Maternity, Post-partum & Well-baby Care during COVID-19 Work Group
July 13, 2020

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What is PHC?

Perinatal Health Collaborative

How did we come to be?

Identified those best served by the collaborative as:

• Women who are experiencing domestic violence
• Treated or untreated mental health issues
• Previous significant perinatal mood and anxiety disorders
• Substance use/addiction
• Homelessness
A closer look...the challenge of engaging mom’s in prenatal care.

This population was not getting medical and behavioral health services needed to promote healthy birth outcomes.

“Falling through the cracks”

**Required:** Care Coordination

**Question Uncovered Along the Way:**
*What was preventing these moms from engaging in routine prenatal care?*
Middlesex County PHC Agency Members

- Middlesex Health
- River Valley Services
- Connecticut Valley Hospital
- The Connection, Inc.
- St. Vincent de Paul Soup Kitchen
- Community Health Center
- Gilead Community Services, Inc.
- Beacon Health Options, Connecticut
- Community Health Network
- Department of Children and Families
- Department of Mental Health and Addiction Services
- Crescent Street OBGYN
- Middlesex OBGYN
- ABC Women’s Center
Middlesex County PHC Guiding Principles

• **Objective:** To provide early intervention to improve engagement in prenatal care. To establish goals for healthy birth outcome. To preserve family unity whenever possible.

• **Core belief:** Community collaboration is necessary to improve health outcomes

• **Core understanding:** Psycho-social problems are community problems. No one entity alone can effectively improve outcomes for this population
Middlesex County PHC Program Development

• Bi-weekly meetings (1st meeting January 2, 2018); for 1 hour

• Expansion of PHC Release of Information form (required for each patient)

• Developed process for patient selection
Additional Benefits

Patient – Improved Quality of Life

• Sobriety
• Mental health stabilization
• Stable Housing
• Re-connection with family
• Safety
• Achievement of feelings of self-worth and respect

Patient – Linkages to Care/Support

• OB/GYN or Primary care physicians, psychiatrists, specialists, etc.
• Supportive housing
• Appropriate outpatient services

Middlesex County PHC Collaborative

• Improved patient care
• Improved agency-specific care plans, increased efficiency
• Improved inter-agency communication and relationships

Society

• Increase in safety to all
• Hypothesis: Reduction in Medicaid & Medicare expense as well as reduced need for DCF intervention
What Have We Learned?

1) The PHC target population does not make significant progress with the traditional model of care delivery

2) Behavioral health chronic diseases require care coordination and customized treatment plans

3) Individualized care plans must have the ability to be flexible and evolve

4) We have an effective system in place to identify those PHC patients who would have better health outcomes when provided care coordination

5) The integration of the community support agencies and medical communities is critical for addressing the social and medical needs of a shared population
Ongoing Steps

- Continued focus on after-care planning.
- Helping moms understand contraception options.
- Are we able to maintain families right after birth or within the first year?
- Continued dissemination about PHC model and how it impacts birth outcomes and family unification.
Questions?

Thank You!

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