Maternal Child Adolescent Health Program Assessment

Rebecca Scherr, MD

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Programs

- Community Health Nursing/MCAH
  - Kids Clinic (clinical-exams for children)
  - Refugee Health program (screening for adult refugees)
  - Nurse Family Partnership (evidence based home visiting program)
  - Healthy Start (home visiting/ case management program)
  - CPS Nurse Liaison
  - Maternal Child Health team (MCH including the nursing case management of children with EBLL)

Programs

- Current staff breakdown:
  - Nurse Family Partnership- 9
  - Kids Clinic- 2
  - CPS Liaison- 1
  - Refugee Health- 1.5
  - Healthy Start- 5
  - Maternal Child Health- 2.5 (this data set includes 5 nurses)
  - Auxiliary staff- 1

MCH Home Nurse Visit Program

- The Maternal Child Health (MCH) Program provides health counseling, referrals and assessments to pregnant women, mothers, infants and children living in Clark County.

- http://southernnevadahealthdistrict.org/community-health-nursing/maternal-child-health.php

MCH home visit

- During home visits the MCH nurse provides the following services:
  - Health screening
  - Health counseling
  - Parenting skills education
  - Newborn assessment
  - Nutrition and feeding counseling
  - Referrals to doctors so mother and child can get proper medical care
  - Referrals to other agencies or providers, if needed

http://southernnevadahealthdistrict.org/community-health-nursing/maternal-child-health.php

Referrals

- Clients are identified by the MCH program through a variety of sources including:
  - UMC Labor & Delivery provides information about patients who are in the Neonatal Intensive Care Unit (NICU), have high risk pregnancies, and patients with potential postpartum issues.
  - MCH nurses go on home visits with Child Protective Services to ensure children 3 years and under are in good health.
  - Community providers inform the health district about patients with a high risk pregnancy.
  - Anyone who needs assistance, or knows of someone who needs assistance, can call the health district at (702) 759-0896 to schedule a home visit.

http://southernnevadahealthdistrict.org/community-health-nursing/maternal-child-health.php

Referrals

REFERRAL STATS- SNHD MCH PROGRAM			
Referral Source	2012	2013	2014
UMC	569	682	494
Other	309	217	244
Total Referrals	**878**	**899**	**738**

- Admitted January 1- August 1, 2014- 154 clients

Current data collection

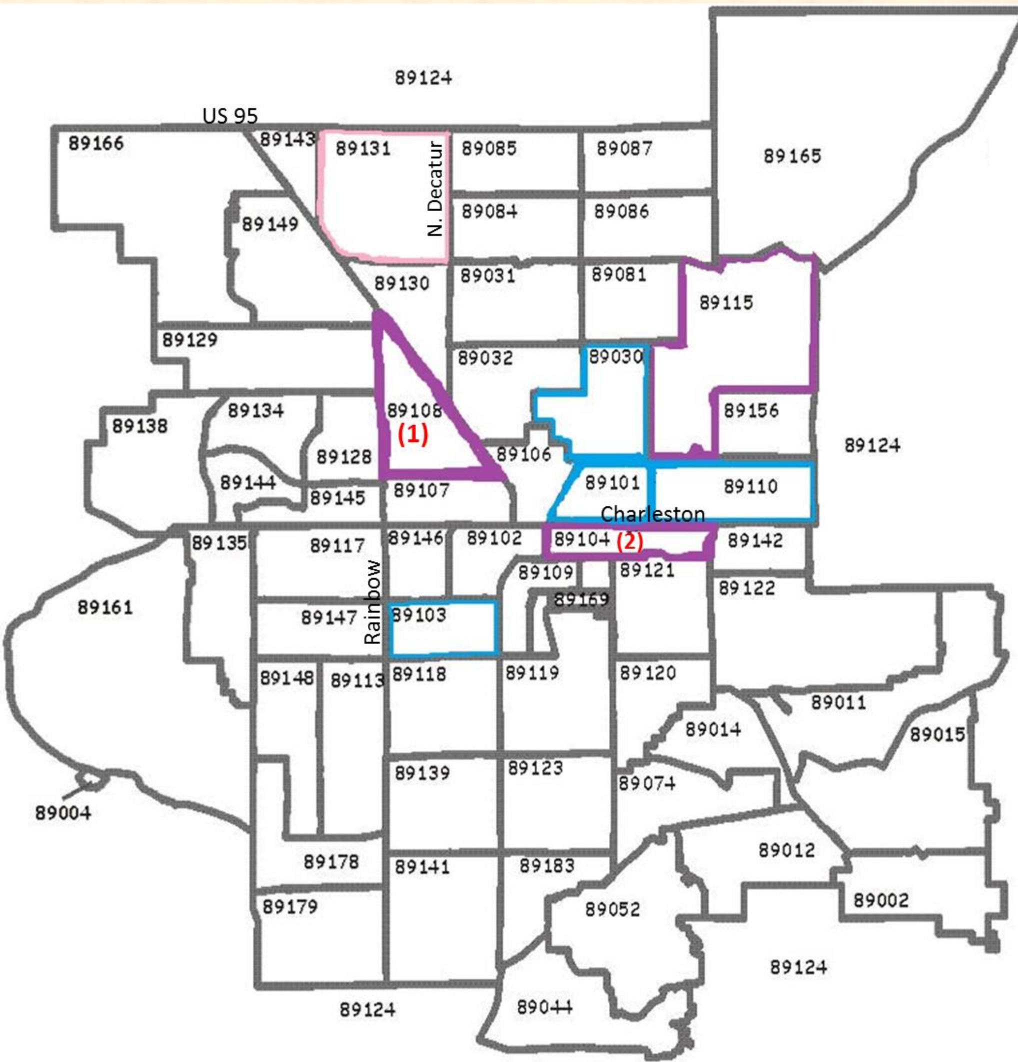
- 98 infants/children
- 21 women (ante-partum/post-partum)
- Admitted January 1, 2014-August 1, 2014
- Discharged before December 31, 2014
- 5 community health nurses

