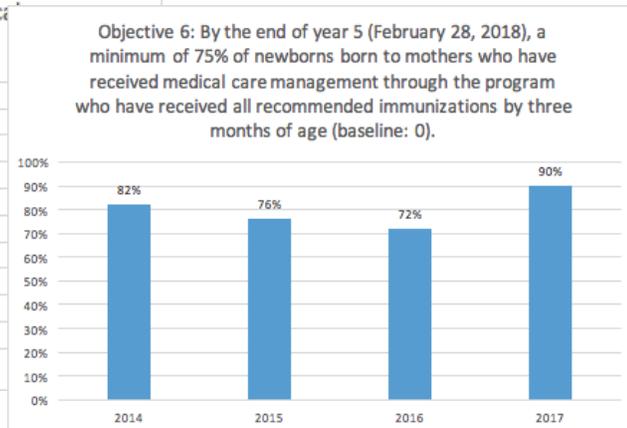
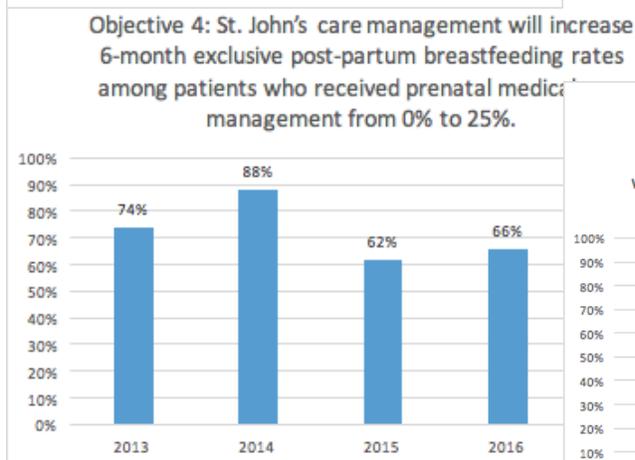
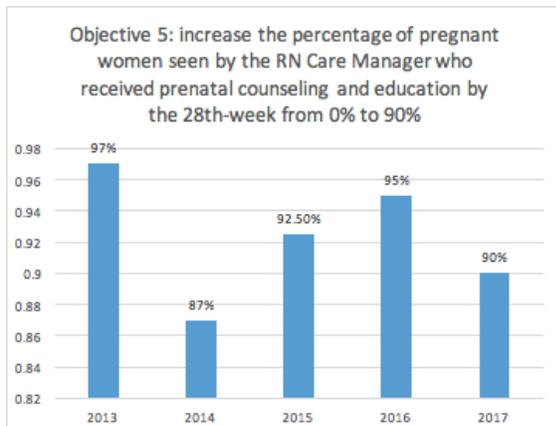


met or exceeded each of the following years of the life of the program fulfilling Outcome Objective 2.

While retaining newborn patients of women after delivery remains challenging, the improvements in year two, which include the RN Medical Care Manager following up with all women prior to delivery and after the baby is born to encourage them to bring their child back to St. John's for well-baby care, have

yielded consistent results.

St. John's is pleased to report that Objective 3 has been met or exceeded each year of the life of the grant with a five-year average of 80%. St. John's medical leadership team continues to prioritize immediate prenatal care as a measure of quality improvement within the women's health program.



St. John's also met or exceeded our objectives of increasing rates of initiation of and breastfeeding at 6-week post-partum among patients in the MCMCPP with a five year average of 74.4% significantly higher than the goal of 25%. The MCMCPP care team, providers, and other support staff working with prenatal patients promote

breastfeeding and provide referrals and

linkage to lactation assistance from the MCM as needed. Breastfeeding is supported through education, support groups, assessment of barriers and one-on-one support from the care team, as well as distribution of breast pumps as needed at patients' first post-partum visits.

