

Community Collaborations Impacting Health Equity

The Delivering Change Model

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Delivering Change: Healthy Families,
Healthy Communities

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Kansas Perinatal Quality Collaborative

Kansas Maternal Mortality Review

Kansas Department of Health & Environment



objectives

- 1/ Delivering Change model
- 2/ Understand cross-system collaborations
- 3/ Impacts on local health equity
- 4/ 4th Trimester- Statewide model
- 5/ Recognize potential collaborative partners in your own communities

Delivering Change: Healthy Families, Healthy Communities

Non-profit agency in Geary County aimed at reducing the morbidity & mortality of infants & women in our community.

Achieved through:

- Comprehensive & centralized care coordination
- Serving the community through the life progression



"Healthy moms make healthy babies, which creates a healthy family as a part of a healthy community."

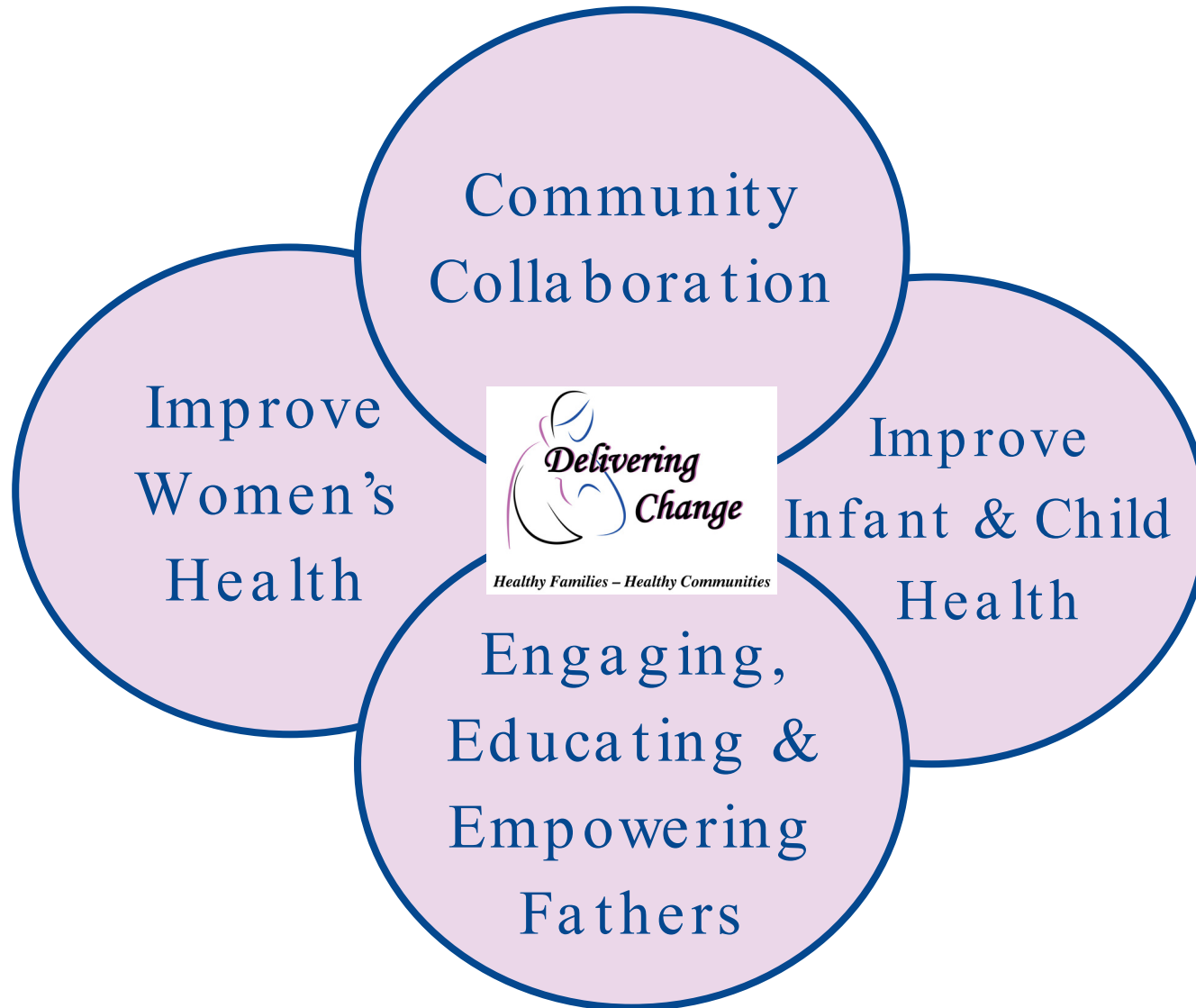
Delivering Change History

- 2011-IMR- 10.4/1000 live births (top 4 in the state)
- Geary County Perinatal Coalition- “call to action”
- Coalition grew into Delivering Change Model