Proposed outcome measures

1. Percent of infants/children up-to-date on immunizations at discharge from program
2. Percent of women and infants/children with health insurance at discharge from program
3. Percent of children/infants that received at least two well child visits with their medical primary care provider (medical home) at discharge from the program.
4. Percent of women that enroll prenatally that received a prenatal care visit within 8 weeks of enrolling in the program
5. Percent infants that have received the second newborn screening at discharge
6. Percent of women enrolled that are screened for IPV by discharge
7. Percent of women who enroll prenatally that initiate breast-feeding
8. Percent of necessary referrals completed by enrolled women and infants/children

Infant/child referral source

- Referral source
  - NICU (only)- 72.4% (71)
  - NICU/CPS- 7.14% (7)
  - CPS (only)- 10.2% (10)
  - Olive Crest- 2% (2)
  - PMD- 2% (2)
  - NFP- 3.1% (3)
  - Self referral- 1
  - Outside health department- 1
  - Other- 1
- 3 previous clients (all categories)



- Most common infant zip codes- 58%
  - 89104- 11.2%
  - 89108- 11.2%
  - 89030- 9.18%
  - 89110- 8.16%
  - 89101- 6.1%
  - 89103- 6.1%
  - 89115- 6.1%
- Most common women's zip codes- 47.6%
  - 89108- 19% (4)
  - 89104- 9.5%* (2)
  - 89115- 9.5%* (2)
  - 89131- 9.5% (2)

Infant/child discharges

- Reason for discharge after admit
  - Lost to follow-up- 35 (35.7%)
  - Declined services- 20 (20.4%)
  - Goals met- 43 (43.8%)

Newborn screen

- Newborn screen completion
  - Completed- 83.6% (82)
  - No documentation- 10% (10)
  - Plan but no follow-up data- 4% (4)
  - Not applicable (>12 months old)- 1
  - Not completed- 1
- Date of completion documented- 37.7%

Immunizations

- 2 month immunizations
  - Yes- 64% (63)
  - No documentation- 8.2% (8)
  - Lost to follow-up/other- 26.5% (26)
  - Pending- 1% (1)
- 4 month immunizations
  - Yes- 42.8% (42)
  - No documentation- 9.2% (9)
  - Lost to follow-up/other- 45.9% (45)
  - Pending- 2% (2)

Immunizations

- Immunization status at discharge:
  - Up to date- 62.2% (61)
  - Lost to follow-up before immunizations- 29.5% (29)
  - No documentation- 7.1% (7)
  - Pending- 1% (1)
- Infants followed through 4 months- 49%

Well child checks

- Well child check with PMD #1
  - Yes- 71.4% (71)
  - No- 3% (3)
  - No documentation- 25.5% (25)
- WCC #1 date documentation- 23.4%

- Well child check with PMD #2
  - Yes- 34.6% (34)
  - No- 1% (1)
  - Lost to follow-up- 8.2% (8)
  - No documentation- 56.1% (55)

- Infants with a documented primary care provider- 94%

Infant/child insurance

Insurance status on admission

- Yes- 39.7% (39)
- No- 17.3% (17)
- Pending- 32.6% (32)
- No documentation- 10.2% (10)

Insurance status on discharge

- Yes- 69.4% (68)
- No- 0
- Pending- 8.16% (8)
- Lost to follow-up- 5.1% (5)
- No documentation- 17.3% (17)

Infant/child WIC

WIC status on admission

- Yes- 59.18% (58)
- No- 11.2% (11)
- Pending- 6.1% (6)
- Declined/didn’t qualify- 2% (2)
- No documentation- 21.4% (21)