In 2013 and 2016, the MCMCPP served almost all pregnant patients with prenatal counseling and education by the 28th week, at rates of 97% and 95% respectively. As a rule, 100% of women who

received care management services within the MCMCPP also received this counseling and education as part of their participation in the program, even if it may have been after the 28th week. As previously mentioned, St. John's medical leadership works diligently to quickly identify positive pregnancy diagnoses and refer patients for initiation of prenatal care at the earliest possible moment, yet there are some patients who are seen at St. John's for the first time within their third trimester who, despite being immediately connected to care, receive these services after the optimal time frame.

All parents and guardians of children 2 years of age and under are given resources and education as to why childhood immunizations are important and protective as part of routine clinical visits. The MCMCPP care team also provides this education and explains the reasons why compliance with recommended vaccination schedules is good for the babies and those around them. It should be noted that typically over 70% of children who were seen at St. John's Frayser clinic for well-baby and well-child visits during the project period obtained all required immunizations on or before their third birthday.

Lessons

MCMCPP staff and leadership identified several lessons and areas for growth following five years of program operation. As St. John's staff refer expectant mothers to sites within their health plans, MCMCPP staff and leadership explored several mechanisms by which to ensure that care providers become consistent, familiar figures and that patients are made aware of the multitude of resources available via the MCMCPP program. Orientation to the full range of services offered has proven especially key when serving patients from other clinics. In addition to prenatal care, MCMCPP staff are able to engage in more in-depth conversations with new and expectant mothers, creating vital opportunities to address multiple stressors.

MCMCPP care providers found that scheduling pregnant patients in advance for all appointments that they will need for their prenatal, birth and postpartum care made clients more likely

to attend appointments throughout their pregnancy, birth and postnatal needs. Staff had the capacity to make appointments far in advance and then provide a printout of all needed appointments and educate clients that they can schedule a follow up appointment within two weeks of any missed appointment. This structure increased retention for both mothers and babies and supported clients to consider their maternal health and supportive service needs holistically and as centered around the services and referrals that St. John's can provide.

Staff and leadership reported that the use of St. John's simple but highly effective "prenatal card" also supported mothers to keep track of their appointments and to link supportive services and educational opportunities with their medical visits in one tool. The prenatal card is colorful and well-designed, providing a branding and community engagement aspect to tracking activities that support mother and child's wellness. After 20 weeks, expectant mothers are invited to attend baby showers held at St. John's where they can show their activity on the prenatal card (which includes prenatal, nutrition and dental, among other options to track activities) in order to participate in raffles and other activities. All of these activities build rapport, trust and familiarity which has increased likelihood that clients will make their scheduled appointments and provide honest information about their needs to St. John's staff so that they can have an optimal positive impact. Staff are then able to connect clients to resources beyond the OB visit and patient make a more accurate report of symptoms and needs. In fact, staff have observed that a sizable number of patients come to the baby showers every eight weeks and report building relationships there that have become an additional support system.

Providers found that there was a need for additional supports to be able to serve patients who do not speak either Spanish or English. Staff reported that it was challenging to communicate with speakers of other languages, especially given the need to ensure confidentiality. Staff has requested a "blue phone" to be implemented in the clinic to support staff's capacity to serve patients who are speakers of languages other than English and Spanish.

Systems Changes

In terms of systems changes, key shifts occurred via implementation of the Family Specialist Model, expanding tracking of outcomes and services to new mothers to six months after birth and adding additional supports for new mothers in the first six months. St. John's has especially focused on increasing/capturing data for mother's who return for their six-month visit post birth by scheduling follow-up appointments at birth and by improving screening and assessment for additional supportive services. By systematizing and scheduling appointments for the entire cycle of a pregnancy and post-birth, St. John's works to ensure that new moms keep the same provider. By expanding and improving screening for services during early assessments, patients develop an understanding that St. Johns is a multifaceted resource. In our fifth year of operation we have especially improved our capacity to assess for and address symptoms of postpartum depression via screening and on-site located Behavioral Health staff.

Over the life of the grant, St. John's experienced turnover of the RNMCM position. Recruiting a culturally competent, bilingual RNMCM proved challenging. Despite staffing challenges, as of the fifth year of operation, the MCMCPP demonstrates an increased ability to access more patients and address a significantly wider pool of potential concerns.