Delivering Change Model

Collaborative Approach

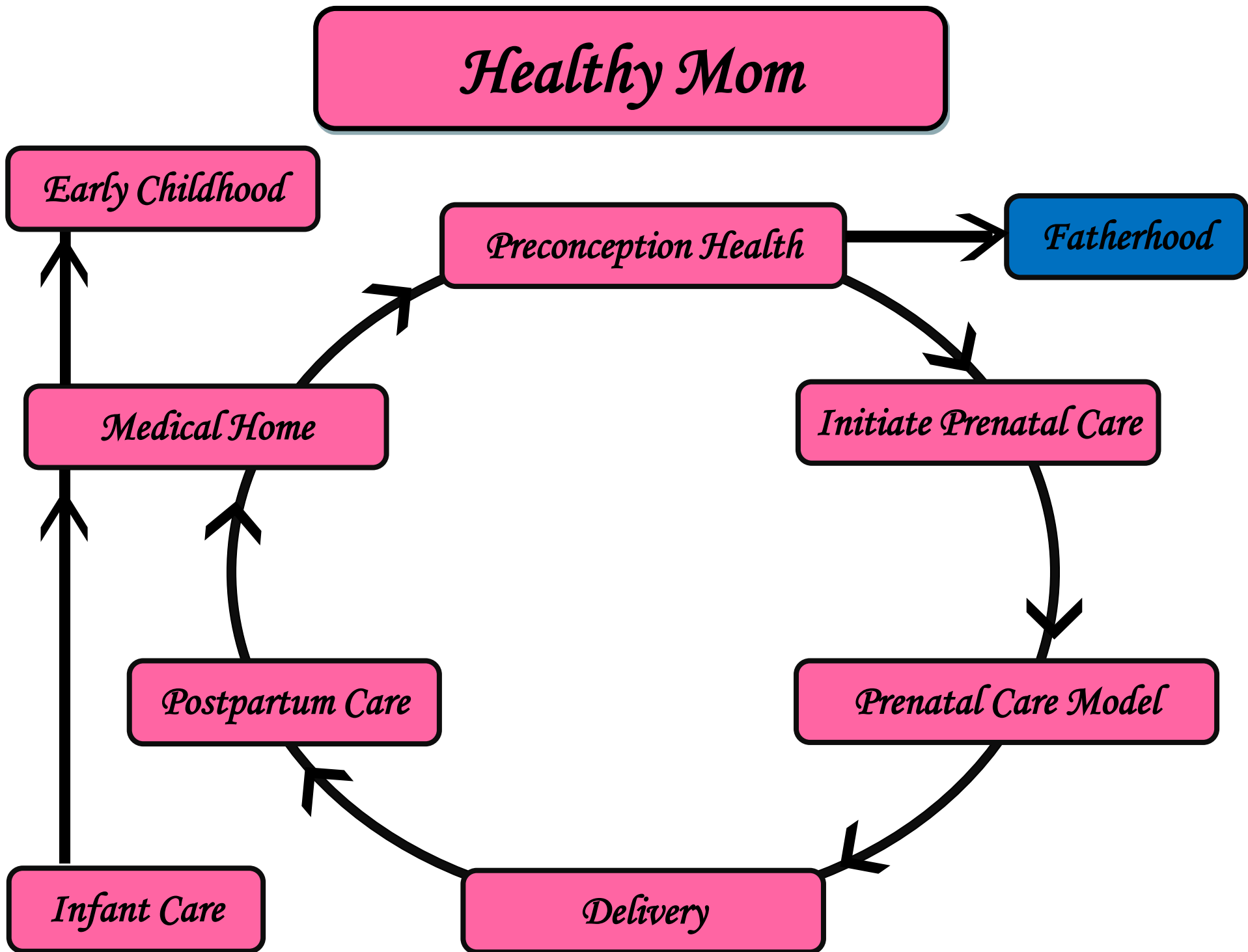


Cross System collaboration

Integration across organizations, disciplines,
& systems to improve patient services &
outcomes

Delivering Change

Patients Outcomes Social Services
Hospital Junction City **Konza** Maternal & Child Health SNAP
Live Well Geary County Parents as Teachers Health Geary County DCF
Navigators KDHE WIC Department **Family Planning** Wellness
Communication



Annie, 23

Third pregnancy, second baby (18-month-old)
Delivered 1st baby at 34 weeks
No current insurance coverage;

Attends annual Well Woman Exam
at local FQHC- has a positive
pregnancy test

Fatherhood

Referred into Delivering Change-
KanCare application; Initiates
prenatal care; SDOH screening

Referrals throughout pregnancy
made; transportation assistance;
education provided

Mental Health

WC

Housing

Employment
Assistance

Parents As
Teachers

Healthy Delivery at 40 weeks

Breastfeeding clinic;
Postpartum

Mental Health

WC

Referral back to PCP

Infant Care

Healthy Father

```
graph TD; MH[Male Health] --> PP[Partner Pregnancy]; PP --> D[Delivery]; D --> IC[Infant Care]; IC --> MedH[Medical Home]; MedH --> EC[Early Childhood]; MedH --> MH; EC --> MH;
```

