INTRODUCTION TO THE COMMUNITY PARTNERSHIPS FOR HEALTHY MOTHERS AND CHILDREN TOOLKIT

About the CPHMC Project:

- Project is a 3 year, cooperative agreement, funded by the Centers for Disease Control, Division of Community Health.
- The target population for this initiative are underserved mothers and children with the goal of improving the health of this population within their states.
- ACOG, in collaboration with the National WIC Association, have successfully spearheaded this project in which 32 local WIC agencies throughout the United States have created community based interventions to increase access to healthy foods and reduce chronic disease.
- A Physician Advisor shares insight and guidance for formulating interventions. Coalitions have also created vital alliances with various healthcare establishments and organizations throughout this partnership.
- For the first cohort of the project, agencies from: New Mexico, Iowa, Missouri, Kansas, New Jersey, Virginia, Maryland, and Texas created community coalitions within their designated service area and developed objectives and activities centered around healthy food access, breastfeeding, and WIC/primary care referrals, cultural competency, and WIC trainings for healthcare staff.
- These efforts have been sustained within these communities past the project period. Cohort 2 of this project will implement similar initiatives within their areas.

This toolkit will focus on ACOG's engagement in this project, the role of the OB/GYN provider, as well as describing local WIC agency success stories and samples of their work.

In this toolkit:

- Flyer describing ACOG's engagement on this project
- Flyer describing WIC/Provider connection
- Provider webinar, describing the OB/GYN provider role within the project (webinar was given to local agencies)
- Success stories depicting community clinical linkage initiatives
- List of Cohort 1 and Cohort 2 participants
- Examples of work by local WIC agencies
- Greater with WIC website flyer

ACOG ENGAGEMENT IN COMMUNITY PARTNERSHIPS FOR HEALTHY MOTHERS AND CHILDREN

Community projects for the Community Partnerships for Healthy Mothers and Children Project will focus on improving access to healthy foods and improving access to prevention and chronic disease management services. With more than 57,000 members and 90% of qualified OB/GYNs within the United States, ACOG serves a significant population of women and children and is the nation's leading group of physician's providing care to women.

ACOG's Mission:

ACOG is a membership organization dedicated to the advancement of women's health care through continuing medical education practice and research. ACOG's vision is to provide safe and effective health care for women throughout all lifespans.

ACOG's Involvement: ACOG has provided support and technical assistance for each agency and has also taken the lead on recruiting members to serve as the physician advisor on the leadership team. ACOG has strong membership activity in many of the target states for the project and has played a vital role in connecting agencies with these members. ACOG's Program Manager assists in the management of the agencies in the form of webinars and other trainings as well as local agency technical assistance calls. ACOG has also assisted in the dissemination of communications regarding the project through its various communication channels which include newsletters that reach members in the various districts with ACOG members throughout the United States.

Additional partnerships that are beneficial for the project include those with other women's health care provider organizations through the Council on Patient Safety in Women's Health Care. This established partnership between the National WIC Association and ACOG is vital to improving the health of women and children through increasing opportunities for chronic disease prevention, risk reduction, and management through clinical and community linkages and through increasing access to environments with healthy food and beverage options. By the end of the cooperative agreement, ACOG hopes to successfully promote postpartum care and educate its members about WIC and how to successfully utilize this program.

National WIC Association

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS · WOMEN'S HEALTH CARE PHYSICIANS · 1951

WIC IS MORE THAN BABY FORMULA

The American College of Obstetricians and Gynecologists and the National WIC association have significant ties to healthcare providers and their practice. These organizations serve significant maternal, infant and early childhood populations and help to prevent and reduce chronic diseases.