6. PUBLICATIONS/PRODUCTS: List publications/products resulting from the project and the audiences for which each was designed. Products include but are not limited to: pamphlets, manuals, forms, surveys, questionnaires, CDs, DVDs, electronic educational products, slides, newsletters, training materials, web based training modules, protocols, standards, books, workbooks, brochures, articles, presentations, database formats. If the contact person for a particular publication/product is someone other than the Project Director, please provide his or her name, address, telephone number, and e-mail address.

St. John's staff developed and implemented an attractive, well-designed "St. John's prenatal card" mimicking a punch card that links medical appointments, social service needs, health education and social events in one place. In addition, St. John's contracted with an outside firm to develop MCMCCP marketing and outreach materials.

7. DISSEMINATION/UTILIZATION OF RESULTS: Describe action taken to share information/findings/products/resources with others within and outside the State.

St. John's Chief Medical Officer and Development Director engaged public relations and communications assistance from Elle Communications to develop a comprehensive prenatal program strategic marketing and community outreach campaign. The intention of this effort was to promote the services offered through the prenatal program, including the MCMCCP program, and raise awareness among both local hospitals, healthcare providers, current and potential patients. This campaign entailed print media, inreach and community outreach efforts to target women of childbearing age as well as those who are already pregnant.

Marketing activities also target other organizations in South L.A. that serve this population in order to inform them of St. John's MCMCCP and prenatal services. Elle Communications conducted media training with appropriate staff and worked with St. John's to identify patients for profile stories, creating pitches for media outlets.

The MCMCCP is also marketed through St. John's Outreach and Community Organizing Department. St. John's employs a team of Community Health Promoters and Outreach Workers, all of whom are mothers and/or grandmothers themselves, who participate in community events and publicize services available at our network of health centers, including special programs such as the MCMCCP. They have been intrinsic in furthering St. John's services by word of mouth and distributing

flyers.

8. FUTURE PLANS/SUSTAINABILITY: Describe plans for continuing the activities initiated by the project and future funding. Include anticipated results and both the short and long-term impact of the project.

Sustainability and Future Plans

In 2014, St. John's developed a sustainability plan with support from the HRSA Healthy Tomorrows Technical Assistance team. The sustainability plan incorporated both institutional integration of the program and objectives towards obtaining additional matching funding and maximizing reimbursement for all possible services to support the program in the long-term. Technical assistance was helpful in identifying strategies for improving the sustainability of the program, both through funding and institutional integration of program services. The sustainability plan addresses both institutional and financial sustainability issues, and includes insight from St. John's senior leadership and the MCMCPP program leadership and Advisory Board. In compliance with grant requirements and the sustainability plan, St. John's obtained the matching funding that is required of all grantees between years 2-5.

During year 3, St. John's MCMCPP became institutionalized within the St. John's OB practice. St. John's senior leadership invested in the OB practice and the MCMCPP and provided support needed to maintain the program. Beyond institutional sustainability, St. John's staff and leadership found other ways to support the activities of the program.

St. John's engaged in aggressive fundraising among private sources to support its programs. In 2013, St. John's received a \$280,000 grant (above the program-match requirement) from the California Community Foundation over two years to expand our perinatal service program and provide the medical care management program to complex prenatal patients. The same year, St. John's received a \$20,000

grant from the Jewish Community Foundation to support the salary of a pediatric provider to provide primary medical care to children ages 0-3 at St. John's Frayser Pediatric and Women's Health Center. In 2015, St. John's received a one-year grant from Kaiser Southern California (\$95,000 total; \$47,127 in matching funds) to support expansion and promotion of its OB practice. These funds satisfied the matching funding requirement of the HRSA Healthy Tomorrows grant and supported a portion of the salary of the RNMCM that is not covered by the HRSA Healthy Tomorrows funds, as well as a portion of the salary for an Outreach Worker to promote the program. CPSP reimbursement has also provided additional support to the salaries of the MCMCPP care team and OB providers to cover matching funds in years 2016 - 2018.