Male Health

Partner Pregnancy

Delivery

Infant Care

Medical Home

Early Childhood

Harry, 25

Annie's partner; 1st time father;
looking for employment

Seen yearly for physical

Referral to FQHC for Primary
Care- use of sliding scale

Primary
Care

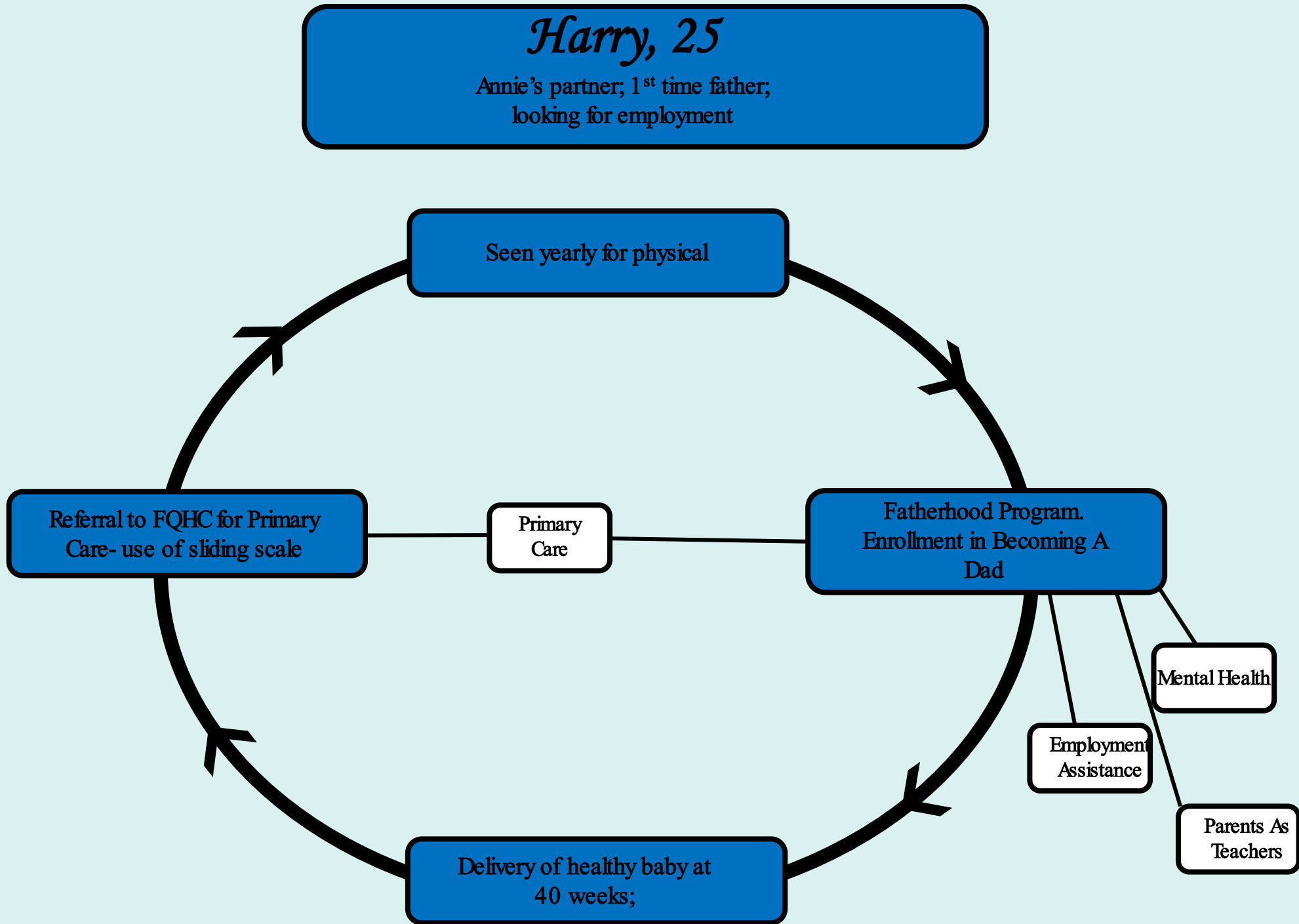
Fatherhood Program.
Enrollment in Becoming A
Dad

Mental Health

Employment
Assistance

Parents As
Teachers

Delivery of healthy baby at
40 weeks;



Healthy Child

```
graph TD; P[Pregnancy] --> B[Birth]; B --> MH[Medical Home]; MH --> EC[Early Childhood]; EC --> SA[School Age]; SA --> PA[Preconception Age]; PA --> P; PA --> B; PA --> HC[Healthy Child];
```