Some ways that WIC/ACOG tie into OB/GYN practice are:

- Registered Dieticians who work in WIC, work with patients on healthy eating habits and weight issues.
- Pre conception care is also a topic that is closely tied to OB/GYNs that is also addressed by WIC staff.
- WIC/ACOG also support breast feeding initiatives. ACOG strongly supports breast feeding as the preferred method of feeding for newborns. Counseling for breastfeeding is provided by WIC.
- Greatly related to chronic disease prevention, WIC can refer to primary care and OB/GYN care.
- Stressing the importance of post-partum checkups which address weight, and BMI as well as nutrition habits, breast examination, and counseling and referrals for other health issues.

UNDERSTANDING YOUR PROVIDER'S ROLE AND ENGAGING YOUR SERVICE PROVIDER

Hosts:
Anna-Maria Roaché, Senior Program Manager ACOG
Jeanne Mahoney, Project Director ACOG,

In This Webinar We Will Explore:

- Importance of Post Partum Visits In Chronic Disease Prevention
- Effective Provider Engagement and Integration

Chronic Disease Prevention

- One significant purpose of the Community Partnerships for Healthy Mothers and Children project is to increase the access to chronic disease prevention, risk reduction, and management opportunities.
- In order to prevent chronic disease effectively, it is important for mothers to receive the proper healthcare

Importance of Post-Partum Visit

- Pregnancy is the window of future health for women.
  - Conditions of pregnancy often return in subsequent pregnancies and later in life.
    - Diabetes
    - High Blood Pressure
    - Infection
    - Heart problems
    - Intensive weight gain
- They can usually be modified by applying healthy practices

Sources: Centers For Disease Control, 2007; Postpartum Care Visits --- 11 States and New York City, 2004

Postpartum Contraception/ Birth Spacing

Particularly important if pregnancy resulted in:

- Still birth
- Premature baby
- Low birth weight or small for gestational age
- Need for Neonatal Intensive Care
- Conditions of pregnancy (HBP, diabetes, blood clots)

And if mother has

- Severe maternal mood disorder
- Tobacco, at-risk alcohol use, or drug abuse

Importance of Post Partum Visit

- Post partum visits are considered to be an effective indicator for preconception health.
- For this reason, it is imperative for women to attend these visits to help manage these conditions.

Post Partum Visits Address:

1. Weight and BMI
2. Nutrition Habits
3. Blood Pressure
4. Breast Examination/Self Examination
5. Review of Immunization Status and Vaccinations
6. Counseling on Breast Feeding
7. Psychosocial Evaluation
8. Counseling and referrals for other health issues such as: tobacco use, substance abuse, birth spacing, family history of heart disease etc.

Barriers to Post Partum Care

- According to a study conducted by Johns Hopkins, less than half of women attend post partum visits
- Some barriers to attending post partum visits include:
    1. Fear of negative health findings
    2. Perception of being in good health already – why bother??
    3. Fear of tests and examinations
    4. Dislike constant check ups
    5. Long office visit wait times
    6. Lack of Transportation

What Is The Role of the Service Provider?

- The primary role of the provider for the Community Partnerships is to:

1. Advise on the development and implementation of community chronic disease prevention/reduction intervention strategies during coalition meetings and during leadership discussions.
2. Actively help build partnerships with other clinical services providers and institutions providing services in the community for smoother implementation of strategies.

What Is The Role of the Service Provider?

- When engaging a service provider, it is important to explain to them what their role is specific to the coalition and what your team wishes to achieve.
- Coalitions should work with their service provider to help develop strategies to educate women about the importance of chronic disease prevention

CCI links WIC participants to primary & preventative services in Montgomery County, MD

Ayan Ibrahim, M.S., CHES

Summary

Although Montgomery County, MD is a thriving region, acute poverty is found in neighborhoods where CCI Health & Wellness (CCI) centers are located. These areas are concentrated with individuals who face a host of challenges. Poorer health outcomes run rampant especially when primary and preventative services are not sought as a necessity, but as a luxury. In addition to providing WIC services to over 33,000 participants, CCI Health & Wellness Services delivers high quality, affordable, primary care to over 26,000 individuals across all stages of life. Over the past year, CCI discovered there is often not a cross utilization of services. A large percentage of WIC participants are unaware that CCI can be their primary medical home that can address not only their need for WIC services, but also for primary care, behavioral health care, prenatal care, and dental services. The Healthy Jumpstart Coalition (HJC) developed and implemented a workflow designed to address this barrier, with the potential of connecting thousands of WIC participants to primary care and preventative services with ease.