Future Funding

St. John's will continue to expand its successful strategy of fundraising among private sources (institutions and individuals). In addition, all three of St. John's clinic sites that provide OB services are designated Federally Qualified Health Centers, and as such receive annual funding to provide care to indigent populations. This status also qualifies these sites for a higher rate of Medi-Cal reimbursement. Furthermore, St. John's works diligently to ensure that all eligible patients are tied to the revenue stream for which they are eligible through enrollment in existing third party payor programs including Medi-Cal, and where applicable the State's Family Planning, Access, Care and Treatment (Family PACT). St. John's is a member of Health Care L.A. Independent Physician's Association (IPA), a non-profit managed care network. Through this IPA the agency contracts with numerous health plans. Additionally, a large number of St. John's patients became eligible for Medi-Cal coverage through the health reform expansions, creating sustainable reimbursement for health services for otherwise uninsured patients. Furthermore, L.A. County implemented the MyHealthLA program, which provides no-cost healthcare services for individuals and families who are currently uninsured and those who cannot obtain or may not be eligible for insurance. St. John's is a named Community Partner in this program, and is the

recipient of funds to cover healthcare services for patients enrolled in MyHealthLA.

Short term Impact of the Project

The short term impact of the MCMCPP program includes more high-risk pregnant women engaged in enter prenatal care early, more newborns born in high-risk pregnancies receive their first well baby visit within four weeks after delivery; more mothers with high-risk pregnancies initiate and sustain breastfeeding up to 6-months; and more infants born in high-risk pregnancies receive the recommended immunizations by three months of age. Through surveying and anecdotal feedback, MCMCPP staff and the RNMC have received positive reviews regarding the information learned by participants about breastfeeding, immunizations, nutrition, and general lessons on prenatal and post-partum care.

Long Term Impact of the Project

The long-term impact of the program on participants and their babies includes improved health outcomes. St. John's now serves a larger population of complex prenatal patients in concert with its dramatically increased capacity to link patients with additional healthcare services and a wide variety of supportive services capable of addressing the multiple stressors that can negatively impact maternal and child health outcomes. The implementation of MCMCPP has strengthened information sharing and care coordination between the hospital and all St. John's health centers and improved access to comprehensive medical services in a medical home for mothers during and after their pregnancy. The MCMCPP will have a long-term impact as a replicable program in an area of high need. As stated previously, South L.A., home to nearly one million people, is the largest area of contiguous poverty in the western United States. The region's residents face grave disparities and obstacles in accessing health care, making the MCMCPP program a significant support for low-income, minority women with complex pregnancies. The total number of patients served by this program is not high enough to affect the MCH population on a regional or national scale, but for those served, it has made a significant difference

locally. St. John's patient retention rates demonstrate the success of the program in an area facing great need.

The benefits of this program are exemplified through the following patient story: A African American female presented in her second trimester with preeclampsia and marijuana use. Upon first being referred to the program, the patient missed multiple appointments due to transportation issues. The RN Medical Care Manager was persistent in following up with the patient and connecting her to services to facilitate her attendance in prenatal visits. The patient was also referred to a local food bank and WIC for food assistance after it was revealed that she was food insecure. The RN Medical Care Manager also provided comprehensive prenatal education. The patient delivered a healthy baby, and the RN followed up with the new mom and linked both her and her baby back to the clinic for post-delivery follow up care.

ANNOTATION:

The primary goal of the MCMCPP is to improve health outcomes for low-income mothers and their children in South L.A. and to enhance the capacity of our Perinatal Health Initiative to provide diverse, interlocking services for complex prenatal patients who present with multiple needs. The goals and objectives of this project reflect our commitment to a holistic approach to patient care, integrating different components of the safety net delivery system under one roof.

KEY WORDS:

Medical Care Management; Complex Prenatal Patients; Coordinated Care