Pregnancy

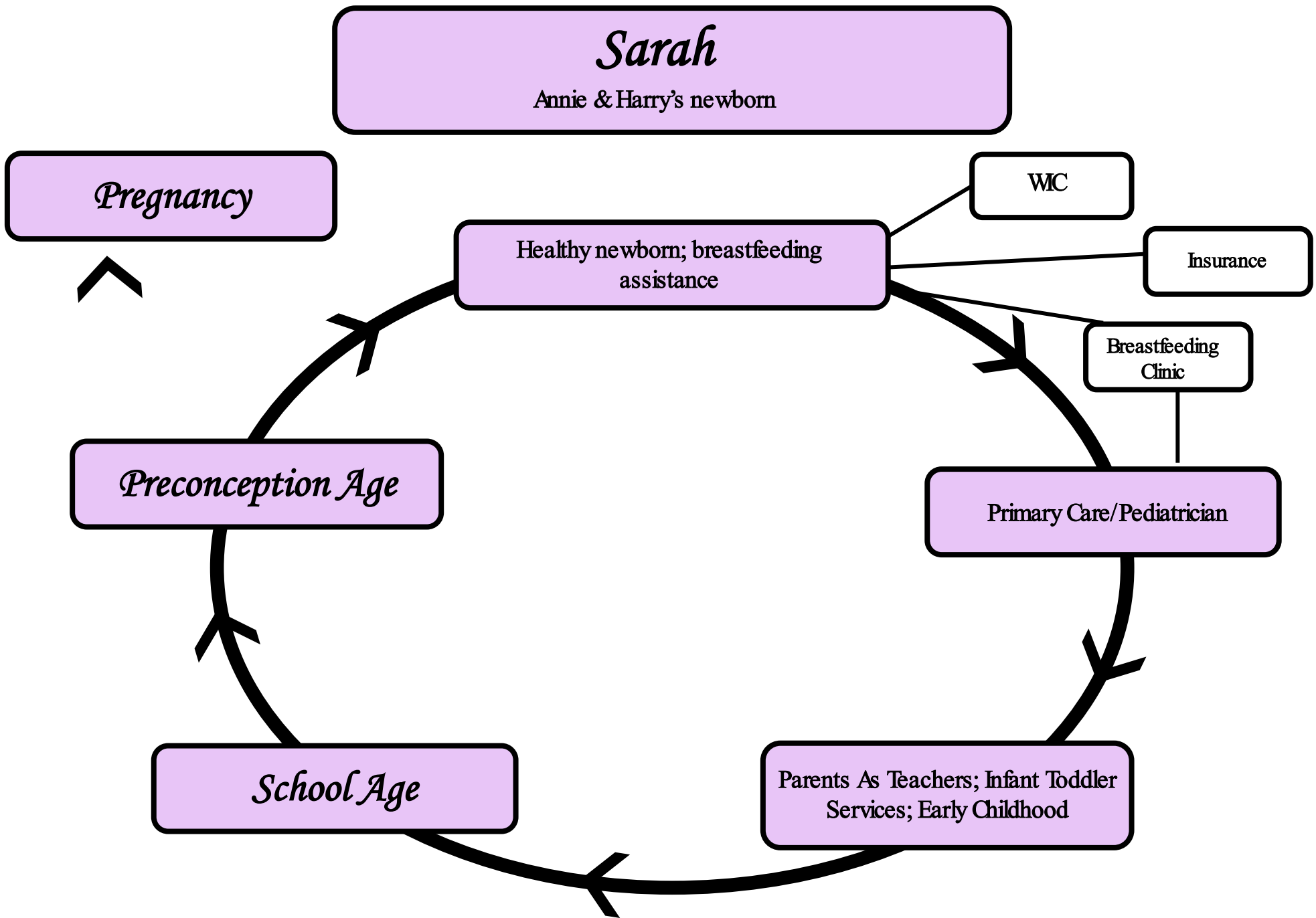
Birth

Preconception Age

Medical Home

School Age

Early Childhood





Impacts on Local Health Equity

Local Health Equity Impacts



Reduction of IMR

- 2011- 10.3/1000
- 2022 - 5.7/1000



Prenatal Care Initiation

- 2011- 73%
- 2020 - 76.3%



Teen Pregnancy Rate

- 2011- 44.7
- 2021- 23.1

Local Health Equity Impacts



Reported cigarette use

- 2011- **18.9%**
- 2022- **6.2%**



Premature Birth Rate

- 2011- **10.8%**
- 2021- **10.2%**



Breastfeeding Rates

- 2011- **75.8%**
- 2021- **89.3%**



FOURTH TRIMESTER INITIATIVE

Key KMMRC Recommendations

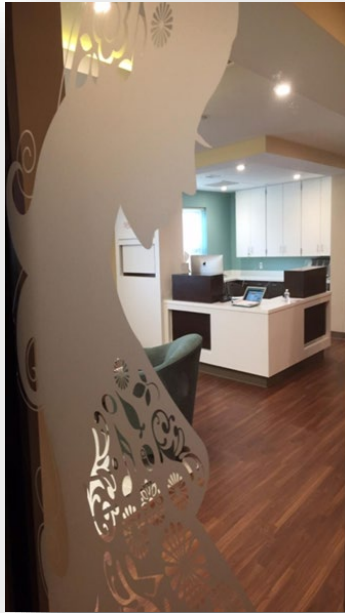
Based on 23 preventable pregnancy-related deaths, recommendations are as follows:

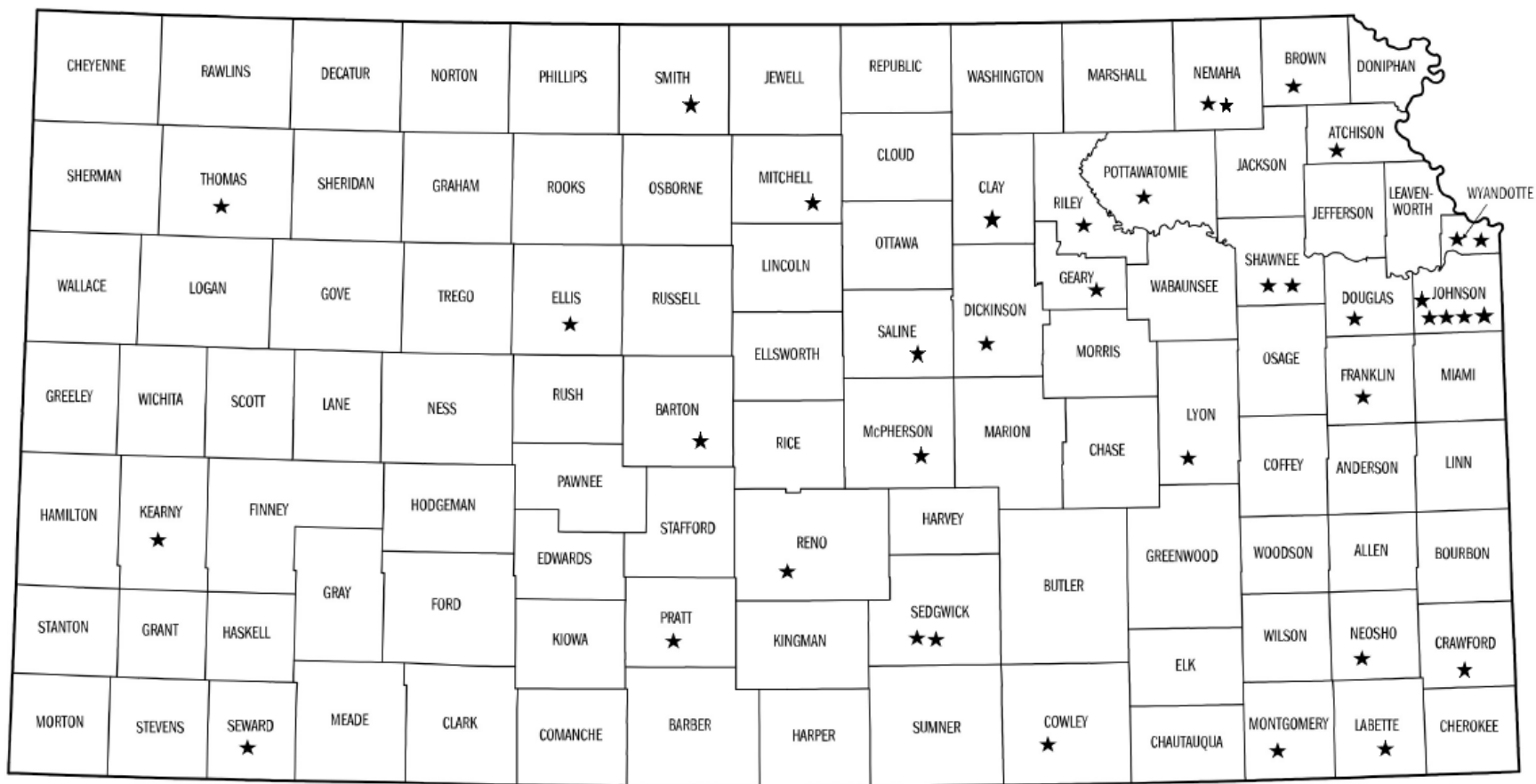
- **Patient education and empowerment**
- **Screen, brief intervention and referrals to treatment (SBIRT) for:**
 - **Comorbidities and chronic illness**
 - Intimate partner violence
 - Pregnancy intention
 - Mental health conditions (including postpartum anxiety and depression)
 - Substance use disorder - alcohol, illicit or prescription drugs
 - Social Determinants of Health
- **Better communication and multi-disciplinary collaboration** between providers, including referrals

Source: Kansas Maternal Mortality Review Committee Report, 2016-2020, (Preliminary Data, Subject To Change)



Who are we? 40 Birth Settings!





Enrolled Hospitals = Impact **91%** of Kansas Births.

Facilities

AdventHealth Ottawa, Franklin Co.
AdventHealth Shawnee Mission, Johnson Co.
AdventHealth South Overland Park, Johnson Co.
Amberwell Atchison, Atchison Co.
Amberwell Hiawatha Community Hospital, Brown Co.
Ascension Via Christi Manhattan, Riley Co.
Ascension Via Christi St. Joseph, Sedgwick Co.
Ascension Via Christi Pittsburg, Crawford Co.
Citizens Medical Center, Thomas Co.
Clay County Medical Center, Clay Co.
Coffeyville Regional Medical Center, Montgomery Co.
Community Healthcare System, Pottawatomie Co.
Hays Medical Center, Ellis Co.
Hutchinson Regional Medical Center, Reno Co.
Kearny County Hospital, Kearny Co.
Labette Health, Labette Co.
Lawrence Memorial Hospital, Douglas Co.
McPherson Center for Health, McPherson Co.
Memorial Health System, Dickinson Co.
Mitchell County Hospital Health System, Mitchell Co.
Nemaha Valley Community Hospital, Nemaha Co.
Neosho Memorial Regional Medical, Neosho Co.
Newman Regional Health, Lyon Co.
Olathe Medical Center, Johnson Co.
Overland Park Regional Medical Center, Johnson Co.
Pratt Regional Medical Center, Pratt Co.
Providence Medical Center, Wyandotte Co.
Sabetha Community Hospital, Nemaha Co.
Salina Regional Health Center, Saline Co.
Smith County Memorial Hospital, Smith Co.
Southwest Medical Center, Seward Co.
Stormont Vail Health Flint Hills, Geary Co.
Stormont Vail Health, Shawnee Co.
University of KS Health System Great Bend, Barton Co.
University of KS Health System KC, Wyandotte Co.
University of KS Health System St. Francis, Shawnee Co.
Wesley Medical Center, Sedgwick Co.

Birth Centers

New Birth Company Overland Park, Johnson Co.
Sunflower Birth & Family Wellness, Cowley Co.