Challenge

Montgomery County, MD is saturated with primary care physicians, preventative services and social programs. However pockets of poverty in the county ranks the county at 39.22 on the disparity index according to the county's community health needs assessment. An index between 1-40 indicates the county is at some disparity. To narrow our scope, access to primary and preventative services is one of social determinants in which impact individuals in these pockets of poverty. The access to adequate and consistent care is vital to sustain life. The HJC developed the resource navigator program which links families to service. Since the launch of this program we have extended our efforts in developing a strong bond between WIC staff and CCI providers to increase knowledge and share with families that having consistent primary care will establish the importance of prevention. We emphasize primary prevention (detecting early warning signs before disease) or secondary prevention (detecting of disease at an early stage) will increase the likelihood for individuals to reduce chronic illness.

Solution

As a Joint Commission Accredited, patient centered medical home (PCMH), we know that quality of care, patient experience, and care coordination and access significantly improve quality of life. So as a result of this program, we have fostered a strong bond between the CCI-WIC program staff and CCI primary care providers in an effort to increase knowledge of available primary care services at CCI and the importance of preventative health care. As a result, all CCI staff can now emphasize the importance of primary prevention (detecting early warning signs before disease) or secondary prevention (detecting of disease at an early stage) in decreasing the likelihood of chronic illness. To this end, the HJC developed a workflow that CCI-WIC staff and CCI primary care providers implemented to ensure that WIC families identified as needing primary care services are referred to, and have an appointment made for CCI primary care services. The workflow developed, creates a universal referral process so that WIC families at all 5 CCI-WIC locations, are made aware of, and have help to gain access to any of the eight CCI primary care locations.

Results

After testing the referral model in a few locations, needed changes were identified. The WIC-primary care provider referral initiative was revamped in February of 2016 to include the following: a monthly meeting between WIC center managers and medical center managers allowing cohesiveness, establishing day to day communication between managers and education of services. The systematic workflow introduced an organized way for WIC staff to communicate about primary and preventative services, how to best refer families, and how medical staff at CCI primary care locations can follow up with the referral. In addition, the WIC prescription form now comes with a newly developed cover letter form explaining concerns of participant nutrition status and what is recommended by the WIC nutritionist. Since the implementation of monthly meetings, educational sessions of WIC services, and new prescription cover letter, 441 participants were referred from CCI-WIC to CCI medical. Of those 441 participants, 331 had never previously accessed a CCI primary care site.

"The CPHMC initiative has been effective for our WIC participants to access necessary health care services. Our participants are now receiving care in a timely manner" *–Laura Sullivan, WIC Communications and Outreach Manager*

Sustaining Success

The WIC program is an essential component of whole health. As a WIC participant, individuals receive nutrition education and access to healthy food; and now through this initiative, WIC families are encouraged to access preventative primary care as well. The ability for WIC staff and CCI primary care providers to work collectively in an integrated environment, promotes positive health outcomes for families. The established monthly meetings, assigned point of contact at each primary care location, and same day doctor appointments available for children emphasize how important integrated health is to CCI. As a result, this initiative has become standard practice across all sites. Implementing a clear channel of communication for WIC staff and primary care providers where they can discuss challenges and identify solutions will attribute to the success of this initiative. Furthermore, continuous education about WIC services to providers and medical staff will foster success ultimately stimulating WIC families in having the greatest impact of health and well-being.

Your Involvement is KEY

Through the National WIC Association's support for Community Partnerships for Mothers and Children (CPHMC) they have made it possible to implement policy, systems and environmental improvements. Your ability to increase support by spreading awareness for initiatives such as CPHMC will increase opportunities for nutrition education and chronic disease prevention through community clinical linkages in the most vulnerable populations.