WIC status on discharge

- Yes- 70.4% (69)
- No- 2% (2)
- Pending- 0
- Declined/didn’t qualify/ lost to follow-up- 4.1% (4)
- No documentation- 23.5% (23)

Infant sleeping environment

- Documented crib check- 54%
- Unsafe sleeping environments- 37 incidences documented
  - Cribs for Kids referrals- 13
  - Co-sleeping- 9
  - Unsafe sleep conditions (blankets, pillows, etc)- 12
  - Prone sleeping- 3

Mother referral source

- NICU/postpartum- 47.6% (10)
- CPS- 9.5% (2)
- NFP- 23.8% (5)
- NFP/CPS- 1
- NICU/CPS-1
- Olive Crest- 1
- Other-1

Mother discharges

- Lost to follow-up- 23.8% (5)
- Declined services- 14.3% (3)
- Goals met- 61.9% (13)

Prenatal and Postpartum care

- All women admitted antepartum had prenatal care visit (3 clients)
- Follow-up visit with provider at 6 weeks post-partum
  - Yes- 38.1% (8)
  - No- 23.8% (5)
  - Lost to follow-up- 33.3% (7)
  - Pending- 1

Screening

- Interpersonal violence screen documented:
  - Yes- 66.7% (14)
  - No data- 33.3% (7)
- Reproductive life cycle screening documented:
  - Yes- 81% (17)
  - No data- 19% (4)
- Depression screen documented:
  - Yes- 66.7% (14)
  - No data- 33.3% (7)
  - Edinburgh screen used- 23.8% (5 clients)

Women's insurance status

Insurance status at admission

- Yes- 28.6% (6)
- No- 38.1% (8)
- Pending- 19% (4)
- No data- 14.3% (3)

Insurance status at discharge

- Yes- 42.9% (9)
- No- 28.6% (6)
- Pending- 14.3% (3)
- No data- 9.5% (2)
- Lost to follow-up- 1

Women’s WIC status

WIC status at admission

- Yes- 9.5% (2)
- No data- 76.2% (16)
- Pending- 14.3% (3)
- Other- 9.5% (2)

WIC status at discharge

- Yes- 38.1% (8)
- No data- 47.6% (10)

Strengths

- Sleeping environment interventions
- Pediatrician/ immunization clinic access
- Breastfeeding encouragement
- Handouts

Weaknesses

- No standard documentation
- Outcome measures not clearly documented
  - No dates (immunizations or PMD visits)
  - No follow-up data on immunizations or PMD visits
  - Demographic sheet not UTD with MC numbers
- Demographic data missing
- Inappropriate referrals (NICU)
  - See new referral guideline sheet

Referral criteria

Southern Nevada Health District Maternal Child Health Program

Referral Criteria

<u>Medical Diagnosis Risks</u>

- <32 weeks gestation or
- < 2500 grams
- Cardio-respiratory depression at birth –Ph<7.0 or low APGARS
- Persistently unstable NICU course
- Medically fragile NICU, i.e.:
  - requires follow up with 3 or more specialists over the first year or longer
  - Congenital syndrome/anomalies
  - Oxygen use >28 days/Chronic Lung Disease
  - Cardiac, INO, Extra Corporeal Membrane Oxygenation
  - Intracranial Pathology
  - Seizure activity
  - Hyperbilirubinemia-severe
  - Retinopathy of Prematurity requiring surgery
- Failure to thrive
- Children up to 72 mos. of age with blood lead level (venous) of ≥ 10 ug/dl

<u>Physical Environment: Living Situation</u>

- Homeless OR
- Living situation changes frequently OR
- Home may have major safety hazards (i.e. mold, wiring problems)
- Family unable to meet basic needs-clothing, food, shelter

<u>Psychosocial/Emotional /Behavioral-Caregiver/Family</u>

- Caregiver has significant disabilities that will affect provision of care (needs assistance with ADL)
- High risk behavior indicating recent or current substance abuse
- There is proven substance abuse-positive drug toxicology in mother or neonate
- Recent known abuse or neglect or domestic violence and abuser remains in the home
- Caregiver is critical, negative or exhibits hostility
- One or more family members exhibit abnormal emotional behavior
- Caregiver hospitalization for mental illness and/or attempted suicide in past year
- Caregiver is unable to cope with problems and is unsafe to use problem solving skills (cognitive problems) and has no supportive network or refuses to use them
- Primary caregiver is young adolescent ≤ 16 yrs. old without a supportive network or refuses to use them
- Caregiver fails to follow through for appointments or medical care

Future

- Should the program continue with the same outcome measures?
- Should the program continue with the same target population?
- Determine high risk populations in the community and apply for grant funding for evidence based interventions