**Postpartum Discharge Transition
Bundle-In Development**



**FOURTH
TRIMESTER
INITIATIVE**

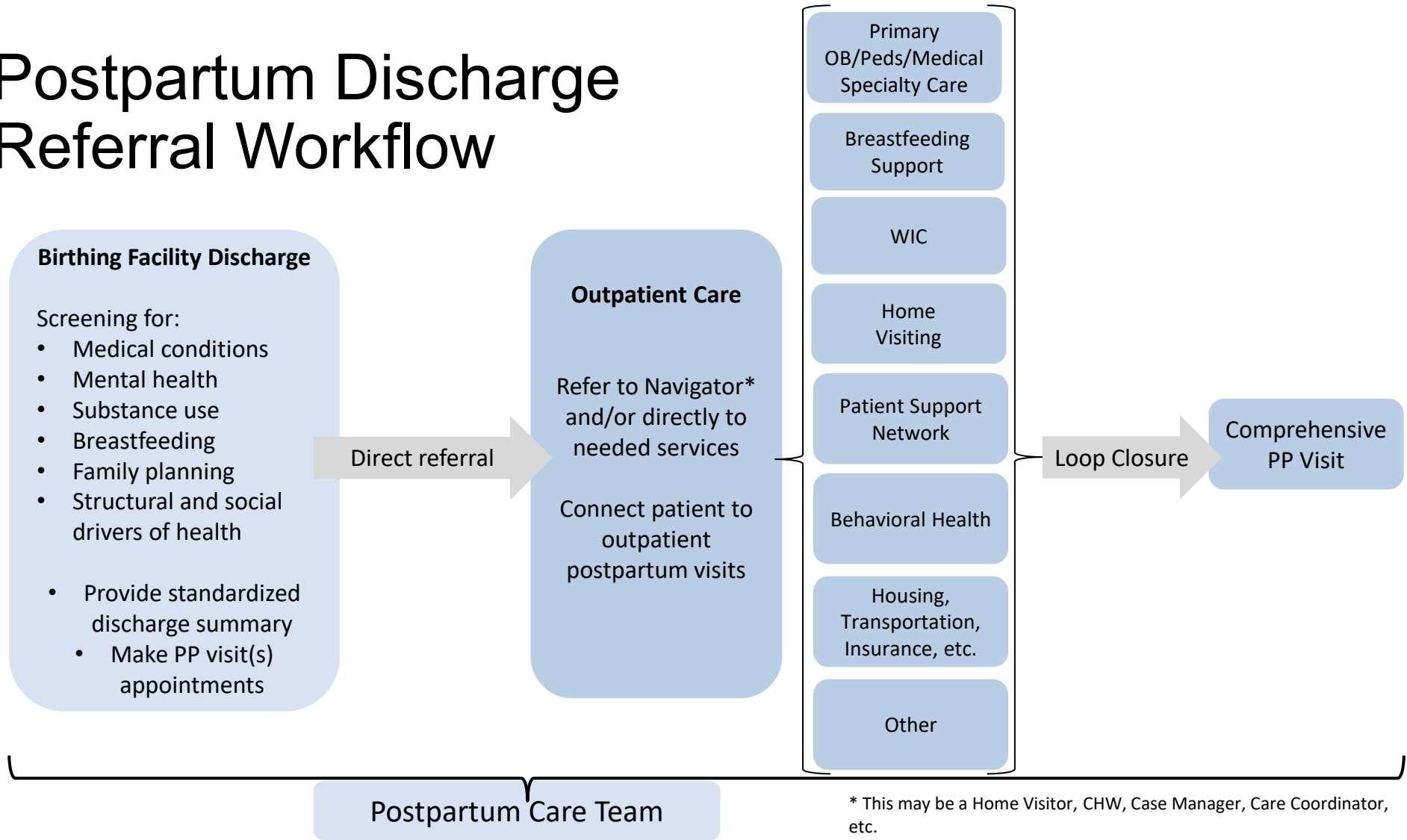
The NEW Postpartum Model

Educate, Screen, Refer

In EVERY patient, EVERY Birth Setting, EVERY Protocol

- ✓ Maternal Warning Signs
 - POST-BIRTH Education and Recognition
 - ED/EMS Triage (Universal question)
- ✓ Maternal Mental Health
- ✓ Structural and Social Determinants of Health
- ✓ Postpartum Appointment Scheduled Prior to Discharge (Within 3 weeks)
 - Family Planning
 - Primary care/specialty care for chronic health conditions
- ✓ Breastfeeding
- ✓ Postpartum Care Team
 - Patient at the center
 - Utilize navigation- warm referrals/connections
 - Connection to community services (MCH, Title X, Home Visiting, CHW, Safety Net Services)