Healthy Families of Oceana County (HFOC)

Coalition Goals & Activities

April 2015-March 2016

Goal 1: Increase access to environments with **healthy foods** and **beverages**

Activities:

- Shelf labels and signs at local grocery stores and food pantries that help shoppers locate healthy food items
- Healthy menu guides for local restaurants
- New tools that help community members locate healthy foods and resources for healthy eating in Oceana County
- Fresh produce market for WIC clients at DHD#10, provided by Rennhack Orchards Market
- Promotion of the "Project FRESH" program and other food assistance resources at community events

Goal 2: Increase access to preventive services through **clinical** and **community** linkages

Activities:

- Physician referrals to the WIC program and to insurance enrollment assistance, via a new "Rx for Healthy Families" prescription pad
- Promotion of health services at various community events
- New tools that help community members locate health services in Oceana County

HFOC
Healthy Families of Oceana County

Healthy Choices, Healthier Lives!

Contact Information:

- 3986 N Oceana Drive, Hart, MI, 49420
- (231) 316-8567
- hfocmichigan@gmail.com
- www.hfocmichigan.wix.com/hfoc
- facebook.com/healthyfamiliesofoceanacounty

HEALTHY FAMILIES OF OCEANA COUNTY (HFOC)

Coalition Accomplishments

April 2015-March 2016

Goal 1: Increase access to environments with **healthy foods and beverages**

Accomplishments:

- √ **Shelf labels implemented at 2 local grocery stores and 1 food pantry**: Gale's IGA (Hart), Cherry Hill Supermarket (Shelby), Bread of Life Food Pantry (Hart)
- √ **Healthy menu guides developed for 2 local restaurants:** Trailside Restaurant (New Era), Daniel's Restaurant (Hesperia)
- √ **New tools created that help residents locate healthy food sources and resources for eating healthy**: HFOC website, HFOC Facebook page, online resource map, Resource Bookmark, healthy shopping guide
- √ **Promotion of the "Project FRESH" program, Double Up Food Bucks program, and WIC program at local community events:** Project Homeless Connect, Maxine's Closet, Walkerville Thrives Resource Fair, Patient Appreciation Day at NMHSI, Farmworker Appreciation Night
- √ **Produce market** for WIC clients and general public at DHD#10 office, provided by Rennhack Orchards Market

Goal 2: Increase access to preventive services through **clinical** and **community** linkages

Accomplishments:

- √ **"Rx for Healthy Families" referral pads distributed to local healthcare providers:** Hart Family Medical, Spectrum Health Family Medicine (Pentwater), Mercy Health Partners– Lakeshore Campus, and Northwest Michigan Health Services
- √ **Outreach for WIC program and insurance enrollment assistance at DHD#10 at community events**: Project Homeless Connect, Maxine's Closet, Walkerville Thrives Resource Fair, Patient Appreciation Day at NMHSI, Farmworker Appreciation Night
- √ **New tools that help residents locate health services and resources:** HFOC website, HFOC Facebook page, online resource map, Resource Bookmark

★ Other Accomplishments: ★

- √ Bi-monthly HFOC newsletter distributed to community members and partnering agencies
- √ Project highlights included in blog post by the National WIC Association: **https://goo.gl/pHty7N**
- √ HFOC Success Story distributed nationwide via the Centers for Disease Control and Prevention (CDC)
- √ Project updates included in articles published in Oceana's Herald Journal and online: **http://goo.gl/BGNZrc**

List of States Participating In Cohort 1

1. New Jersey
2. Virginia
3. Texas
4. New Mexico
5. Iowa
6. Maryland
7. Kansas
8. Louisiana
9. Michigan
10. Illinois

List of States Participating In Cohort 2

1. Colorado
2. Connecticut
3. Georgia
4. Idaho
5. Iowa
6. Michigan
7. Missouri
8. New Mexico
9. Wisconsin
10. New York
11. Virginia

The H.A.N.D.S. on Approach to Tackling Nutrition through Environmental Changes and Community Partnerships.