Postpartum Discharge Referral Workflow



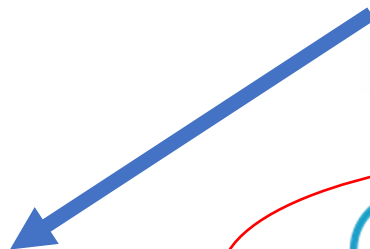


KANSAS
MATERNAL &
CHILD HEALTH

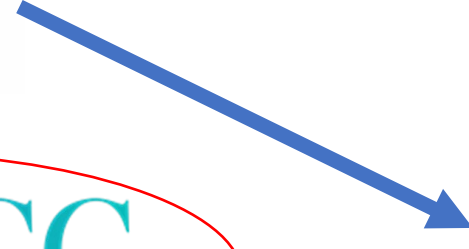


KPCC

Kansas Perinatal Community Collaboratives



Kansas Perinatal Quality Collaborative



Kansas Maternal
Mortality Review
Committee





Community Support for Positive Clinical Outcomes

Birth Centers

Kansas Perinatal
Community
Collaboratives

Prenatal
Education

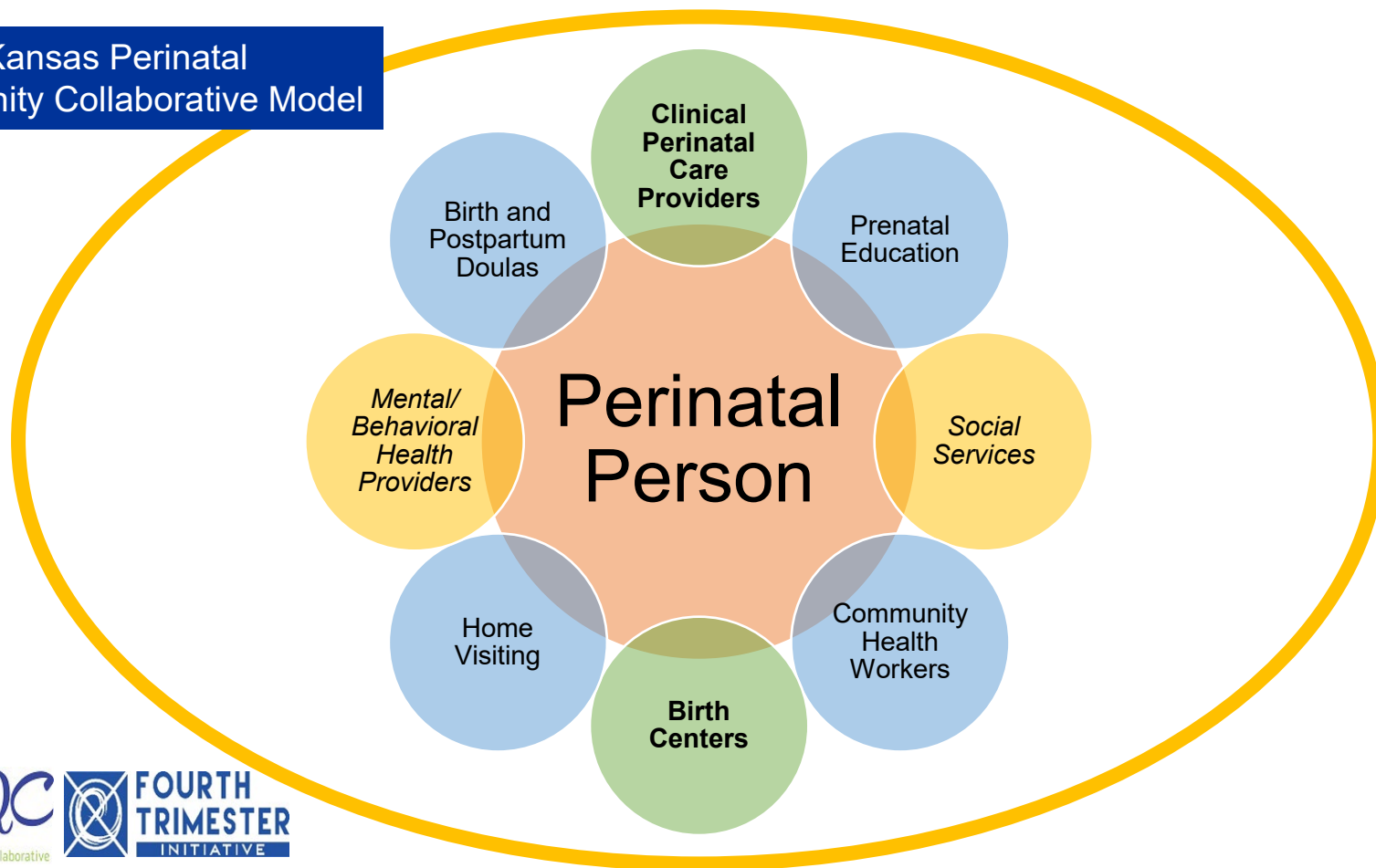
Community
Health Workers

Home Visiting

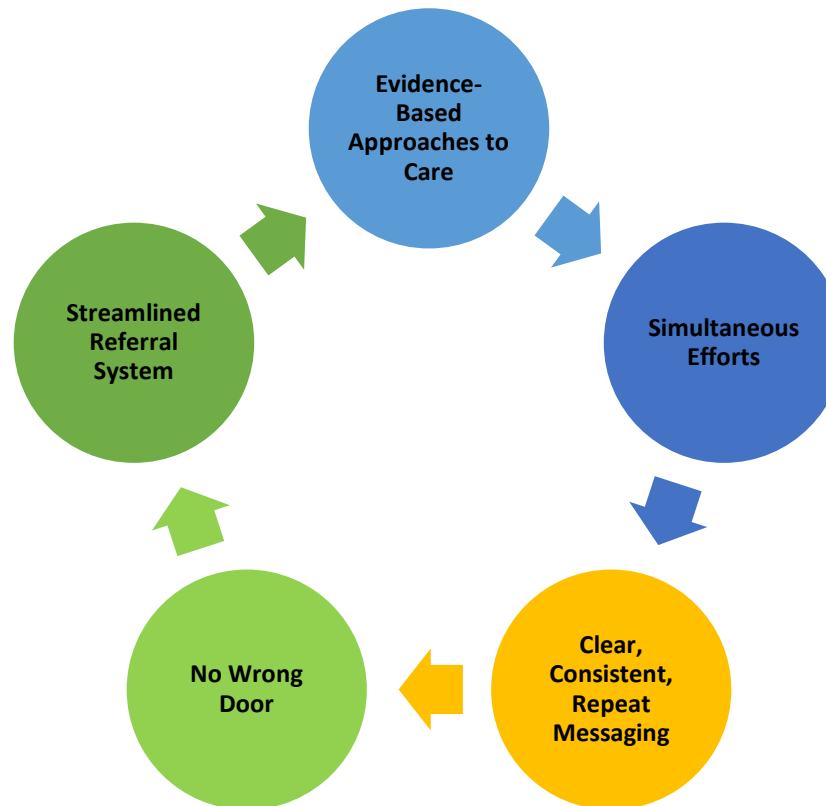
Birth and
Postpartum
Doulas

Community Support for Positive Clinical Outcomes

Kansas Perinatal
Community Collaborative Model



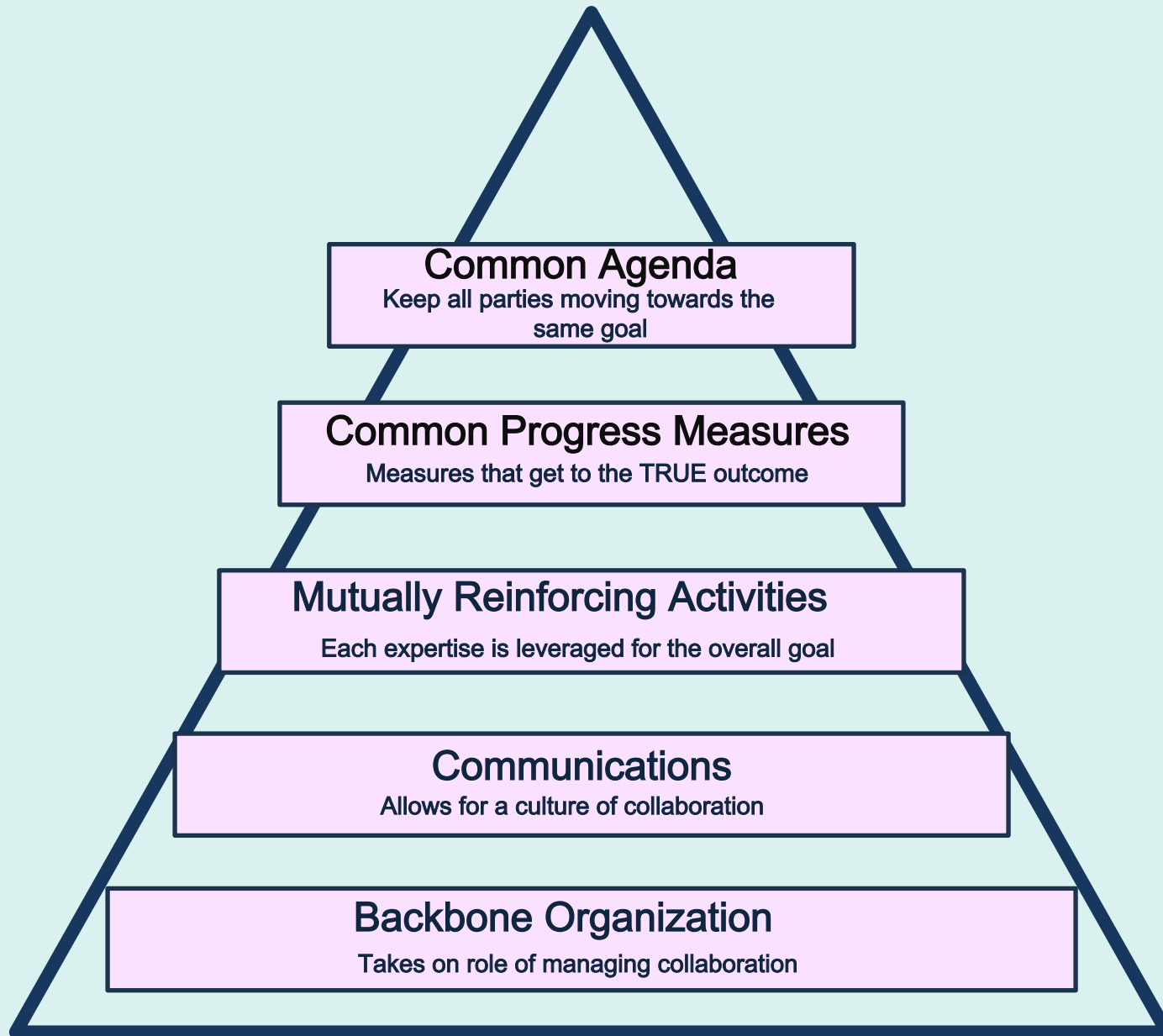
Community Support for Positive Clinical Outcomes





What would
this look like in
your
community

Collective Impact Approach



Starting your Community Coalition

First....

- ❖ Identify “Lead” organization to function as backbone, responsible for convening meetings and communication
- ❖ Identify and invite all relevant stakeholders across disciplines: medical, social, educational, civic organizations, foundations and business
- ❖ Gather county and/or community level data: Vital Statistics Annual Summary, Community Health Needs Assessment; State and Federal Data
- ❖ Identify YOUR community's health equity need(s)

Starting your Community Coalition

Then.....

- ❖ Leverage existing resources and programming in the community. Who is funded to provide what services? What can be built upon or expanded?
Where do gaps still exist?
- ❖ Are there innovative ideas to help fill gaps? Can funding be realigned to help us reach these goals? Are there additional or expanded funding opportunities?

Final Goals...

- ❖ Service Coordination/Navigation: Do all agencies know what resources are available to those in the community? “No Wrong Door” policy; Do agencies know how to connect patients into services?
- ❖ Clear and Consistent Messaging Across Agencies Making sure all “experts” are speaking the same language., across disciplines, around all important topics.
- ❖ Ongoing Education & Training: In order to deliver ongoing clear & consistent messaging across the community, EVERYONE must receive the same education and training
- ❖ Continuous Quality Improvement (CQI): A minimum annual review of county level data and assessment of progress toward community goals

Contact Information

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