Health Access and Nutrition Development Services | Mount Rogers Health District | Galax, VA

Project Overview:

The Mount Rogers Health District (MRHD), in Southwest Virginia , is one of 17 local WIC agencies across the nation to be a part of the Community Partnerships for Healthy Mothers and Children (CPHMC) project. MRHD used a multisector approach to address nutrition disparities in rural communities through the Health Access and Nutrition Development Services (H.A.N.D.S.) task force, a subgroup to the Twin County Prevention Coalition in Galax, VA. The H.A.N.D.S. task force consists of a diverse group of collaborators with various backgrounds and expertise. In building capacity, MRHD sought to establish a group of key stakeholders that would stand as a representation of the community at large and resources available. During the 15-month project period, the group used a hands on approach to effectively identify the needs of the community, assess and strengthen existing resources, initiate agency partnerships/collaborations, and implement a comprehensive plan that addressed nutrition disparities and resource gaps in areas of need. H.A.N.D.S. multifaceted approach seeks to implement system and environmental changes that increase availability and awareness of healthy food options, while creating an atmosphere that promotes positive lifestyle choices.

H.A.N.D.S. on Convenience: a healthy corner store pilot initiative that increases the availability of fresh produce and healthy snack options in rural convenience stores by increasing the stores' capacity to sell healthy options, providing nutrition education and in-store training/technical assistance that makes selling healthy options profitable.

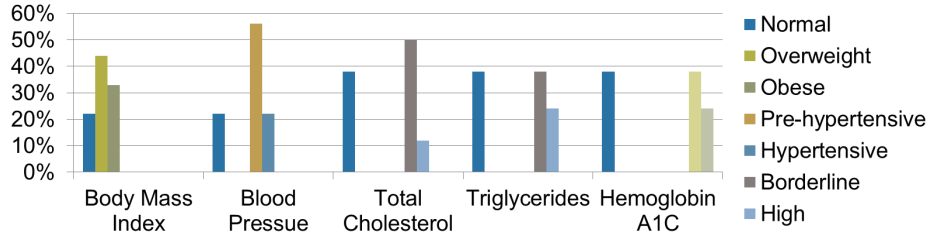
Outcomes:

•Healthy Corner Store Pilot Business Plan produced in partnership with the Office of Economic Development, Virginia Tech.

•2 stores increased their capacity to sell and market healthy options. Partnerships established between store owners, Virginia Cooperative Extension agents, local growers, and fresh food distributors in the region.

•Collaborations formed with extension agents, Virginia Foundation for Healthy Youth, and business experts to provide in-store training and technical assistance to make healthy changes profitable and sustainable long term.

•Partnered with Mount Rogers Health District's Wellness Team to provide health screenings to store owners and their employees. Of the 9 people tested, 75% had low Vitamin D levels, 3 had osteopenia, 2 men over 40 years old were referred to their physicians for high PSA levels, and 2 had abnormal thyroid levels. 6 out of 9 of the participants received referrals to the doctor for various medical reasons. Wellness screenings are the first of three offered to those enrolled in the Healthy Corner Store Network.



Contact:
Lakesha Butler, Health Educator | Lakesha.Butler@vdh.virginia.gov | 276-781-7450

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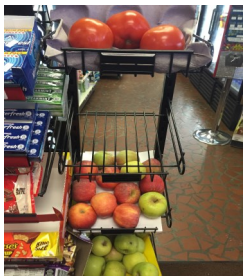

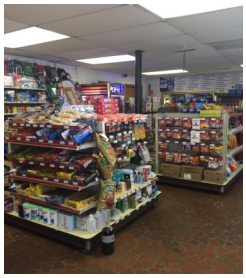

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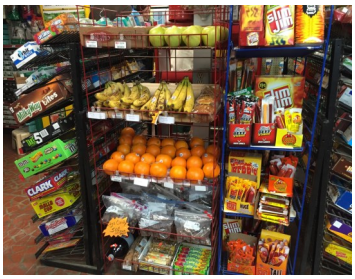


H.A.N.D.S. on Breastfeeding: an initiative that focuses on improving breastfeeding initiation and duration rates through system and environmental changes that support women where they work, play, and live.

Outcomes:

•4 lactation rooms sponsored by Twin County Prevention Coalition and Twin County Regional Hospital implemented in the local pediatric office and three school systems.

•4 festivals sponsored mobile breastfeeding stations potentially reaching over 3,000 women of childbearing age during the 3 months offered. Air conditioned mobile units were donated by Jeff Johnson RV Dealership and MRHD Wellness Team.

•15 agencies registered for the Building the Business Case for Breastfeeding training, held in partnership with the Twin County Prevention Coalition.

•Over 25 health professionals registered for the Certified Lactation Consultant Training held in partnership with the

H.A.N.D.S. on Farmers' Markets: an initiative that improves access and increases awareness of fresh locally grown foods in the Twin Counties.

Outcomes:

•Collaborated with VA Tech OED, Hillsville Town Manager, local extension agents, and farmers' market managers to develop a feasibility study of the regions farmers' markets, best practices, and funding resources to strengthen farmers' markets in the area.

•3 Market Managers attended the Farmers Market Manager meeting to discuss best practices and ways to strengthen market.

•6 local growers trained in Food Safety Best Practices for Market Growers, offered through Virginia Cooperative Extension.

•Linked farmers' market managers with community partners to establish clinical linkages and nutrition programming at the market.

•Collaborated with WIC and social services to disseminate targeted outreach and direct marketing to populations less likely to frequent market.

H.A.N.D.S. on Cooking Matters at the Store: provides community partners with the training and tools needed to equip those they serve with nutrition education and smart shopping skills to make healthier choices at the grocery store.

Outcomes:

•6 community organizations trained in the Cooking Matters at the Store curriculum, with the potential to reach approximately 71,505 people.

Tarrant County WIC

Fort Worth, Texas

COMMUNITY PARTNERSHIPS FOR HEALTHY MOTHERS AND CHILDREN

Breastfeeding Boot Camp

- Modified a successful training model from City of Dallas WIC
- Partnered with 2 local hospitals
  - John Peter Smith Hospital
  - Medical Center Arlington
- Over 750 staff from 2 hospitals will be trained during the pilot
- 6 modules with hands-on practice
- Training team hopes to expand the training in 2017

Participants rotate through 20 minute stations about:

- Skin to skin contact
- Latch and positioning
- Breast pumps
- Positive messaging
- Supplementation
- Hand expression

Participants discuss provider-bias and participate in role-play scenarios to utilize new concepts and skills

Fort Worth Community Food Access

- Partnered with Tarrant County Food Policy Council and Blue Zones Project Fort Worth
- Developed a local ordinance to allow for the sale of produce in public places and neighborhoods
  - Mobile fresh market
  - Produce push cart

Tarrant County Resource Guides

- Provide food assistance and chronic disease resource information for the public
- Extended version available for staff reference includes education and physical activity facilities, like parks and libraries
- Shared with partners to distribute as needed
- Highlight local service databases - Tarrant Cares and United Way's 2-1-1.

TARRANT CARES
one resource, countless solutions

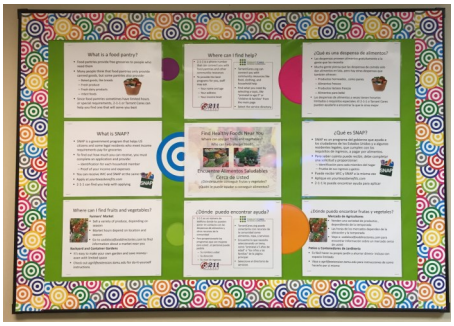
Call United Way 2-1-1™
Get Connected. Get Answers.

Tarrant County WIC

Amy Nelson, MS, RD - Project Coordinator
1101 S Main Street, Fort Worth, TX 76104
(817) 321-5436

Basic WIC Training

- Provided overview of benefits
  - Healthy foods
  - Nutrition education
  - Breastfeeding support
- Discussed eligibility
- Dispelled common misconceptions
- Provided training for hospital staff, including social work department



WIC Clinic Resource Displays

- Installed in lobbies or classrooms
- Provide resources for
  - Food assistance
  - Chronic disease programs
- Food access display highlights farmers' markets and home gardens
- Both highlight 2-1-1 and Tarrant Cares

Grocery Store Tours

- Developed a grocery store tour highlighting Blue Zones Foods, foods found to be commonly consumed in areas with long-living populations
- Tour utilizes the MyPlate icon to emphasize the importance of variety in the diet
- Students from TCU have also modified the training for tailored audiences, like individuals with diabetes
- The trainings will be implemented in three chain grocery stores in Fort Worth

Community Partners

Blue Zones Project Fort Worth

John Peter Smith Hospital

Medical Center Arlington

Tarrant Area Food Bank

Tarrant County Food Policy Council

Texas A&M AgriLife Extension

Lessons Learned

- There is a wide range of opportunities for WIC to partner with other organizations to promote community health
- Community involvement allows WIC staff to provide better resources to participants
- Duplication of efforts is greatly reduced when WIC partners with other organizations
- Impactful community health initiatives are not always expensive

Made possible with funding from the National WIC Association and the Centers for Disease Control and Prevention (CDC) and does not necessarily represent the views of CDC.

Date: _____

Prescription for Healthy Families of Oceana County

Patient Name: _____

Date of Birth: _____

Reason for Referral to WIC:

- ☐ Pregnant
- ☐ Breastfeeding
- ☐ Postpartum/Non-Lactating
- ☐ Infant
- ☐ Child age 1-5

Health Insurance

- ☐ Healthy Michigan/Medicaid
- ☐ Affordable Care Act/Marketplace

Nutrition Counseling with RD

- ☐ Gestational Diabetes
- ☐ High Blood Pressure
- ☐ Prematurity
- ☐ Other (please list)

Nutrition Education

- ☐ Prenatal
- ☐ Breastfeeding
- ☐ Infant Feeding
- ☐ Child Nutrition

Signature: _____

Name of Physicians Office: _____

Oceana County WIC Clinic- Hart
3986 N. Oceana Drive
Hart, MI, 49420
231-873-5813

Maternal Infant Health Program
3986 N. Oceana Drive
Hart, MI, 49420
616-873-2193

Michigan WIC Hotline
1-800-262-4784

Mason County WIC Clinic
916 Diana St.
Ludington, MI, 49431
231-316-8584

Shelby WIC Clinic
119 S. State St.
Shelby, MI, 49455
231-861-6349

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National WIC Association

THE COMMUNITY PARTNERSHIPS *for* HEALTHY MOTHERS and CHILDREN PROJECT

WIC's integration into the communities it serves, its strong community influence, and its existing partnerships with a diverse range of stakeholders make it uniquely positioned to drive broader social change. The Community Partnerships for Healthy Mothers and Children (CPHMC) Project is all about harnessing these WIC assets to improve community health beyond the clinic walls. During this 3-year cooperative agreement with the Centers for Disease Control and Prevention (CDC), the National WIC Association is partnering with 30 local WIC agencies to reduce and prevent chronic disease by improving access to healthy food environments and strengthening referral networks between WIC and other community providers.

www.greaterwithwic.org

Learn more about CPHMC by visiting our website: **www.greaterwithwic.org**. There, you will find an interactive map with all of our 30 CPHMC communities, local agency success stories, and much more!

ON SOCIAL

CPHMC is also on Twitter: **#Gr8rWithWIC**. Check out what partners have tweeted about our project!